AUT

Comparing efforts across jurisdictions in assisting mental health services toward elimination of restrictive practices: Two case studies

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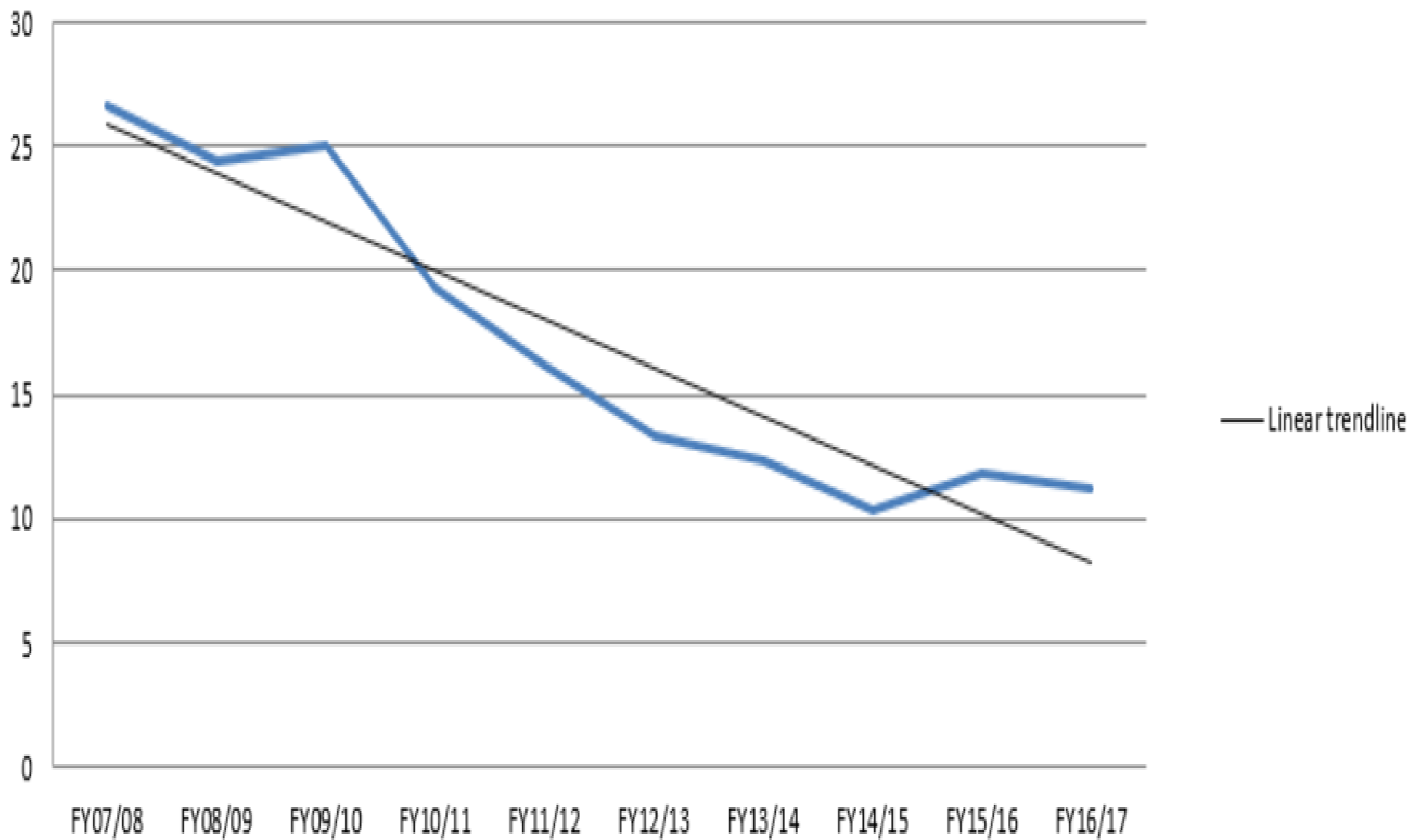
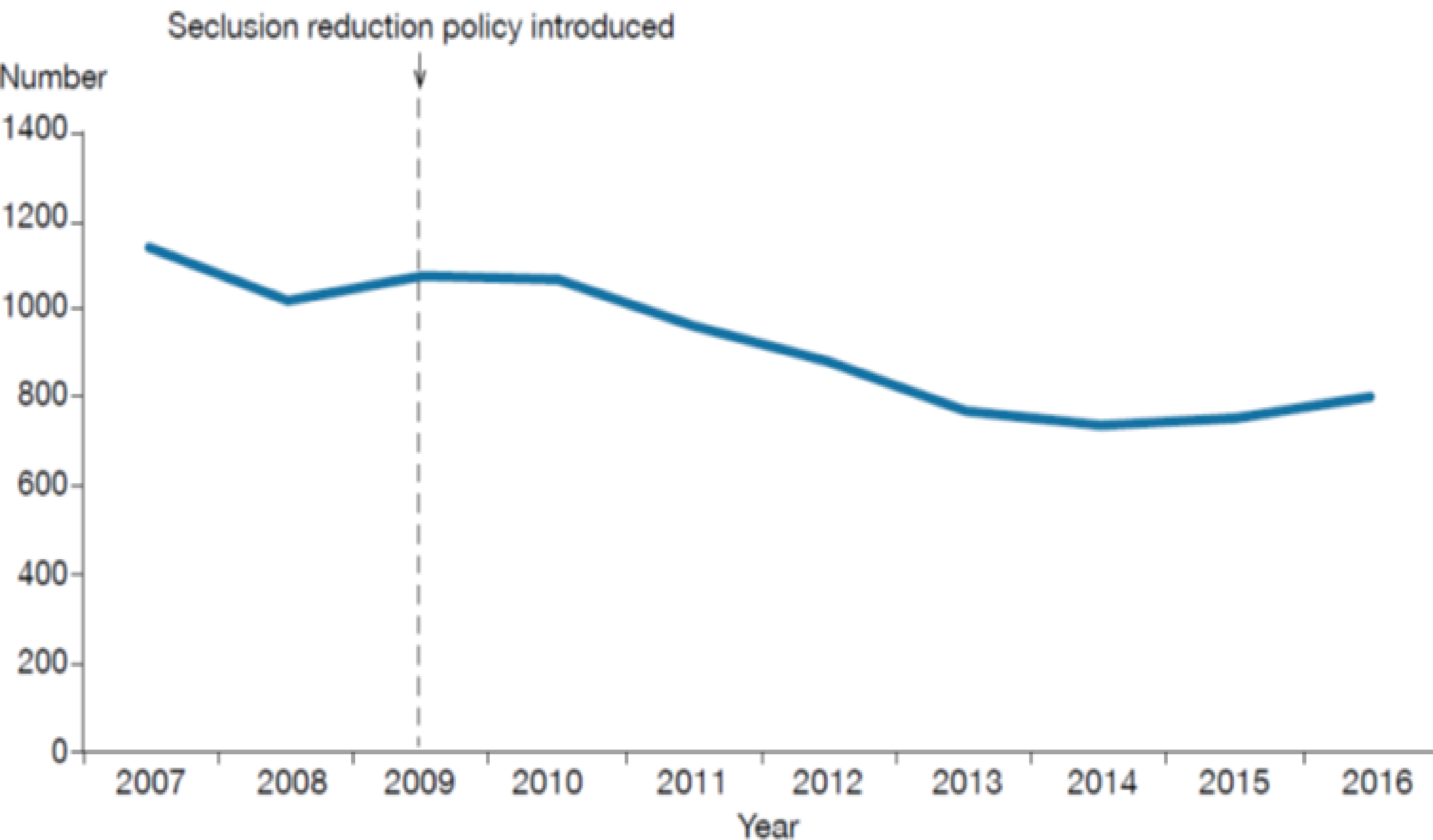
- Leadership
- Use of data
- Workforce development
- Evidence based interventions
- Peer support workforce
- Debriefing

- Department of Health and Human Services
  (Victoria)
- Te Pou o Te Whakaaro Nui
  (NZ)
- Both >10 years

Victoria:
Seclusion - episodes per 1,000 occupied bed days.



New Zealand: Number of people secluded in adult inpatient services, 2007–2016



Source: Office of the Director of Mental Health annual reports 2007–2015 and PRIMHD data for 2016, extracted on 27 July 2017. Auckland and Southern DHBs supplied data manually

- How TERP developed in each organisation ?
- How area mental health services have responded?
- Best practice approach by combining.

- **Development**
- Interviews with key leaders in each organisation
- (Victoria, n = 10; NZ , n = 6).
- **Responses**
- Interviews with the person responsible for TERP in area mental health services
- (Victoria, n = 21; NZ, n = 20).
- Thematic analysis

- 2007
- Teaching resource based on the Six Core Strategies.
- Nursing leadership took over.
- Recovery-based framework + Mental Health Act 2014.
- The use of data.
- Reducing Restrictive Interventions Project.
- More recent
  - OCMHN + OCP.
  - Consumer and carer expertise
  - Collaborative approach services
  - ED, prevention, Safewards.

We put some good governance and structures and systems in place, to underpin the management of aggression, but also demystify that for people.

(Rural service)

There are various different ways we monitor. We look at the data that we send to the DHHS monthly. When we've identified there's been some not good practice or slippage in practice we've now started to monitor… We're also reporting to the Department any patient who has been in seclusion for a long duration of time.

(Director of Nursing)

Every ward's got a dedicated sensory room…. They are quite well utilised … our well- known consumers now come in and on admission they'll say "Can I please have the wombat", or "Can I please have the weighted blanket".

(Metropolitan service)

- Safewards – evidence based model of care

- ***We did employ a consumer and a carer peer in one of our acute units, which had the highest rates of seclusion and restraint. And they worked, full-time on the inpatient unit, and worked directly with staff and with consumers and carers around what's most helpful for them, and provided a different type of support to people really. And we saw the rates of restrictive interventions plummet within weeks.***

- **(Metropolitan service)**

- Drug induced psychosis
- Indigenous

- ***Just having that direct line and being able to access them, I think, yeah, it’s what’s valuable. The face-to-face or even phone call. It’s having that capacity to talk it through at a level where you’ve got a really good level of experience and understanding of the framework.***
- **(Rural service)**

- Safewards – resources and resourcing

- 2008 seclusion only
- Teaching resources based on the SCS.
- 2010- Six Core Strategies.
- Co-production.
- “Working with the willing”
- Emphasis on Māori
- Supported physical restraint preventative training .

I think the biggest change has been senior management have taken it on board to drive seclusion reduction. Senior leadership have come together and put strategies in place and supported those processes.

(South Island rural DHB)

- ***The data that we collect shows us where we are at in terms of numbers, whether there's trending up or down, it's one way we can monitor where we are at with seclusion reduction. (North Island metropolitan DHB)***

Staff have a culture of 'what else can we put into place.' This might mean de-escalation, or use of our developed sensory modulation area, in lieu of the use of seclusion. All those steps are used first.

(South Island metropolitan DHB)

- ***For two years, we had two consumer advisors, plus a family advisor….embedded within our team, including spending time with every person, so that we could get some constructive and helpful feedback. When that contract got put out, we've had absolutely minimal consumer engagement since.***

- ***(North Island rural DHB)***

- Methamphetamine and synthetic cannabis
- Indigenous – aware but limited strategic planning.

- ***We wouldn’t be as far as we are without the Te Pou input and resources, and guidance from Te Pou. That’s kind of been the foundation of the work that we’ve done and Te Pou has been crucial.***

(South Island rural DHB)

- Six Core strategies - upfront and transparent.
- Every strategy given equal weight.
- Best practice interventions include models of care e.g. Safewards.
- Focus on all restrictive practices.
- Adapt SCS for vulnerable population.
- Co-production with consumers, carers and clinicians.
- Genuine partnership and empowering proactive engagement.

- ***I see it as going from strength to strength with a continued push to reduce restrictive interventions and the contact that we get from the (institutions). Like getting that tap on the shoulder and being made accountable. If that dropped off, I would have a legitimate concern that we would fall back on old practices.***

- Don’t take your foot off the throttle.