# How DHBs are successfully reducing the use of seclusion

**In mental health and addiction (MHA) services, people who arrive at hospital in a distressed state are sometimes put into seclusion. Seclusion is traumatic and harmful for consumers, whānau, visitors and health workers. The Health Quality & Safety Commission's (the Commission's) goal is to work with district health boards (DHBs) to eliminate seclusion in MHA services.**

The Commission is supporting DHBs to find other ways to help people in distress, as alternatives to seclusion. This is being done using quality improvement methodology, with different tools being tested.

By using this quality improvement approach, we have learnt that effective ways to support people in distress include bringing them into a quiet space, actively listening to their concerns and needs, learning about what happened to them, discovering their triggers and what calms them, offering them food or a drink, and involving their whānau early on, and throughout if the person wishes.

Knowing about these other effective approaches mean people in distress can be supported in positive ways, achieving a reduction and eventual elimination of seclusion.

**We feature the experiences of six health professionals who have successfully reduced the use of seclusion in their DHB's MHA services.**

## Frazer Rangihuna, Auckland DHB

**Let me tell you a story, says Frazer Rangihuna (Ngāti Porou) a mental health nurse educator at Auckland DHB.**

"When I think about an example of a tangata whai i te ora (mental health consumer) who could easily have ended up in seclusion, my mind goes back four years to when a young Māori man was admitted. I'll call him Te Rangitāwaea. The handover I received from the crisis nurse included that he had paranoid schizophrenia, a history of polysubstance abuse, a forensic history (aggravated robbery, assault, property damage, wilful damage, threats to kill) and that he was gang affiliated."

Frazer says Te Rangitāwaea had also stopped his medication and was using large amounts of cannabis.

"His family said he was acting really paranoid, he was talking about people being after him, was carrying weapons in public for protection and staying up all night. Before he was admitted he assaulted a dairy owner, believing the person was trying to set him up."

Frazer says when Te Rangitāwaea arrived he was agitated and aggressive, but he quickly calmed down when the police left.

At a later date, Frazer gave the same handover about Te Rangitāwaea to a group of colleagues and asked them which information stood out for them in the handover, how this information made them feel and how they might prepare for his arrival.

"It wasn't surprising that some staff were anxious and scared about what they heard, whereas other colleagues were not fussed at all. However, it was concerning that restrictive practices such as medication, use of high numbers of male staff and the most restrictive practice of all, seclusion were suggested, and this was without even having met the tangata whai i te ora.

"I'd like to remind nurses to empathise, to think about what the journey has been like for the service user. Te Rangitāwaea says he was physically restrained by police and handcuffed then brought to the unit, so was it any wonder he was agitated and aggressive? I think we have a massive opportunity to reduce the use of seclusion if we empathise, especially on admissions when emotions are high. We need to take an intentional deep breath and be responsive rather than reactive."

Frazer says in order to reduce restrictive practices it's important to understand the consumer's triggers.

"Te Rangitāwaea was described as challenging, irritable, agitated and demanding when his needs weren't met."

However, Te Rangitāwaea's interpretation was that he felt controlled by staff who gave him ultimatums.

"He'd had enough of being controlled. From his father, to gang members, to the prison staff, prisoners, police and now nurses. He was sick of hearing 'you can't' all the time. It also made him angry when staff were 'fake' or expected him to suddenly be 'nice' after 22 years of being himself."

Frazer says he realised that being a stickler for enforcing the rules and not having any flexibility

**Frazer says in order to reduce restrictive practices it's important to understand the consumer's triggers.**

just inflamed the situation with Te Rangitāwaea so he started looking at his own behaviour.

"I looked at my own trauma history as a child and thought about the decisions I had made in my adult years to stop this trauma having any more control over me, such as not putting up with any abuse, threats or intimidation from anyone, and that I'd always have the last say. As you can imagine, this didn't work very well in practice! So, it is essential that we know ourselves, our triggers and how to manage our own behaviour."

Lastly, Frazer says it's crucial to speak up and support colleagues if you see they are stressed or not coping, to help create a culture where restrictive practices are an absolute last resort.

That culture change is happening, although there is still work to be done.

"We are making some good gains. We used to have three seclusion rooms, now we only have one room and zero seclusion is the aspirational goal at Auckland DHB. Staff need to be knowledgeable about least restrictive alternatives because soon, seclusion will simply not exist."

Frazer says steering away from restrictive practice is about engagement and whakawhanaungatanga or establishing links.

"You need to make connections with tangata whai i te ora and their whānau – no one knows what pushes a person's buttons better than whānau. Offer manākitanga by feeding people and being authentic – service users can really see if you're being fake. Trust service users to be able to self-soothe and treat them with kindness and you'll be less likely to need to worry about restrictive practices."

## Lesley Turner, Waitematā DHB

**Lesley Turner, a clinical improvement coordinator at Waitematā DHB, says throughout her work on the Commission-led zero seclusion project, she's learned that staff would prefer safe alternatives to seclusion.**

Committed to working towards zero seclusion, Lesley realised she had to focus on viable alternatives when discussing strategies with staff.

"The fear was about someone getting hurt and there was some hesitation about zero seclusion because of that fear. So, we started out with strategies that were low risk and easy to implement."

One of the first things the teams did was a co-design workshop with staff and tāngata whai i te ora to discuss experiences of seclusion.

"We brainstormed change ideas that would be easy to implement, to make tāngata whai i te ora feel more welcome, and help them to feel supported and safe when distressed. Things like painting chalkboards, more sensory equipment and board games. We also got everything fixed in the sensory room."

Another helpful thing several teams did was to create cardboard sensory boxes for tāngata whai i te ora with sweets, cotton wool with lavender oil, relaxation cards, teabags and a stress ball. The boxes were tested and items were added or removed after evaluation.

Lesley says these changes were helpful, but the biggest impact came from implementing more quality-of-life interventions such as outings, increased phone time and working with whānau within the regional forensic service to ensure they were available when called.

Her focus now is on processes.

"We're looking at learning from debriefs after seclusion events and identifying touch points throughout the seclusion process that might cause stress or ignite a flight or fright response, and how we can make improvements at each of these points," she says.

> **"It's so important to have whānau support. People aren't one dimensional, we need to treat the entire person and to do this with compassion and respect."**

Another helpful idea the team had was to create information sheets about the admissions process.

"People are calmer if they know what to expect and there are no surprises."

She advises anyone starting out to be sure to co-design a plan with tāngata whai i te ora.

"And to build staff awareness of what the seclusion experience is like. We all come in wanting to do our best but need to make sure we don't get stuck in rigid ways of doing things. I encourage staff to take time out and think 'Do we actually have to do things that way?'"

It's important to avoid finger-pointing or blame, she says.

"I let people know it's not about staff personally, it's about the processes we work within."

Lesley's team has also found implementing daily safety huddles useful within the adult mental health inpatient units.

"In the middle of each shift, staff meet to discuss each tāngata whai i te ora and check in on how they're doing and if any extra support is needed."

Tracking seclusion-free days serves as a constant reminder of the team's zero seclusion aspiration and, whenever there is a seclusion, a multidisciplinary team reviews the event and uses it as a chance to learn.

The teams now want to embed more cultural input across units and involve whānau in the admission process in the adult mental health inpatient teams.

"It's so important to have whānau support. People aren't one dimensional, we need to treat the entire person and to do this with compassion and respect," she says.

## Alan Witt, Northland DHB

**If you can walk into seclusion, you can be de-escalated, says Alan Witt, clinical nurse manager at the Tumanako inpatient unit at Whangarei Hospital.**

Alan started work at Tumanako in March 2020 and is proud to be helping his team minimise and work towards the eventual elimination of seclusion.

Having staff 'buy in' by including them in the vision is key, Alan says.

"If people are used to acting in a certain way, it's difficult to break that culture. You need education, role modelling, to be there for people to talk to." Alan says active learning is key, having teammates enable each other and model good behaviour. "We're busy, but if we want to enable best practice, we need to make the time."

Seclusion had traditionally been a last resort at Tumanako Hospital.

"It was used to provide a place of 'safety'. Particularly for violent people, or those at risk of self-harm. We know now that it's a punitive approach and we need to find different ways to de-escalate situations.

"Things like providing structure, and having more cultural input and education for staff can all help head off antisocial behaviour."

Alan says the use of safe practice and effective communication (SPEC), talking therapies and staged entries have all been useful.

> **"It can be mentally exhausting to keep up, forever role modelling, but it's worth it in the end."**

"It's not just a medical model – we bring in culturally appropriate people to negotiate with distressed clients. We provide more resource to enable better management. We encourage active intervention from whānau and from community teams."

Tumanako has a minimal stimulation lounge where consumers can have one-on-one support from staff.

"There's access to toilets and showers, to good kai and cups of tea. If patients want to talk, they can."

However, Alan says consumers who need to access the minimal stimulation lounge are often experiencing trauma.

"It's important to debrief after incidents and enable staff to go through the client experience. I take a group of staff members into the minimal stimulation lounge. We ask them to go into the room, lay on the floor and then we get them to go in as a team. The empathy goes up."

Alan can't over-emphasise the importance of supporting staff.

"It can be mentally exhausting to keep up, forever role modelling, but it's worth it in the end. We're not perfect, we're not where we need to be yet but it's an ongoing best practice model."

## Pauline McKay – Auckland DHB

**For Pauline McKay, a nursing director at Auckland DHB, the journey towards zero seclusion started a decade ago.**

The first step was adding tools to the team's nursing toolbox.

"We invested a lot in additional resources and training, including sensory modulation, an evidence-based practice used in mental health. It's about what alerts you and what calms you. We also employed a new restraint minimisation coordinator. She brought us all together as a steering group and we started working more closely with data," Pauline says.

When Pauline started, Auckland DHB had seven seclusion rooms and seclusion was being used for about 3000 hours each year. Now there is only one seclusion room and last year it was used for around 300 hours in total.

Pauline says celebrating success is important, as is having specific plans for consumers who have had a seclusion event in the past 12 months.

"That's about having an alert on their files and intervening earlier in the crisis. These aren't the people you want to wait in the emergency department becoming more distressed. They've had an experience that could have been traumatic and might not be as trusting of staff."

Looking for patterns as to when seclusions occur is also important.

> **"We had to show that if you reduced seclusion you wouldn't increase assaults. We had to distil that fear through staff engagement."**

"We've changed our after-hours staffing model to recognise that seclusion events most commonly occur outside of normal business hours," she says.

Pauline encourages staff to step back and look at the bigger picture, to take a moment to breathe,

pause and plan interventions, instead of being reactionary.

The culture around the use of seclusion is changing, she says.

"In the past if someone was behaving aggressively before admission, there would be conversations around getting the seclusion room ready – that doesn't happen anymore."

Pauline says it is important to continually reflect and debrief, particularly after a seclusion event occurs.

"One thing we've been focused on is looking at the data. What are the contributing factors that are common when seclusion has been used? One is showing a forensic history, another is methamphetamine use. We're working with staff to help them better understand what methamphetamine intoxication looks like."

Another helpful change came when the team looked at the model of care in the intensive care unit (ICU). Previously there were four different consultants looking after different people.

"That meant our patients had four different doctors looking after them, who might have four different practice styles. We've trialled having only one team in ICU, recognising it's a specialist area, and this has helped with quicker patient reviews."

Pauline says staff started off feeling quite uncertain about changes.

"We had to show that if you reduced seclusion you wouldn't increase assaults. We had to distil that fear through staff engagement."

Pauline's team have monthly meetings about the use of seclusion.

"We look at assaults, age, ethnicity, gender and the time of the day events happen. It's a rare event that we must learn from any time it does happen. We look at what was going on for both staff and the client. We're trying hard to find alternatives."

2020 hasn't been an easy time for the team.

**"One thing we've been focused on is looking at the data. What are the contributing factors that are common when seclusion has been used? One is showing a forensic history, another is methamphetamine use. We're working with staff to help them better understand what methamphetamine intoxication looks like."**

"We've seen a 60 percent increase in the need for beds over Covid-19, and most of this has been through the intensive care unit. To have so many admissions and such low levels of seclusion is an achievement in these challenging times."

Offering consumers a warm welcome has definitely helped, Pauline says.

"Often people have long delays prior to actually arriving in the units, they might be cold, tired and hungry. We offer blankets, hot food, access to wireless headphones."

Having experienced staff, who are often older and have mana is also helpful.

"We have a lot of grandmothers, kaumātua, but there's no instruction manual. We've done a lot informally."

Ultimately, Pauline says seclusion is traumatising for all involved, and empowering staff with alternatives is the best approach.

## Louise Martin, Auckland DHB

**When Louise Martin, a charge nurse manager at Auckland DHB, first started mentioning zero seclusion to her staff, she knew it was going to be a challenge and that she would have to go about things differently.**

"As a manager you must be prepared to take risks. Not in a sense of anything bad happening but in terms of your credibility.

"What I'd seen is people focusing on behaviours and behavioural interventions. That approach was not successful for us. We need to understand the nature of aggression differently. It's a culture change achieved by constant questioning, brainstorming and challenging ourselves."

Back in March 2018, Louise gathered her team to put up story boards and brainstorm different aspects of seclusion.

"We put categories up and got people to write down their emotions, thoughts and reactions prior to seclusions. I analysed lists of words. The words fear and anxiety were used three or four times more than any other words. Not control or punishment – it wasn't a power issue, it was fear of staff being hurt.

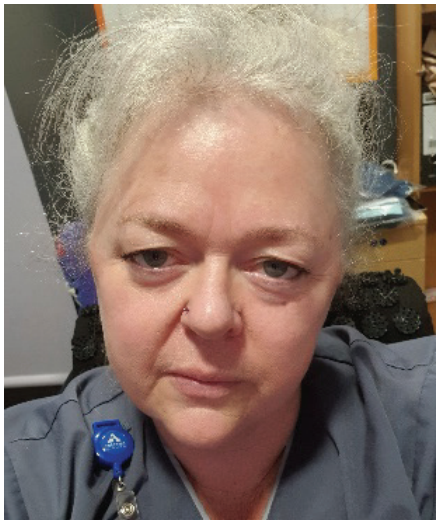
"What do you do when you don't want your staff to act out of fear? You empower them.

"If there is an assault, we encourage and support staff to make police reports, they can go during work time with taxi chits. Employee assistance programme services are offered every time.

"I take a rigorous approach to managing sick leave and annual leave. I make sure staff are properly paid for travel time, breaks, etc. It's small but it's a culture of compassion. I talk to my staff if they are off sick to see if it's a result of stress. There will be a robust discussion about how to manage the stress and what support we can offer."

Louise says staff expect to be treated in a way that honours their own mental health, and her staff retention rates are good.

Another important focus for Louise has been managing male staff.



> **"I say, seclusion numbers and times have decreased, assaults have come down. Assaults down, seclusion down – what conclusion can you draw? People had expected rates of assaults on staff to increase with using less seclusion, but the opposite has occurred."**

"I had a conversation with all male staff separately about their experiences relating to gender. They didn't come in to be enforcers, they were sensitive, caring men who were being put in front of patients who were in distressed states and expected to deal with most of the aggression themselves, and it was wearing them down. We ran some male supervision groups, talked through issues and gathered feedback."

Louise says the staff members most likely to calm a distressed person down are older females.

**"We examine our internal biases rigorously. I have 30 staff and 18 nationalities. We're hugely diverse. This ensures that no one single viewpoint is over-represented and encourages a range of conversations. We have a cultural support team and work hard to be inclusive and make sure everyone's done tikanga and Treaty training. It's visible to staff throughout our work."**

"If you offer kind care to a distressed person they soften. If you combine that with lots of food and sensory interventions, weighted blankets, lavender oil spray, you'll be much more successful."

She says removing any element of confrontation between male staff and male patients is vital.

"Particularly if a client is coming from the police cells with handcuffs on, we need to get those handcuffs off quickly. These things are obvious but take courage to implement."

Louise says constant staff feedback and role modelling are important.

"If staff are considering restrictive practices I say, 'Can you justify it?' They might say 'Well they have a history of this or that', but I question if the person is actually doing it now."

Louise suggests managers look at shift patterns to see if it is the same pairings of staff who are more inclined to use seclusion, and if this is the case, to put those people on different shifts.

Louise is proud of the low number of Māori secluded.

"We examine our internal biases rigorously. I have 30 staff and 18 nationalities. We're hugely diverse. This ensures that no one single viewpoint is over-represented and encourages a range of conversations. We have a cultural support team and work hard to be inclusive and make sure everyone's done tikanga and Treaty training. It's visible to staff throughout our work."

She encourages her staff to show empathy to the people they care for.

"It's easier to empathise with someone once you've looked them in the eye and had a conversation. I want staff to live the ADHB values of togetherness, aiming high, respect."

She also identifies staff willing to 'pick up the purpose' and works with them.

"I've got a group of staff who are reliable role models. I offer them support and encouragement wherever possible and we talk about how to empower ourselves so we have the strength to offer compassionate care."

She challenges her staff by showing them seclusion data.

"I say, seclusion numbers and times have decreased, assaults have come down. Assaults down, seclusion down – what conclusion can you draw? People had expected rates of assaults on staff to increase with using less seclusion, but the opposite has occurred."

Louise emphasises the importance of not just talking about reducing the use of seclusion but eliminating the conditions under which it's needed.

"Try and understand the journey that led the person to being in hospital in the first place," she says.

## Paula Mason, West Coast DHB

**For clinical nurse manager Paula Mason, a highlight in 2020 was the Manaakitanga inpatient unit at West Coast DHB celebrating 174 seclusion-free days.**

Paula has worked in mental health for more than 30 years, and has seen a shift in the way distressed people are managed when they are admitted.

"There was a culture 20 years ago in forensic services of every patient going into the seclusion area for assessment. I remember a time when we questioned, 'Is this the right way to be treating people?'"

However, as recently as 2017, seclusion was still routinely being used when Paula became involved in the Commission-led zero seclusion project.

"Even after considerable work and effort by the team, our seclusion rates had not really reduced. We had made environmental changes, increased safety and staffing, developed positive workplace cultural changes and increased awareness around zero seclusion.

"As a project team we said, 'What's going to make a difference?' We know seclusion events are preventable. We decided that each month we'd sit down as a team and review the patient's whole journey, including community care and the involvement of both the crisis team and the admitting team to see if there were opportunities to do things differently. All teams found there were opportunities to improve service delivery and outcomes."

When Paula's team celebrated 100+ seclusion-free days, they met to discuss what their 'stretch goal' would be and how they would manage if they did have a seclusion.

"We surveyed staff and tried to understand what they thought had shifted in our workplace culture, how safe and supported they felt, what the impact for them and for the patient was."

Staff said some relatively small things had made a big difference. Examples included providing an extra bed for whānau and being able to offer kai.


> **"We put these projects together, so we look at the whole journey – if we get the journey into and out of hospital right for patients, we're going to reduce distress and reduce seclusion and improve outcomes for our patients."**

Other things like weighted furniture, increased staffing and alarms have also helped staff to feel safer.

"We look at the patient's experience coming into our service – we are embedding the use of pōwhiri, making sure people feel welcome, safe, supported and whenever possible including whānau and having kaumātua present."

Being flexible is also key to reducing seclusion rates and Paula's team also celebrates what they call 'a good catch' when staff avert a potential seclusion event.

"Our 'good catches' are when there's been a tense situation where we've had to really negotiate,

*Paula's team's 174 seclusion-free day celebration*

and staff have worked hard to divert a negative outcome for everybody.

"We had an example when a patient booted his way out of the courtyard as he was incredibly distressed by his psychotic experience, screaming loudly. We nursed him in seclusion as at that time we could not safely contain him in the open ward. It was distressing for staff and other patients.

"He was recently readmitted, after his medication had been reduced and he was in the early stages of becoming unwell. We used top up oral medication and were able to nurse him on an open ward. The first three of four days he did yell but we worked with the other patients to understand that he wouldn't harm them. He has since been discharged. That's a fantastic outcome. He was quickly picked up before becoming acutely unwell, his stay in hospital was shorter, he was less distressed, and his life was less disrupted by his admission."

Other tips Paula has for avoiding seclusions include maintaining the consumer's dignity by not coming in with a huge team of people, introducing yourselves and being clear about who is involved in treatment. She says being able to provide an extra bed for a patient's partner or whānau member to stay is useful. Another important aspect is listening to the consumer voice.

"We have surveyed and provided consumers with one-on-one feedback opportunities to help us understand their perspective, which has proven to be extremely valuable."

Paula is the project lead for zero seclusion and the connecting care project, which is about inpatient discharge to the community team.

"We put these projects together, so we look at the whole journey – if we get the journey into and out of hospital right for patients, we're going to reduce distress and reduce seclusion and improve outcomes for our patients."

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