



Zero seclusion: Safety and dignity for all – change package

**Aukatia te noho punanga: Noho haumanu, tū rangatira mō
te tokomaha – mōkī aroha**

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**Te Kāwanatanga
o Aotearoa**
New Zealand Government

Te Tāhū Hauora
Health Quality & Safety
Commission



Solitary confinement | Noho mauhere

Seclude me into silence,
break my spirit today.
Lock me in that bare cell,
take my humanity away.
Yes, I'm so, so angry,
I'm about to explode!
No longer can I manage, life's unmanageable load.
Or welcome me and love me,
listen to my distress.
Soothe me and respect me,
help me work out this mess.
Don't fear me; but hear me,
I'm a human being too!
End seclusion forever,
you know, it's the right thing to do!

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(Endorsed by the Consumer Advisory Group)

Acknowledgements and thanks | Ngā whakamihi

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Zero seclusion consumer advocates: Penelope Jane Saunders-Francis, Suzie Baird, Synthia Dash, Martin Burke, Fiona Perry, Dianne Black, Johnnie Potiki, Rana Aston, Caro Swanson.

Māori Advisory Group: Guy Baker, Jason Haitana, Joanne Henare, Johnnie Potiki, Aaryn Niuapu, Dean Rangihuna, Millie Berryman, Robbie Walker, Adrienne Rangimokai Fruean

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Background | Kōrero o mua

The idea of gathering and integrating clinical and cultural interventions into a [change package](#) developed while the mental health and addiction quality improvement programme team at Te Tāhū Hauora Health Quality & Safety Commission (Te Tāhū Hauora) was working with Zero seclusion project teams in the then-district health boards (DHBs). This work included national workshops, online sessions and on-site visits to mental health and addiction (MHA) services.¹

It was during on-site visits in May and June 2021 that our team confirmed seclusion rates were falling. This was gratifying but not unexpected as the mid-point evaluation of the MHA quality improvement programme had shown that in July 2020 five DHBs had already given signals of a reduction in their seclusion rates.²

We identified successful clinical and cultural interventions (change ideas) that project teams had been working on and integrated these into the MHA quality improvement programme's Treaty of Waitangi Health Equity Framework³ and Māori cultural driver diagram.⁴ MHA service staff, consumers and whānau have co-designed and developed these successful elements. They have also used the scientific methodology of the Institute for Healthcare Improvement's Collaborative Model for Achieving Breakthrough Improvement⁵ to test the effectiveness of each intervention.

Te Tiriti o Waitangi overarches the programme. This means the programme forms strong partnerships and shares care with Māori, upholding the articles and principles of Te Tiriti. These articles and principles are contained in the Treaty of Waitangi Health Equity Framework developed under the guidance of the Māori Advisory Group. The Framework is the starting point for the bicultural service approach, accurate collection and analysis of inequity data, co-designed care decisions that include consumers and whānau, and the use of the Institute of Healthcare Improvement's quality improvement methodology to deliver safe, effective health outcomes.

Our [clinical bundle](#) and [cultural kete](#) include some words about the values and behaviours expected of health workers in acute and intensive care units. We cannot overestimate the importance of compassion and patience, a calm manner and a kindly attitude when working with highly distressed consumers and whānau. Indeed, the success of the change idea that employs older women, 'The Aunties', is based on this approach and has contributed markedly to the trend towards de-escalating and reducing seclusion. The kete also contains a list and brief description of the Māori workers who are responsible for carrying out this mahi (work).

In a series of online and face-to-face hui, we tested the change package contents, the change ideas and interventions, and built our understanding of their relevance in the mental health and addiction and quality improvement culture and in the infrastructure of the overall programme. We invited members of the following groups to provide feedback and contribute their unique perspectives: Zero seclusion project teams from 19 DHBs, Māori Advisory Group, Consumer and Whānau Advisory Group and the Zero Seclusion Champions Group. All of these groups provided guidance across the overall project.

In 2023, the Consumer and Whānau Advisory Group collated the change ideas related to consumer involvement in the improvement effort. Like the clinical bundle and cultural kete, these change ideas have been used by various teams across the country. The collated

change ideas resulted in a set of strategies, which we have shown as a driver diagram in the [consumer kit](#) section of this change package. This adds to our approach of using different methods and improving practices in MHA quality improvement.

MHA providers seeking guidance on eliminating seclusion can use the consumer kit to support consumers in their services. It can also be used by the growing consumer workforce involved in the consumer/peer support/service user/lived experience or mātau ā-wheako workforce.

While the consumer kit did not go through the same formal process as the rest of the change ideas, the national programme team discussed it with our Consumer and Whānau Advisory Group and a national association of mental health service users. We also gathered input from the Drua Pasifika Consumer and Family Experience Network and the Te Tāhū Hauora Māori Advisory Group.

Zero seclusion change package | Mōkī aroha

The Zero seclusion change package is an evidence-based set of interventions that aim to improve the experience of care for tāngata whaiora while moving towards the goal of zero seclusion. Our change package is aligned to the Six Core Strategies,⁶ which is an evidence-based approach and globally recognised tool in reducing seclusion.

When the change package is implemented, Zero seclusion project teams will have wider access to effective holistic Māori cultural interventions and mātauranga Māori change ideas, as well as Western clinical interventions. The beliefs and needs of other cultures and vulnerable populations are also referenced.

Purpose of the change package

The purpose of this package is to gather, define and describe successful interventions that will contribute to improving health outcomes and health equity and reducing the use of seclusion in mental health inpatient units. The package includes mātauranga Māori change ideas and Western clinical interventions.

Our change package is a coaching tool and resource for Zero seclusion project teams as they plan, design, test and apply the evidence-informed practices in their local environments. When they use and apply the package effectively, teams can expect to achieve breakthrough improvement and gain the ability to spread their learning across the health system as appropriate to help with system-wide improvement.

The change package consists of four distinct parts.

1. **Driver diagram** illustrates the main drivers in the system.
2. **Change ideas** include clinical and cultural evidence-informed interventions and practices.
3. **Measures** lists possible measures for recording progress.
4. **Learning system** lists tools for testing plan–do–study–act (PDSA) cycles, reporting progress and creating a plan to hold gains.

How to use this change package

We encourage multidisciplinary team leads and clinical leads, with their teams, and Māori mental health providers to review the change package to determine:

- what practices might already be in place in their area and whether further work is needed
- which changes the team will undertake and what improvements these changes will lead to
- what other changes they may need to make later.

In addition, teams should make a point of using a formal improvement method such as the Model for Improvement to guide their improvement work. This model is a simple but powerful tool for accelerating improvement.

The Model for Improvement

The Model for Improvement provides a framework to structure improvement efforts. It was originally developed by Associates in Process Improvement (www.apiweb.org) to provide the best chance of achieving goals and adopting ideas.⁷ The model is based on three key questions, known as the thinking components.

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What change can we make that will result in improvement?

These questions are then used together with small-scale testing of change concepts. The 'doing' component is known as the PDSA cycle, which Figure 1 outlines.

Figure 1: The plan–do–study–act (PDSA) cycle



Acknowledgement: Deming WE. 2018. *The New Economics for Industry, Government, Education* (3rd edition). MIT Press.

Zero seclusion driver diagram

The Zero seclusion driver diagram provides an overview of key practices in inpatient MHA services and describes the elements that need to be in place to improve the experience of care for tāngata whaiora by reducing and ultimately eliminating seclusion in all inpatient MHA settings. The Commission and Zero seclusion project teams developed the driver diagram based on:

- the best evidence available
- learning from testing
- key areas that senior leaders and frontline staff could have an impact on
- the Six Core Strategies⁸ service review tool, which is embedded within the primary drivers.

Primary drivers within a driver diagram are high-level ideas that, if implemented, will achieve the improvement aim. The best way of implementing primary drivers is to identify a series of actions (secondary drivers) that will contribute to the primary drivers and in turn help to achieve the aim.

Aim

The Programme will aim to reduce seclusion rates in both Māori and non-Māori/non-Pacific population groups in mental health and addiction adult unit inpatient settings to less than 3 percent by 1 June 2025, working towards the goal of health equity and ultimately zero seclusion.

Primary drivers

- Effective leadership for cultural and organisational change
- Using data to support improvement and equity
- Workforce development
- Equitable care provision that is person-, family- and whānau-centred
- Proactive care and seclusion reduction interventions
- Quality-designed system

Secondary drivers

- Kāwanatanga – shared decision-making
- Evidence of a quality culture
- Planning for sustainability
- Data dashboard – using local data including on ethnicity
- Stories
- Process measures
- Standardisation
- Cultural competency
- Quality improvement expertise
- Peer support, kaiāwhina
- Growth of Māori workforce
- Kindness, compassion – cultural bundle
- Including whānau in care provision
- Establishing healing relationships
- Whanaungatanga
- Wairuatanga
- Clinical bundle and cultural kete
- Effective pathways
- System thinking and sustainability
- Facilities – new builds

Interventions

- Co-leadership – governance model
- Equity plan: unconscious bias and institutional racism training
- Māori non-governmental organisation (NGO) shared care commissioning
- Regular meetings with chief executive, sponsors, MHA and Māori service
- Collecting and analysing ethnicity data
- After-hours cultural support, including through emergency department (ED)
- Police liaison
- Emergency department liaison
- After-hours peer support available
- Individualised plan of care
- Safety huddles
- Allowing whānau to self-refer to community teams
- Welcoming processes including pōwhiri
- After-hours activities
- Whānau part of care team
- Reducing unnecessary restrictions
- Increasing access to meaningful activities
- Incorporating kaupapa Māori concepts
- Sensory modulation including cultural pack
- Individualised plans
- Providing nicotine replacement therapy before admission
- Debriefing
- Predictive plans
- Early treatments
- Visual data – project displays
- Aunties' de-escalation coercion-less technique

Change concepts and change ideas

A change concept is a general notion or approach to change that has been found to be useful in developing specific ideas for changes that lead to improvement. A **change idea** is an action that is expressed as a specific example of how a particular change concept can be applied in practice. It is an evidence-informed activity that leads to improvement within a system.

Zero seclusion clinical bundle | Mōkī haumanu

The Zero seclusion clinical bundle does not contain the entire range of clinical change ideas. What it does include are those change ideas that the groups consulted have identified as contributing significantly to a reduction in seclusion and inequity.

Some of the change ideas in the clinical bundle are similar to those in the cultural kete. For example, the kete encompasses the 'pōwhiri' process that comes from Māori kaupapa. The bundle contains a corresponding 'welcome' process. Six of the change ideas in the kete and bundle are complementary, suggesting a high degree of agreement about the current approaches that are successful in reducing seclusion and inequity across MHA service teams.

Key interventions

Safe transitions

Change concept

- Provide timely access to treatment and care in the community.⁹
- Conduct regular community reviews for those tāngata whaiora who were secluded on a previous admission.
- Review processes for tāngata whaiora with high rates of admissions to the inpatient unit.
- Agencies collaborate to help seamless care transitions.
- Community teams and police collaborate to reduce use of force and therefore the risk of seclusions on admission.¹⁰

Involving whānau and family

Change concept

- Include whānau and family as partners in care at all stages of care.¹¹
- Involve whānau and family in the arrival and welcome process.
- Whānau and family support tāngata whaiora during an inpatient stay.
- Develop policy, staff training and facilities capacity to support whānau and family in providing inpatient support.¹²
- Include whānau and family in planning care and transitions to the home environment.

Therapeutic welcome process

Change concept

- Uphold the safety and dignity of all those involved by being compassionate, understanding trauma-informed care,¹³ creating a therapeutic relationship and offering culturally appropriate processes (see the cultural kete for more details).
- Provide welcoming environments, including with the option of offering food and drink.
- Whānau and family are involved in the welcome process whenever possible.

Effective use of medication

Change concept

- Use psychotropic medications in a timely manner during assessments and admission processes (reducing delays in care).
- Use a standardised guideline for managing acute behavioural disturbance.¹⁴ Local examples are available throughout the country, including Acute Behavioural Disturbance Guidelines developed by Northern Region DHBs.
- Use Dynamic Appraisal of Situational Aggression (DASA)¹⁵ or a similar tool.
- Use sedation scales with a guideline.

Effective use of nicotine replacement therapy (NRT)

Change concept

- Use NRT in a timely manner before admission or on the pathway into the inpatient setting.
- Offer different NRT options immediately as part of the admission process.
- Clinicians use standard guidelines for NRT.
- Have a clear local policy on smoking alternatives such as vaping.

After-hours leadership

Change concept

- Clinical leadership is available after hours to all staff.
- Leadership includes support to on-call medical staff who are less familiar with inpatient care, and the use of best practice guideline for acute behavioural disturbance and NRT.
- Cultural leadership is available (either from within the DHB or from kaupapa Māori NGO services).

Safety huddles

Change concept

- Have reliable safety huddles on each shift.
- Standardise content of the safety huddle process.
- Include proactive assessments, interventions and support in huddles. Good huddles anticipate needs, challenges and risks (safety issues) during a shift of the day.¹⁶

Sensory modulation

Change concept

- Staff are competent in using sensory modulation for all tāngata whaiora. This can include community staff who are using sensory modulation before admission.¹⁷ Have appropriate resources available to support this practice.
- Cultural sensory modulation for Māori requires training beyond general responsiveness and Te Tiriti o Waitangi. This training may include cultural supervision or a mentor to help staff apply the cultural sensory modulation kete. (For more details, see the cultural kete section.)

Debrief¹⁸

Change concept

- Have an inclusive debriefing process.
- Have timely debriefing sessions.
- Identify a key person to lead the immediate debriefing process.
- All care providers are competent in leading debriefs.
- Identify activities and strategies that staff can undertake to reduce the associated trauma.
- Debriefing sessions produce reliable feedback and learning.

Zero seclusion cultural kete | Mōkī mana tangata

The Zero seclusion cultural kete does not contain the entire collection of mātauranga Māori approaches and interventions from the Zero seclusion project teams. Note also that it includes some non-Māori interventions. However, the delivery of these interventions differs from mainstream. Wrapping them within kaupapa Māori processes and approaches makes them much more effective in meeting Māori needs.¹⁹

MHA service teams in many DHBs are using the interventions, practices and values in the kete, testing their effectiveness using the Institute of Healthcare Improvement's scientific methodology for quality improvement.^{20,21} The Commission will include successful kete elements in our collection of evidence as we build our knowledge in this area. This is critical in the current environment of the mental health and addiction sector where:

- te ao Māori approaches and mātauranga Māori service models are poorly resourced
- MHA services' engagement with kaupapa Māori health providers is of variable quality
- DHB investment in Māori mental health generally has stagnated.

Partnership with kaupapa Māori mental health providers

Māori are disproportionately high users of MHA services. Further, they hold the unenviable record of being the highest users of seclusion in New Zealand.^{22,23} It is critical that Zero seclusion project teams form partnerships with kaupapa Māori health providers in their districts and align their cultural approaches to local iwi kawa (traditional practice).

Expertise in tikanga (customs), te reo (language) and mātauranga (knowledge) are fundamental prerequisites for delivering culturally effective care. Kaupapa Māori health providers are the best qualified to provide these services.^{24,25} Māori place great emphasis on establishing a trusting relationship with their health care provider. For tāngata whaiora and whānau to be satisfied with treatment and find it acceptable, providers must be able to show they understand Māori and their specific cultural needs and interventions. A provider's culturally effective approach is an important element in both people's willingness to access services and the success of any treatment or care that follows.²⁶

The interventions in the kete

Note that interventions, practices and values contained in the kete do not represent the entire cultural menu. Use of kete elements varies across DHBs because access to Māori resource is difficult for some.²⁷

Āraia te māuiui hinengaro | Early intervention support

Early intervention support reduces the impact of mental health problems by providing effective interventions for identified at-risk populations, people experiencing a mental health illness for the first time and people who experience early indications of a relapse of illness.²⁸

The aim of early intervention support is to support tāngata whaiora and whānau to be independent of the system by preventing problems from occurring at home. Teams of clinical and cultural support workers resourced with a range of clinical and holistic service options tackle problems head-on when they appear, before they get worse and require hospital care.²⁹

Anecdotal evidence shows early intervention support can be successful when MHA services partner with Iwi Māori health providers and tāngata whaiora and their whānau to co-design care using effective clinical therapies enhanced by culturally aligned treatments. This model has shown positive results, with less use of seclusion and improved Māori health equity.³⁰

Te arotake māuiui hinengaro Māori | Māori cultural assessment

Cultural assessment is a process for determining the relevance of culture to mental health. It is accepted as a key element in mainstream MHA services' delivery of services and their responsiveness to Māori.³¹ Cultural assessment complements clinical assessment and only those who have the required training and expertise should carry it out.³²

Te whiri ratonga hauora hinengaro Māori | Service coordination

Service coordination is a process for accessing effective and relevant services to meet the needs and aspirations of tāngata whaiora and their whānau. Given the high prevalence of mental health issues in Māori, MHA services need to engage with kaupapa Māori mental health providers, consider how shared care might work and enable access to effective holistic interventions.

Cultural supervision

Cultural supervision is about cultural accountability and cultural development. It provides a way to:

- respect and explore the aspirations of all cultures within the supervisory relationship
- deliver services through culturally responsive, effective and acceptable practices.³³

Whānau engagement and involvement

Among the ways to deliver MHA services to Māori, whānau engagement approaches and kaupapa Māori services are strongly preferred. These services are fully inclusive of whānau and place higher value on the power of sharing stories and building trusting relationships with them, than on prescribing medicine.^{34,35}

The concept of whānau engagement is critical to Māori health and wellbeing, whereas the practice of working with tāngata whaiora in isolation from their whānau is not. Some services seek to be inclusive but achieving that in practice is difficult when they lack appropriate cultural approaches.

Pōwhiri/mihi whakatau | Welcoming ceremony process

The pōwhiri is a process in which the host people welcome visitors to their marae. Kaupapa Māori MHA services value the traditional pōwhiri process because its protocols are based on the notions of respect and developing positive relationships between the tangata whenua and manuhiri³⁶

The pōwhiri is founded on mutual respect using the elements of karanga (first cry of welcome to the marae), mihihihi (connecting and getting to know each other), whaikōrero (formal speeches of welcome and sharing stories) and koha (gift, donation or contribution). These are important steps in building trust and confidence and helping bind all parties into mutually rewarding relationships.

On some occasions, tāngata whaiora and whānau are unable to participate in the pōwhiri process. In these circumstances, all parties involved need to use their discretion as the needs of tāngata whaiora and whānau are paramount in these situations. They may need to decide whether to hold the full pōwhiri – or the shorter version, the mihi whakatau – or to postpone the event.

After-hours Māori service

Often MHA services are only available to people once their condition deteriorates to the point of being an almost unmanageable crisis. Māori usually access services at a later stage of their condition, more likely after hours and on weekends, due to unmet need: in the hospital, in the home or in their communities. They are overrepresented in admission, readmission, seclusion and compulsory treatment escorted by the police.³⁷

It is critical to provide an after-hours service with an appropriately skilled and experienced workforce, including the right mix of cultural and clinical expertise. This is vital not only for the effectiveness of MHA services, but also to better support police, justice and emergency departments. Admissions from these areas have become the fast-track option into seclusion facilities, particularly for Māori. Conversely, anecdotal evidence suggests that MHA services can avoid that fast-track when they have appropriately resourced models and interventions.

Among the small number of DHBs with an after-hours service that includes cultural expertise, evidence indicates that with this model it is entirely possible to reach and sustain zero seclusion and reduce inequity for all tāngata whaiora.³⁸

Tāngata whaiora tautoko | Peer support

Peer support workers are people who have lived experience of mental health challenges themselves. They use these experiences and empathy to support other people and their families receiving mental health services. Like kaupapa Māori services, peer support services are poorly resourced. Yet where they do have a presence and are strongly led, anecdotal evidence suggests they have an impact on lowering seclusion use.³⁹

Rongoā Māori

Rongoā Māori is the traditional healing system of Māori, which includes plant-based remedies and spiritual healing. Tohunga (experts in a particular field) are the practitioners of rongoā māori. By establishing a good relationship with Māori tāngata whaiora and their whānau, mental health workers enable them to talk about their needs, including the rongoā they use. Mental health workers should be aware of interactions between rongoā and conventional treatment or medications.⁴⁰

Māori Sensory Modulation Pack

Sensory modulation is a potential alternative to more coercive practices in acute mental health settings. The approach offers a way of supporting tāngata whaiora to self-regulate when distressed or agitated. It uses sensory-based equipment, strategies and environments to help tāngata whaiora to optimise their emotional levels and engagement in everyday life.

The Māori Sensory Modulation Pack is a recent addition to the kete. Several DHBs are trialling it and monitoring its effectiveness.⁴¹

Mātauranga Māori practitioners

Following is a list and brief description of the kaupapa Māori mental health workers who have responsibility for carrying out this mahi (work) in MHA services visited by the Commission's MHA quality improvement programme team.

Kaupapa Māori practitioners in MHA services provide a range of tikanga practices. They typically include kaumātua and kuia and offer iwi, hapū and whānau wisdom, te reo, knowledge and cultural guidance.⁴²

Kaiāwhina, kaimanāki, kaiatawhai, kaitakawaenga and mataora are hospital, community or whānau cultural support workers and health system navigators.

Mātauranga Māori practice values

Mātauranga Māori practice values are important values and behaviours expected of kaupapa Māori mental health workers that can contribute towards improving health equity and eliminating seclusion. These values are:

- tikanga Māori – safe and timely delivery of traditional high-quality customary practice
- kia mākohā – providing effective care in a manner that is compassionate, amicable and placid, patient, gentle and kindly
- manaakitanga – providing efficient care in a manner that is supportive and protective, hospitable, respectful, generous and caring
- whanaungatanga – inclusive kinship relationships, involving iwi, hapū and whānau
- whakapapa – accurate genealogical links with iwi, hapū and whānau
- mana ake – empowerment of consumer and whānau
- te reo Māori, waiata (music) and karakia (prayers)⁴³
- Te Tiriti o Waitangi – understanding and enacting Te Tiriti articles and principles.

The Aunties

The Aunties offer an alternative to coercive practice and a good example of the values behavioural approach that we are promoting to Zero seclusion project teams. It is based on the traditional teaching, mentoring and generally supportive role of older Māori women in the whānau and in their communities at traditional cultural events. The Aunties are respected for their wisdom, patience, compassion and guidance. All of these are very useful skills where de-escalation from seclusion is required.

Zero seclusion consumer kit | He mōkī eke noa

‘Nothing about us without us’

The Zero seclusion initiative aims to eliminate seclusion in Aotearoa New Zealand's mental health care. Involving mental health service users at every phase is pivotal, aligning with the ‘Nothing about us without us’ principle. This consumer kit has been developed to ensure insights from those with lived experiences drive efforts to eliminate seclusion and improve mental health care.

The contents result from a mix of evidence from Zero seclusion project teams, global literature and co-design principles aligned with the [code of expectations for health entities’ engagement with consumers and whānau](#). These ideas have been organised into categories for teams to use.

While not all consumer strategies used by project teams are included, all teams across districts are actively using the kit’s interventions and assessing their efficacy.

The change ideas within the kit (displayed in the driver diagram below) do not all have a formal scientific basis, however, they are important. We encourage exploration using quality improvement science to build New Zealand's evidence base.

The kit is particularly valuable for quality improvement in secondary mental health services and can aid funding and planning for the growth and support of the consumer workforce.

It is also a vital part of the overall changes, bringing together clinical and cultural ideas to eliminate seclusion. It includes elements like safe transitions and cultural sensory modulation, emphasising the experiences of those who use services.

The kit directs new workers to resources like the health sector standard NZS: 8134 and policies on adverse events. It also highlights consumer and whānau engagement legislation, providing guidance for MHA services, including clinicians and cultural workers. Knowing about these resources is crucial as MHA services are now required to report on their engagement efforts.

The resources may also help the paid MHA workforce identify partnership opportunities with consumers; partnership would include clinical staff, kaupapa Māori services, primary health care doctors and staff, police, Pacific services, other cultural services, gender-focused services and social services staff as well as statutory MHA inpatient services.

Please note the term ‘consumer’ refers broadly to anyone using health or disability services. It is helpful to clarify definitions such as this one.⁴⁴ Healing environments should be gentle, not resembling prisons, respecting personal language preferences.

We would like acknowledge Shaun McNeil, the inaugural Consumer and Family Engagement Advisor at Te Tāhū Hauora, for his contribution to this work.

Consumer kit driver diagram

Aim	Primary drivers	Secondary drivers	Change concepts
<p>To reduce seclusion rates to 3 percent by 1 June 2025 by: improving engagement with consumer, lived experience experts plus whānau/family at all levels of service design, development, delivery and review to eliminate the need for seclusion</p>	Workforce growth and development	Peer support workforce training	Increase peer support workforce numbers, with attention to equity for Pacific and Māori peer workers. ⁴⁵
	Co-design and quality improvement capability	Grow staff to be competent in quality improvement methodology and skills	Train peer and consumer workforce to deliver consumer-led debriefs of consumer experience and post-seclusion reviews.
	Consumer and whānau engagement	Service planning using co-design ⁵²	Include consumer, peer support and lived experience in training delivered to police, families, primary care, clinical staff in emergency departments, ambulance, inpatient and community sector; also include consumer rights with consumer and family experiences.
		Service reviews fully engage with consumers involved in care episodes; involvement of consumer workforce for those not directly involved in receiving services	Use co-production to develop individual care plans. ⁴⁶
		Develop consumer governed and consumer roles employed within a range of services	Make consumers part of, and linked to, other consumer spaces for restraint approval committee and complaints review processes.
	Increased crisis and respite services	Care plans accessed as part of standard procedure for crisis responses	Make seclusion review ⁴⁷ part of the consumer harm review team's role. ⁴⁸
		Pacific and other cultural considerations	Provide consumer welcome packs that highlight inpatient ward programmes.
	Co-production of new service provision	Inpatient participation	Use conversation café methodology for co-design and feedback. ^{49,50}
		Quality review	Make consumer workers part of the crisis response team. Fund consumer-led crisis respite services.

			<p>Establish consumer and whānau partnerships with police crisis response teams.⁵¹</p> <p>Contract more consumer support and advocacy services.</p> <p>Engage families in inpatient care planning.</p> <p>Use interventions such as cultural sensory kits.</p>
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Key improvement areas/change concepts

Peer support

Project teams that have strong relationships with their peer support workforce have given anecdotal evidence that receiving more frequent and quality feedback from consumers helps to reduce duration and seclusion rates. Teams with reduced capacity (including staff leave, over capacity and/or after hours) have identified potential in growing their peer support.

Like the cultural kete, peer support requires those involved to have a clear understanding of their role and consumer rights, and to learn from the experiences of consumers and their families.

To address equity, teams should focus on the inclusion of Pacific and Māori peer workers.

Debrief (consumer, peer support and lived experience)

Clinical team debriefs improve understanding of and reduction of seclusion rates. Anecdotally, teams with consumer, peer support and lived experience debriefs say this allows them to source more in-depth feedback on experiences of seclusion and restorative practices.⁵³ It also enables teams to be more responsive to the relationships and dynamics within the unit and gain a greater understanding of consumers.

Co-design (inclusion)

Teams need to recognise the significance of co-design practices in order to emphasise the empowerment of consumers to actively address issues through collaborative problem-solving.⁵⁴

Our project teams successfully reduced seclusion using the 'world café' approach⁵⁵ as a change concept. They named this intervention 'conversation café'⁵⁶ and used it to actively seek consumer feedback in the community. They addressed not only seclusion but also other aspects of the inpatient setting.

Ensuring consumer involvement in relevant committees is crucial, for example, teams focused on restraint approval, complaints review, seclusion reviews and consumer harm review.⁵⁷ To support participation, training programmes need to equip consumers to engagement in quality improvement work.

Project teams also need to refer to guidance provided by existing policies and standards, such as the Code of Health and Disability Services Consumers' Rights and Standards New Zealand NZS: 8134,⁵⁸ when facilitating consumer participation. Placing an emphasis on national policy statements helps to guide consumers through the quality improvement process, with the goal of eliminating seclusion.⁵⁹

Welcome process

Some teams provide consumer welcome packs and report that being transparent and highlighting inpatient ward programmes has improved therapeutic relationships and staff ability to de-escalate previous seclusion attempts.

Crisis response/co-response teams: Consumer workers

Anecdotally, crisis response/co-response teams that use safe transitions and involve family and whānau have seen reductions in seclusion. When teams use a therapeutic welcome process or pōwhiri process these have been shown to reduce seclusion rates in the first 24 hours. Important traits for team members include building nurturing relationships and understanding cultural needs. Teams that use consumer workers trained in these skills can increase empathic relationships and reduced distress.

Crisis respite: Peer support/consumer led/kaupapa Māori led

Teams across the country have tried different approaches to crisis respite. One team has worked with the local kaupapa Māori health provider to co-design and deliver an alternative space to the emergency department. This allows teams to assess and de-escalate consumers who may be in distress but may not require urgent attention.

Other teams are using peer support respite as a step-down service for consumers transitioning from the inpatient unit.

Pasifika Cultural Sensory Modulation

Sensory modulation is an alternative to more coercive practices and has been identified in the clinical bundle and cultural kete. The approach offers a way of supporting Pacific consumers to self-regulate when distressed or agitated. It uses sensory-based equipment, strategies and environments to help consumers optimise their emotional levels and engagement in everyday life. The Pasifika Sensory Modulation Pack has been trialled at two sites and other teams are looking at trialling it and monitoring its effectiveness.

Measures | Tātai mahi

Measures are essential to help project teams understand the systems they work in so that they can identify areas for improvement. Teams also use them to identify whether changes they make actually lead to improvement. The measures contained in the Zero seclusion change package will help project teams to identify data that will support their improvement work. We recommend collecting this data alongside specific measures of each change idea.

Outcome measures

- Rate of seclusions, including by ethnicity
- Percentage of tāngata whaiora with whānau support identified and documented

Process measures

- Percentage of tāngata whaiora with documented plan, including whānau support
- Percentage of tāngata whaiora receiving the change package
- Percentage of cases where the team uses the change package

Balancing measures

- Restraint rates
- Assaults on staff resulting in time off work

Cultural kete

- Percentage of Māori in workforce
- Percentage of tāngata whaiora receiving cultural interventions

Next steps | Tiro whakamua

The following questions may be useful to project teams when using the change package to inform their work.

- How will you generate commitment to changes?
- What time scales will you work to?
- Which leaders can help?
- What assets and resources do you have?

Learning system tools

Teams create a learning system when they continually expand their capacity to achieve their aim, encourage new and expansive ideas, set free collective goals and continually learn how to learn together.

The seven key components to developing a learning system are:

1. shared purpose
2. shared language
3. autonomy
4. collective leadership
5. connections and relationships
6. data and measures to understand variation
7. infrastructure to support the learning system.

Our tools | Ngā rauemi

- [Model for Improvement](#)
- [Project planning form](#)
- [Driver diagram template](#)
- [PDSA cycle worksheet](#)
- [PDSA cycle checklist](#)
- [Action plan template](#)
- [PICK \(Possible/Implement/Challenge/Kill\) chart template](#)
- [30–60–90: Ideas for action template](#)
- [Reporting template](#)
- [Review session template](#)

We set out these tools on the following pages. They are also available to download as printable and editable versions at www.hqsc.govt.nz/resources/resource-library/zero-seclusion-change-package.

Model for Improvement

The Model for Improvement⁶⁰ is a simple yet powerful tool for accelerating improvement, which has two parts:

- three fundamental questions, which can be addressed in any order
- the plan–do–study–act (PDSA) cycle to test and implement changes. The PDSA cycle guides the test of a change to determine if the change is an improvement.

Setting an aim: To achieve improvement, project teams first need to set an aim. The aim should be time-specific and measurable. It should also define the specific population of tāngata whaiora that will be affected.

Establishing measures: Project teams use quantitative measures to determine if a specific change leads to an improvement.

Choosing changes: All improvement requires making changes, but not all changes result in improvement. For this reason, organisations must identify the changes that are most likely to result in improvement.

Testing changes: The PDSA cycle is shorthand for testing a change in the real work setting – by planning it, trying it, observing the results and acting on what you learn. This is the scientific method used for action-oriented learning.



Acknowledgement: Deming WE. 2018. *The New Economics for Industry, Government, Education* (3rd edition). MIT Press.

Project planning form⁶¹

Team:	Project:
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Driver (list the drivers you'll be working on)	Process measure	Goal
1.		
2.		
3.		
4.		
5.		
6.		

Driver number (from above)	Change idea	Tasks to prepare for tests	PDSA	Person responsible	Timeline (T = test; I = implement; S = spread)															
					Week															
					1	2	3	4	5	6	7	8	9	10	11	12	13	14		

Driver diagram template

Aim	Primary drivers	Secondary drivers	Interventions

PDSA cycle worksheet

Plan

List the tasks needed to set up the test of change. Predict what will happen when the test happens. Decide who will run the test.

Do

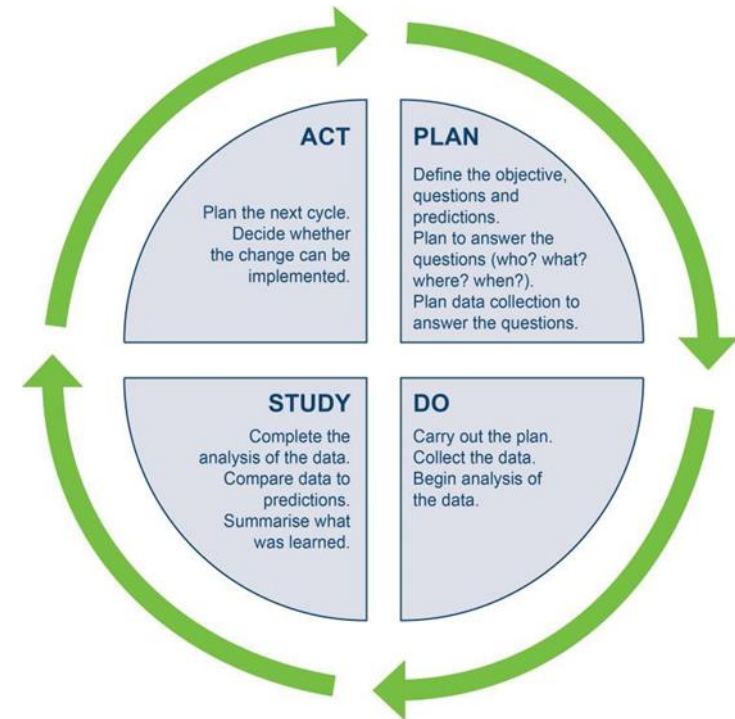
Run the test. Document what happened when you ran the test. Describe problems and observations.

Study

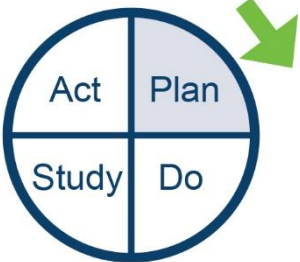
Describe the measured results and how they compare with your predictions.



Act


Decide what your next PDSA cycle will be based on your learning.



PDSA cycle checklist

Cycle number: Meeting number – date:	Start date: End date:
Objective of cycle	___ Collect data to develop a change ___ Test a change* ___ Implement a change** Short objective of the cycle:
Plan 	Questions 1. ? Prediction: 2. ? Prediction: 3. ? Prediction: 4. ? Prediction:
Note * For testing checklist, see <i>Improvement Guide</i> , p 96 ⁶² ** For implementation checklist, see <i>Improvement Guide</i> , p 136	Test/implementation plan What change will you test or implement? How will you conduct the change that you are testing or implementing? (Consider small scale early.) Who will run the test or implementation? Where will they run it? When will the test or implementation take place? Collect data plan (usually required for all PDSA cycles) What information is important to collect? Why is it important? Who will collect the data? Who will analyse the data before the study? Where will data be collected?

	<p>When will the collection of data take place? How will the data (measures or observations) be collected?</p>
<p>Do</p> 	<p>Observations Record observations not part of the plan. Did you need to modify the original plan? If so, how? Begin analysis of data (graph of the data, picture).</p>
<p>Study</p> 	<p>Questions (Copy and paste questions and predictions from plan above and add results. Complete analysis of the data. Insert graphic analysis whenever possible.)</p> <p>1. ? Prediction: Learning (comparison of questions, predictions and analysis of data):</p> <p>2. ? Prediction: Learning: New issues: Summary:</p>

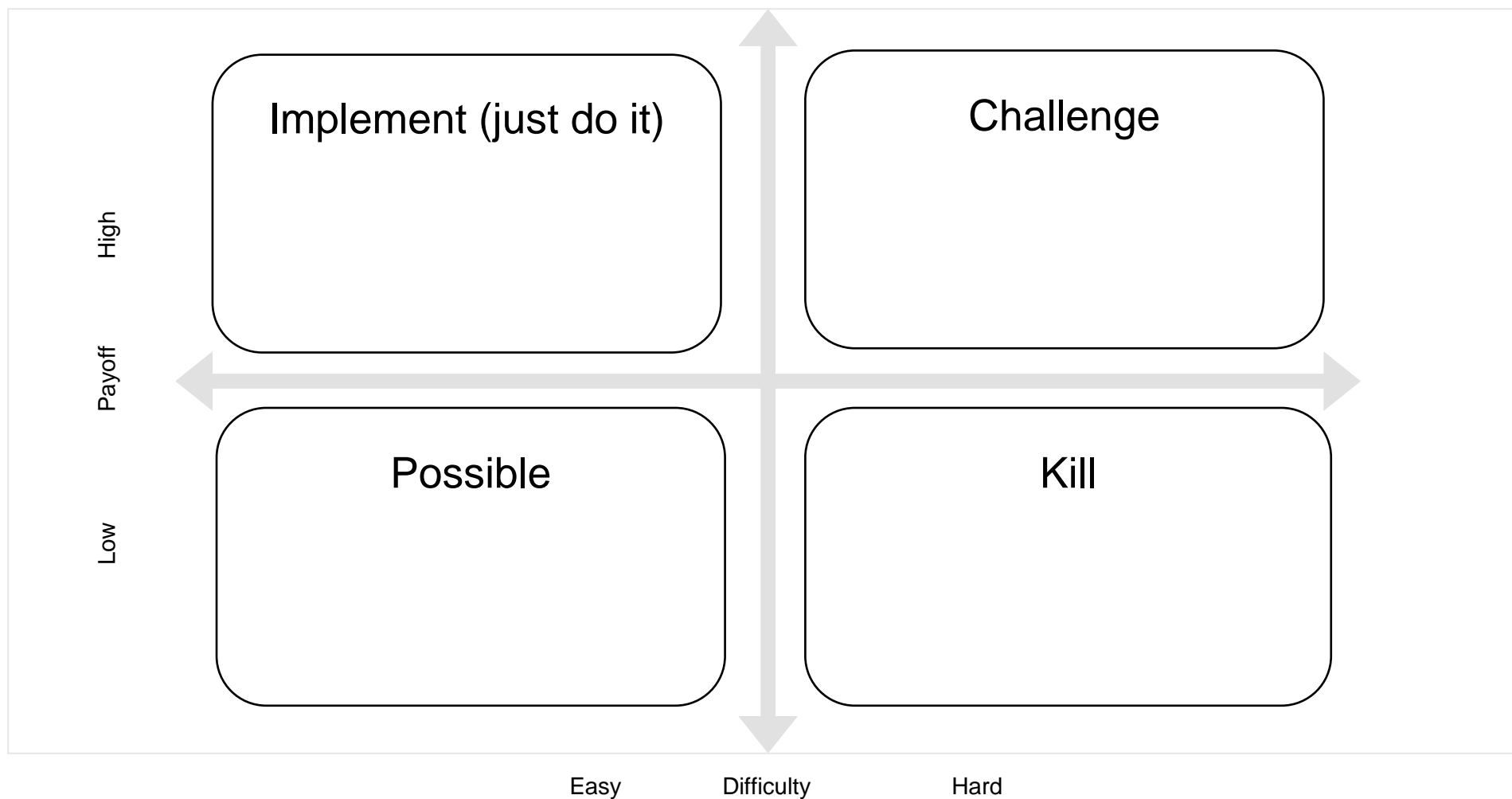
<p>Act</p> 	<p>Describe next PDSA cycle: new questions to answer, decisions to make, action to take.</p>
<p>Ad hoc contributors</p>	<p>Recognise subject-matter experts and others who have contributed to the learning.</p>

Action plan template

Change ideas we plan to test.

Clinical bundle		Cultural kete	
Key driver	Change concept	Key driver	Change concept
Safe transitions		Āraia te māuiui hinengaro Early intervention support	
Whānau or family involvement		Whānau engagement and involvement	
Therapeutic welcome process		Pōwhiri/Mihi whakatau Welcoming ceremony process	
Effective use of medication		Te arotake māuiui hinengaro Māori Māori cultural assessment	
Effective use of nicotine replacement therapy		Te whiri ratonga hauora hinengaro Māori Service coordination	
After-hours leadership		After-hours Māori service	
Safety huddles		Tāngata whaiora tautoko Peer support	
Debrief		Rongoā Māori	
		The Māori Sensory Modulation Pack	
		Mātauranga Māori practitioners	
		Mātauranga Māori practice values	
		The Aunties	

PICK chart template



30–60–90: Ideas for action template

	Next month	The next two months	The next quarter
What we could speed up/do more of: Accelerate			
What we could stop doing: Brake			
What we could start doing: Create			
	Longer-term actions		
	[Empty box for longer-term actions]		

Reporting template

Project name:

Organisation:

Project sponsor:

What are we trying to achieve?

Example

Project start: June 2019

To reduce seclusions that occur in the first 24 hours of admission by 50% by 30 June 2022.

Aim:

- (Patient outcome measure being defined)

PDSA cycles in progress now

Changes we plan to test

Barriers and specific needs from sponsor to overcome them

Why is it important to work on this now?

(Current data and knowledge)

Team

Project leads:

Expert group:

Working group:

Project manager:

Recommendations and next steps

Plan for making change permanent

(TBD)

Review session template

How will we know it is an improvement?

Outcome measures:

Process measures:

Balancing measures:

Project name:

Organisation:

Project sponsor:

Measurement graphs

Endnotes | Kupu tohutoro

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