

Victorian Travelling Fellowship Fellow Project Report

Section 1: Project information

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Study area: Systems Improvement (Acute Adult Psychiatric intensive care)

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Title of project: *Psychiatric intensive care: developing an evidenced based, least restrictive model of inpatient care*

Fellowship study area:

The purpose of this project was to investigate a variety of best practice models of psychiatric intensive care. The Alfred Psychiatry Department will become the largest provider of psychiatric intensive care beds in Victoria and will have a role in providing specialist services to the state's mental health services and to patients with acute serious mental illness. In addition, of great interest is the Pennsylvania seclusion and restraint reduction initiative. A feature of their seclusion reduction strategy is the training '*Creating violence and coercion free mental health treatment environments*' and this was undertaken during the study tour. A number of consultations also explored various models across the UK. The chosen healthcare organisations visited were ones that had demonstrated achievements in caring for people with acute psychiatric illness in the least restrictive way. The consultations explored and provided opportunity to see first hand innovative clinical interventions, workforce development initiatives and the treatment environments themselves. The challenges in creating least restrictive models of care, whilst keeping patients and staff safe, were achieved in different ways across the UK and USA. The aims, for this international perspective, were to provide exposure to the range of approaches where new ideas and inspiration could be generated and to develop a model of care most suited to our Victorian healthcare context. The intensive investigation of a range of services has meant that an informed comparison can be made, and the most appropriate models and strategies can be adopted, which are sympathetic to health philosophy in Victoria as well as having proven efficacy.

Date of Report: 23rd June 2006.

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Section 2: Project summary

Top three outcomes:

- The inspirational efforts and achievements of mental health programs in the USA and UK in the area of seclusion and restraint reduction in acute psychiatric care settings has shown that better outcomes can be achieved in Victoria.
- That opportunity exists to learn from other programs' success and barriers in seclusion reduction. The learnings from these initiatives have identified six-core strategies fundamental in achieving least restrictive treatment environments for patients with severe mental illness.
- Development of an appreciation for strategies/prevention tools that assist the workforce in creating alternatives to restrictive interventions and observation of these approaches being translated/operationalised into the treatment environment.

Main activities undertaken

- Consulted with project managers, clinical leaders, leaders of change and clinical staff from 11 different healthcare organisations in the USA and UK.
- Undertook two day training in Boston, USA, that targeted staff working in adult acute mental health settings, titled 'Creating violence free and coercion free mental health treatment environments'.
- Visited targeted programs (with similarities to the Alfred Hospital Psychiatry) that have successfully reduced seclusion, in Massachusetts and the United Kingdom.
- Participated in a National Association of Psychiatric Intensive Care Units (NAPICU) clinical governance learning-set day, which included staff from seven psychiatric intensive care units (PICUs) across the UK.

Major learnings

- That it is possible to transform restrictive, coercive and rules orientated mental health treatment environments without significant additional resources.
- Reducing seclusion within an acute mental health treatment setting is possible.
- Successful seclusion reduction initiatives have in common six key success factors:
 1. leadership towards organisational change
 2. using data to inform practice
 3. workforce development
 4. use of seclusion reduction tool
 5. involving consumers in inpatient units
 6. debriefing techniques.
- Use of sensory modulation approaches in acute psychiatric settings is a useful intervention in the acute care context as one part of a seclusion reduction strategy.
- More emphasis should be placed on prevention of violence and aggression in order to reduce it.
- That a public health prevention model is a useful framework to consider seclusion reduction initiatives.

Lessons for the Victorian healthcare system

- The Victorian Travelling Fellowship is a very worthwhile activity on a variety of levels. It allows people to see first hand clinical innovation in practice. Things might not always be as they seem in an article or circumstances change rapidly from the time of writing the article and publication; what people perceive as being a key success factor in services might not necessarily be captured in an article; or perhaps the articles are not yet written. The fellowship

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gives the opportunity to consider service context, external factors such as policy, law, funding, workforce and other variables that may influence a program's success or otherwise.

- That with the recent identification of seclusion reduction in the Commonwealth National Safety priorities in Mental Health: A plan for reducing harm, 2005, there is an increasing need for mental health services to 'reduce use of seclusion and restraint wherever possible'. If system change is at the core of a project, it is important to start small, set realistic goals, have frequent review of the data, strong leadership, and allow at least three years to see meaningful results.
- The North American seclusion reduction experiences and six key success factors could be used as a framework for change for services in Victoria.
- That the Victorian healthcare system would benefit from the development of statewide standards and policy for the management and prevention of aggression in inpatient psychiatric settings. The National Institute for Clinical Excellence (NICE) Guidelines on the short-term management of disturbed/violent behaviour developed in the UK could be used as a reference.
- The development of comprehensive data systems could collect quality seclusion and restraint data from mental health services across Victoria.
- Further research activity into seclusion practices across Victoria is desperately needed to better understand its use.
- That the public health prevention model is a useful framework to consider seclusion reduction initiatives.
- Patients who have experienced seclusion and restraint are an influential force and have important testimonies regarding their experiences of these interventions. Their stories need to inform the treatment system, guide policy, and be part of training to staff in aggression management.

Feedback – key lessons learned

The Victorian Travelling Fellowship was a very productive and worthwhile experience. The support provided by my employer, the Alfred Hospital, and my professional senior, Mr Rod Mann, was invaluable. The support and encouragement aided in surviving the anxiety provoking stage between planning visits and receiving confirmation from overseas.

The use of an action plan was very helpful; while overseas I would often refer to it to ensure I was on track with my aims. I would recommend maintaining such an application process; it ensured that fellows maintained both a project specific focus while being mindful of the wider implications of the project.

Finally, I also received generous support from Paula Marsh, from the Victorian Travelling Fellowship Program, whose friendly and informative manner ensured that I could contact her with any concerns.

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Section 3: Description of study itinerary

This section has been subdivided into countries. First, each healthcare organisation, activities undertaken and key learning will be described.

United States of America

During the fellowship I visited three healthcare organisations in the Boston area, and also attended training there.

Training Boston, USA

Provided by the National Association of State Mental Health Program Directors (NASMHPD) Technical Assistance Centre (NTAC), Boston Massachusetts, '*Creating Violence free and coercion free mental health treatment environments for the reduction of seclusion and restraint*'.

- 300 participants attended from adult acute mental health treatment settings across the state of Massachusetts.
- The agenda included presentations from key people involved in the seclusion and restraint reduction initiatives across the state and country.

Day 1:

Included the following presentations: current assumptions regarding seclusion, the experience of seclusion and restraint, the neurobiological and psychological effects of trauma, leading organisational change, trauma informed care, elevating the importance of seclusion and restraint, identifying and managing seclusion and restraint risk factors, and real reduction experiences.

Day 2:

Included consumer roles in inpatient settings, workforce development, creating a culture of recovery for staff, seclusion and restraint prevention tools, debriefing activities, and developing a reduction plan.

Key learnings

1. The Pennsylvania seclusion and restraint reduction initiative

Pennsylvania's Department of Public Welfare's Office of Mental Health and Substance Abuse Services (OMHSAS) became the first public mental health system in the United States to publicly announce that its nine state mental health hospitals would strictly control and monitor use of seclusion and restraint and work aggressively toward their immediate reduction and ultimate elimination. They have been collecting information about individual restraints and seclusion since 1985. They found, from this information, that almost 50 per cent of the justifications for use of seclusion and restraint had nothing to do with behaviour posing an imminent threat of serious bodily harm to the patient or others. Instead they reflect attitudes characteristic of the prevailing hospital culture:

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1. 'The peace and order of the ward routine must be maintained'
2. 'People must learn that bad behaviour has consequences, therefore, punishment is necessary for effective treatment'
3. 'Staff are in control'.

In 1990, 93,553 hours of seclusion were used across the 15 state hospitals.

In early 1997 OMHSAS officially recognised the dangerous and dehumanising effects of seclusion and restraint. Under the leadership of Charles Curie it began an all out initiative to control and curtail these practices and the aspects of hospital culture that perpetuate their use. Pennsylvania became the first public mental health system to publicly announce that its nine state hospitals would strictly monitor and control use of seclusion and restraint and aggressively work towards their reduction and ultimate elimination. Mr Curie began by stating these measures are not treatment; they reflect treatment failure. By 1998, when the Hartford Courant brought the dangers of seclusion and restraint to the attention of the public, the media, standard setters, regulators and legislators, the reduction initiative was well underway and already demonstrating that the goal of significant reduction was safe and achievable.

In 2000, Pennsylvania received the Innovations in American Government Award – sponsored by Harvard University, the Centre for Excellence in Government and the Ford Foundation – for improving the quality and dignity of treatment for thousands of mental health consumers by significantly reducing seclusion and restraint in it's nine state hospitals. (S & R Training manual)

1.1 Pennsylvania mental health service context

Pennsylvania has nine state hospitals and an emphasis on community based care. Since 1995 the hospital patient population has been reduced by 33 per cent in a trend towards providing psychiatric care in the community.

The daily bed census indicates 2600 patients. Included in these numbers are three maximum-security forensic centres with a total of 200 beds. Over 26 per cent of the patients have been convicted of a crime prior to admission; 20-60 per cent has coexisting substance misuse problems.

The staff to patient ratio in the nine hospitals averages two staff, including admin and support personnel, for each patient.

There is approximately one psychiatrist for every 30 patients and the professional/non-professional nursing staff to patient ratio averages slightly less than one to one. It is estimated that 197,000 of its citizens live with a mental illness. (NETI S & R Training manual, 2006)

1.2 Pennsylvania seclusion and reduction (S&R) reduction outcomes

- In 1990 pre-reduction figures include 93,553 hours of seclusion were used across 15 hospitals in Pennsylvania.
- By 2001, the combined incident rates of seclusion and restraint have been reduced by 90 per cent per patient, 1000 bed days since the mid 1990's, while hours of use per 1000 patient days have declined by 95 per cent.
- Overall there has been a 90 per cent decrease in incidence and a 95 per cent decrease in hours of use of seclusion and restraint combined per 1000 bed days since 1993.
- In June 2001 with average daily census of 2580 civil and forensic patients, tallied 77,460 patient days in June 2001. Combined, the nine state hospitals used 29 hours and 48 minutes of mechanical restraint in June during 23 restraint incidents. The average restraint lasted one hour 18 minutes. (Hardenstine, 2003)

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With committed leadership, treatment and assessment innovations, policy changes and improved staff training, seclusion and restraint have successfully been reduced without increased staff or patient injuries, without increasing patient to staff ratio, and without increasing the cost to taxpayers.

The resources necessary include:

- access to computerised data collection and analysis
- organisational change strategies
- medications that target aggressive behaviour
- staff training in risk assessment, crisis prevention and intervention
- patient debriefing methods
- recovery based treatment models.

The Pennsylvania S&R initiative has worked. The initiative has made the state hospitals safer for patients and staff, reduced risk of patient and staff injuries, promoted more effective treatment, and offered patients greater dignity and control over their own lives.

1.3 Staff and patient safety

The most frequently asked question, or voiced concern about the Pennsylvania initiative, is that it is dangerous – staff and patients will get hurt and injury rates will rise. That has not been the experience in Pennsylvania. Data again was used to compare staff injury rates for the four years prior to the onset of the initiative with those for the four years since the initiative began.

- The rate of minor, assault related staff injuries (cuts, scrapes, bruises, contusions) with no lost time from work averaged 0.61 per 1000 bed days from 1993 through to 1996. There was no change between 1997 and 2000; the rate remained 0.61.
- The rate of disabling staff injuries (more than one day off work) declined from 0.12 injuries per 1000 patient days from 1993-1996 to less than 0.10 per 1000 patient bed days since 1997. (Hardenstine, 2003: 31)
- The hospital using the least seclusion and restraint in Pennsylvania over the last two years (a nearly seclusion and restraint free hospital) actually saw a 67 per cent decline in disabling injuries. Additionally, patient-to-patient injury rates have remained fairly stable at 1.5 per cent per 1000 bed days. (Hardenstine, 2003: 31)

1.3.1 Psychiatric emergency response teams (PERT)

Much of the success at reducing the use of restrictive procedures at Allentown State Hospital in Pennsylvania can be attributed to the use of psychiatric emergency response teams (PERT). PERT was created in response to the increased number of patient and staff injuries and lack of structure when handling psychiatric emergencies.

It is believed that an organised team response, in the use of all restrictive measures, would provide an added measure of safety for patients and staff alike. It was also thought that specialised training to select staff would promote cohesiveness among team members, which could enhance the quality of staff reaction to the emergency teams, consisting of all disciplines and led by a PERT captain. PERT captains are selected based upon their leadership ability, and working knowledge of the hospital and the PERT process. The captain makes the final decision for the approach needed. The role of PERT has evolved from one of assuring patient and staff safety to one that includes managing psychiatric emergencies in the least restrictive manner. The nurse's role has changed to have primary responsibility for monitoring the patient's health and safety during crisis. It is thought that this team approach has changed a hospital culture that depended upon the use of restrictive procedures as their first response to psychiatric emergencies to a culture that now uses these procedures as the last method of choice for managing these emergencies. Allentown now boasts the elimination of seclusion. PERT has shown that most challenging psychiatric emergencies can be safely managed through maximum use of positive, non-offensive verbal intervention skills with the

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most minimal use of hands-on measures. (Gregory Smith CEO Allentown state hospital training manual)

1.4 The Pennsylvania seclusion and restraint reduction initiative

Policy highlights

- 'That seclusion and restraint are not treatment, they reflect treatment failure.' (Curie 1997)
- Seclusion used for behavioural emergencies may only be used when the patient's behaviour presents an imminent danger of serious physical harm to the patient or others.
- Orders for seclusion must be made by a physician and may not exceed one hour. Reorders may also not exceed an hour.
- A physician must physically assess the patient within 30 minutes of the first order and each reorder.
- Persons in seclusion must be kept under face-to-face human observation.
- Use of pharmacological restraint is prohibited.
- All incidents are followed up by debriefings of the patient and staff involved in the incident.
- Extensive staff orientation and educational requirements involving crisis intervention techniques, alternatives to physical intervention, risk assessment and prevention skills, are defined in policy.

Testimony of Charles Curie, Administrator Substance Abuse and Mental Health Services Administration, US department of Health and Human Services, Pennsylvania.

This speech was delivered on the 25th February 2003 for the Senate Select Committee on Developmental Disabilities and Mental Health in California. It provides some useful insights into the Pennsylvania success. I have included some parts of this testimony in this report as it contains extremely useful insights into a successful seclusion and restraint reduction initiative. Charles Curie quoted specific conditions that must be met before systematic reduction and control of the incidence and the duration of seclusion and restraint can be successful.

He lists:

- The number of qualified staff must be adequate to meet patient treatment needs at the appropriate level of acuity.
- Staff training needs must be met, especially in the areas of verbal crisis management techniques and safe physical management.
- Regularly scheduled and meaningful treatment programs to help patients develop skills and abilities are needed for discharge.
- Active risk assessment and risk based planning must be in place.
- The availability of second-generation antipsychotic medications must increase.
- An environment of care that promotes patient comfort, dignity, privacy, and personal choice must be created.
- At the state level, aggregate data about each hospital's incidence and hours of seclusion should be collected and shared.

2. Successful reduction initiatives are characterised by six core strategies

2.1 Leadership and organisational change

- The seclusion and reduction initiatives reviewed during the travel fellowship in the Boston area and the examples provided in the Boston training were characterised by significant leadership from the respective Departments of Mental Health in Massachusetts and Pennsylvania. They were all top down strategies. The Departments of Mental Health, in both Massachusetts and

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Pennsylvania, had licensing and regulatory functions over mental health services, which gave them authority to promote and monitor organisational change.

- In order for treatment environments to be transformed from rules oriented, custodial, restrictive treatment environments with high usage of seclusion and restraint there needed to be a reframed paradigm of care.
- The Department of Mental Health and Substance Abuse in Pennsylvania communicated a set of new system values through their policy '*Use of restraints, seclusion and exclusion in state mental hospitals*'.
- The philosophy of care and value statements was framed and included statements such as:

'Seclusion and restraint may only be used as an intervention of last resort following a series of efforts by staff to promote less restrictive problem solving by the patient and used in emergency situations to prevent serious harm to self or others.'

'All clinical staff with a role of implementing restraint or seclusion must be trained and demonstrate competency in their proper and safe use.'

'All decisions to initiate seclusion and restraint shall be used based on assessment of the patient; assessments shall address history of sexual or physical abuse, violence history, and medical/psychiatric history pertinent to use of seclusion and restraint.'

'Seclusion shall not be initiated or maintained as a substitute for treatment, as punishment, or for the convenience of staff.'

'Leaders of hospitals, leaders of clinical departments and leaders of wards are held accountable at all times for the initiation and usage and termination of seclusion, restraint, and exclusion procedures.'

'Psychiatric advance care directives shall be referenced and utilised in the development of individualised plans to eliminate seclusion and restraints.'
(NETI S&R Training manual, 2006)

2.2 Using data to inform practice

- The Pennsylvania seclusion and restraint reduction initiative referred to the collection of data as the performance management system. This was a state-wide initiative to benchmark critical indicators that contribute to patient risk and patient outcomes. Incidence and duration of seclusion and restraint use were among the first of many indicators tracked in Pennsylvania. The system allowed them to objectively compare and contrast the performance of every hospital.
- The Pennsylvania data was risk adjusted per 1000 patient bed-days to permit the comparison among large and small facilities, and to accurately measure comparable performance over time, even as the hospital census decreased as the S&R initiative occurred during the downsizing of state hospitals and the development of community based care. The sharing of the performance data on seclusion and restraint use gave notice to the public in Pennsylvania that they were willing to be publicly accountable for the success of their reduction goals.

Along with the collection of data related to S&R was the development of a risk management incident reporting system. The system has capacity to document events such as incidence and duration of seclusion and restraint, medication errors, incidents of assault, adverse drug reactions, patients absent without leave, patient injuries sustained and a host of other risk laden events in the context of precipitating events, time, location, staff involvement, demographic and clinical information. The system also permits monitoring of PRN and STAT medications associated with aggressive incidents and seclusion or restraint use. The system prompts and documents post incident debriefing, treatment team review and corrective actions.

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2.3 Workforce development

The training provided was an example of a workforce development initiative driven by the Department of Mental Health in Massachusetts. Significant written information and verbal presentations were provided to staff. The S&R reduction tools, how to develop a reduction plan, how to achieve cultural changes and leadership were very clearly explained. The use of patient testimonies was a powerful way of conveying the consumer perspective and the need for systems to be more traumas informed.

Skills around verbal de-escalation, risk assessment, identifying triggers, trauma informed assessment, public health prevention model, and reduction experiences were all features of the training.

2.4 Use of seclusion reduction tools

2.4.1 Rationale: why reduce?

Much information was provided about the rationale for reducing these restrictive interventions with many patient testimonies made available.

- First is the recognition that seclusion is not treatment but constitutes an emergency intervention that reflects an overall failure of the treatment system to meet the needs of the person.
- Second there is considerable risk associated with its use. Serious injuries, even death, have been associated with its use. (Allen 1998)
- Third, individuals being secluded almost invariably experience this as psychologically stressful even terrifying, and the staff involved also may experience similar experiences.
- Seclusion is thus traumatising and for those already traumatised – potentially re-traumatising. (NETI, 2003) More and more consumers, families and oversight bodies view a program's use of restrictive procedures as reflecting an underlying deficit based treatment philosophy and the limitations of its clinical practices.
- There is a wealth of research that demonstrates that physical force, bodily immobilisation, and isolation inherent in the practice of seclusion and restraint are dehumanising treatment options. (Curie 2002)

2.4.2 Public health prevention model

The public health prevention model is recognised as one of the major underpinning approaches that has contributed to the success of Pennsylvania.

There are three different levels of prevention – primary, secondary, and tertiary prevention.

Primary prevention involves creating circumstances that prevent the onset of problems for an entire population. So primary prevention also occurs when the structure and climate of a setting, such as an acute psychiatric setting, is organised so as to meet the needs of the population and to create a sense of wellbeing, respect and trust. In this way, there is prevention of the potential for re-traumatisation.

Secondary prevention involves responding to at risk individuals within a group or population, prior to the onset of serious problems. In treatment settings, it is the early identification and response by staff to the distressed person that often determines the success of the secondary prevention effort.

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Tertiary prevention involves treatment of an identified disorder but such treatment is also preventative in terms of containing the problem, preventing co-morbidity, improving function and capacity.

At all the above levels, prevention is based on an ecological model that includes adult, family, and the goal is to understand as much about each of these variables as possible so that prevention and intervention can reduce risk factors and promote protective factors. (Greenberg et al pp3-4)

2.4.3 Seclusion and restraint reduction programs and primary prevention model

Primary prevention:

- creating culture, climate, clinical knowledge base, and therapeutic relationships in order to prevent crises
- meet the needs of the person proactively, and to avoid need for coercion and restrictive procedures
- wellness approaches both individual and group based
- use of screening and de-escalation tools on admission or shortly after.

Secondary prevention:

- responding to crises or imminent crises through use of relationships and de-escalation approaches in order to prevent escalation and need for restrictive procedures, including restraint and seclusion
- early intervention, warning sign identification, avoidance of power struggles and coercive responses
- maintaining a soothing environment
- responding immediately to any signs of conflict, disruption to the milieu, or changes in behaviour indicating distress
- a focus on strengths and positive intentions.

Tertiary prevention:

- terminating a restrictive procedure – where it has become necessary as a last resort to preserve safety – as soon as feasible, and learning from the incident, to benefit patient, staff and program.

Prevention comes through the learning and debriefing process that follow discontinuation of the restrictive procedure. The restrictive intervention is implemented for the shortest necessary interval. The person is told clearly of the criteria for its discontinuation.

Along with the theoretical underpinnings of seclusion reduction comes the practical clinical tools for assessment and management of acutely disturbed patients. Organisations were issued with tools and training to assist them with S&R reduction initiatives.

Tools included:

- checklist to promote positive therapeutic culture (Gordon Hodas MD)
- checklist for assessing your organisations readiness for reducing seclusion and restraint (David Colton, PhD)
- two-day training: *Creating violence and coercion free mental health treatment environments* National Association of State Mental Health program directors National Technical Assistance Centre for State Mental Health Planning
- Checklist for interviewing and assessing violent tendencies (adapted from: Fishkind, A. 2002)
- trauma assessment for adults (adapted from the Trauma Assessment for Adults-Self Report version (Resnick, Best, Kilpatrick, Freddy, & Falsetti 1993)
- the ten commandments of de-escalation. (excerpted from Fishkind, 2002, and adapted by K. Huckshorn)

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Many of the programs I visited were using crisis prevention tools, referred to as safety tools, de-escalation plans, or advance care plans, to identify triggers and strategies prior to escalation, so crisis may be averted or minimised. (Carmen et al, 1996; Jonikas et al; LeBel et al., 2004)

Risk assessment and treatment of risk factors

Uniform risk assessment was an early and essential element in the seclusion and restraint reduction initiative. In 1997, a risk assessment tool was developed to help treatment teams become more aware of the historic and current behaviours of each patient that pose a risk of harm to themselves or others.

Based on recent violent prediction research, such as the McArthur studies on mental illness and violent behaviour, the assessment tool provides a complete history of each patient's assaultive, self-injurious, criminal, and substance abuse behaviours. It also encourages treatment staff to identify the internal precipitants and external situations that triggers high-risk behaviours. Treatment planning can subsequently focus on helping patients identify triggers to aggression and how to avoid or better manage situations that provoke high risk responses. Treatment interventions now target the specific behaviours likely to require the use of seclusion and restraint from the moment the patient is admitted. (Hardenstine, 2003)

2.4.4 Sensory approaches in inpatient psychiatric settings

Reducing seclusion and restraint requires innovative methods to facilitate the processes of consumer self-organisation, self-care, and positive change. Sensory-based approaches and multi-sensory rooms are useful resources as cultures of care shift to become more collaborative and responsive.

Sensorimotor approaches in psychiatry

The brain seeks information primarily by directing individuals to look, listen, smell, touch and taste. (Freeman 1991; Thelen & Smith, 2000)

Examples of common activities using the five sensory systems include:

1. watching fish in a tank (sight)
 2. smelling lavender (smell)
 3. squeezing a stress ball (touch)
 4. eating salty, sour, sweet foods (taste)
 5. listening to classical music (sound).
- It is important to note that the experience is usually multimodal, involving both sensory and motor systems (Thelen & Smith 2000). For example, watching clouds or looking at a lava lamp involves eye movements and their perceptual consequences, which create a spatial map in the brain. Although one may focus on a primary source of sensation coming from one sensory system, or a combination of several, the function is a dynamic, integrated process between the sensory and motor systems. Thus, most of the forms of stimulation and sensory based activities promoted for use in psychiatric settings involve sensorimotor activities.
 - Wilbarger (1984) coined the term 'sensory diet' and this refers to the preferred sensorimotor experiences that help an individual function optimally within their environments. People modify their sensory diets automatically throughout the day without necessarily being conscious of doing so.
 - People with mental illness, or addictions, or who have developed problematic behaviour patterns, are sometimes unaware of their particular sensory needs or stress responses. (Champagne, 2003)
 - Multiple opportunities exist for staff in psychiatric settings to help individuals understand and participate in the development of a sensory diet. Developing a sensory diet includes identifying certain experiences or activities that help ground, calm, centre, and/or alert individuals to a process called self-organisation. (Champagne 2003) For example exercising, cleaning, moving

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furniture, performing isometrics, and chewing gum are examples of sensorimotor activities that are performed against resistance.

- Occupational therapists commonly use brushing, joint compression, and weight in acute psychiatric settings. The Wilbarger protocol is one type of brushing protocol in which a trained practitioner applies firm pressure, touch and exerts rapid brushing strokes with a soft surgical brush to the arms hands and legs, followed by joint compression to these areas.
- Weighted blankets are common and used frequently in acute adult psychiatric settings across Massachusetts.
- These techniques have proven to be helpful in conjunction with counselling, pharmacology for patients with depression, self-injurious behaviour, anxiety and mania. (Champaigne 2004)
- Each person's sensory diet is an important self-organising concept and needs to be considered in the identification of individual crisis prevention strategies for use at critical times. (Champaigne)

2.4.5 Multi-sensory treatment rooms

- Jan Hulsegge and Ad Verheul at the Hartenberg institute in the Netherlands developed the first multi-sensory room in 1975. These environments were initially created for people with profound physical and mental limitations and were referred to as 'snoezelen' (Hulsegge & Verheul, 1987). Over the last 20 years, occupational therapists have been creating treatment spaces filled with equipment necessary for implementing a combination of directive and nondirective sensory-based therapeutic exchanges.
- Multi-sensory environments are currently being used in a variety of psychiatric facilities with different age groups and populations. Since 1999, in collaboration with occupational therapists, many adult psychiatric units have begun developing sensory rooms, and currently, use of these rooms is growing in trend nationwide. (Champaigne 2003) In 2002, the majority of inpatient child and adolescent programs in Massachusetts began to develop sensory rooms in response to an initiative led by the Commonwealth of Massachusetts Department of Mental Health aimed at preventing the use of seclusion and restraint.
- Although few published research studies have evaluated the effectiveness of multi-sensory treatment rooms, one study demonstrated that the therapeutic exchanges occurring within these rooms were effective in reducing maladaptive and stereotypical behaviours. (Hutchinson & Haggar, 1991)
- These rooms, sometimes also called comfort rooms, are used for individual and group sessions and offer a combination of sensorimotor activities, with calming and alerting options for each of the sensory areas.
- The South Florida state hospital set up comfort rooms, which were formerly called a timeout room. They defined it as 'a room that provides sanctuary from stress, and/or can be a place for persons to experience feelings within acceptable boundaries'. It was set up to be physically comfortable and pleasing to the eye, included a recliner chair, walls with soft colours, murals (images to be the choice of persons served on each unit) and colourful curtains. The room had a comfort box which contained items used by patients such as stuffed animal, reading material, blanket wrap, and headphones for listening to music.

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Multi-sensory room in the Adult Psychiatric Ward, Cooley Dickinson Hospital Northampton, Massachusetts.

2.5. Involving consumers

The seclusion and restraint reduction initiatives in North America have had several secondary, but very positive, outcomes for consumers.

- The S&R reduction initiative requires that staff pay systematic attention to the specific precipitants and contexts of assaultative and self-injurious behaviour
- The S&R reduction initiative also forces staff to help the consumer to creatively resolve or avoid such situations.
- Intensive internal and external attention to each incident of seclusion encourages the focus of state-wide resources on those few patients for whom treatment processes are as yet unsuccessful, rather than relegating these patients to a continuous cycle of aggression, seclusion and restraint. Risk of injury, death, and psychological trauma to patients has been reduced accordingly.
- The initiative also encourages staff to identify and remedy environmental factors, like arbitrary ward rules for staff convenience rather than patient safety or treatment efficacy. Staff are also required to pay closer attention to medication efficacy and patient satisfaction.
- There is a theme of consumer partnership in treatment that permeates the S&R reduction initiative.

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- Consumers teach staff what works.
- Staff are required to listen harder and seriously consider what consumers tell staff about their feelings, wishes and frustrations.
- Patient risk assessment, patient debriefing, patient input into treatment programming, and patient choices about how to live their daily lives.

This initiative has required staff to create a partnership with patients and actively engage them in the treatment process rather than rely on physical force and coercion to control patients. This participation has transformed their role from one of powerlessness to one of partnership with staff.

2.6 Debriefing techniques

Patient and staff debriefing after each incident of seclusion and restraint was a core feature of the Pennsylvania initiative.

- In 1996, one Pennsylvania hospital conducted a study of the validity and value of the debriefing process. The study, which surveyed consumers following incidents of seclusion or restraint, found that 87 per cent of respondents were able to suggest ways they could have better managed the events culminating in seclusion and restraint. In addition, 91 per cent made recommendations for staff interventions and responses that might have altered the outcome.
- Debriefing after the incident, when the patient is calm but the incident is fresh, has five primary objectives:
 1. assist the patient to identify the precipitant of the event, and suggest methods of more safely and constructively responding to the event, or of avoiding it
 2. assist staff to understand the precipitants and develop alternative methods of helping the patient avoid or to cope with such events
 3. provide an opportunity for both patients and staff to assess the appropriateness and efficacy of staff response during the emergency, and attend to the patient's feelings and perceptions of the seclusion or restraint use
 4. help treatment staff devise treatment interventions to address the root cause of the incident and its consequences, and to modify the treatment plan
 5. help to assess whether the intervention was necessary, and whether it was implemented in a manner consistent with staff training and hospital policies. (Hardenstine, 2003:25)
- Many of the hospitals in Pennsylvania used clinical management staff, who do not work on the treatment team, as mediators during each seclusion and restraint debriefing. This tactic puts focus on identifying and solving problems rather than placing blame and escalating conflict. In several hospitals the CEO, or another senior manager with excellent people skills, performs the mediator role. Such management mediation has the added benefit of reinforcing the seriousness with which seclusion and restraint are regarded.

Trauma informed systems of care

The training emphasised that acute psychiatric settings need to provide 'trauma sensitive care'. This refers to care that recognises the phenomenon and consequences of trauma. The key goals include promoting wellness and a therapeutic experience for the person, preventing crisis, and intervening early at the signs of a problem. A key principle is the avoidance of coercion, both physical and verbal, in favour of approaches that promote partnership and build on the strengths, needs and treatment plan. Trauma informed care is based on the public health concepts of prevention and strengths-based beliefs and practices.

Potential barriers to a trauma informed program:

- lack of attention to organisational culture and the need for organisational change
- lack of adequate skill sets for direct care staff, based on insufficient training, supervision and oversight
- lack of adequate response to the trauma histories and experiences of persons served
- lack of awareness of the potential impact of each clinician – positive and negative. One study in the use of coercion in acute psychiatric settings found that more than half of the crises were

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precipitated by overly controlling, unnecessary behaviour of staff. Crises were iatrogenic (Russel Hughes, 2002)

- a program overly concerned with rules and procedures
- a prevailing belief that we are doing this already saps motivation and creates disincentives for staff to advocate for change, or think creatively
- programs that don't allow sufficient staff to patient contact time.

Primary prevention steps to create trauma informed system of care:

- a clear statement from program leadership that identifies the commitment to trauma informed, non-violent, healing, and therapeutic milieu
- a willingness on the part of leadership to examine and change program culture and practices
- efforts to make the treatment environment appealing and culturally competent
- use of screening and de-escalation tools.

Widden Unit, Cambridge Health Alliance, Cambridge Massachusetts

Profile: Acute inpatient unit part of a large general hospital in Cambridge. Locked, 20-bed unit.

Activity: Spent the morning in the unit with the Unit Manager, Leslie, who involved me in a ward round meeting with the consultant psychiatrist, senior nurse, nurse manager, social worker and occupational therapist. Patients attended with their families. This time gave me a sense of the patient population and management approaches used in this setting. I also observed a stress management group conducted by a stand-up comic and toured the facility.

Learnings/key approaches:

- use of the safety tool important as an aggression prevention strategy
- group program for patients a significant part of the treatment approaches.

Faulkner Hospital

Profile: General Hospital in Boston with 2 20 bed adult psychiatric units.

Activity:

- PowerPoint presentation, Elaine Hazleton re: reduction plan and numbers.
- Met with Kevin Donnelly, Nurse Manager.
- Looked at the sensory work being done, cart and sensory room.
- Reviewed guidelines for use of sensory room and cart.

Learnings:

- That there needs to be guidelines for staff and patients regarding the use of the sensory cart, such as, available for 1:1 sessions and groups, staff should always supervise the cart, education should be provided to staff regarding items on the cart.
- Theraputty (a kind of modeling clay) is useful and broadly used for management of anxiety, anger and for grounding.
- Fleece weighted blankets, and other items on the sensory cart need to have a procedure for use, maintenance, and good infection control practices.

Cooley Dickinson Hospital, Northampton, Massachusetts

Profile: Cooley Dickinson is a general hospital in Northampton, with a locked 20-bed psychiatric unit situated within it. It provides short-term multidisciplinary care with an average length of stay of 10 days. The behavioural health unit is one of the leaders in the creation and implementation of nurturing, sensory supportive treatment approaches. This includes offering the latest in evaluation

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tools, integrative therapies, sensory modulation and sensory rooms. These approaches are collaborative, meaningful, trauma informed, and sensory supportive. Integrative therapies include:

- clinical aromatherapy
- pet therapy
- light therapy
- music and sound therapy
- art therapy
- brushing protocols
- humour therapy
- creative writing
- movement therapy.

The purpose of this visit was to meet with Tina Champaigne, an Occupational Therapist with expertise in sensory approaches in psychiatry.

Activity: Spent the afternoon with Tina discussing sensory approaches in psychiatry. Viewed the sensory room and sensory cart. Discussed code SAM (sensory approaches and methods) policy across the hospital and its benefits.

Key approaches: Code SAM

Purpose: The Cooley Dickinson hospital has established a systems approach, which aids individuals anywhere in the hospital who are experiencing extreme emotional stress that may lead to dangerous behaviours associated with self inflicting harm or physical injury to others. As with other emergency codes in the hospital, this team is alerted to rapidly respond to such individuals by using advanced therapeutic, facilitative, approaches to help prevent, divert or decrease escalating patient behaviours.

As with others codes in the hospital, the code SAM is an emergency response that hospital staff can call to their unit for immediate assistance to prevent dangerous or unsafe behaviours. The nurse calling the code makes a judgement to use the team intervention to prevent a patient from harming themselves or others. If behaviours are too dangerous or happening too quickly a code orange is called. The code SAM is used when the patient is not dangerously acting out. The code SAM is utilised to help to facilitate self-organisation when patients appear to be in the anxiety and defensive levels, as defined by the crisis development model. It's an opportunity for specifically trained staff to offer a variety of skilled approaches and expertise to all parts of the hospital. Ultimately, this will facilitate a hospital-wide interdisciplinary, interdepartmental and person-centred model of crisis prevention, intervention and care. There belief is that this will help decrease the need for the use of seclusion and restraint and increase continuity of care across departments.

The code SAM cart: This is like an emergency trolley but filled with items that could be used by patients to assist in calming and regaining control. Items include TV/VCR, CDs, diversional bin with Game Boys, magazines, puzzles, deck of cards, crayons, weighted blanket, and bins for some different sensory area's: smell, taste, tactile, visual. It is thought that when a person escalates up the stress continuum the intensity of the stimulation needs to either decrease or increase. Facilitating a change with self-soothing techniques, diversional activities, or environmental modifications are all considerations for the code SAM team.

Training for staff provided many practical examples of what interventions to use for different levels of anxiety. For example:

- Calm and pre-anxiety levels: preventative-supervision and assistance. The training suggests staff use themselves therapeutically and in collaboration with the patient to maintain a calm state.
They suggest:
Do not ignore the person, build rapport assess what helps the person to maintain a calm state and to prevent anxiety; active listening by helping the person identify potential sources of

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stress and preventative strategies; and monitor emotional cognitive, behavioural, and physical signs and symptoms.

Tina Champagne and Alison Berryman, both Occupational Therapists, have initiated the code SAM program at Cooley Dickinson Hospital. This initiative formed part of their overall reduction in seclusion and restraint plan. It is the belief of the hospital and the Massachusetts Department of Mental Health 'that most patient restraint and seclusion can be prevented if meaningful therapeutic interventions are applied before the patient reaches the acting out stage of behavioural escalation'. (Code SAM training manual, 2005)

The crisis development model and neuro-dynamic perspective are the theoretical underpinnings of the code SAM project.

Cooley Dickinson has chosen the Crisis Prevention Institute, Inc. (CPI) as the non-violence, crisis intervention, staff training program provided to employees. The CPI crisis development model suggests a series of recognisable behaviours that staff members can use as a guide to help them through the process of establishing therapeutic rapport with an individual before, during and after a crisis, and as a guide for structuring staff debriefings. They also use the therapeutic, facilitative approach, which refers to the skilled and responsible therapeutic rapport building necessary to facilitate a shift in an individual's dynamic crisis state. They believe the therapeutic use of self is a clinician's most valuable tool.

The neuro-dynamic perspective refers to the way our brain seeks information and directs us to look, listen, smell, taste, and touch. (Stromberg, Freeman, Thelen & Smith, 2000)

Learnings:

- the public health primary prevention model drives reduction activities
- code SAM system
- the enormous potential sensory modulation strategies have in acute psychiatry in Victoria
- how the strategies are applied, use of the safety tool, sensory cart, code SAM and sensory assessment, weighted blankets
- the potential occupational therapists have in psychiatry to develop expertise in this area.

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England

Goodmeys Hospital, Pathways PICU

Profile: This service was attractive as the Director, Stephen Periera, is the President of the National Association of PICU. Pathways PICU has a three star rating and has done some innovative partnership work with patients.

- 15-bed (four female, eleven male) PICU locked adult psychiatric intensive care unit. Separate areas for males and females but joint dining, smoking, and laundry area
- nursing staff profile: 22 EFT, five nurses (D, E, F, G grades) five AM, five PM and four ND
- combination of RNs and support workers
- F/T psychologist, OT, plus an O/T assistant
- art therapist comes in once a week
- social worker refers to, not based in the unit
- average length of stay is six weeks.

Activity:

- Attended ward round, tour of unit, meeting with the unit manager, and Consultant, Dr Pereira.
- Given psychiatric intensive care text, ward policies and assessment tools.
- NICE guidelines emphasised as underpinning practice.

Learnings/key approaches:

- Assessment process thorough and rigorous, which enabled accurate and timely understanding of patient risks and needs.
- Staffing numbers are important in PICUs, literature links reduced seclusion with high staff/patient ratios.
- Training in control and restraint can lead to a reduction in violent behaviour and injury as staff has greater confidence enabling them to diffuse situations before they escalate (Gold Award 1976, Lion 1977 cited in Pereira et al 2001:226)
- Structure in the ward environment is important to contain and facilitate meaningful engagement. Group program initially appeared rigid and demanding for patients but offered a range of positive activities from tai chi to reflexology.
- Partnership forum process positive. Conducted twice a month with patients and staff aimed at responding to service user concerns and initiating service improvements where possible.

Wotton Lawn Hospital, Grey Friars PICU and Montpellier Low Secure Unit, Gloucester

Profile:

- Two PICUs (Grey Friars and Barnsley).
- Grey Friars and Barnsley units are both six-bed, nurse led, PICUs, the only ones in the UK
- Staff profile: 20.5 nursing EFT, 75 per cent registered nurses, all health care assistants are trained for six months; four staff on AM/PM shift, three at night.
- 1 F/T OT across both PICUs.
- As a nurse-led service, each PICU works with all the clinical teams within each hospital, with admitted patients retaining their responsible medical officer during admission. The consultant nurse has overall clinical responsibility for both PICUs.
- Average length of stay in Grey Friars PICU is 20 days, 29 for Barnsley. 80 per cent of admissions are under Mental Health Act. PICUs have had two episodes of seclusion in six years

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- Members of the PICU teams are part of the Executive Committee for the National Association for Psychiatric Intensive Care (NAPICU). Members of the team have published and are proactive leaders in this field.

Activity:

- Spent the day with Roland Dix, Editor of the Journal of Psychiatric Intensive Care. Roland's role at the hospital is the Consultant Nurse, Psychiatric Intensive Care Units.
- Obtained and discussed some key documents; the national minimal standards for psychiatric intensive care and low secure environments; new book chapter on seclusion psychiatric intensive care text, risk assessment process.

Learnings:

- Set up travel diary on the NAPICU website with Alan Metherall.
- Workforce numbers and training needs thoughtful consideration in establishing a PICU. See London survey of PICU document for guidance (Pereira et al 2005: 7-15). If looking at nurse to patient ratios in PICU, Roland suggests one nurse to two patients.
- Services need to account for varying attitudes of staff, the need to monitor the effects of staffing levels, and the perceptions of race and age. In addition, accurate levels of all patient behaviours and ward environment factors that preceded seclusion must be kept and regularly reviewed.
- Seclusion book chapter with literature review discussed with author Roland Dix. The debate about seclusion and how to understand the arguments was discussed. The moral, consequentiality and treatment arguments are reviewed.
- The majority of patients perceive seclusion as a negative experience. Much of the evidence for positive effects can be questioned in terms of scientific rigor (Whittington and Mason 1995)
- During a year long study in the US across 82 medical centres, the primary reason for the use of seclusion was 'disturbing the ward environment', not necessarily violent behaviour itself. Closely followed was patient agitation, physical and verbal aggression. (Betemps et al 1993 cited in Pereira et al 2001: 138)
- There is a correlation between staff attitude, ward culture and the frequency of seclusion. Tolerance levels towards disturbed behaviour, anxiety levels, the need to control behaviour because of low staffing levels, as well as the perceptions of the therapeutic benefits of seclusion, were all highly significant. (Gerlock and Solomons, 1983)

The Tarn PICU, Oxleas Mental Health Trust

Profile: The Tarn PICU is 15 beds, of mixed gender.

Activity:

- Spent the day with Chris Naikin, Nurse Unit Manager, PICU.
- Met with Psychologist, Hanne Jakobsen.

Learnings:

- Nurse protected time* for engagement with patients is a useful initiative. Allows nurses time away from non-direct care activities to spend more time in direct care activities. Nurses complete a daily patient engagement and involvement form, which maps out activities for the day. Rationale is to provide structured activity and engagement with patients.
- Risk assessment is thorough.

Northumberland, Tyne and Wear NHS Trust, Newcastle

Profile: St Georges Park is a large stand-alone psychiatric hospital within the trust. It has a 10 bed PICU, Stephenson Court, on site.

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Activity:

- Met with Harry Cape, Practice Development Nurse, and Marc House, Management of Violence and Aggression Coordinator.
- Visit to St Georges Park. Les Stewart, Project Manager, showed me around a new £200 million, purpose built psychiatric facility.
- Many photos taken of the treatment environment fixtures and fittings.

Learnings:

- Standardised training in aggression management is essential for mental health services. Variation in providers creates inconsistency in practice and training emphasis.
- Train-the-trainer model used across UK, with accredited trainers and training for staff of five days is comprehensive.
- Incident reporting is key for every incident involving physical interventions, by way of understanding how to prevent further incidence of violence and for staff to develop reflective capacity.

Kimble Unit, Amersham Hospital Buckinghamshire Mental Health Trust:

Profile: Kimble Unit is a locked, 10-bed PICU. It provides a seclusion suite and a de-escalation room. This is a mixed sex unit that has designated lounge area for female patients. The unit accepts referrals from inpatient wards at the Hale Care Unit, Amersham, the Tindal Unit, and Aylesbury.

Activity: Spent the morning with a consultant psychiatrist looking over the unit and participating in a ward round.

Learnings:

- Risk screening and assessment are comprehensive and important to assist the person to prevent aggression and identify triggers for crisis escalation.
- It's acknowledged that the best clinical risk assessment procedures cannot prevent something from going wrong, but the key issue is that whilst we cannot eliminate risk various systems can be implemented to reduce risk.
- Dr Stephen Pereira and Dr Lipsedge have identified ten important, multidisciplinary skills to assist risk management in a PICU.
 1. initiate, communicate, and develop rapport and a caring relationship with the patient
 2. listen effectively and communicate early
 3. learn to identify verbal and non-verbal cues
 4. write concise, easily understood and legible notes
 5. validate perceptions
 6. create a therapeutic milieu by individual and collective participation in programmes
 7. develop easily available and understood risk management plans
 8. pay attention to personal and professional development
 9. ask for help in managing difficult situations
 10. be aware of negative attitudes towards patients, environmental stressors and examine own coping strategies.
- Accessed and discussed the UK-wide development and use of the NICE guidelines for managing acutely disturbed or violent behaviour.

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Ladywell Unit, South London, and Maudsley Trust, Lewisham

Profile: Stand alone psychiatric inpatient unit with PICU and country's only triage ward. It has two adult admission wards, all locked.

Activity: Spent the day with the nursing director and manager of PICU. Explored the group program for patients and their nurse protected time policy.

Learnings:

- Organised activity with patients facilitates engagement and is highly valued within this organisation.
- Unorganised and unpredictable activity can lead to increased rates of aggression and violence in psychiatric wards.

Huntercombe Hospital, Roe Hampton

Profile: A private, 39-bed locked, mental health inpatient treatment facility. Three wards PICU, low, secure, and high dependency. Male and female patient wards. All patients admitted are under the Mental Health Act. The National Health Service (NHS) funds the beds for public patients.

Activity: Spent the day with Iqbal Gomally and Andy Johnston. The purpose of visit was to look at the physical environment, as it's considered a benchmark for other services. Andy Johnstone is the key NAPICU contact, and see a private hospital.

Learnings:

- Environment is important when developing a model of care it has a powerful impact in patient care.
- Safety requirements often create harsh and barren clinical environments. There are many ways to add warmth and comfort to these settings.

Section 4: Improving the Victorian healthcare system

What impact will the study have on your own work practice?

Individually, it has affirmed that my current workplace has supportive and strong leadership, and great capacity for system change.

I have developed confidence that mental health treatment environments can operate without restrictive interventions such as seclusion, and without additional resources. I now view seclusion differently than before my fellowship. I now support the notion that seclusion and restraint practices are indicators of treatment system failure, are trauma inducing for patients and need to be reduced and ultimately abolished within mental health treatment environments.

I will energetically pursue opportunities within my own workplace, now and in future, to work with others to seek alternatives to these restrictive practices and advocate for a mental health treatment environment that is violence and coercion free. Whilst major long-term shifts are required to achieve this end, there are many things that can be done immediately, particularly within the environment, to create a more hopeful and positive paradigm.

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I will continue to review every incident of seclusion in my workplace, as nurse manager, but now within a prevention framework, exploring every opportunity to assist the patient and staff to find alternatives to these restrictive interventions.

What impact will it have on your organisation?

Being awarded a travel fellowship in itself has had a positive impact on the organisation. Sharing with the team that others around the world experience similar issues and challenges and have found creative solutions has created a great deal of inspiration for change. Optimism has developed within the team that seclusion reduction is possible that wasn't previously evident.

The USA initiatives, particularly the Pennsylvania seclusion reduction achievements, will raise important questions for our organisation to consider. I hope the knowledge acquired regarding these successful initiatives will inspire us to work towards this longer-term objective.

In the long term the fellowship findings will contribute and help shape the development of our model of care for the new expanded psychiatric intensive care unit.

Next steps for local service improvement

The next steps are:

- To continue with the dissemination of information. I want to saturate the workplace with the findings and provide as much information to people as possible to reflect upon.
- Disseminate this report within the organisation and table at the Alfred Psychiatry Acute Program Committee for discussion and planned action.
- Collate the last five years of seclusion data to better understand our current use. Disseminate quarterly reports.
- Hope to develop a seclusion reduction plan for the acute program with realistic, short and long-term goals.
- Improve our risk assessment and management practices to include a public health prevention approach. Use of sensory strategies in the acute care setting to be considered for further development.
- Develop an education initiative around seclusion reduction tools and public health prevention model.

What steps have you undertaken in the short to medium term to improve the Victorian health care system?

I have already begun sharing my experiences and findings within my own organisation and more broadly to staff from other organisations. The timing of my fellowship with recent national mental health policy identifying the need for mental health services to reduce seclusion has been useful. The momentum is building within the Victorian health care system to more proactively address these restrictive practices within mental health treatment settings.

I hope, in the short to medium term, to assist in maintaining this momentum through disseminating the information broadly within the Victorian health care system. I have the opportunity to do this through two conference presentations later in the year and more recently as a guest speaker at the Centre for Psychiatric Nursing and Research and Practice's (University of Melbourne) inaugural seclusion working group on my fellowship findings. This dissemination improves the health care system by spreading inspiration for change, providing information regarding strategies that have worked to reduce restrictive interventions, and creates confidence in

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the system of success, and also helps support and raises awareness within the system of the broader Commonwealth agenda.

I am committed in the medium term to participating in further research into seclusion. A joint initiative between the Alfred and Forensicare services has already been explored with plans to develop further.

Factors that would facilitate and block introduction of these factors

Facilitate:

- supportive and strong leadership
- positive organisational culture
- adequate resources
- research expertise and support
- consumer involvement and voice.

Block:

- serious incidents involving staff injury
- inadequate workforce training and support
- change in leadership
- lack of published research evidence into the reduction initiatives.

I have a positive view that, over time, greater awareness of successful seclusion and restraint reduction initiatives will inspire and promote change across the Victorian healthcare system. There is increasing momentum across the world to reduce the use of restrictive interventions within mental health treatment environments.

Section 5: Sharing and promoting the project

I have undertaken and plan to undertake the following activities to share and promote the project.

- Formal presentation at a dinner meeting 18th May 2006, which allowed me to present the information to my colleagues in the acute program at Alfred Psychiatry.
- Informal evening presentation for ward staff scheduled for 28th June 2006.
- Formal presentation to both ward team meetings.
- Formal presentation, as invited guest speaker, at the inaugural Centre for Psychiatric Nursing Research and Practice (CPNRP) Seclusion Forum at the University of Melbourne 16th June 2006.
- The fourth activity was a written article for the Carillon magazine on the Victorian Travelling Fellowship experience.
- Abstract accepted for a conference in October this year. The Australia and New Zealand College of Mental Health Nurses Conference in Alice Springs.
- Abstract accepted for a conference in Melbourne in September this year. The Psychiatric Nursing Collaborative Conference. Presenting information related to the seclusion and restraint reduction initiatives in the USA.
- Formal presentation at the Alfred Hospital Grand Round in July.
- Write a journal article about my observations in the USA and UK.
- Provide a brief report to the international hosts to share the outcomes of the fellowship.
- Contributed an article to the Centre for Psychiatric Nursing Research and Practices Carillon magazine.
- Guest speaker for the opening of the first Psychiatric Nursing Journal Club for the Wangaratta Mental Health Service in July.

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