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What is happening at the Seclusion Review that makes a difference? – a consumer led research study



| Bradley Foxlewin



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## Author:

Bradley Foxlewin      Principal Consumer Researcher

## Collaborators:

Jane Cure,      Secretariat. ACT Mental Health, Justice Health, Alcohol and other Drugs. I was glad to be a small part of the project; I believe that the weekly scrutiny of seclusion events by all involved in the consumers' care, including consumer and carer representatives, and Wardsmen, helped create the necessary daring to change the old conventions and standard treatment protocols.

Sheree Dimitrescu      Clinical Nurse Consultant. PSU, Canberra Hospital. I found the experience both challenging and inspiring to both myself professionally and as a person. A breath of fresh air! Change is always hard but when you do things over and over again it soon becomes a habit. We can always improve on what we do now; as we learn and research better ways to care and provide care.

Kerry Fry      Consumer Representative. ACT Mental Health Consumer Network. I have been a voice hearer for 25 years attempting suicide several times. Each time I ended up in the seclusion room, which was always a trauma on a trauma. I am pleased that this practice is no longer enforced thanks to the efforts of the Seclusion and Restraint Review Meeting. The collaboration with consumers and staff has been a very successful exercise with changes reaching far into the culture at the PSU

Wendy Kipling      Team Leader, PSU, currently Acting Director. Access and Acute Mental Health Services. My experience of the

SRRM is of founding member and chairperson. My experience of the research has been enlightening and affirming.

David Lovegrove Senior Consumer Representative. ACT Mental Health Consumer Network. The research project and the reform process from which it evolved, the SRRM, have formed a uniquely significant and empowering collaboration in process and achievement. It has not only had significant impacts on the use of seclusion and restraint but also on broader cultural and systemic reform within and beyond its own cultural setting. The research project establishes the credentials of consumers proposing, writing and co-creating valuable research studies that flow from reform processes they themselves are jointly developing and leading.

Anne Tighe Occupational Therapist. PSU, Canberra Hospital. You have achieved a remarkable outcome, to capture different voices, shedding some light on the phenomena that has, and continues to be, reducing seclusion and restraint from mental health services. This document is a credit to your dedication, energy, rigour and creativity.

Ellyte Walsh Acting Team Leader. PSU, Canberra Hospital. I was the Acting Clinical Nurse Consultant during this research. During my initial involvement in the Seclusion Review Meeting I was not always open to ideas about the reduction of seclusion and restraint. I had always believed that I was never punitive and when I did seek an order for seclusion, I was doing this therapeutically. It was not until I heard the experiences of consumers that my once held thoughts and beliefs changed. I am forever grateful for having the privilege of being involved in this very important process. It has changed my practice and me as a person forever.

### Consumer Reference Group:

Patricia Green Consumer Representative. ACT Mental health Consumer Network, ACTMHCN

David Harris Consumer Representative. ACTMHCN

Sarah Howard Consumer Representative. ACTMHCN

Maureen MacInerney Consumer Representative. ACTMHCN

## *Acknowledgements*

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The current and past members of the Seclusion Review meeting whose tenacity in tackling the issue of seclusion and restraint has led to such significant reductions. This includes consumer representatives, nurses, allied health staff (Occupational Therapy and Psychology), secretariat, Wardsmen and Doctors. A particular mention must go to Wendy Kipling, whose focus on changing culture within the PSU has remained unstinting over the past 2 and more years.

The members of the Consumer Reference Group (ACTMHCN) who met with the author on three occasions to maintain the project from a consumer perspective. This group, in no small part, supported the project's integrity; reminding the author that the consumer voice is particular, and allowing the author to manage the project's progression from margins to centre.

Mental Health ACT Strategic Executive for having the forethought to take up independent consumer research as a consumer participation strategy.

Beverley Raphael who has mentored the author over the research period even when she was not always completely convinced of the methodology chosen. Beverly has shaped the project most usefully by her care and support whilst holding back the gaze of "SUPER" vision enabling what is truly a consumer led process and document.

Lai Ning (Consumer Research and Evaluation Unit) and the staff of the Victorian Mental Illness Awareness Council for providing collaboration in regard to structuring the document as well as providing access to resources and proofreading literature reviews.

Mental Health Foundation, Innana Counselling Service and the Canberra Men's Centre for providing debriefing options for research participants.

To the staff and members of the ACT Mental Health Consumer Network who provided admin support but more importantly were always supportive, reminding, re-storying the importance of the untold consumer lived experience.

Elizabeth Foxlewin who provided personal support, word-smithing and editing expertise beyond what could be expected in any other situation. My most sincere thanks go to Elizabeth for her more than significant contribution.

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## **Foreword by Professor Beverley Raphael**

This is a unique and important initiative. It is a consumer led research program that has engaged with people who have experienced seclusion, have been involved in review of practice, and have shaped and developed the policy for this component of the ACT mental health service.

The report describes the research processes, and the engagement with the challenges of seclusion, it is a 'beacon' for those who experience a mental illness, those who provide their care and for all who would wish to see a better way of helping the distress that leads to such a response. The review of quantitative data sits embedded with the voices of consumers, and the qualitative analysis of the themes that have helped to modify practice in positive and effective ways.

There is a music of hope in what is written, in the voices, in the findings and in the changes that have occurred. It is an important and significant contribution to both recognition of the knowledge and needs of those who use our services and the power of their abilities to see, speak and act for better mental health in the future.

## Executive Summary

This research pilot study has been conducted by people who have experience of mental health challenges and the mental health care system, and is focused specifically on the Psychiatric Services Unit, PSU, at the Canberra Hospital. The aim of the research was to explore, in collaboration with consumer representatives and clinical staff, what has occurred during the weekly Seclusion and Restraint Review Meetings (SRRM) that has led to the huge reduction in the use of seclusion at the PSU.

The SRRM closely examines every incident of seclusion, restraint and many ‘near misses’ to find out what happened, what could have been done differently, or what – in particular – is working to prevent seclusion.

The SRRM has developed a culture in which difficult situations can be discussed without blame, where every point of view is valued, every voice is heard and respected; where practices of exclusion, such as values that privilege staff over consumers, or beliefs that rob consumers of agency and dignity, are rigorously investigated. This is not always an easy process.

Nonetheless, in creating this culture, attitudes are challenged and changed, and the renewed energy passes ‘downstairs’ to the acute ward, maintaining systemic and cultural changes that enable all stakeholders to better support consumers.

This research study elicits and documents stories of these changes, told by consumers and clinicians in collaboration. The research takes the epistemological standpoint that change is enabled within social and relational domains and that individual identity development, both professionally and personally, is a consequence of engagement.

The research was proposed and conducted by an independent consumer researcher to reiterate the importance of including the consumer voice in implementing systems change.

The document utilizes quantitative data first collected for the Beacon Site Project, and now collected by ACT Health to support “the use of data to drive change” (Kipling, 2011, pers. com.), to set an historical context, and to provide a visual perspective on the significant reductions on the use of seclusion at the PSU. The data can be viewed on pages 8-25 of the

research document, tracking the use of seclusion at the PSU from 2006 to 2012, and shows a dramatic drop in both episodes and hours of seclusion from 2009, when the SRRM was first established.

The document is also supported by literature reviews on both seclusion reduction and consumer led research (pages 26-30) and makes recommendations (pages 81-82) in regard to future research and the possible implications for Mental Health Services.

Two sites were researched: the SRRM members and the Consumer Reference Group, CRG. The CRG were consulted about the relevance and appropriateness of the research process, as key players in maintaining consumer perspectives. Focus groups, the CRG research method, were conducted on three occasions: at initiation, prior to submitting for ethics approval, and at report (advanced draft) stage. The results of the CRG consultations guided the proposal, the ethics application, the methodological approach and the final documentation, to ensure consumer perspectives were included at all stages of the research. The lived experience of the CRG and their embodied expertise as Consumer Representatives to the Mental Health care system provided both a relational base and a collective intuitive voice.

The SRRM research process, conducted on two separate occasions, included a focus group (Narrative Definitional Ceremony) followed by Collective Biography writing. SRRM data was analysed, firstly through the interaction of research participants, secondly through content analysis in collaboration with research participants and thirdly by a performative dialogic analysis.

Both methods took up a process of open inquiry around separate sets of questions. For the CRG these were focused on the research process itself and its resonance with consumers. The SRRM inquiry sought answers to the research question, “What happens at the Seclusion Review that makes a difference?” The Interview Schedule can be found in the appendix. (Appendix 1)

The research methods matched the intuitive process of the SRRM. Definitional Ceremony values relationships, respect, taking turns to ensure everyone’s voice is heard, keeping consumers’ lived experience at the centre, defining issues and themes as emergent outcomes. Collective Biography honours the community outcome agenda taken up by the SRRM.

The research document is a constructed research dialogue about the SRRM. It is drawn from collective research material positioned in such a way as to bring seclusion, and the ideas that underpin the practice of seclusion, to the fore as the very material that has informed the changing culture, personal and professional identities, and practices at the SRRM and the PSU.

The most significant factor was the inclusion of the consumer voice in the Meeting, allowing subjective stories of exclusion and emotional restraint that reflected seclusion practices on the acute ward to be part of the discussion. Following the consumers' lead, staff members of the meeting were able to speak subjectively of their own experiences on the Ward. These stories enabled vulnerability, honesty, compassion and humanity to bring people together, joined in a common understanding that seclusion is a failure of care.

These stories appear in the research document (pages 42-62) within the themes of Consumer Voice, Diverse Shared Experiences, Inclusion and Exclusion, Inviting the Wardies, Othering and Mutuality, Relationships, Processes and Produce of SRRM, Contexts, Creativity, Practice / Reflective Practice / Reflexive Practice, Commitment, Contexts, Learning Community, The Journey, and Change.

Having reached the understanding that seclusion cannot be considered therapeutic, the meeting then searched for other means to care for people in acute distress. This gave rise to the Coping and Safety Tool, the Early Support and Intervention Team and staff training in Sensory Modulation, encouraging therapeutic relationships throughout the whole of nursing care.

Stories of these positive changes can be found between pages 50 and 70 of the research document, under the themes of The How-To in regard to Documents and Tools, Change, Trickle Down, Ripple Out, Ripple In, Produce / Outcomes.

It is not to be supposed that the cultural change achieved at the PSU happened easily and without obstacles. The research documents two years of work by the SRRM, during which time personal and professional identities were challenged. People's stories of Challenges, Discomfort, Conflict, Benefit, Rewards, and Celebrations are told on pages 70-77.

Overall, research findings showed that the SRRM members considered consumer voice and the lived experience of both consumers and

clinicians to be the central driver for cultural change in relation to seclusion reduction.

The meeting moved from allowing the consumer voice to privileging it, at the same time accepting affect and subjectivity into discussions. Much of what happened in the SRRM was based on negotiating changes of mind and heart.

The concept and practice of learning community, in which members were supported as they questioned the appropriateness of certain ways of working, enabled both personal and professional development. The role of challenge and discomfort was recognized as the precursor of cultural change.

The voices of consumers, clinicians and allied health workers, as heard in the stories collected by this research, are testimony to the value of including lived experience in professional discussions. Personal attitudes and attributes are not separate from professional identities. The SRRM

gave permission for both consumers' and other members' lived experience to become part of the dialogue, leading to increased understanding and trust. As professional distance recedes, humanity and compassion comes to the fore.

At the day-to-day level of change and practice, the findings point to respect, relationship and awareness. Consumer/clinician collaboration is a key strategy for the implementation of any work related to systems change. All persons with a stake in the project need to be in attendance at the SRRM, and all voices need to be supported to equal value.

The research makes a clear case for the advancement of consumer led research as a means to understand the needs of mental health consumers in situations where the possibility of restrictive practices may be imminent. Continuing research would seek evidence in settings where collaboration, shared decision-making and the validation of struggle are central features.

## Introduction

This research pilot study has been conducted by people who have experience of mental health challenges and the mental health care system, and is focused specifically on the Psychiatric Services Unit, PSU, at the Canberra Hospital. The aim of the research was to explore, in collaboration with consumer representatives and clinical staff, what has occurred during the weekly Seclusion and Restraint Review Meetings (SRRM) that has led to the huge reduction in the use of seclusion at the PSU.

Two sites were researched: the SRRM members and the Consumer Reference Group, CRG. The CRG were consulted about the relevance and appropriateness of the research process, as key players in maintaining consumer perspectives. Focus groups, the CRG research method, were conducted on three occasions: at initiation, prior to submitting for ethics approval, and at report (advanced draft) stage. The results of the CRG consultations guided the proposal, the ethics application, the methodological approach and the final documentation, to ensure consumer perspectives were included at all stages of the research.

The SRRM research process, conducted on two separate occasions, included a focus group (Narrative Definitional Ceremony) followed by Collective Biography writing. SRRM data was analysed, firstly through the interaction of research participants, secondly through content analysis in collaboration with research participants and thirdly by a performative dialogic analysis.

Research findings showed that the SRRM members considered consumer voice and the lived experience of both consumers and clinicians to be the central driver for cultural change in relation to seclusion reduction. Further findings highlighted the concept and practice of learning community, the role of challenge and discomfort, the capacity for personal and professional development, and unsuspected and far-reaching benefits for health services and the service users.

At the day-to-day level of change and practice, the findings point to respect, relationship and awareness. The research makes a clear case for the advancement of consumer led research as a means to understand the needs of mental health consumers in situations where the possibility of restrictive practices may be imminent.

This research is unique in the Australian context for having been proposed and conducted by an independent Consumer Researcher, and is transgressive for a number of reasons:

- ✚ It centres the consumer voice through the methodology.
- ✚ It works from evidence based in other criteria than traditional, quantifiable research that aims for provability, repeatability, and is rated against a control. Instead, it is grounded in relevance, resonance, probability and verisimilitude; what ‘rings true’ for the reader.
- ✚ It inverts the traditional knowledge base established through distanced, psychiatric, bio-medical ‘expert’ knowledge by focusing on the lived experience and close proximity of consumer / clinician collaboration.
- ✚ It has expanded the capacity for incorporating affect in decision-making, moving away from reaction towards response.
- ✚ It has been a dynamic, liberating and rule-breaking process within a culture that is rule-bound, and requires some vigilance to maintain, because of perceived threats to professional and personal identities.
- ✚ It holds onto “us and them” whilst at the same time bypassing formal separation, celebrating “I / thou”
- ✚ It is radical in the sense of reaching down to deeper dialogue, forging functional and supportive relationships and outreach, whilst creating liminal space for possibilities to manifest. The whole has become more than the sum of the parts. It has allowed “more light, less heat.”

Whilst individual input forms much of the text of this report, identities have been erased and original contexts bleed into each other. Decontextualisation was part of the original intent of the research in developing a collective account, whilst presenting the report in a way where both participants and readers could ‘see and read themselves’ in the text.

To achieve this aim the author has followed a process of deep immersion, ‘taking back’ to collaborators the ongoing shaping of the document. This allows for individual and collective integrity. The author invites readers also to see themselves in the text, to immerse themselves in what is essentially a messy text made readable through the artifice of chapters.

The chapters containing **The Stories**, the chapter on **‘Seclusion’** and the **‘Third Analysis’** are composed of participants’ voices, edited simply for ease of reading and to dis-identify individuals. The resulting text makes use of various fonts to indicate random voices engaged in dialogue, and sometimes repeats data that fits into more than one conversation.

The research document is a constructed research dialogue about the SRRM. It is drawn from collective research material positioned in such a way as to bring seclusion, and the ideas that underpin the practice of seclusion, to the fore as the very material that has informed the changing culture, personal and professional identities, and practices at the SRRM and the PSU.

The document utilizes qualitative data first collected for the Beacon Site Project, and now collected by ACT Health to support “the use of data to drive change” (Kipling, 2011, pers. com.), to set a historical context, and to provide a visual perspective on the significant reductions on the use of seclusion at the PSU. The document is supported by literature reviews on both seclusion reduction and consumer led research and makes recommendations in regard to future research and the possible implications for Mental Health Services.

## Seclusion

*It is most important to understand the traumatising effects of seclusion and the need to avoid it; despite some consumers having voiced through the Seclusion review documentation that they felt the seclusion was beneficial for them and the only option.*

*Through training, where the raw, unmediated experiences of seclusion have been presented and through hearing consumers in the SRRM speaking clearly about seclusion and other practices of exclusion, we have come to understand that when consumers say that seclusion was a neutral or positive experience, then we need to examine whether this may have been a forced choice, the better of two evils e.g. Where a person has no other place to find some peace on the ward, or that the person may be reporting on their experience so that staff will understand them as compliant.*

*Because seclusion has come to be regarded as non-therapeutic and a failure of the system, nurses have had to look at the reasons behind consumer distress and find ways of alleviating it. It involves looking past the bad energy being expressed, to seeing a person with a problem.*

We were all professionals in the room with a united goal and that was to reduce trauma for consumers of Mental Health Services and to ensure their journey was dominated by positive therapeutic interventions.

*Pavlov's research on negative reinforcement verses positive reinforcement is a good example of the Seclusion Review process. The quorum as a whole was committed to introducing positive reinforcement tools rather than the negative ones such as seclusion.*

*The SRRM took up an exciting challenge at a time in Australia when mental health is on the verge of transition into a recovery orientation. It is times like these when people become inspired and fight to come out from under the yoke of dominant and outmoded ideas, claiming their own place in caring community and inspiring others to join them, because it makes ordinary sense to do so.*

## What is SRRM?

All you need to know about the SECLUSION and RESTRAINT REVIEW MEETING (SRRM), a consumer and clinician collaboration, at the Psychiatric Services Unit (PSU) at The Canberra Hospital

The purpose of the SRRM is to reduce seclusion and restraint at the PSU.

### History

In 2006 in Australia there were 6 regional trainings conducted by the National Association of State Mental Health Program Directors (NASMHPD) from the US. The trainings were titled “Reduction of Seclusion and Restraint: Creating Violence Free and Coercion Free Mental Health Treatment Environments”. From these the Beacon project emerged, commencing in August 2007. The Beacon Project included 11 demonstration sites of which the Psychiatric Services Unit, Mental Health ACT, was one. 18 scholarships were also awarded, and 4 staff and consumers from the ACT travelled to the US, the UK, Italy and the Netherlands and reported back to the project on overseas developments in the reduction of seclusion and restraint.

The Seclusion and Restraint Working Group was established by Mental Health ACT during this same period to implement locally the direction of the National Initiative and to set up the SRRM in May, 2009 as a practical, in situ strategy for continuing the previous work. During the Beacon Site Project, 2007-08, seclusion was reduced to 8.5% (of patient admissions), during 2008-09 to 6.9% and in the years after the SRRM was established, to 2.3%, and in the last year to less than 1%. In 2009-10 there was a four-month period with **no** seclusions and in 2010-11 a period of 5 months. How was this accomplished?

### Processes

The SRRM closely examines every incident of seclusion, restraint, and many ‘near misses’ to find out what happened, what could have been done differently, or what - in particular - is working to prevent seclusion. The meeting comprises four consumers, the PSU team leader, nurses, ward services personnel and allied health workers and doctors. The SRRM takes into account the skill mix present on the ward, what else

was going on, the time of day, medication, the history and the social context of the person concerned.

The SRRM has developed a culture in which difficult situations can be discussed without blame, where every point of view is valued, every voice is heard and respected; where practices of exclusion, such as values that privilege staff over consumers, or beliefs that rob consumers of agency and dignity, are rigorously investigated. This is not always an easy process.

Nonetheless, in creating this culture, attitudes are challenged and changed, and the renewed energy passes ‘downstairs’ to the acute ward, maintaining systemic and cultural changes that enable all stakeholders to better support consumers.

For example, staff used to call on the ward services to restrain an agitated consumer; now the same wardspersons are part of an Early Support and Intervention Team (ES&IT), whose role is to defuse and pro-actively prevent seclusion. The team’s special training includes hearing consumers’ stories of seclusion.

The ES&IT is an initiative of the SRM, as is the Coping and Safety Tool (C&ST), an ongoing consultative process that engages consumers in identifying their own triggers and coping skills, reinforcing Recovery principles of active involvement in managing symptoms. The collaborative consultations also inform staff of how best to support individuals in acute distress, offering other options, sensory modulation being one of these.

## Conclusion

Seclusion at the PSU is now seen as a failure in care and is no longer viewed as a therapeutic option.

## Beyond the Beacon Site Project, Quantitative Data

As part of the National Seclusion and Restraint project MH-ACT has had a specific focus on seclusion as a participating beacon site member of the project. This has led to a review of the use of seclusion and efforts to reduce the rate of seclusion as part of the project aims. This has led to the ongoing Seclusion Review Working group monitoring seclusion events since 2009-10.

### PSU Seclusion Data

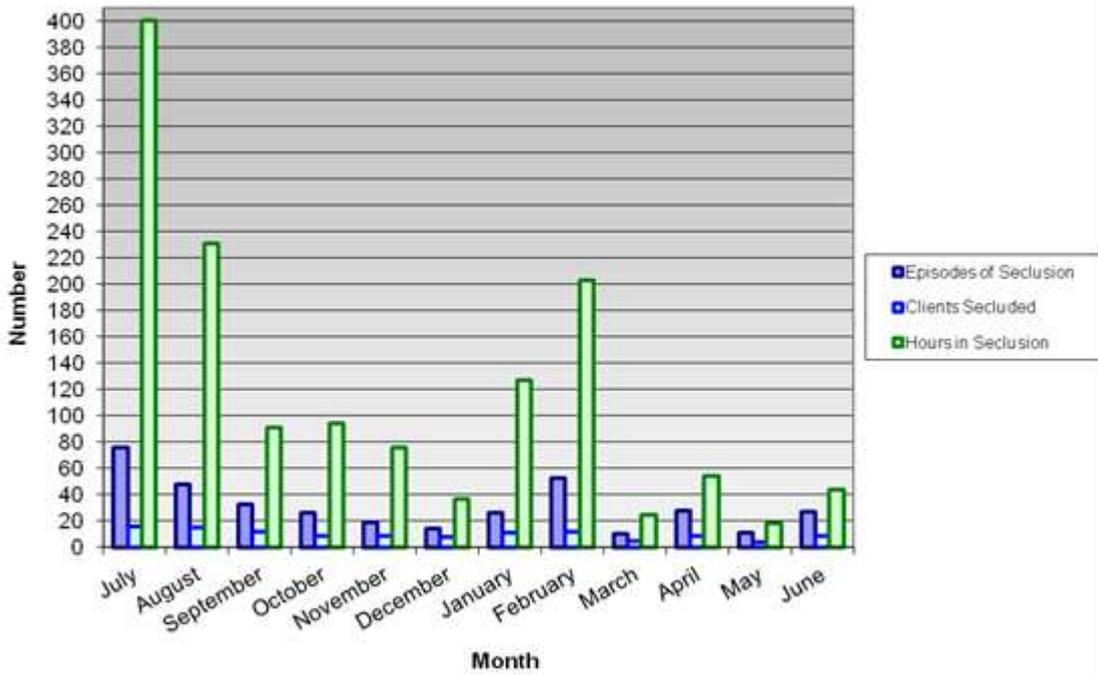
2006/07					2007/08				
Month	Episodes of seclusion	Number of clients secluded	Total hours of Seclusion	Hours	Month	Episodes of seclusion	Number of clients secluded	Total hours of Seclusion	Hours
July	76	16	400hrs 30min	400.5	July	19	8	43hrs 54min	43.9
August	48	15	231hrs 6min	231.1	August	21	10	41hrs	41.0
September	33	12	90hrs 45min	90.8	September	70	16	233hrs 20min	233.3
<b>Quarter 1 TOTAL</b>	<b>157</b>	<b>43</b>	<b>722hrs 24min</b>	<b>722.4</b>	<b>Quarter 1 TOTAL</b>	<b>110</b>	<b>34</b>	<b>318hrs 12min</b>	<b>318.2</b>
October	26	9	94hrs 30min	94.5	October	24	11	128hrs 45min	128.8
November	19	9	76hrs 15min	76.3	November	18	7	38hrs 55min	38.9
December	14	8	36hrs 30min	36.5	December	20	6	65hrs 25min	65.4
<b>Quarter 2 TOTAL</b>	<b>59</b>	<b>26</b>	<b>207hrs 18min</b>	<b>207.3</b>	<b>Quarter 2 TOTAL</b>	<b>62</b>	<b>24</b>	<b>233hrs 5min</b>	<b>233.1</b>
January	26	11	127hrs 5min	127.1	January	43	12	111hrs 55min	111.9
February	53	12	203hrs	203.0	February	43	14	113hrs 35min	113.6
March	10	5	25hrs	25.0	March	16	5	52hrs 15min	52.3
<b>Quarter 3 TOTAL</b>	<b>89</b>	<b>28</b>	<b>355hrs 5min</b>	<b>355.1</b>	<b>Quarter 3 TOTAL</b>	<b>102</b>	<b>31</b>	<b>227hrs 48min</b>	<b>277.8</b>
April	28	9	54hrs 30min	54.5	April	12	5	21hrs 20min	21.3
May	11	4	18hrs 36min	18.6	May	7	3	12hrs 25min	12.4
June	27	9	43hrs 40min	43.7	June	18	5	30hrs 25min	30.4
<b>Quarter 4 TOTAL</b>	<b>66</b>	<b>22</b>	<b>116hrs 48min</b>	<b>116.8</b>	<b>Quarter 4 TOTAL</b>	<b>37</b>	<b>13</b>	<b>64hrs 10min</b>	<b>64.2</b>
<b>2006-07 TOTAL</b>	<b>371</b>	<b>119</b>	<b>1401hrs 30min</b>	<b>1401.5</b>	<b>2007-08 TOTAL</b>	<b>311</b>	<b>102</b>	<b>893hrs 14min</b>	<b>893.2</b>

## PSU Seclusion Data

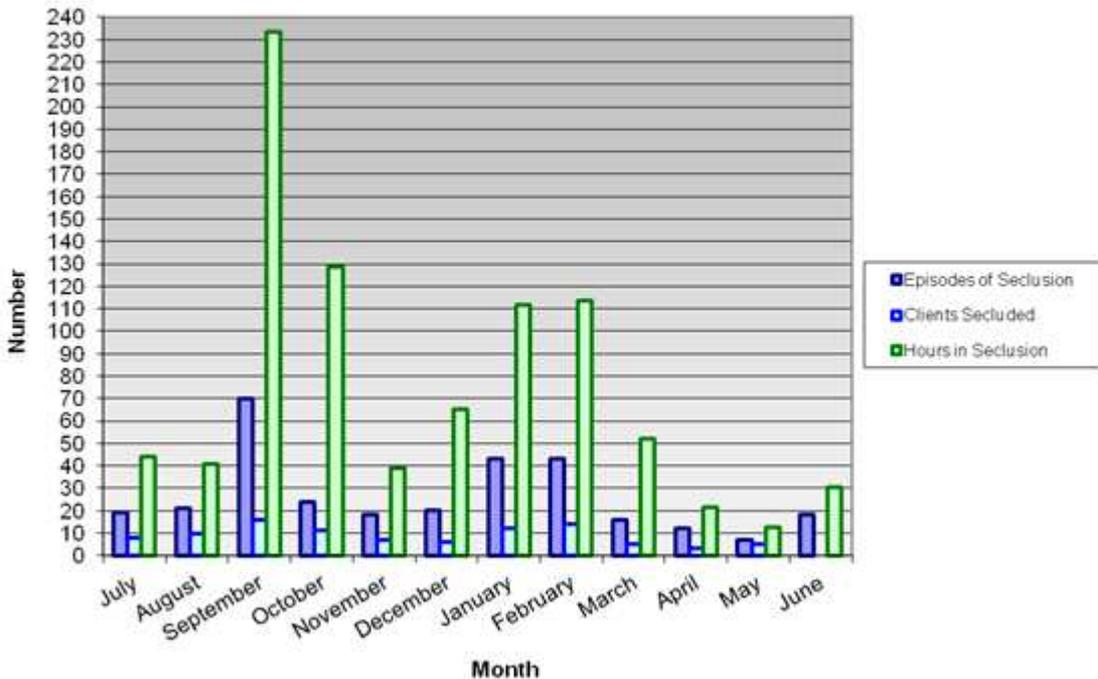
2008/09					2009/10				
Month	Episodes of seclusion	Number of clients secluded	Total hours of Seclusion	Hours	Month	Episodes of seclusion	Number of clients secluded	Total hours of Seclusion	Hours
July	37	9	75hrs 15 min	75.3	July	10	5	14hr 20min	14.3
August	47	9	86hrs 18 min	86.3	August	3	3	3hr 20min	3.3
September	37	9	68 hrs 15 min	68.3	September	5	4	5hrs 20min	5.3
<b>Quarter 1 TOTAL</b>	<b>121</b>	<b>27</b>	<b>229hrs 48min</b>	<b>229.8</b>	<b>Quarter 1 TOTAL</b>	<b>18</b>	<b>12</b>	<b>23hrs</b>	<b>23.0</b>
October	25	10	32hrs 50 min	32.8	October	4	4	6hrs 5min	6.1
November	10	7	18hrs 5 min	18.1	November	4	4	5hrs 45min	5.8
December	20	7	51 hrs 15 min	51.3	December	3	3	4hrs 45min	4.8
<b>Quarter 2 TOTAL</b>	<b>55</b>	<b>24</b>	<b>102 hrs 10min</b>	<b>102.2</b>	<b>Quarter 2 TOTAL</b>	<b>11</b>	<b>11</b>	<b>16hrs 45min</b>	<b>16.6</b>
January	16	5	20hrs 15 min	20.3	January	1	1	1hr 0min	1.0
February	14	8	21hrs 45 min	21.8	February	2	2	1hr 15 min	1.3
March	27	4	69hrs 26 min	69.4	March	0	0	0	0.0
<b>Quarter 3 TOTAL</b>	<b>57</b>	<b>17</b>	<b>111hrs 26min</b>	<b>111.4</b>	<b>Quarter 3 TOTAL</b>	<b>3</b>	<b>3</b>	<b>2hrs 15min</b>	<b>2.3</b>
April	12	7	14hrs 40min	14.7	April	1	1	2hrs 30min	2.5
May	42	11	61hrs 22min	61.4	May	4	2	8hrs 20min	8.3
June	10	3	9hrs 5min	9.1	June	2	2	4hrs 30min	4.5
<b>Quarter 4 TOTAL</b>	<b>64</b>	<b>21</b>	<b>85hrs 7min</b>	<b>85.1</b>	<b>Quarter 4 TOTAL</b>	<b>7</b>	<b>5</b>	<b>15hrs 20min</b>	<b>15.3</b>
<b>2008-09 TOTAL</b>	<b>297</b>	<b>89</b>	<b>528hrs 30min</b>	<b>528.5</b>	<b>2009-10 TOTAL</b>	<b>39</b>	<b>31</b>	<b>57hrs 10min</b>	<b>57.2</b>

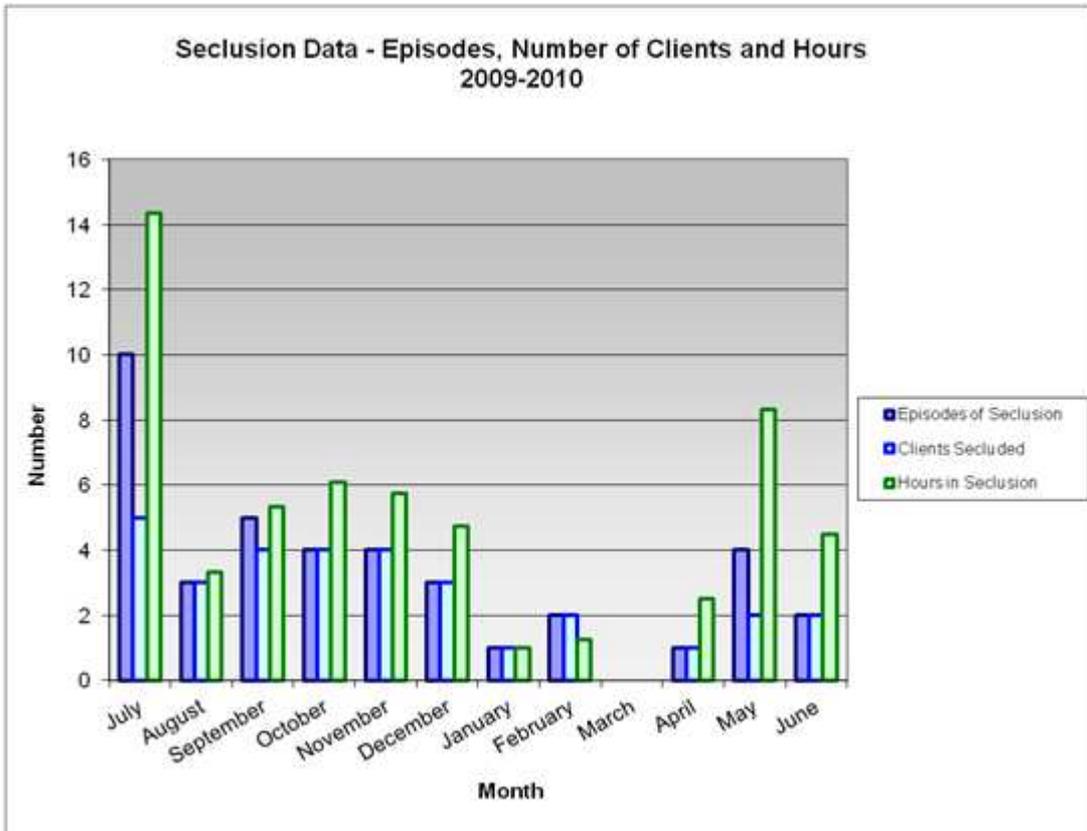
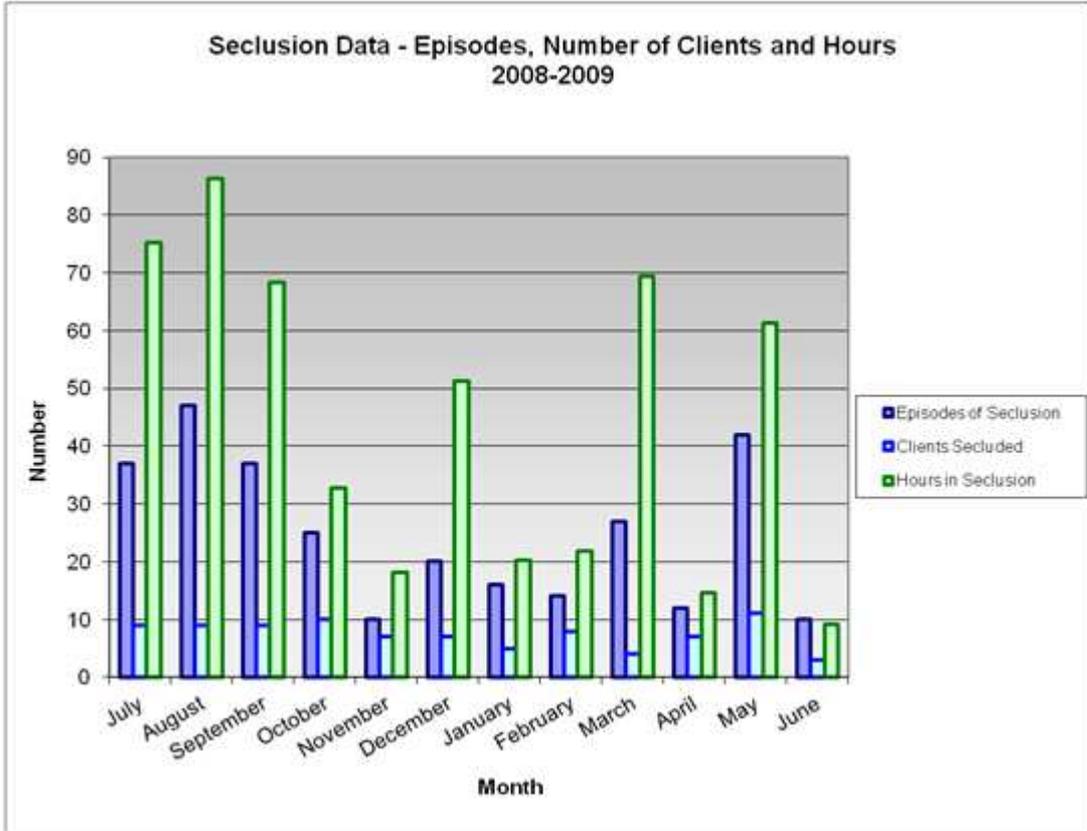
2010/11					2011/12			
Month	Episodes of seclusion	Number of clients secluded	Total hours of Seclusion	Hours	Month	Episodes of seclusion	Number of clients secluded	Total hours of Seclusion
July	0	0	0	0.0	July	11	3	19hrs 30min
August	4	3	4hrs 50min	4.8	August	0	0	0
September	1	1	15min	0.3	September	0	0	0
<b>Quarter 1 TOTAL</b>	<b>5</b>	<b>4</b>	<b>5hrs 5min</b>	<b>5.1</b>	<b>Quarter 1 TOTAL</b>	<b>11</b>	<b>3</b>	<b>19hrs 30min</b>
October	0	0	0	0.0	October	2	1	2hrs 15min
November	0	0	0	0.0	November	0	0	0
December	1	1	90min	1.5	December	2	1	5
<b>Quarter 2 TOTAL</b>	<b>1</b>	<b>1</b>	<b>90min</b>	<b>1.5</b>	<b>Quarter 2 TOTAL</b>	<b>4</b>	<b>2</b>	
January	1	1	30min	0.5	January	0	0	0
February	4	2	3hrs 30min	3.5	February			
March	0	0	0	0.0	March			
<b>Quarter 3 TOTAL</b>	<b>5</b>	<b>3</b>	<b>4hrs 0min</b>	<b>4.0</b>	<b>Quarter 3 TOTAL</b>	<b>0</b>	<b>0</b>	
April	0	0	0	0.0	April			
May	0	0	0	0.0	May			
June	5	1	14hrs 45min	14.75	June			
<b>Quarter 4 TOTAL</b>	<b>5</b>	<b>1</b>	<b>14hrs 45min</b>	<b>14.8</b>	<b>Quarter 4 TOTAL</b>	<b>0</b>	<b>0</b>	
<b>2010-11 TOTAL</b>	<b>16</b>	<b>9</b>	<b>25hrs 20min</b>	<b>25.3</b>	<b>2011-12 TOTAL</b>	<b>15</b>	<b>5</b>	

Seclusion Data - Episodes, Number of Clients and Hours  
2006-2007

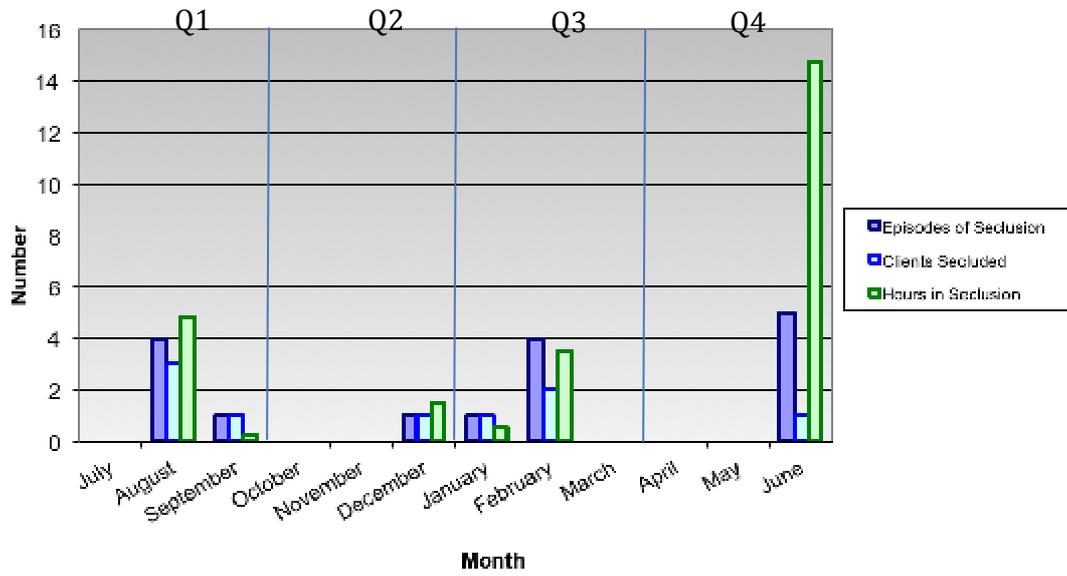


Seclusion Data - Episodes, Number of Clients and Hours  
2007-2008

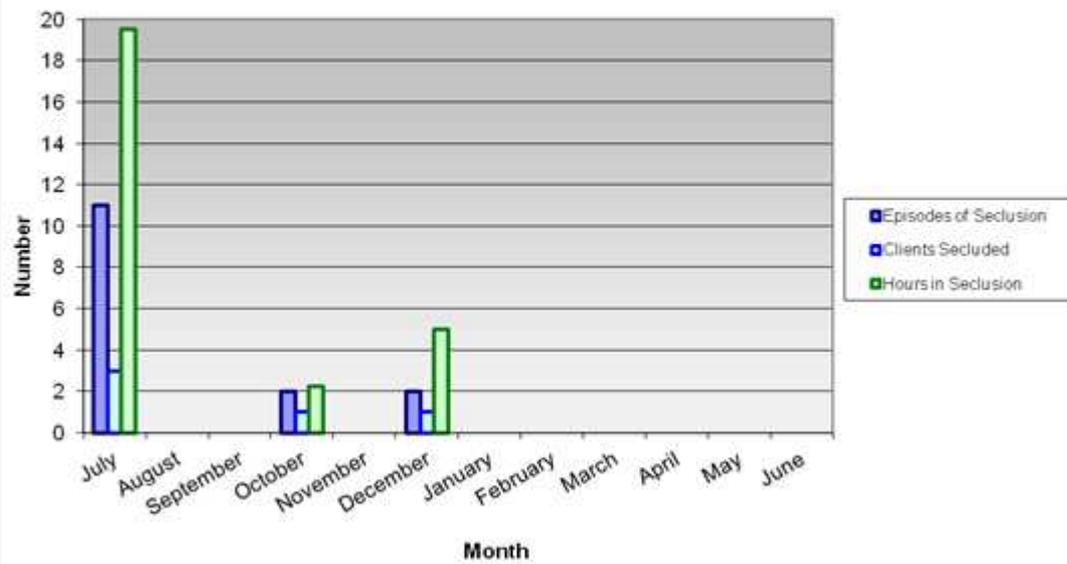




**Seclusion Data - Episodes, Number of Clients and Hours  
2010-2011**

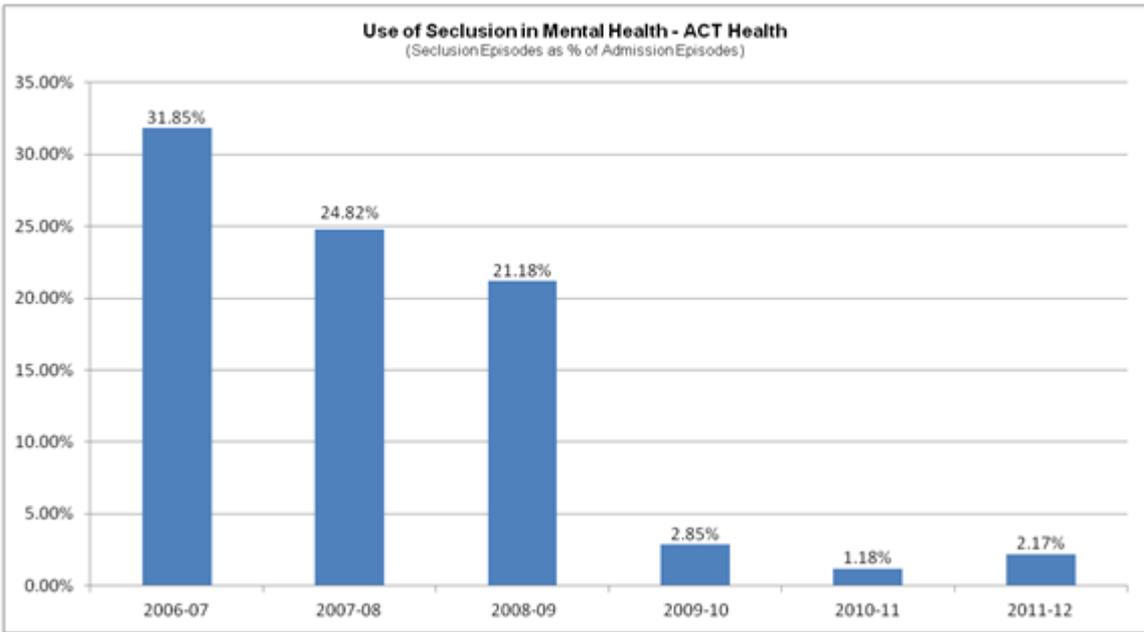


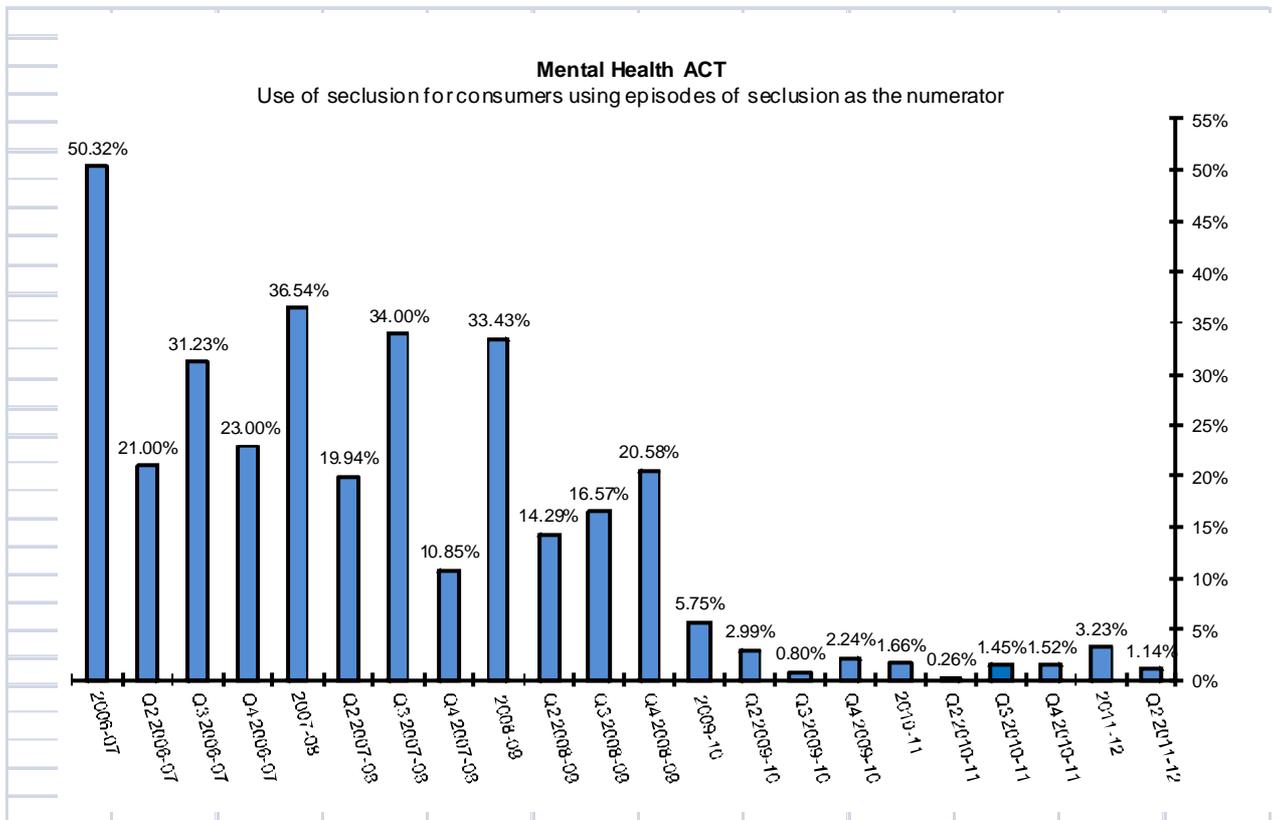
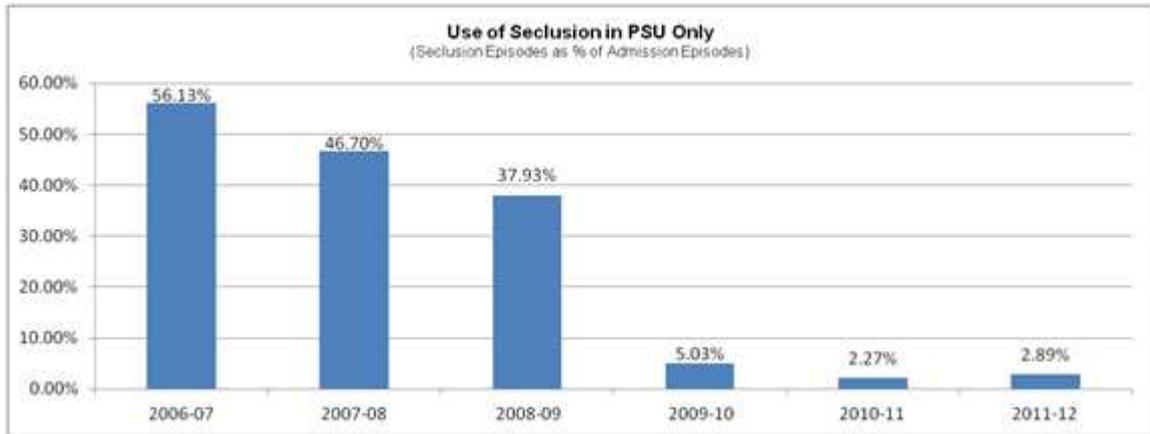
**Seclusion Data - Episodes, Number of Clients and Hours  
2011-2012**

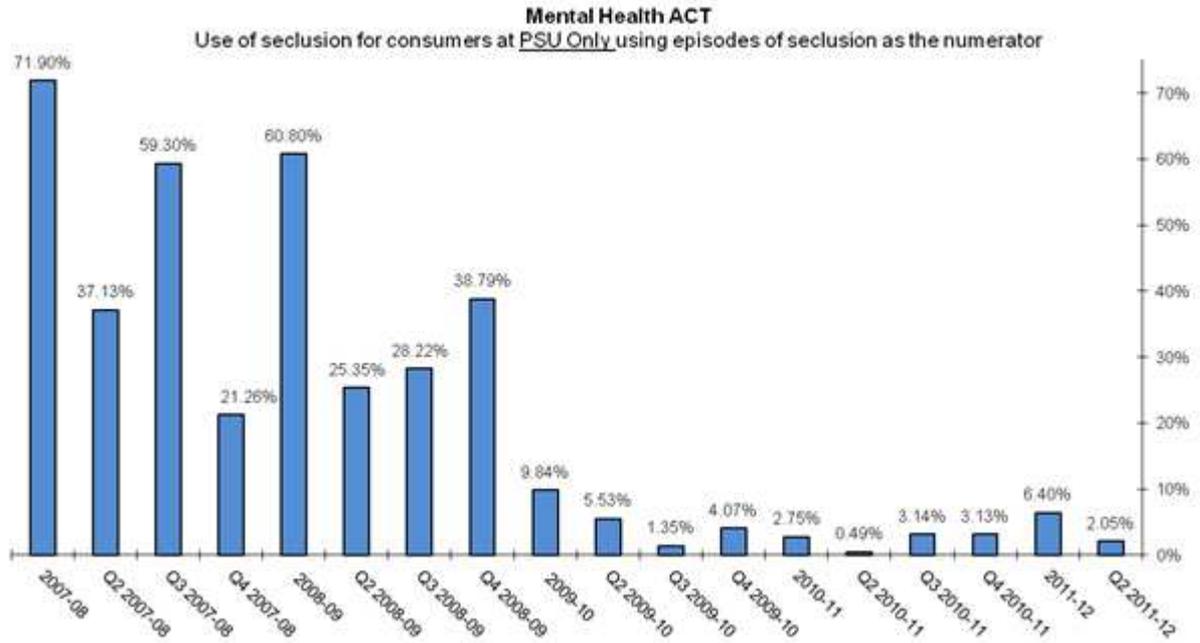


## Use of seclusion for consumers

Use of seclusion for consumers														
	No of Inpatient Separations				No of Seclusion Episodes (PSU, BHRC & OPMHU)								PSU Only Rate	PSU Only YTD
	TCH-PSU	Calvary-2N	BHRC	OPMHU	Total Inpatient Separations Mental Health Service				% seclusion episodes					
					mth	ytd	mth	ytd	QTR	YTD	Target			
2006-07	193	110	9	0	157	157	312	312	50.32%	50.32%	9.00%	81.35%	81.35%	
Q2 2006-07	164	112	5	0	59	216	281	593	21.00%	36.42%	9.00%	35.98%	60.50%	
Q3 2006-07	162	99	23	1	89	305	285	878	31.23%	34.74%	9.00%	54.94%	58.77%	
Q4 2006-07	142	122	12	11	66	371	287	1165	23.00%	31.85%	9.00%	46.48%	56.13%	
2007-08	153	123	7	18	110	110	301	301	36.54%	36.54%	9.00%	71.90%	71.90%	
Q2 2007-08	167	120	7	17	62	172	311	612	19.94%	28.10%	9.00%	37.13%	53.75%	
Q3 2007-08	172	95	7	26	102	274	300	1199	34.00%	22.85%	9.00%	59.30%	55.69%	
Q4 2007-08	174	134	8	25	37	311	341	1253	10.85%	24.82%	9.00%	21.26%	46.70%	
2008-09	199	132	5	26	121	121	362	362	33.43%	33.43%	9.00%	60.80%	60.80%	
Q2 2008-09	217	139	1	28	55	176	385	747	14.29%	23.56%	9.00%	25.35%	42.31%	
Q3 2008-09	202	111	4	27	57	233	344	1091	16.57%	21.36%	9.00%	28.22%	37.70%	
Q4 2008-09	165	110	4	32	64	297	311	1402	20.58%	21.18%	9.00%	38.79%	37.93%	
2009-10	183	103	3	24	18	18	313	313	5.75%	5.75%	9.00%	9.84%	9.84%	
Q2 2009-10	199	129	10	30	11	29	368	681	2.99%	4.26%	9.00%	5.53%	7.59%	
Q3 2009-10	222	118	5	29	3	32	374	1055	0.80%	3.03%	9.00%	1.35%	5.30%	
Q4 2009-10	172	101	8	32	7	38	313	1368	2.24%	2.85%	9.00%	4.07%	5.03%	
2010-11	182	74	10	35	5	5	301	301	1.66%	1.66%	5.00%	2.75%	2.75%	
Q2 2010-11	205	126	5	42	1	6	378	679	0.26%	0.88%	5.00%	0.49%	1.55%	
Q3 2010-11	159	126	17	42	5	11	344	1023	1.45%	1.08%	5.00%	3.14%	2.01%	
Q4 2010-11	160	137	8	24	5	16	329	1352	1.52%	1.18%	5.00%	3.13%	2.27%	
2011-12	172	118	8	43	11	11	341	341	3.23%	3.23%	5.00%	6.40%	3.08%	
Q2 2011-12	195	100	9	43	4	15	351	692	1.14%	2.17%	5.00%	2.05%	2.89%	
Q3 2011-12								692	#DIV/0!	0.00%	5.00%	#DIV/0!	2.89%	
Q4 2011-12								0	692	#DIV/0!	0.00%	5.00%	#DIV/0!	2.89%

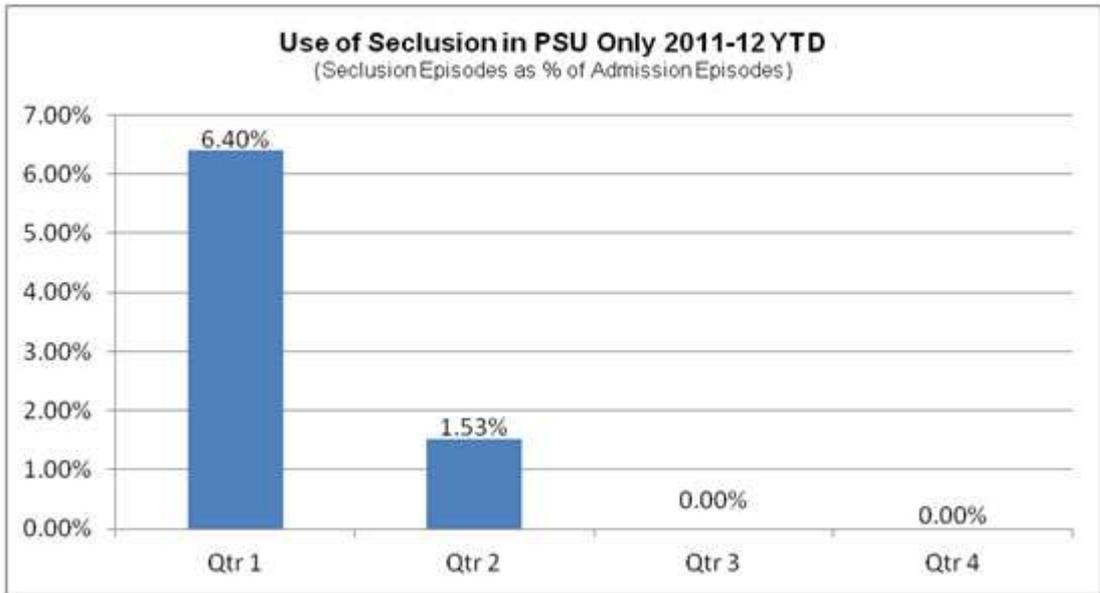
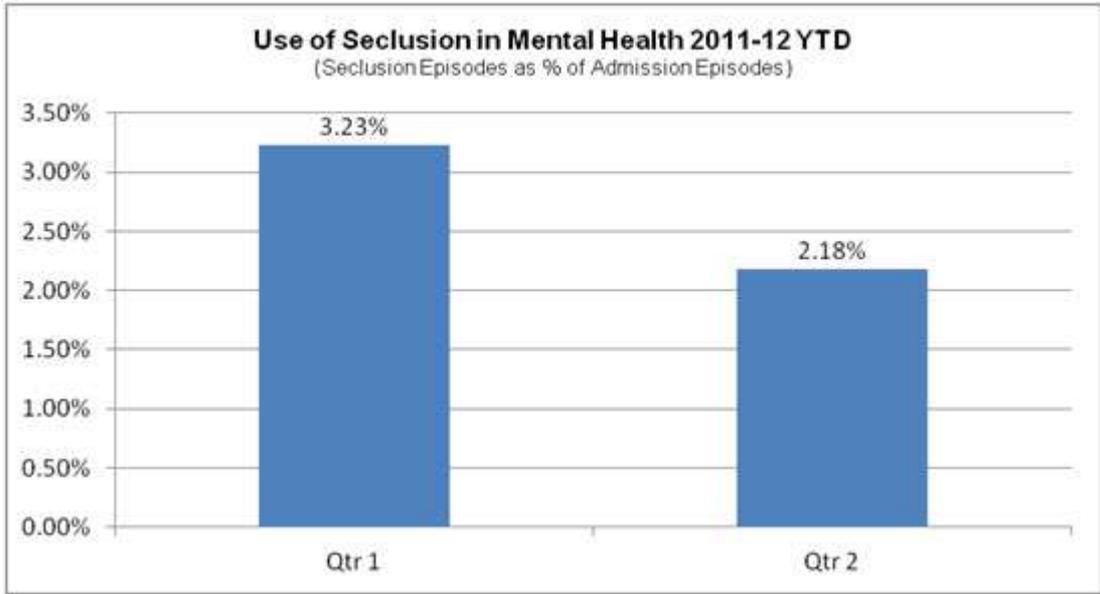




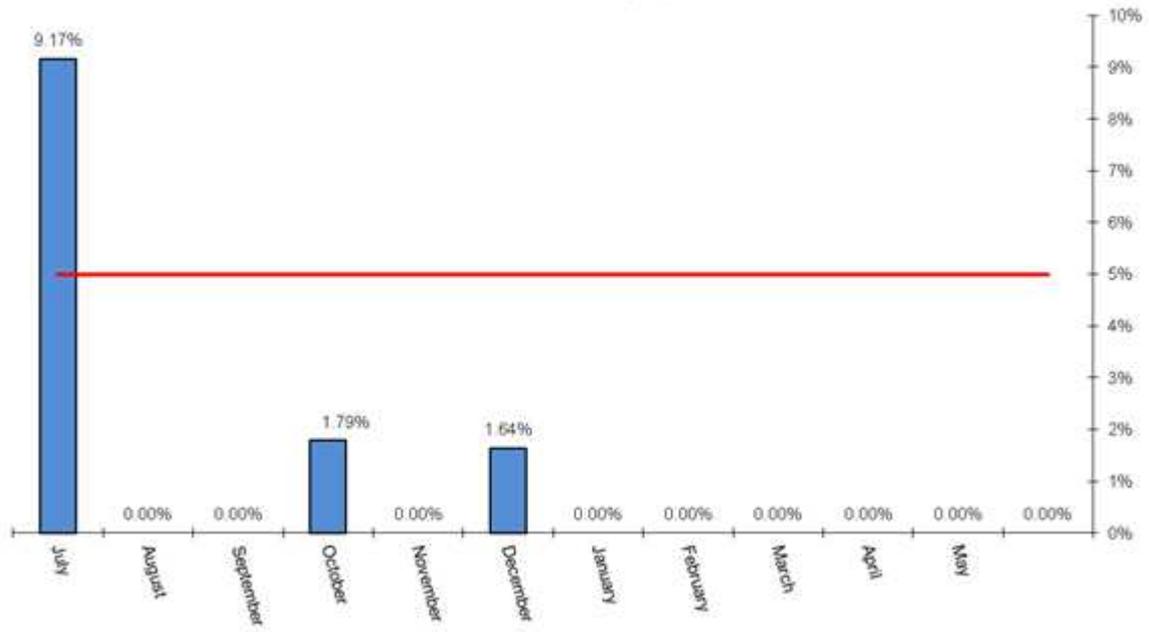


## Use of seclusion for consumers 2011-12

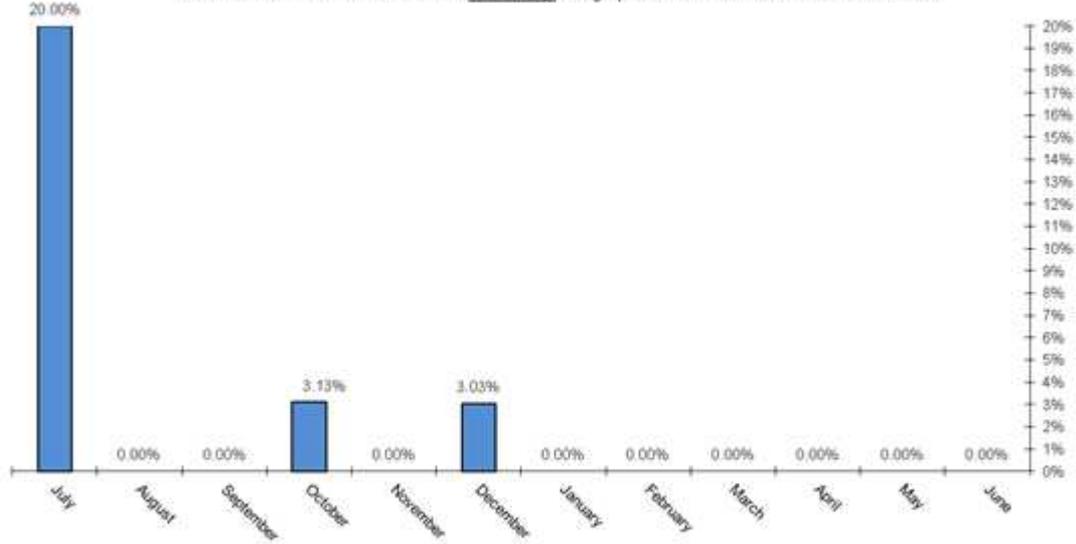
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						No of Seclusion Episodes (PSU, BHRC & OPMHU)											
						Total Inpatient Separations Mental Health Service											
						% seclusion episodes											
		TCH-PSU	Calva	BHRC	OPMHU	mth	ytd	mth	ytd	Mthly	YTD	<Target	PSU Only Rate	PSU Only YTD			
	July	55	46	3	16	11	11	120	120	9.17%	9.17%	5.00%	20.00%	20.00%			
	August	54	39	3	15	0	11	111	231	0.00%	4.76%	5.00%	0.00%	10.09%			
Qtr 1	September	63	33	2	12	0	11	110	341	0.00%	3.23%	5.00%	0.00%	6.40%			
	October	64	37	3	8	2	13	112	453	1.79%	2.87%	5.00%	3.13%	5.51%			
	November	65	31	2	15	0	13	113	566	0.00%	2.30%	5.00%	0.00%	0.00%			
Qtr 2	December	66	32	4	20	2	15	122	688	1.64%	2.18%	5.00%	3.03%	1.53%			
	January	79	43	2	11	0	15	135	823	0.00%	1.82%	5.00%	0.00%	0.95%			
	February					0	15	0	823	#DIV/0!	1.82%	5.00%	#DIV/0!	0.95%			
Qtr 3	March					0	15	0	823	#DIV/0!	1.82%	5.00%	#DIV/0!	#DIV/0!			
	April					0	15	0	823	#DIV/0!	1.82%	5.00%	#DIV/0!	#DIV/0!			
	May					0	15	0	823	#DIV/0!	1.82%	5.00%	#DIV/0!	#DIV/0!			
Qtr 4	June					0	15	0	823	#DIV/0!	1.82%	5.00%	#DIV/0!	#DIV/0!			



**Mental Health, Justice Health and Alcohol & Drug Services 2011-12**  
 Use of seclusion for mental health consumers using episodes of seclusion as the numerator

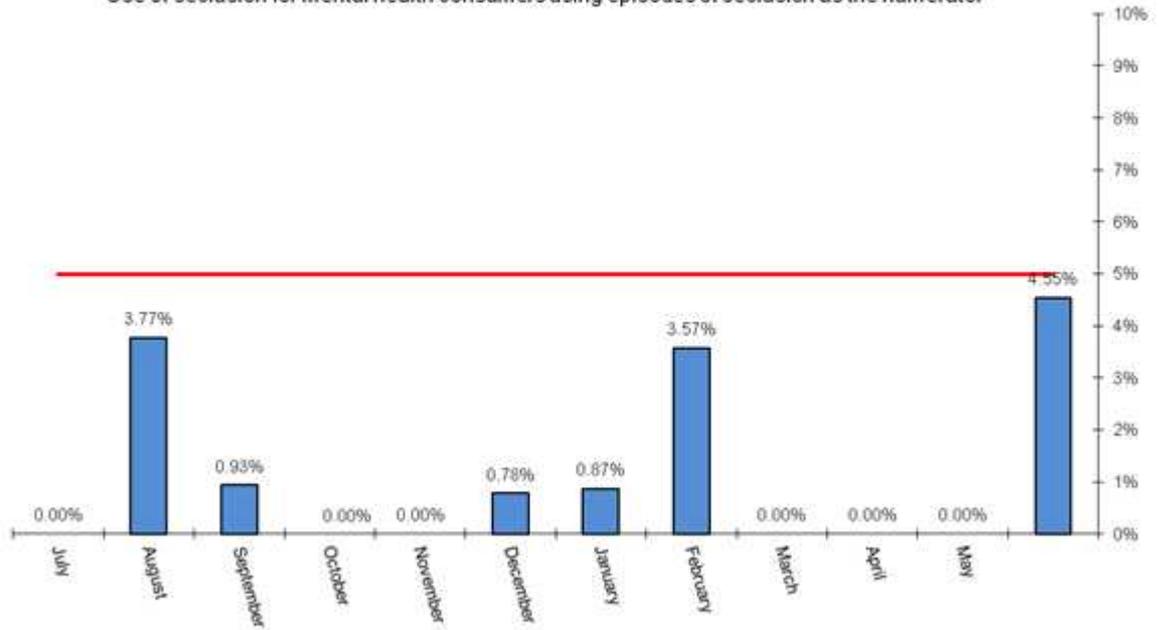


**Mental Health Monthly 2011-12**  
 Use of seclusion for consumers at PSU Only using episodes of seclusion as the numerator

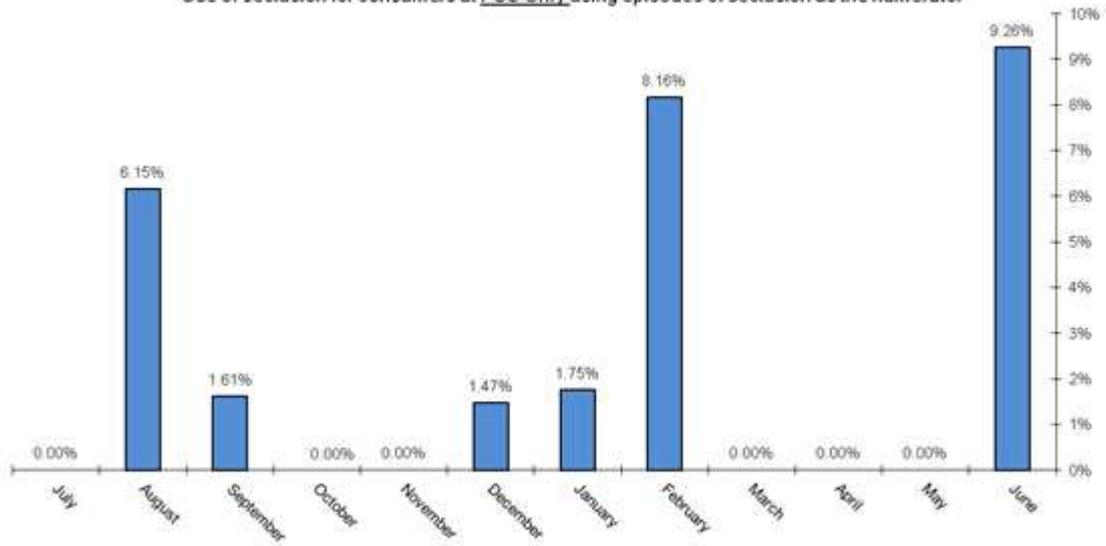




**Mental Health, Justice Health and Alcohol & Drug Services 2010-11**  
 Use of seclusion for mental health consumers using episodes of seclusion as the numerator

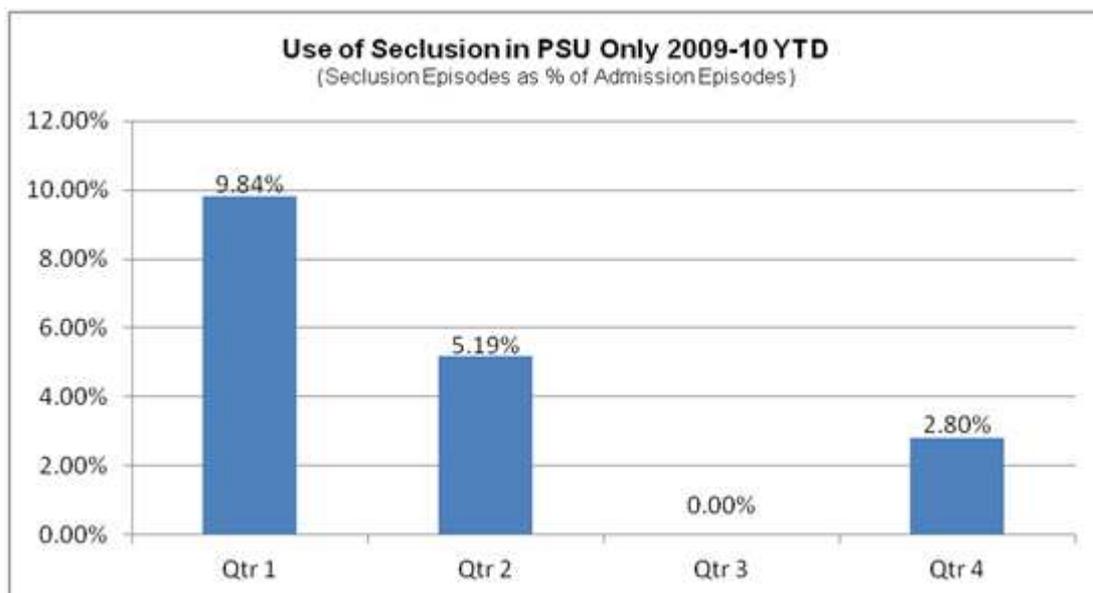
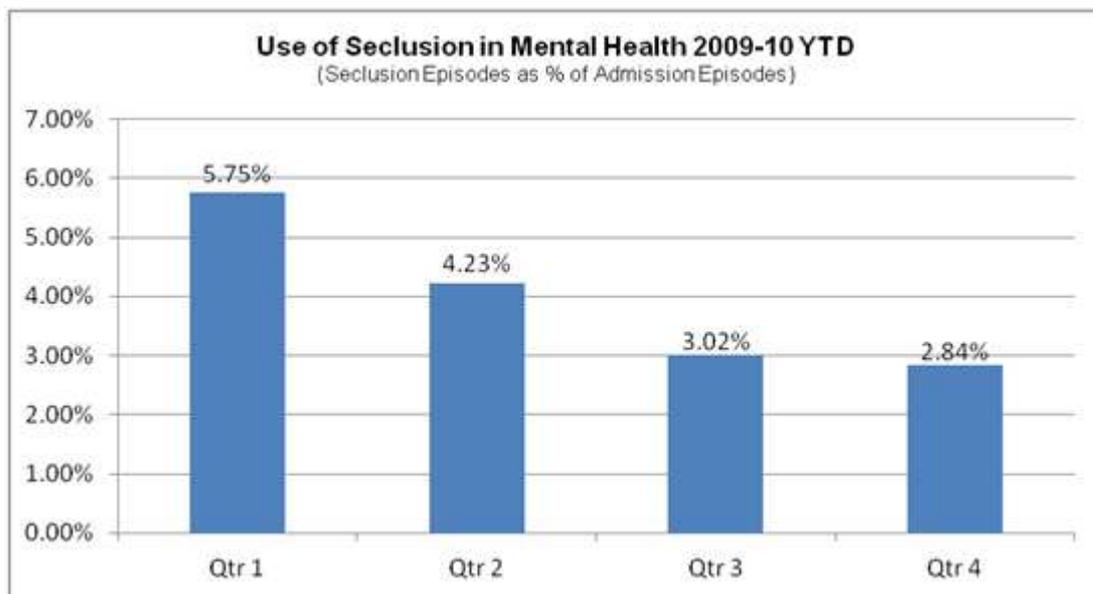


**Mental Health Monthly 2010-11**  
 Use of seclusion for consumers at PSU Only using episodes of seclusion as the numerator

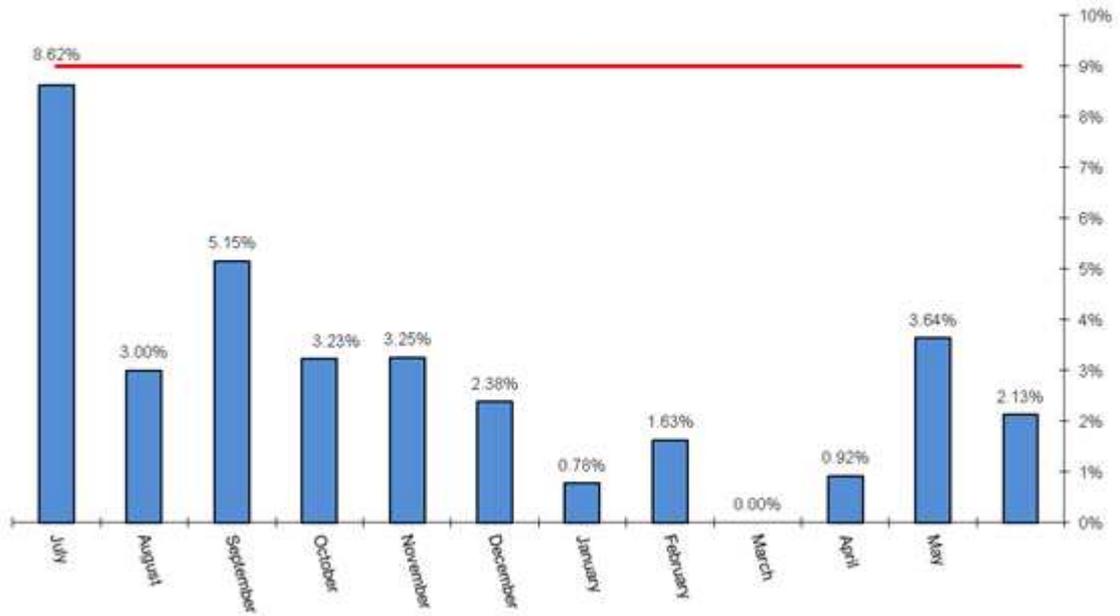


## Use of seclusion for consumers 2009-10

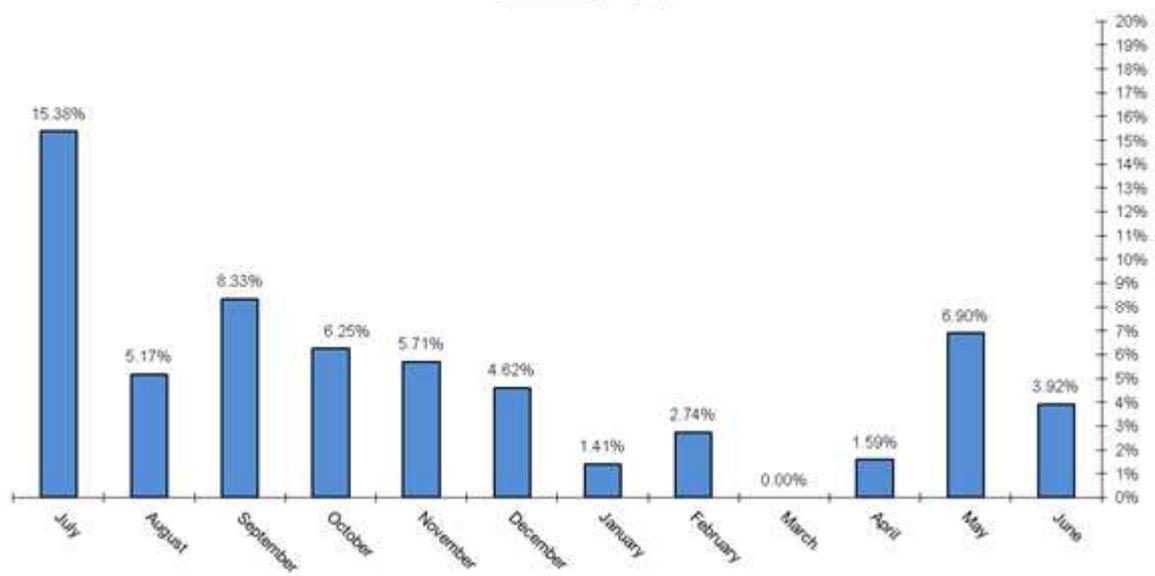
Use of seclusion for consumers															
No of Inpatient Separations					No of Seclusion Episodes (PSU, BHRC & OPMHU)										
	TCH-PSU	Calva	BHRC	OPMHU	mth		ytd		Total Inpatient Separations Mental Health Service			% seclusion episodes		PSU Only Rate	PSU Only YTD
									Mthly	YTD	<Target				
July	65	39	1	11	10	10	116	116	8.62%	8.62%	9.00%	15.38%	15.38%		
August	58	32	2	8	3	13	100	216	3.00%	6.02%	9.00%	5.17%	10.57%		
Qtr 1	September	60	32	0	5	5	18	97	313	5.15%	5.75%	9.00%	8.33%	9.84%	
	October	64	46	7	7	4	22	124	437	3.23%	5.03%	9.00%	6.25%	8.91%	
	November	70	40	4	9	4	26	123	560	3.25%	4.64%	9.00%	5.71%	5.71%	
Qtr 2	December	65	43	4	14	3	29	126	686	2.38%	4.23%	9.00%	4.62%	5.19%	
	January	71	45	2	11	1	30	129	815	0.78%	3.68%	9.00%	1.41%	3.88%	
	February	73	39	2	9	2	32	123	938	1.63%	3.41%	9.00%	2.74%	3.58%	
Qtr 3	March	78	34	1	9	0	32	122	1060	0.00%	3.02%	9.00%	0.00%	0.00%	
	April	63	35	6	5	1	33	109	1169	0.92%	2.82%	9.00%	1.59%	0.71%	
	May	58	41	2	9	4	37	110	1279	3.64%	2.89%	9.00%	6.90%	2.51%	
Qtr 4	June	51	25	0	18	2	39	94	1373	2.13%	2.84%	9.00%	3.92%	2.80%	



**Mental Health 2009-10**  
Use of seclusion for mental health consumers using episodes of seclusion as the numerator

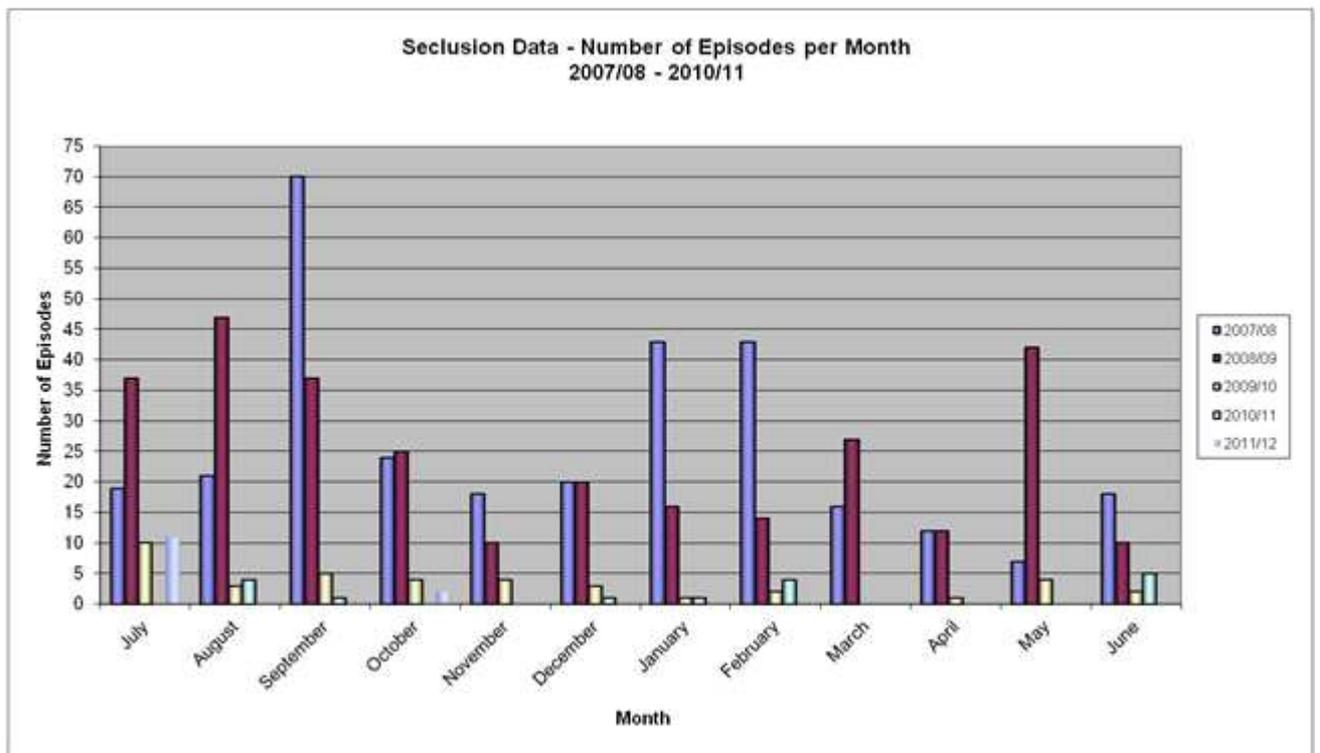


**Mental Health Monthly 2009-10**  
Use of seclusion for consumers at PSU Only using episodes of seclusion as the numerator

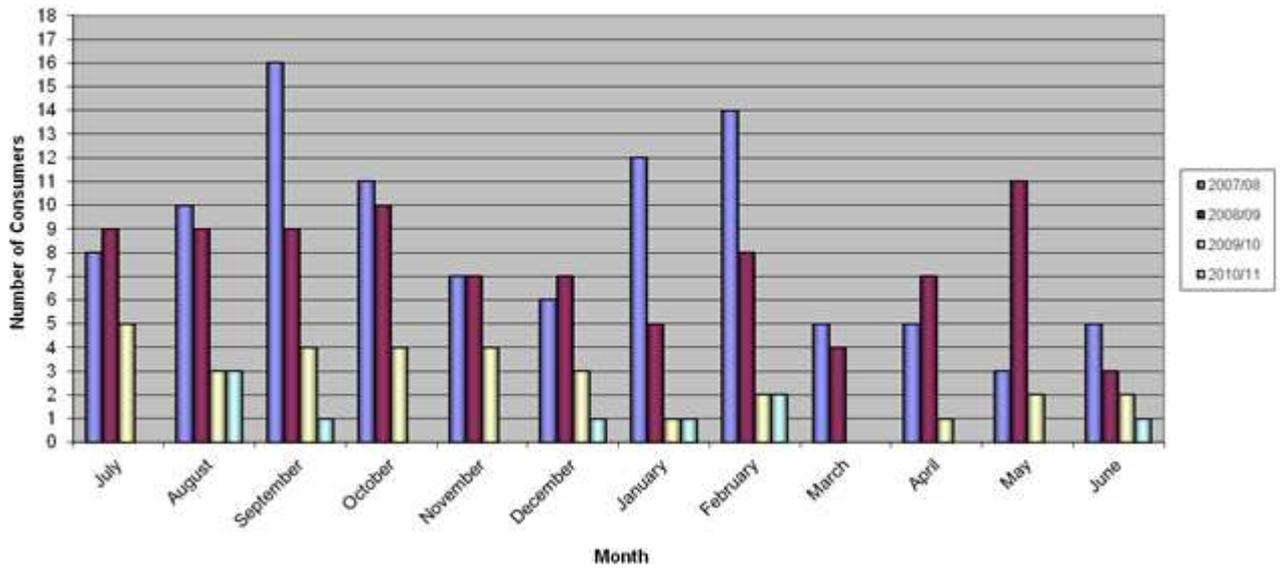


# PSU

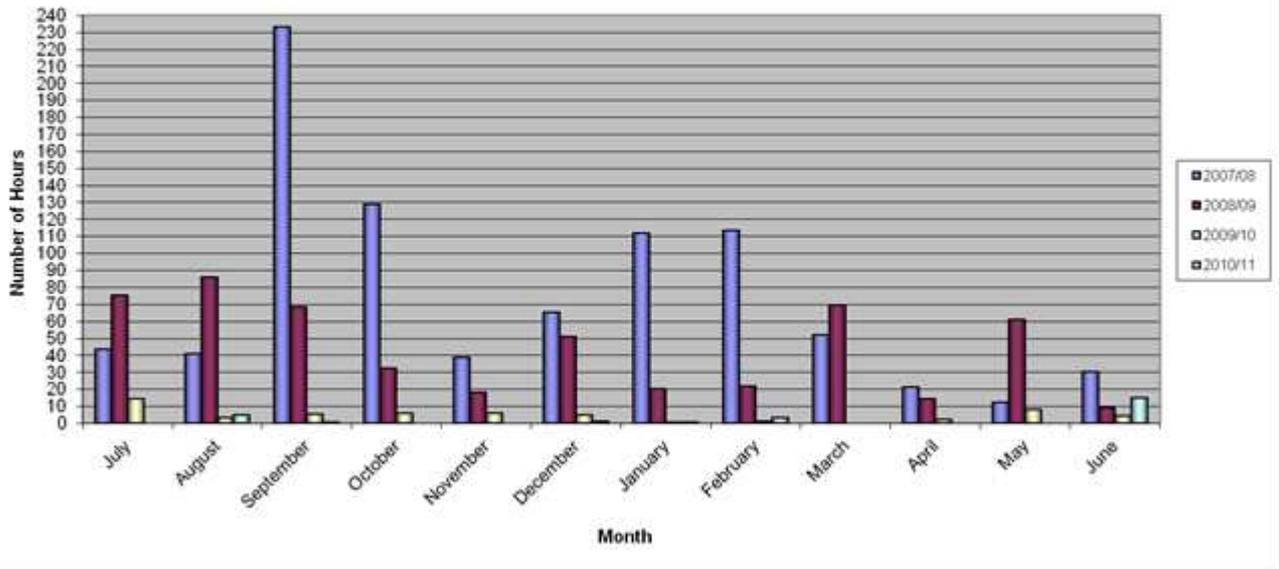
Seclusion	Year	July	August	September	October	November	December	January	February	March	April	May	June
Episodes	2007/08	19	21	70	24	18	20	43	43	16	12	7	18
	2008/09	37	47	37	25	10	20	16	14	27	12	42	10
	2009/10	10	3	5	4	4	3	1	2	0	1	4	2
	2010/11	0	4	1	0	0	1	1	4	0	0	0	5
	2011/12	11	0	0	2								
Consumers	2007/08	8	10	16	11	7	6	12	14	5	5	3	5
	2008/09	9	9	9	10	7	7	5	8	4	7	11	3
	2009/10	5	3	4	4	4	3	1	2	0	1	2	2
	2010/11	0	3	1	0	0	1	1	2	0	0	0	1
	2011/12	3	0	0	1								
Hours	2007/08	43.9	41	233.3	128.8	38.9	65.4	111.9	113.6	52.3	21.3	12.4	30.4
	2008/09	75.3	86.3	68.3	32.8	18.1	51.3	20.3	21.8	69.4	14.7	61.4	9.1
	2009/10	14.3	3.3	5.3	6.1	5.8	4.8	1	1.3	0	2.5	8.3	4.5
	2010/11	0	4.8	0.3	0	0	1.5	0.5	3.5	0	0	0	14.8
	2011/12	19.5	0	0	2.3								



Seclusion Data - Number of Consumers per Month  
2007/08 - 2010/11



Seclusion Data - Number of Hours in Seclusion  
2007/08 - 2010/11



<b>Proposed National KPI - Seclusion rate per 1000 bed days</b>			
<b>Bed days</b>	<b>2008-09</b>	<b>2009-10</b>	<b>2010-11</b>
PSU	9914	10324	10927
2N	6766	6635	6819
OPMH-IU	3440	4507	5195
BHRC (non-acute)	10661	10598	10143
<b>Acute</b>	<b>20120</b>	<b>21466</b>	<b>22941</b>
<b>Non-Acute</b>	<b>10661</b>	<b>10598</b>	<b>10143</b>
<b>Episodes of Seclusion Acute</b>	295	38	16
<b>Episodes of Seclusion Non-acute</b>	2	1	0
<b>Seclusion Rate per 1000 bed days (Acute)</b>	<b>14.7</b>	<b>1.8</b>	<b>0.7</b>
<b>Seclusion Rate per 1000 bed days (Non-Acute)</b>	<b>0.2</b>	<b>0.1</b>	<b>0.0</b>

## Literature Review

There are two parts to this study: the progress of reviewing seclusion events from the early 80's to the present, and the history of consumer-led research.

### Reviewing Seclusion Events

In 1982, a United States Supreme Court concluded that there “is overwhelming empirical evidence for using seclusion and restraint to limit the progression of disruptive behaviour to actual violence” (Soloff et al 1985). In the mid 80's we were still seeing titles like “Training for Battle: Thoughts on Managing Aggressive Patients” (Lion 1985). It was during this period, though, that we also began to see calls for research on “the interaction between milieu and physical controls (*seclusion and restraint*)” (ibid). This begins to suggest **review**.

Binder and McCoy (1983 in Kipen R. 1990) found that “the majority of patients reported that seclusion did not have an adverse effect on their attitude towards treatment on the ward”. The Royal College of Psychiatrists in London, when reviewing this study in 1998, stated that “all but three (of 27) patients had only negative reactions to the experience”. They also paraphrase a report by Craig et al (1989), ‘Seclusion and Restraint: decreasing the discomfort’, repeating that “change was attributed to improved staffing patterns, education and participation with management” which also suggests review. In an unpublished study, Davidson et al (1984 in Kipen R. 1990) discussed the benefits of “clear guidelines on incident management.....**regular feed back**... which led to a significant decrease in the use of seclusion”.

Kenneth Tardiff (1989) focuses on the “architecture and environment of the seclusion room” and sets out a table for “Assessing and Monitoring the Patient”, whereas Kalogjera et al (1989 in Kipen R. 1990) report incidents of seclusion and restraint falling by 64% and attribute this fall to “therapeutic intervention” after “staff **review** and in-service training were performed”.

In their 1994 book, “Seclusion and Mental Health: a break with the past”, Ann Alty and Tom Mason quote Shields, Morrison and Hart (1988) who suggest that “nurses are resistant to **patient feedback** and perceive patient involvement as criticism, finding this threatening both professionally and personally”. They go on to state, “patients’ views

*(about seclusion)* ought to be held as the most valuable reference tool” (ibid). Tooke and Brown (1992), however, found that “nurses felt like they were doing the right thing, that seclusion was sometimes helpful and that, in the circumstances they faced, it would be impossible to cope without”.

During the 1990s there were a number of studies that focused on “attitudes” (Mann et al; 1993), “views” (Martinez et al; 1999, Alty and Mason; 1994) and “perceptions” (Meehan et al; 2000) of patients about seclusion. Before this, Linda M. Finke (2001) identified that “most of the research on the use of seclusion had been chart **reviews** that record the demographics of patients or count the documented use of seclusion”.

In 1994, the Mental Health Branch of NSW Dept. of Health suggested “exploring the distress that may arise from being exposed to disturbed patients and to physical danger or criticism, for reflection on how seclusion was managed and what can be learned from it, and for review of training needs that may have come to light”. Under “Quality Assurance” in the same document, they stated, “Some issues can be targeted for **review**”, such as care planning, reasons for intervention, and patient and family perceptions and the standard of documentation.

Also in 1994, the Ministry of Health in New Zealand identified “Contextual Violence” stating that “violence occurs in response to an interaction and so cannot be dealt with solely by addressing the narrow issue of consumer behavior ... that mental health practice must be constantly **reviewed**, monitored and changed when new evidence comes to light” and that consumer input is required on “**incident review** teams”.

Charles G. Curie (2005) reports that in October 2004, the Substance Abuse and Mental Health Services Administration, SAMHSA (US), funded State Incentive Grants to support eight states “to adopt best practices that will reduce and ultimately eliminate the use of seclusion and restraint”. One criterion for these grants was that “whenever seclusion and restraint is used, patient and staff debriefing must occur, and **feedback** must be included in the treatment plan to prevent the use of seclusion and restraint in the future”.

2006 saw Australia welcome the US trainings ‘Reduction of Seclusion and Restraint; Creating Violence Free and Coercion Free Mental Health Environments’ from which the Beacon Project emerged, commencing in August 2007. At the completion of the Beacon site project in May 2009, MH ACT in consultation with ACTMHCN set up the SRRM to conduct

weekly reviews into practices of seclusion and restraint to complement the work of an ongoing Seclusion and Restraint Working Party.

Some of the most recent writing encourages “structured, making in mental health ... supporting service user involvement ...[that] provides a process to open all treatment and service decisions to informed and respectful dialogue” (Curtis et al 2010). Woltmann and Whitley (2010) describe a “close collaboration at the point of decision making” and Drake, Deegan and Rapp (2010) report, “consumers often view decision making in the broader context of having ongoing relationships”.

## Consumer-Led Research

*“The master’s tools will never dismantle the master’s house. They may allow us temporarily to beat him at his game, but they will never be able to bring about genuine change” (Lorde 1984)*

Consumer-led research has its roots and lineage in disability service-user research, human rights legislation and understandings of equal opportunity, citizenship, politicisation and participation (Barnes 2003 in Sweeney et al 2009). A significant milestone was reached in 1992 when Mike Oliver, who coined the phrase “nothing about us without us”, called for research to be emancipatory, shifting control of research from the powerful to the marginalized, which evokes a “survivor frame” where those who have been marginalized write themselves into academia (Church K; 1995).

Consumer-led research in the context of this pilot study takes its lead from work in the United Kingdom (Beresford, 2005; Wilson and Fothergill, 2010), in the United States (Davidson L. et al 2010), and in Australia (Malins, 2005; Ning , 2010; Griffiths et al, 2004) to reduce stigma and promote the **utility** of self advocacy and research for mental health consumers. Self advocacy is the right of a person living with a mental illness to speak up on their own behalf and in their own interests in contrast to practices of individual advocacy i.e. ‘speaking up on another’s behalf’ which is generally the rule.

The utility of consumer-led research lies in its parallels with the process of Recovery: finding hope, re-establishing identity, finding meaning in life; personal growth, self-acceptance, autonomy, positive relationships (Kartalova-O Doherty and Doherty, 2010.) “The research process was found to be generally therapeutic and empowering” (Ning et alia, 2010)

*So many people feel that research is done to them... [User-led research] is all part of the rising tide of empowerment really, people feeling more in control of what they do. (Nichols 2001)*

In the Australian context there are a number of research projects in which consumers have evaluated services (Telford and Faulkner; 2004; Malins 2005.) Consumer Researchers from the Consumer Research Unit (CRU), part of the Centre for Mental Health Research (CMHR) at the Australian National University, have conducted a broad range of research into the quality of information on websites, internet interventions, mental health literacy, stigma, evidence-based treatments and guidelines, and consumer research itself.

CRU has focused mostly on the promotion of consumer research. Kathleen Griffiths, Deputy Director of the CMHR, has expressed her frustration with the slow uptake of consumer, let alone independent consumer-led, research (pers.com. 2011). “There has been little recognition of the particular contributions that consumers with formal academic qualifications and research experience can offer.” (Griffiths et alia, 2004, p. 191)

CRU is one of two Consumer Research Centres in Australia, the other being the Consumer Research and Evaluation Unit (CREU) at the Victorian Mental Illness Awareness Council (VMIAC), who identify that it will “require that the research community review some of its more traditional perspectives, so that consumer research can be embraced” (Ning et al; 2010). In the same article the authors state that consumer research “has the potential to create better relationships between consumers and researchers”. This problematic statement brings forward the precarious situation for individual consumers who identify as early career researchers as opposed to researchers who disclose their mental illness/health condition and are working within an established research unit, as is the case with CRU and CREU.

Independent research by consumers outside an established research centre is virtually unknown, despite “the continuing need for consumers to be able to work on their own to devise projects as well as working in partnership with provider organisations” (Happell et al. 2002).

“Beresford (2002) identified three levels of consumer participation in research. The first level is consumer involvement ... whereby consumers act as advisors to varying degrees in the research. ... The second level is collaborative research, ... a partnership between consumers and researchers

in all aspects of the research process. The third level is consumer research, ... initiated, directed and led by consumers” (Ning, et al. 2010)

This research incorporates all three levels: consulting consumers through focus groups to advise on the design, ethics and findings; including consumer representatives alongside clinicians in the data collection; yet what makes this research significant is that it was independently led by a consumer-researcher, unaffiliated to any structured support.

## Methodology

In the context of consumer led research, it is critical to take account of what is important to consumers when choosing what methods are utilised in regard to what it is that we want to find out. The research is “deliberately political in that its purpose [*is to*] intervene in the existing social system to create change” (Morrow 2003)

Consultation with consumers supported the development of imaginative strategies that had the capacity to position research participants close to events, to re-experience them to a greater or lesser degree, to see how we are effected and affected by them, and to tell and write them.

The Consumer Reference Group (CRG) provided significant input into the shape of research methods and supported strategies that led to data co-authored by consumers and clinicians. The key concerns for CRG were that the processes should get to the nitty gritty of relationships, the quality of listening, and that the methods should invert the concept of ‘who knows best’.

Other concerns were that the research methods should be non-threatening yet honest and open, and investigate the subtleties around ideas, roles and preconceptions and ‘what follows’ from slavish adherence to these. Affect should be a key player in any methods pursued.

These directions and concerns supported the choice of strategies and methods for the research, honed the questions and placed greater emphasis on strict positions for telling and witnessing in all areas.

The methodology is informed by Recovery principles and practices (Davidson et al, 2009), Narrative Research (Chase, 2005) and Psychology (White, 2000) and Dialogic/Performative Social Science (Kohler-Riessman, 2008, Hermans and Kempen, 1993).

Phenomenological understandings (Van Manen, 1990) that seek to bracket out, or hold at arm’s length, preconceptions and assumptions about what is possible have a good fit with the project, both SRRM (as a consequence of ongoing practice) and research (as a strategy to gather rich data).

The methodology also assumes that some ideas, contexts, practices and people’s roles (and sometimes people themselves) become invisible through acceptance of particular norms, and that exploration of these are

best examined through what is created between the people involved (Rose, 2008; Davies and Gannon, 2006), in this context, the SRRM.

*We can search out the ways in which things were made evident, fixed and apparently unchangeable. Our stories, in showing the detail of our collective enmeshment in that fixed world, set out to make it more fluid, more open to other possibilities.” (Davies and Gannon, 2006)*

In the first part, the research utilises a specific narrative consultation method, Definitional Ceremony (Morgan 2000), which centres the consumer voice by setting strict telling and listening positions.

The tellings and retellings are all connected back to the original story told and this helps participants theorise about what is occurring, or what may have occurred, while maintaining the lived experience of consumers at the centre. Questions asked of witnesses are couched in terms of how witnesses were moved, touched or made curious about the story told and what stories were evoked for them.

This research strategy has a close fit with Autoethnography as it seeks “to make relevant those aspects of being that are suppressed by analytic strategies that draw a veil of silence around emotions and bodies” (Davies and Gannon, 2006)

The second research method utilises Collective Biography, which in the case of SRRM research maintains Auto-ethnography situated within a collective endeavour.

The initial transition to collective voice for the thesis occurs at the completion of each Definitional Ceremony (DC). Each participant writes a short story about what has emerged as important for them out of the DC. The stories are shared, and added to, which provides further space for marginal, and sometimes dissenting, experiences to be centred and explored for all participants.

This enables a multiplicity of voices to converse and provides for the development of a research landscape where it is possible for each person to observe his or her self participating within an increasingly collective environment.

The third method has to do with the textual product of the research. Although it takes quite a traditional form, the collected data resembles a montage or layered text that enables readers/viewers to “put sequences together into a meaningful emotional whole,” (Denzin and Lincoln 2000).

As well, the montage is able to “draw out the tensions provoked by juxtaposing analysis and emotion” (Bochner and Ellis 1996), shifting back and forth between narrative accounts and theoretical analysis.

## Analysis

The project employed three layers of interpretive analysis, the first a process of collaborative interpretation defining content analysis groups; the second a researcher-centred immersion and analysis whereby chapter headings were initiated and then corroborated by research participants; and the third a dialogic/performative analysis conducted with participants around issues of identity.

Seclusion is firstly an experience of the body. The SRRM is like seclusion in that it is a process that involves the bodies of the people involved; it presses buttons, it evokes emotion and this embodied experience is central to the content and the presentation of the research. The embodied performance of stories, as in Definitional Ceremonies, established the initial findings.

A key feature of definitional ceremonies is the capacity to generate initial analysis of content through defining meanings both individually and collectively (Morgan, 2000). By utilizing Collective Biography to understand and ‘dialogue’ our worlds creatively, the interpretation of our initial findings was collaboratively negotiated and analyses proposed.

Strictly speaking, in quantitative research, content analysis involves the study of objects or texts, counting them or interpreting themes contained in them (Strauss and Corbin 1990). However, in complexity theory approaches, content analysis groups, ‘themes’ or ‘codes’ emerge from the data itself, as resonance, or “moments of impact” (Stewart, 2005) in the process of “cultural poesis” (ibid).

Step two of the analysis relied on resonance and verisimilitude in seeking to present chapters as embodied, affective experiences that informed changes in culture, instead of finished representations. This aligned well with consumer preferences. A focus was maintained on the question “What happened?” as opposed to “How can this be repeated?”

The researcher is an “active presence in the text” (Kohler-Riessman 2008) and has significant potential influence on the interrelations between research participants, the research, and each other.

The third analysis sought to deepen “What happened?” into “What happened to you in relation to others?” in regard to changes around identity in the context of SRRM. This involved staying close to how people experience SRRM on a week-by-week basis, paying attention to

issues of injustice, re-traumatisation, working with people who have been made abject, (Denzin 2003) and exploring how these experiences are performative (Goffman 1959 in Denzin 2003).

The third analysis was conducted through a focus group of the research collaborators, who chose the metaphor of a tree to represent identity transportation, seen as growth or movement.

A fourth analysis is expected as the reader interprets the text, feeling some resonance with ideas and experiences, and paying attention to what 'rings true' for them.

## **Consumer Reference Group (CRG)**

The CRG comprised four consumers who are members of the Consumer Representative Program at ACT Mental Health Consumer Network. They were asked to provide feedback to the research project as a ‘work in progress’ to maintain a diverse, consumer-centred approach to methods and ethical considerations.

The first consultation was conducted at the initial proposal phase. The research was introduced and four questions were put to the group; discussion arose from people’s answers. What follows represents individual responses.

### **Q.1 Is what’s being proposed in this research valuable from your perspective?**

It publicises what happens at PSU, making it more accountable.

With consumers having a voice through other consumers, SRRM and this research makes the mental health sector responsible to become a “learning community”.

It increases transparency for both positive and negative outcomes.

It educates as to the roles of people at PSU.

The research could recognize the value of well trained “secluders”.

It encourages the value of first hand experience.

The research presents consumers as possessing agency and expertise even when the person is ‘irrational’ – “because people always have something to say”.

It closes the gap between experiencing and telling.

Consumers’ experiences resonate with other consumers.

“It makes sense when you hear it from other consumers”.

People who are feeling left out can feel included because someone who has experienced mental health challenges is writing for and with them.

The research could find out the reasons for the drops in seclusions, for example how PHAMs and increased consumer traffic (non-resident) may have made a difference

People wanted to know “what led to us joining this conversation?” at the SRRM.

*People also wanted to talk about personal events, including experiences of seclusion, although this was not the intent of the consultation. This ‘other’ material informs the research nonetheless.*

These events and experiences were described as “shared experiences.” One person said that the consultation was a “safe setting” and that people, consumers, were starved of opportunities for the telling of “emotion” and to have some “release.”

“We don’t often get the chance to voice our concerns and an opportunity to be honest – not having to bottle up these experiences”

It was identified that the Better Access Program was an example of an early intervention program where this “starvation” might be addressed.

With regard to the reduction in physical seclusion, people were concerned about greater uptake of pharmaceutical restraint and other restrictive practices. “Restraint disallows voice”.

In the discussion around “starvation” or “disallowed voice” it was suggested that a person could be “talking the leg off an iron pot”, but not “getting to say what it was that they really wanted to say”.

“Talking without trying” was suggested as a strategy for meeting with consumers when distress was present and that “personal attention” was what was needed.

The nurse-patient relationship needed to be at the centre of what happens in the acute setting. Instead, there was an expectation of punishment from Wardsmen and other “security.”

Nurses need to reclaim their position in the MH sector, instead of being the minions of the doctors and reduced to giving out meds.

Nurses are afraid of consumers and consumers are afraid of nurses. When fear comes into play, both consumers and nurses are vulnerable. Everyone getting pushed about by fear.

Nurses are human beings and continuous aggression and negativity wears anyone down; nurses are vulnerable in a workplace where acts of violence of any kind, and including seclusion, are the norm.

On many occasions clinicians are having to deal with a variety of evils and the debate continues as to which are less traumatic than others e.g. seclusion or chemical restraint.

On the other hand, “if ‘they’ were doing it that well then they shouldn’t need to seclude you.”

It seems that the SRRM mirrors what happens on the floor at the PSU and vice-versa. The research was seen as “very interesting” and consumers were very pleased that it is happening.

## **Q.2 How do you see this research making a difference in acute settings?**

It should show up that more communication is needed, particularly when “consumers assume that psychiatric nurses would engage on a personal level”.

The research could help re-conceptualise agitation and aggression as manifesting fear and anxiety.

The research allows a place for clinicians to learn how to listen.

The research questions whether medication takes over when seclusion leaves off. This is not an objection to medications per se but a cry for something different, a cry that recognizes “they just don’t know what to do sometimes – the clinicians.” It seems that they are “on opposite sides of the fence” where “patronizing” and “I know best” ideas “take over” and medication/seclusion become the only answer.

Instead of seclusion and restraint being a therapeutic option, it’s seen as a traumatizing experience and forces an examination of concepts of punishment and safety, and considerations about ‘occupational health and comfort’, where it has been more ‘comfortable’ (for staff) to seclude consumers - less work.

Consumers may become more educated about the various “treatment” strategies and therefore have more choice.

The action of consumer-led research increases the perceived and real experience of consumers’ expertise– creates a platform for consumer voices.

### **Q. 3 How would you change this proposal?**

Although the question was asked three times, there were no direct responses.

### **Q.4 What else would you like to see in this research?**

Would like to understand how this research can inform Standard Operating Procedures and Policy development and how these connect.

Would like to see that this research calls for policy development but also that it questions how practice often comes before policy change. Other larger considerations, such as power and dominant norms, e.g., how consumers are thought of as lacking intelligence, akin to developmental delay or intellectual disability, need to be questioned, or at least taken into account.

Prior to application for Ethics Approval the CRG was consulted again, specifically about the methods chosen for collecting data from the SRRM group. In keeping with the research methodology, the second consultation presents a more collective account.

### **Definitional Ceremonies**

In considering Definitional Ceremony, the CRG recognized that it gave a consumer experience directly from the horse's mouth, privileging the consumer voice in a forum in which there was no threat of reprisals.

### **Interviewing the Witness group**

The CRG said that interviewing the clinicians and a consumer (as outsider witnesses) would make them think, lead them to see a different point of view, and make them more accountable.

### **Interviewing the Original Teller**

The return to the Consumer gave his voice legitimacy because his story was reiterated and responded to, which in turn led to increased confidence. As a data collection method, the CRG felt that this reiteration protects the anonymity of the Consumer, ensuring safety for the consumer. The CRG appreciated the degree of rapport between the Researcher and the Consumer.

## **In General**

In regard to Definitional Ceremony in general, the CRG valued the method for allowing honesty and openness, for soliciting an emotional response rather than a clinical one, and for breaking the nexus of perpetrator/victim.

## **Collective Biography**

### **Write a short story (200-300 WORDS)**

Moving on to the writing of stories by the participant group, the CRG discussed how writing enabled the expression of emotion, that expression in writing was easier and sometimes deeper through previous consideration (Definitional Ceremonies), and that it could extend ideas about the challenges being faced by all, including consumers. The CRG felt that considered first-hand through dialogue and writing, informed and evidence-based stories and experiences could be understood with their various sides and subtleties.

### **Telling of short stories (to the group) and asking for the ‘nitty gritty’, asking people to take away clichés and asking for direct experiences (How much of ‘you’ is in the story?)**

The CRG felt that writing the ‘nitty gritty’ is more about personal, embodied experience from individuals and the group, less clinical; it voices deeper concerns and makes the writers think about what they mean, for others and themselves. The stories are easier to understand, being about what happened rather than what’s wrong.

For consumers in the SRRM group, the CRG felt that writing in this way is another way of providing the consumer voice, and might possibly have the capacity of healing from adversity through being listened to while telling the ‘nitty gritty’ experience. Most importantly, Listening is at the centre, providing a space for “Talking without trying”

### **Collective biography (turn-taking around the nitty gritty stories)**

The CRG suggested that the collective nature of the endeavour provided permission for participants to open, that the process both personalized the experience by getting to the nitty gritty, but de-personalized it by making a collective combined account. This would reduce stigma for all storytellers. The CRG also thought that the process would produce a text that would provide evidence for consumer led research and consumer/clinician collaboration, an artifact. The CRG appreciated that

the methods were aimed towards encouraging mutual respect, evoking responses, airing out the room in an open dialogue in ways that were informal, non-official and where input from consumers was not conceived as a complaint.

The CRG supported the methods as they promoted a comprehensive story about the SRRM and how the document might provide ‘snapshots’ around issues, understandings and solutions, and which remained sensitive to “both sides”. It was hoped that the process would support a repositioning of attitudes to Consumer and Clinician roles.

In general the methods were seen as valuable in that they could illuminate seclusion and other distressing events and add to the evidence base for the illumination of seclusion and restraint and the consumers’ ongoing advocacy in relation to these. It was hoped that the project would bring about changes in ideas, culture and policy and promote critical training for staff who “aren’t trained in empowerment”

In the later stages of the consultation concerns about a risk of diluting the consumer voice was mentioned and that the origins of the consumer story could be overwhelmed by clinical opinion. There was also a concern that individual meaning, for all participants, could be lost in the collective account.

## The Stories

### Consumer Voice

Consumer voice, and its value, is the beginning point from which all other stories are told. During the 2 year period at the SRRM, we have moved from *allowing* to *privileging* the consumer voice, which reflects larger Recovery understandings. The SRRM has centred the consumer experience, the individual and collective voice of consumers.

This centering of consumer experience is demanded by the 4<sup>th</sup> National Mental Health Plan, where positive or negative experience, when used as evidence, should drive funding priorities. This reflects what has happened in the SRRM where the centred consumer voice is recognized as evidence for the further inclusion of consumer experience in other settings.

*The consumer voice is invaluable in the culture shift, not only in my practice, but that of the PSU.*

Hearing the consumer voice has promoted an emphasis on empathy. Hearing directly of consumers' experience of seclusion has made a powerful difference to how staff now view seclusion. Hearing the consumer voice was "a unique and somewhat threatening idea" yet SRRM has embraced this idea with vigour and grace. Prior to such value being attributed it was often difficult to get a full understanding of what was the causative factor which led to the seclusion event.

*The SRRM is striking in its dramatic shift from cynical disbelief in the value of including the consumer voice, to full acceptance of the importance of hearing the consumer perspective.*

*Staff attitudes have changed significantly; Consumer representatives brought refreshing insights and ideas where more often than not in the past consumers were conceived as lacking insight, and that this lack of insight entirely explained, and even gave permission for, seclusion. Sometimes this shift in culture was*

*enabled through hearing not only the “raw, unmediated lived experience of seclusion” but also through hearing strong and passionate attempts by Consumer Representatives to articulate other experiences of feeling excluded.*

The strength and experience of the consumers concerned and the ways they complemented and supported each other in this work is a significant factor. The working relationship was something very special, unique. Consumer Reps complemented and supported each other in various ways, even if these were often in unconscious ways of deep understanding that comes out of identifying with shared lived experience. It is acknowledged that the ACTMHCN played a significant historical role in valuing the consumer voice in the SRRM.

*The strength of the consumer voice made it clear that seclusion had no therapeutic value and indicated a failure of the system.*

If the consumer voice had not been present this would have been a dramatically different process and perhaps would be unrecognisable from what we experience today in the SRRM. Including the consumer's voice has profound outcomes, which in turn contribute to cultural shift.

*What I am convinced about is the gains made, the valuable lessons learned, and the empowered actions in changing culture.*

Having the consumers' perspectives in a way kept us honest, and at times supported us to go places that may have been confronting though totally meaningful and enhanced the productivity and upheld the humanity of what we were discussing, people's lives.

The consumer voice has provided me with other ways of looking at so called therapeutic options and has changed my practice and to make changes on the unit.

### **Diverse Shared Experiences**

*Today I feel committed to the statement that seclusion is a failure of the therapeutic process. I am able to say this out loud and mean it.*

The SRRM hasn't had a formal structure to tell our own stories within the meeting, though in the research group today it has been acknowledged that hearing someone's story can give an appreciation of where a person is coming from, helping to provide some context to a point of view being expressed. Throughout the meetings at different times, group members have given glimpses of their story. Lived experience and the personal contexts of people in the group became more informative; gender, positions of power, our own and others' lived experience became a part of how we understood reducing seclusion events. This information was included for the sake of better understanding each other and how this could support alternatives for those who might be excluded or secluded.

### **Inclusion and Exclusion**

*It was impossible for me to remain outside the discussion at times, due to the deeply touching discussions which told of people in great distress, trying to make sense of their lives.*

From the beginning of the seclusion review, we were of one mind to include all voices, no matter how politically correct or incorrect that might be. This meant bringing together ideas about how we could facilitate that inclusion; and what that might mean, particularly for those who have had longer experience of the decision making voice, or the lion's share of that voice. i.e. nurses, doctors, clinicians.

What became evident is the integrity and at times, apparent bravery to speak your mind. Everyone has a voice that must be heard and this was thought about in a different way, developing a more level playing field so that all contribute.

### **Inviting the Wardies**

This was a significant move as the Wardies are at the coalface of the seclusion process and it has made a wonderful difference having them on board. Inclusion of Wardies has

provided everyone with great insight into their role and also their view of the process of seclusion. Their commitment and contribution in this process has been particularly moving, another very successful strategy which promoted them from a very peripheral and last minute role to one of integrated early support.

*The Wardies came to the seclusion review suspicious, ready to be blamed, and I think they were more than a little surprised at what they found, possibly a place they had been looking for, a place of helping, of community, a place to come in from out of the cold. It must be a cold place, when you are seen as the bully, the person who comes in with force and deals with things, provides solutions when all else has failed. Always regarded as the bad guys.*

*Seeing seclusion as a failure in the system is one thing and recognising seclusion as an event at one end of an inclusion/exclusion continuum is another. We looked for where exclusive practices informed a trajectory towards seclusion.*

*We can no longer be ignored.*

The Doctors stopped coming to the SRM somewhere between 6 and 10 months into the process, "Did they exclude themselves or were they excluded?" Many of us remember them as a terrific contribution, sharing of themselves, sometimes vulnerably. The SRRM members are concerned at "what follows" in terms of practice when doctors are not in this loop.

*it is unfortunate that doctors don't attend more regularly as they are a vital point in the procedure. Perhaps things aren't quite equal yet.*

*As an overarching message SRRM is a story of hope and inclusiveness in an atmosphere of honesty and vulnerability.*

## **Othering and Mutuality**

*The early meetings were somewhat stilted and at times fraught, because of the clinical/consumer perspective divide. It seemed that clinicians (nurses, doctors, OTs, psychologists, bureaucrats) and consumers were coming from either side of the ring: there was sometimes a feeling of observing a boxing match, but with punches being pulled, in the early meetings. The clinicians and the consumer reps seemed to be mutually suspicious, with each 'side' afraid that the other had too much say – them and us.*

## **Relationships**

*During the initial ES and IT training, not only hearing the stories of consumers but also the interaction of trainers, clinicians and consumers, I was able finally not only to talk the talk, but was able to walk the walk.*

To establish a relationship with consumers on a day-to-day basis needs to be emphasised. Being close to the workings of the PSU privileges staff, and to ignore this marginalises consumers. Consumers may also find meaning in things that may not be meaningful to staff, so it is important to be attentive to what might support well-being. Far too much of our focus on both the ward and in the SRRM has been on “escalation” during crisis. It is about a person’s life - the quality of that life! - and relationship is key! What do we know about the individual that can shape our interactions, our engagements, our resources, and the environment: physically; emotionally; culturally; spiritually; and occupationally?

*Some of the things that we may find out about are people in differing roles, professional and otherwise, different worldviews, different trainings at different times, biomedical, psychosocial, recovery, where I was trained, where you were trained and how*

*this influences who we are in regard to all this. How we could do it differently if we knew each other better.*

*Critical to this is the relationship between consumer and clinician (to some degree disrobing from our assigned roles to search for what is mutually beneficial). Taking the time and what is required to build a relationship to hear and honour what is the consumer's story and what will make a difference to their recovery that is meaningful to them to build on skills and acquired knowledge - to discover or re-discover what will support well being and to take account of how each shapes the other.*

*Working on this committee has gone a long way to bringing consumers and staff closer together in an ongoing community of respect - we are all human.*

### **Processes and Produce of SRRM, or SRRM is a Garden**

*Hearing, acknowledging and valuing the consumer voice. This has not been as simple as it may have seemed, although a fine example of how this can be achieved is evident through the SRRM. First bring together a group of people who have attended conferences and forums where there have been colleagues promoting consumer collaboration and seclusion reduction. Then lay some ground rules around respect and the various attribution of expertise. Attribution of expertise has been a key tenet of SRRM; that is, consumers are regarded as having critical expertise in regard to the experiences of others who may be experiencing similar things. Always encourage stick-at-it-ness, an attitude that understands that all will not always be easy, the world is not a fair place and that there may be arguments along the way; but if we can only understand that we are working towards a same/similar goal then we can achieve it.*

### **Contexts**

*Central to the process of reviewing the experience of seclusion and restraint is hearing, acknowledging and valuing the voice of the consumer. This can touch us profoundly emotionally, and*

*inspire intellectual rigour, and a significant collaboration of skills and knowledge creating a powerful catalyst for change.*

*The struggle and tussle associated with SRRM has proved liberating. The SRRM has proved a vehicle for further understanding conceptions of identity, both individually and collectively, reflecting recovery practice where recovery guide (worker) and consumer shape each other's identity. In the case of SRRM this shaping has occurred in order to develop a systemic practice that supports seclusion reduction. We suggest it has a much broader application.*

## **Creativity**

*'Staying connected!' So true, and it seems to imply the compelling dynamic of the process and the commitment and discipline involved to maintain the process and stay connected. It highlights the creative nature of the process. The role of creative imagination applied to real situations is so new in such a collective and sustained way. The failure of imagination is a big problem and a really felt lack or limited, especially collectively, in the mundane day-to-day workings or involvement in such a system or institution.*

*The SRRM has created an environment where challenge and imagination intersect, where clinicians are offered permission to be creative in the PSU using the resources available. The SRRM was enabled with existing resources.*

## **Practice /Reflective Practice /Reflexive Practice**

*The process of reflection is as valuable in reviewing the process in the Seclusion and Restraint Meeting as when we engage in reviewing individual occasions of seclusion in the meetings.*

Reflective practice has proved vital to the SRRM as it has given members the chance to stand back from events and view the whole process in context. It also enables them to think in terms of alternative actions to seclusion.

*The raw unmediated experience of consumers who have been secluded, has given me an insight into my old practices and many life changing moments as I have sat in SRRM meetings and thought about my own practice and values as a nurse.*

The central question for nurses, in particular, has been "What else can we do?" This has led to genuine seeking on the part of nursing and allied staff.

*Always searching for what else, what else could be possible for this person - for all consumers in the PSU.*

*The 'what else do we do' has made me think of hundreds of things that I can do differently in my day-to-day practice. I have also been able to critically examine my past seclusions and decisions; decisions I thought were justifiable and consumer-centred at the time, were not so.*

*We understand that reflective practice is crucial and requires time, space and commitment.*

*I believe it has been determination to the point of bloody-mindedness, holding old ideas and biomedicine aside while developing recovery focus to be the main player in the SRRM*

We understand that reflective practice becomes reflexive when other dimensions of experience are included in reflective practice:

*integrity, respect, dedication, commitment, passion, and fierce unbridled empathy! This empathy gives voice to all players, particularly consumers, ensuring an emphasis that is most valuable to illuminate issues and feelings.*

*The role of trauma is significant in being able to see how being in touch with our own in this process, immersing in the pain, or dwelling in its emotions can be a driver or the very route of a positive resolution if we only can stay connected.*

The characteristics of the SRRM are spirit, wisdom, openness and the integrity in which all participated.

Reflective/reflexive awareness at the SRRM was informed by particular theoretical understandings, dualist and pluralist worldviews. This approach was mostly conceived as taking both a systems perspective together with a personalized, individual perspective, but also took account of other popular, historical, contemporary and academic conceptions and understandings that surround mental illness/health and the 'treatment' of consumers. Stigma, internalized stigma and trauma-informed care are clear examples. Drill-down or in-depth analysis, keeping these individual, relational, social, and institutional perspectives and conceptions in mind, has been central to the uniqueness and success of the review meeting. Research from the UK that suggested the initial indicators for seclusion trajectories could be traced back 5 work shifts was particularly formative in Early Support and Intervention Team development.

*Another key element is dialogue entered into by different people with different professional and experiential roles in ways that wouldn't otherwise happen.*

*Part of the dynamic of the meetings was the way in which everyone contributed, from the nurses, allied health, the Wardies and Consumers. Everyone's opinions were listened to and validated. This is what made the discussions so rich and valuable.*

## **The How -To in regard to Documents and Tools**

*The SRRM took pains to create detailed forms for use on the ward, with wording designed to elicit detailed clinical documentation by clinicians at every turn in every event, beginning with admission to PSU. The other 'tools' created by the SRRM included training of all staff into use of the forms, training in rapid (early) response, inclusion of the Wardspeople in these processes, and generally a 'cross-over' approach in all areas of treatment of consumers on the ward. The focus was always to limit consumer and staff trauma, thus limiting the need for seclusion.*

What ensued was nurses asking more probing (read caring) questions of the consumer, thereby reaching a greater understanding of what the consumer was feeling and why they might have become distressed. These were the beginning questions for the Coping and Safety Tool (CST).

SRRM members understand the development of forms and tools to be an organic, ongoing process. It takes time and effort in making sure that all voices, and expressed wishes (as opposed to the best interests of) have been included both in the development and the utilization of forms and tools. A priority for SRRM was to hear the exact wording which would elicit the very feelings of the consumer, in support of digging down to the reasons for each event. This requires mutual understanding, empathy, digging down and bringing forward and to the surface the most relevant matters, using words and phrasing to 'force' a detailed consideration and documentation. Discussions were often described as "meaty". The initial form was created to cover all events leading to seclusion and code blacks, and to debrief after the event. Later adaptations included early intervention and began to take account of Advance Agreements. This form was a requirement after any seclusion and/or code black event. This remains the case.

Some would argue that the weight of paperwork has reduced seclusion rates. The SRRM acknowledges that this is part of the picture, the smaller part. It is interesting to note that the SRRM, and leaders at PSU did not step back from 'force' in relation to documentation and evolving practice.

*The SRRM forced me to review and revisit what therapeutic care and treatment were. In truth seclusion is not a therapeutic process.*

*..... being compelled to creatively find other ways and alternatives to seclusion*

*The SRRM had a compelling dynamic that despite ourselves, we were forced to tackle the real issues lying behind the issues and problems that the incidents and reports brought up.*

Any experiences of feeling forced or bullied into change were soon diluted by experiences of increased care and calm at the PSU. Significant reductions in staff injuries also played a part, as did an increasing level of excitement around feeling included in the process, as part of the change, and recognition of greater professional status. It should be said that there was significant celebration in MH ACT in the higher levels as the MH system was seen to be ‘coming of age’

The focus on language, forms, wording also helped to discipline our efforts and focus, and helped to diffuse any personal feelings of threat, fear, conflict or doubts about what we were doing. The focus on forms allowed some interpersonal distance, supporting the job at hand.

*The specific wording of the forms to be reviewed gave me great insight into a different perspective of what I thought was a therapeutic option.*

Some of the things we considered around development of the initial Seclusion Report Form and also the evidence we were trying to collect in our attempt to reduce seclusion were:

*issues around staffing, over-capacity, acuity (sometimes conceived as a feeling), operational communication between different staff and staff groups, issues around medication, sedation, rapid tranquilisation, factors involving the impacts of Emergency Department, ED, the Mental Health Assessment Unit, MHAU, the Police and other parts of the hospital system as well as MHACT and ACT Health, training difficulties and needs, resources, conditions and pressures in the unit at the time, the person’s own circumstances as to how they entered the unit, expectations by staff around particular consumers and what happened last time, consumers own living/life situation (issues of class, gender, race, socio-economic status, sense of self and place/housing), any pattern or experiences of trauma they may have which may have been aggravated, or not, by those factors and the responses of staff working in that system.*

This approach led us away from focusing on reasons for seclusion and restraint (as told solely by those secluding) to a much greater emphasis on de-escalation and prevention measures, from assertive aggression

responses to early support and intervention strategies, from seclusion to more personalized understanding and care, with new tools and techniques such as sensory modulation evolving a truly recovery oriented approach.

## **Commitment**

What is clear is that there has been a demonstrated commitment to keep coming back to the meeting. The meeting has required an openness to change and a problem-solving attitude. Holding a space for "if not seclusion what else?" has shaped and informed the collective commitment that is clearly demonstrated in the SRRM.

*Instead of feeling that I had to defend the actions of my colleagues, I began to focus my thoughts and practice on options for de-escalation rather than seclusion when this was thought to be the only remaining option.*

*It has required a significant commitment on the part of consumers to keep going, sometimes not knowing the language, feeling daunted by the power brokers in the room, and possibly feeling the effects of internalized stigma, yet keeping on going, trusting that the core business and the core relationships would sustain.*

As a group we have been committed to beating back, or excluding, the idea that seclusion had a place in continuing mental health care, instead holding that seclusion has no therapeutic value. This idea was one of the founding tenets of the Beacon demonstration project. The extent to which staff at the PSU have accepted this tenet, and beyond that, have celebrated the move away from seclusion as any kind of care strategy is one of the primary outcomes of the SRRM.

## **Contexts**

Reflecting on the issues facing people never occurs in a vacuum.

*Hearing someone's story can give an appreciation of where a person is coming from, helping to provide some context to a point of view being expressed.*

In the early days of the SRRM, many wondered at how the meeting took account of story. Some members were surprised, expecting an observational, clinical account of consumers' individual behaviour to be the evidence for examination and review. There was a leaning towards bio-medical accounts at the early stages but the bio-medical soon settled into place alongside other accounts of value.

Whilst the SRRM itself took up little or no extra resources, it did consider a number of deficits which contributed to seclusion episodes, one of these being staffing and actual bed status. The pressure on beds was a significant contributing factor – this was identified on a regular basis as an external factor contributing to seclusion episodes. Staff shortages resulted in many staff working overtime and also bed status was often on or above capacity, at one time the unit being at 126% capacity. When reviewing seclusion events, staff anxieties and their reduced capacity to de-escalate situations at these stressful times would often become apparent.

### **Learning Community**

*It was like trying to keep open a 'worm hole' in space which gave access to another journey, another world, which however took place in a context where a lot of pressures, contexts, culture and practices weren't particularly conducive to maintaining the efforts to keep the wormhole open. Fortunately, many of us helped to keep the 'wormhole' open and productive in his or her own unique ways.*

*Talking about the real interpersonal, inter- subjective and collective dynamics of the SRM is what re-excited me so much about our dialogue today. Trying to adequately explain the multifaceted nature and outcomes of that dynamic in the ways*

*we grappled with each other and the subject matter we were dealing with. Especially our focus on bringing forth and allowing the consumer voice to guide and teach us!*

## **The Journey**

The early days of the SRRM were quite a contrast to present day meetings. The meeting was stepping into unfamiliar territory for us all.

*I think when we first developed the idea of SRRM as a concept it was difficult to imagine that the end result would be what it is today.*

In the early days there was significant ambivalence around seclusion reduction and diverse understandings on the utility and effect of seclusion. What proved to have the most disruptive effect on ambivalence was the idea that we needed to include all voices. This meant engaging other ideas about how we could facilitate that inclusion; and what that might mean, particularly for those who have had longer experience of the decision-making voice, or the lion's share of that voice. i.e. nurses, doctors, clinicians.

*Consumer/clinician collaboration was seen then as problematic, for reasons of confidentiality, re-traumatising consumers, a lack of understanding of the developing consumer role, i.e. expert by experience, and bringing their own experiences to the table (as opposed to leaving oneself at the door).*

Those first days and weeks were a challenge to be able to get the meeting started never mind doing consumer-led research. Members clearly remember the fear and anxiety, the mutual suspicion, around setting the meeting up and how stilted initially the meetings were. There was also a powerful determination on 'both sides' to make important changes in PSU care, and work toward elimination of seclusion.

In the early stages, we looked at seclusion events and we often only saw the event itself, a person becoming upset or distressed and the common trajectory towards a seclusion event. It was later

that other contextual issues began to take up more of the conversation. This was also true of the SRRM group itself, where lived experience and the personal contexts of people in the group became more informative. We spoke time and time again about how easy it is to become isolated in our daily lives, and sometimes, tunnel-visioned about what we do and how we do it.

Although it took some time to unfold, a collective approach shed light on much of our analysis of individual 'cases' or 'incidents' casting them in a more holistic context culturally, systemically and personally. This illuminated those involved in the meeting as well as the person whose situation was being discussed.

*I saw this empathy grow between the various participants and also toward the cases being reviewed. There was a growing understanding of the other's point of view*

The collective form of the meeting took account of different people with different professional roles and experiences, the tools and techniques particular to their roles, professional and otherwise, people's worldviews, different trainings at different times: biomedical, psycho-social, recovery. This collective approach begged the question: *How could we do things differently if we knew each other better?*

*It took time for mutual mistrust to change to mutual trust, to learn in an environment where it is OK to have different views and standpoints and keeping the enquiry alive. Possibilities emerged.*

*As an individual clinician the process was very different to any other meeting in which I had ever been involved. The experience of meeting consumers at a level that was (for lack of a better word) equal - "there was a flattening of the hierarchy". This was for me an invigorating and invaluable experience. Many staff would not have experienced*

*consumers contributing in such ways and in such roles. It's good to see the presence of consumers at the meeting had such a positive effect.*

The consumer voice became heard throughout the whole SRM process. At first, this voice was not always appreciated. We were all on a steep learning curve, as both consumer reps and staff journeyed to the level of acceptance that has been reached. This was a stark contrast to traditional and earlier methods of heavy-handedness and damaging effect of conventional horror stories told by both camps about each other.

*It was a moving experience to watch as the SRM progressed to the point of change in approach by all members involved.*

*The idea of bringing the personal together with the systemic was/is not well regarded in consumer land and the success of the seclusion review is in some part due to the success with which consumers/clinicians have been able to utilise personal evidence with close regard to systemic issues.*

Significantly, it is also as if the systems and big picture thinking of the SRRM meetings taught us to also view each other positively and more realistically in the larger system/cultural picture and the roles and pressures each of us had within those larger contexts. This promoted greater understandings and supports between members in ways that wouldn't otherwise be possible.

*It was really a hands-on or minds-on focus beyond our own individual feelings*

For the SRRM the whole is greater than the sum of the parts. The collective and inter-subjective experience of the work at SRRM speaks directly to outcomes in regard to Community Development and Seclusion Reduction.

*We had to respond as best and constructively as we could to each other's questions, reflections, challenges, in a way some may have*

*felt uncomfortable with but brought us collectively further than we were, that was ultimately rewarding. But it did require a personal submission to the process, which transcended or even transgressed traditional understandings of roles and authority.*

For nurses, allied health professionals and consumers, 'learning community' in the context of SRRM was, and is, collective recovery, a process of exposure to emergent ideas, an opportunity to claim potential shifts in identity, where we blur and even step over the lines from time to time.

The acknowledgement of individual roles is an important one. The issues we (SRRM) grapple with are illuminated and unpacked by hearing different perspectives, informed by personal and professional experience.

*Invaluable knowledge, not only from the SRRM meetings, but also with ES & IT has taught me many things in my life and profession.*

In many ways members of the SRRM found that they were able to relax over time and took permission to step away from the 'traditional manager' or the 'dissenting consumer', challenging what members do as a 'nurse leader' or a 'consumer advocate' and how the boundaries have sometimes bled between these various roles. These shifts augur well for the future of PSU. Members have come to know through walking in each other's shoes the value of various perspectives whilst maintaining the integrity of their own. Working with consumers in these new ways has opened up and made real the very possibility of these new perspectives.

*I have been able to use my role as manager in a better way; however I have been able to develop my role as leader beyond what I previously thought imaginable. I believe that the consumer voice has allowed me to do that but also the collective power of SRRM has allowed me to do that also.*

I think in acute mental health services, somewhere along the way nursing staff became custodians to sick and vulnerable consumers instead of helping and assisting. We became rule makers and enforcers of when those 'rules' were not followed to the letter.

*Permission to do things differently has been liberating for me as well as scary at times, to stretch myself into ways of practicing that I never thought possible.*

Nurses were looking at less traumatic ways to help consumers and training was introduced to assist with this. Wardsmen were also trained with this in mind, and a cross-fertilisation grew with this process, between all participants.

*Wardies, what can I say about that group of people. One thing is that it has been a powerful experience to witness their willingness to change.*

*Wardies were searching for something, a way where they are seen as helpers, not those who are only called upon when the shit hits the fan, the last resort. Seclusion was often conceived this way, as a last resort, but now is seen as a failure of care.*

*The wardies wanted a position where they were/are part of a treating team, making relationships with consumers*

The issue of leadership is such an important theme in this process. Its many facets and layers and the various ways the process allowed each participant to exercise it in his or her own unique ways went way beyond the role descriptions people carried into the meetings.

It was a balancing act between collaborative and directive leadership styles, both exercised with as much transparency of process as we could make possible. Also significantly it showed the process by which consumer leadership roles could come to the fore, through the development of structures for unheard or marginalized voices. These possibilities have evolved over time, to 'allow' more formal consumer leadership and participation, such as in training development and presentation sessions that have flowed out of the SRMs, and just recently by changing the Terms of Reference to include a Consumer Co-chair of the SRRM.

*Exceptional leadership is not one with an iron fist, but one who includes and encourages those around to join in.*

Leadership was and is displayed in the SRRM in various forms. The most evident is the integrity and at times, apparent bravery to speak your mind. Everyone's voice must be heard!

*Leaders come in all shapes and sizes. They can be the formal leaders or informal leaders and the group itself has a leadership capacity.*

## **Change**

Movement, evolution and growth between the personal and the collective dimensions of the process is a critical key to the success and outcomes of the meeting.

*The unique process with tangible outcomes involving the whole person and the whole work environment. Nothing short of real cultural change and reform, stunning.*

*The SRRM has been fragile at times. It has threatened to regress rather than evolve, but on the whole it has evolved nevertheless.*

A change in approach that mirrors and demonstrates Recovery Practice and approach has taken place the SRRM. There now exists a new and embedded mindset toward seclusion. The unique quorum of the SRRM reiterates the key belief in the importance of therapeutic relationships. The commitment to ES and IT training and to have a 'no-one gets left behind' attitude to a one day training for all staff, current and future, was a collaborative effort, with the consumers' voices being prominent.

The openness of the committee demonstrates collective leadership. The way in which the meeting is facilitated and held, where all voices are heard and there is a conscious resistance to leaving anyone behind, supports a unique setting where seclusion events are now reviewed with dignity. The group dynamic has a holding capacity for the range of emotions that can be elicited by reviewing a particular seclusion, allowing individuals to sustain their agency within the meeting. The resulting strength and compassion drives the intent to reduce seclusion.

The SRRM has supported the development of Recovery Practice at the PSU and beyond the Ward to the larger hospital. There is now a significant discussion and an open partnership between these groups.

### **What's Missing?**

*There are still gaps in our ES&IT training regarding skill building, to support and empower staff to confidently support and become guides in consumer self empowerment, particularly when the consumer is in crisis. There is a depth and breadth of clinical and personal skill sets that the PSU and Ward Services staff have, though there is a need to build on these.*

We have sometimes missed out on opportunities to bring the PSU staff with us on the reducing seclusion process/journey. It could be said that we jumped the step of having forums to allow ventilation and education about the changing roles, especially of nursing staff, but also consumers at large. There was legitimate fear from some nurses who had been injured in the past, and who were fearful that not having seclusion as an option would increase staff and consumers being injured. We may not have known how best to address these concerns. Even now, there is more work to be done to communicate better what has been learned in the SRRM, and the ES&IT development and implementation.

### **Trickle Down**

An interesting and emergent outcome was observed as the meetings moved into their second year: staff came to be more in tune with consumers than with the bureaucracy they work under. Goodwill between clinical staff and the consumer consultants and with the secluded consumers in each case study became stronger as time went on. This was considered an amazing achievement which highlighted a certain aesthetic that ensued from working with consumers, creating an environment where all voices are welcomed, a space that could be termed 'liminal' - a place open to possibility - so many new perspectives.

*Nurses and Wardies now see themselves not merely as custodians but as carers and helpers.*

Over the weeks and months, mutual respect and understanding was achieved on both sides. Even the concept of 'sides' came under scrutiny as

collegiality became a more movable feast. And then there were more sides. The Wards-persons were invited to attend.

*The Wardies wanted a position where they were/are part of a treating team, making relationships with consumers, taking care even when having to bring people to the ground when ultimately a person's safety or others' safety came to be at risk. This line, if I can call it a line, where consumers are seen as a danger to themselves and others has not only shifted for nurses, but for Wardies as well. Many other things are now tried before this line is crossed. Wardies are now part of the trying other things. This was not the case even 6 months ago.*

Up until this time Wardies had a very peripheral and last minute role. They now provide integrated early support as much as possible.

*One moment I recall which spoke dramatically of this was an occasion when a clinician told of an escalating event (perhaps a code black?) when a Wardsman arrived and gave the agitated consumer a soft toy and helped to talk the consumer down. This was seen to be in stark contrast to the traditional and earlier methods of heavy-handedness.*

The SRRM members have become leaders and innovators, not only in reducing seclusion, but also for increasing the consumer voice and role within the unit. There is significantly more traffic around the PSU of consumers in various roles.

On the Unit there is a buzz around seclusion reduction, early intervention, and alternate strategies for de-escalation.

*I remember having open discussions with my colleagues and identifying with them the journey of seclusion for the consumer and how this would have a negative impact on the consumer, and cause more anger and escalation in the behaviour of that particular individual. This resulted in staff not secluding the consumer but working together to de-escalate both the individual and the staff.*

De-escalating the staff was a concept that rarely got a mention in the early stages of the SRRM, but is now considered a key strategy for maintaining the lowest possible seclusion rates. The unique combination of clinicians and consumers analysing and critiquing incidents brought a freshness, a reconceptualization around how lived experience was the central player as opposed to symptoms and behaviours, both to the unit and to nursing practice. This led to thinking about alternatives with regard to de-escalation techniques (for all) and that led to discussions outside the meeting. SRRM had implications far beyond just the meeting room. Conversely, conversations with other colleagues outside the meeting fuelled observations and review in the SRRM. For example, being more aware of pressures within a nursing shift, including the impact of skill mix among nurses and increased paperwork. Also, taking consideration of what happens at the Mental Health Assessment Unit prior to admission (whether a person had been 'confined' or whether the person had arrived in a police van).

Even as the incidents of seclusions decreased, the focus of the group was maintained. This gave room in meetings for cultural, social and relational issues and the overall 'intervention' came into focus. We were then able to look at the Unit as a whole and consider the people who frequented the Unit as a community, looking to support individually and collectively where prior to this we were reviewing seclusions at what you might call the sharp end, defusing extreme arousal.

*De-escalation and trauma-informed care became central to the conversations. These were seen as far more therapeutic and often prevented consumers becoming distressed to the point where it would have previously been considered that they 'required' seclusion.*

*Clinical nurse leaders blazed a path for nurses to say, "This is not the way we want to work anymore", and have supported nursing staff every step of the way. Even in those moments when it has been too hard, they have been there.*

The process of the seclusion review has not only opened my eyes and changed my views, but many nursing staff along the way.

SRRM has also opened a door to alternative leadership roles for consumer reps in the meeting, in the unit and for consumers as a whole being leaders in their own care. For example, consumers were involved in the design, development and delivery of Early Support and Intervention Team training, although it had been a frustration and disappointment that we took so long to commit to ES &IT training.

Another key feature of SRRM consumers' instrumental and ongoing critical role was in the development of Seclusion documentation designed to capture the consumer voice and the person's lived experience of a seclusion event. This paved the way for lasting consumer advocacy, support and other roles regarded as expert contribution by others.

Empowerment has manifest in many forms, revaluing the role of Nurse Practitioner, as proximal and critical guides in recovery; Occupational Therapy's significant contribution in regard to sensory modulation; the early work that Doctors achieved in collaboration, setting the scene for a process of multidisciplinary rigour: and consumers' roles as experts by experience (amongst other qualifications). These consumer roles, it should be said, have evolved over time, as those with the lion's share of decision power have 'allowed' these roles to evolve.

*At times, it is as if there is permission to act,  
as it is grounded in the most valuable of investments,  
the well being of individuals.*

*The permission to try something new,  
what a concept.*

*If those who lead do not see the benefit in it and do not walk the walk, how are others supposed to change not only their practice but also have the permission to change others around them? The inclusiveness of the SRRM group has stood out as an example of how things should be done*

*The changes that have occurred in the unit have had a knock-on effect in the greater hospital, not only with the nursing staff but also the wards persons.*

*Wards persons had been asking staff from other wards, and talking with them about ES and IT, which not only made my small contribution worthwhile, but I found a deeper understanding of the seclusion review meetings and their significance.*

Nurses have had to overcome significant fear and negativity about reducing seclusions, a task they initially saw as impossible. Thanks to the consumer involvement and the strong consumer stories about seclusion and other exclusion practices, staff attitudes have changed significantly. This applies to staff throughout the PSU, not only the staff that attend the SRRM. In fact there has been a distinct cultural change throughout the ward and all staff are now asking the question, "What can I do to make this person's stay more comfortable?"

We used these feelings to forward the meeting and to make changes for the consumers on the unit and the whole of the unit in terms of the culture.

Members have taken away issues and themes from the meeting and have been able to act on them without the formal nature of normal meetings i.e. action points attached to minutes. In fact, when a new member suggested that we needed to do that it was highly uncomfortable, and seen as a threat to the effective

operation of what was seen by then as a very robust self organizing system. So even though we have had limited formal feedback from SRRM people, the ward always seemed to know what was said and what were the outcomes.

*The essence of the meeting has filtered down to all staff.*

*This seeming osmosis of the rest of PSU knowing and learning from what occurred in the SRRM, did have roots in many conversations, mentoring through words and action, and preparing ground, planting seeds, and watering to nurture a culture shift. It was not about blame, or telling others what to do, rather fostering opportunities to empower colleagues and consumers to seek out and explore what supported well being.*

*What helps? What do you know helps at home? What would you like now?*

The above questions were equally valid on the floor of the PSU as they were in the SRRM and not necessarily directed towards consumers.

These strategies became known as ripple effect or unconscious non-effort to inform how decisions made and the ideas from SRRM got to the PSU floor. The ideas are almost contagious in their transference. Members are both invigorated and challenged. We often spoke about carrying these experiences in interactions with others around seclusion reduction, group transference and projection, an embodied experience of seclusion reduction and its consequence, inclusion. There was conscious effort and unconscious non-effort, or resonance.

*New people joining the process at different points somehow caught this spirit and dynamic, virtually by doing it, joining in and being committed to the process and its implicit values.*

## **Ripple Out**

The SRRM is indeed an excellent example of the whole being more than the sum of its parts. Dramatic changes have been made in SRRM and the

knock-on effect has taken this not only on the ward, but the concept throughout the hospital. What started as a concept that examined how seclusions were handled in our own back yard has become a movement that "cannot be ignored".

*A change has been brought about in attitudes toward seclusion, by so many different professional groups, including Wardsmen. This suggests that attitudes in society at large are changing and will change toward mental health; the stigma is being reduced, which is highly significant and important.*

The SRRM process, practice and model has serious implications on how Mental Health services are run and developed, and in particular how the various clinicians, workers, and bureaucrats can work with consumers in a radical new way! This has been acknowledged through inclusion of the SRRM in the ACT Mental Health Business Plan, under innovation, through the recent revitalization of the Collaborative Engagement Forum (soon to take up a governance role in Acute and Access Services). The SRRM is also a model that is conceived as a hospital wide process for patient/clinician collaboration. The SRRM has recently decided to have a consumer Co-chair arrangement.

We understood that for some nurses and Allied Health staff the changes being experienced at PSU provided a return to what were central tenets for their own practice, that what they did was to the benefit of the person in all facets of their lives, whereas for others (maybe doctors, but not exclusively) it may be seen as a threat to the tradition of treating the illness, a diagnosis focus. Reflective practice in the seclusion area has led to reflective practice throughout the whole of nurses' duties.

### **Ripple In**

*From the first forum I attended in Brisbane, conducted by Qld Health, in November 2008, the value and imperative of training for all staff has been etched on my psyche for this cultural shift required at PSU, where no seclusions occur.*

*Being in a mindset that seclusion is not an option is a challenging one, which grew in power and possibility. To know that other jurisdictions had achieved this gave me heart.*

At the SRRM there were concerns, as there have been in many other jurisdictions, that a reduction in seclusion and restraint means an increase in staff injury. In many ways this was, for a period of time, the elephant in the room. We came to these concerns and fears along the way as people felt more able to share their lived experience as consumer reps led by example. An increase in injury never eventuated; as seclusions reduced, so did the rate of injuries to all parties.

### **Produce/ Outcomes**

There was one particular question about what the consumer needed or had tried, that was at the centre of deliberations at SRRM. There were many attempts to take this question off the form. This was before the advent of the Coping and Safety Tool, which aimed to offer a selection of possible interventions to assist the consumer to self-soothe. The idea that consumers 'lacked insight' when distressed was always present in these discussions, and that this lack of insight entirely explained, and even gave permission for, seclusion.

Practices whereby the consumer voice might be heard and valued countered the supposed lack of insight, and hence decision making ability, and touched us profoundly, emotionally and practically. It inspired intellectual rigour, and a significant collaboration of skills and knowledge. We rightly emphasised the importance of collaboration and its vital elements of hearing, acknowledging and valuing the consumer voice. And the collective outcome of this was the catalyst and motor of real change and positive outcomes, even way beyond the reduction of seclusion.

*Once the Consumer's voice was included as a core part of the Seclusion documentation, the outcomes and debate within the review meeting became more robust and the de-escalation techniques discussed were more individual-focused, often resulting in changes to the treatment /management plan for the consumer.*

The Coping and Safety Tool in some part came out of the ongoing problematic and rigorous conversation. At the beginning of developing the Coping and Safety Tool and the relational process that surrounds it, we were significantly informed by answers, often short and not always sweet, given by consumers who had been secluded, and also those who had avoided seclusion by some means. (These were termed 'near misses')

*A consumer who had high percentages of seclusion episodes per admission was, through the Seclusion review process and treating team discussion outside the Review meeting, not secluded and other de-escalation / behaviour management strategies were used to successfully and therapeutically resolve the incident.*

*I also experienced discussions with staff outside the meeting that fuelled and helped to define issues to share with colleagues from what had occurred in the meeting. For example, the value of engaging individuals to explore what helped them to feel supported or better, finding out what their interests were and working to increase opportunities for these in the unit*

We began to work, in a much more focused way, with a unique process involving the whole person and the whole work environment, with tangible outcomes for the person. Nothing short of real cultural change and reform. The emphasis is now on therapeutic relationships throughout the whole of nursing care. In this way the cultural change has permeated the whole consumer experience.

Part of this cultural shift is what is offered in place of seclusion, asking, what can make a difference to the well being of the individual? Beyond the development of the Seclusion Review document and its requirement for each and every seclusion event came the development of the Coping and Safety Tool and the Early Support and Intervention Team (ES &IT). Once each of these strategies was developed, a training program was rolled out for each.

The Coping and Safety Tool was developed from the previous de-escalation form, drawing on other Health Service forms. Training and implementation of sensory modulation is also integral to both

CST and ES &IT and is reflected by the structure of the Coping and Safety Tool. The SRRM became critically aware of how sensory input/diets are unique to each individual and a significant amount of work went into understanding how staff might support the use of sensory modulation to self soothe, and support emotional regulation. The CST is designed to support and guide the conversation, to support engagement between consumer and clinician and discover and acknowledge what could be triggers to feelings of being unsafe and distress, how the person knew this was occurring, what others may notice, and what strategies would support the person at these times. The CST and its process documentation, as well as an informal mentoring arrangement were implemented 12 months into the project. Again collaboration and its vital elements of shared decision-making is beginning to reap benefits, supporting the discovery of what helps when someone is overwhelmed, vulnerable, highly agitated, angry or upset. Rates of up to 65% completion of CST and surrounding conversational strategies have been achieved.

*The ES&IT training has been instrumental in expanding the use of these strategies leading to greater skill sharing amongst the whole community.*

*The ES&IT training days were and continue to be a very important component of cultural change, shifting to a team practice of not secluding.*

## **Challenges**

Members have faced difficult personal challenges in attending SRRM. We have been challenged to change practice and to use our influence to promote ideas from the SRRM outside that meeting. Some of these challenges have been shared by consumers and clinicians, others are particular to each person or role.

For staff, some of the feelings and concerns were, trepidation and fear, discomfort, anxiety, disbelief, distrust.

These were at times some of the most challenging times in my work life and at times I felt my internal resolve wandering and I felt frustrated that the consumers did not see where we or I was coming from. At times I walked out thinking aagh..... oh my god.

Attitudes, beliefs and practices, sometimes presented as policies, informed any actions that flowed from the SRRM. When we began the meetings there was a commitment to reduce seclusion and restraint but we were yet to find the collective means at the local level.

*I felt I was being made wrong and I was harming consumers that I was in charge of caring for. I initially went into these meetings determined that the idea of reducing seclusion and restraint was not going to work on the ward and in the environment.*

*Challenging beliefs and practices was, and continues to be, a week by week process. Attitudes and beliefs changed "somewhere along the way" individually and collectively, something that grew in power and possibility.*

*I could not in all good conscience train others in something I was not 100% committed to. During the initial ES and IT training, not only hearing the stories of consumers but also the interaction of trainers, I was able finally not only to talk the talk, but was able to walk the walk.*

*Today I feel committed to the statement that seclusion is a failure of the therapeutic process. I am able to say this out loud and mean it.*

For consumers there were issues of staying available to the process, even when it all seemed too daunting.

I remember times when the consumer line or way of wording things came, not under attack, but when there was an attitude, just below the surface, of paternalism, times when you could just about hear a whisper, "how much more of this do I have to

sit through and what is the point this consumer is trying to make".

These times were discomfoting when they came and it speaks to a great commitment on the part of consumers to keep going, sometimes not knowing the bio-medical language, sometimes feeling daunted by the power brokers in the room, and possibly feeling the effects of internalized stigma. These times also brought forward issues of resilience and self-care as a critical consideration for those who identify as 'recovered' and those who identify as 'recovering'. Constant exposure to problems and issues of the mental health system can be very wearing.

For all members it was important to highlight the traditional or conventional fears or suspicions between consumers and clinicians. This provided a dynamic that diluted, or "gradually unbuilt" these fears and suspicions.

*These were the challenging yet exhilarating aspects of the SRRM*

And yet it is still not easy and the powers that be sometimes appear frightened, as these ideas threaten their power base:

*"nothing has changed at the PSU, there has been no cultural change and it has only been the weight of paperwork that has now to be done around seclusion that has made people think twice."*

## **Discomfort**

*Total elimination of seclusion is the ultimate goal. I believe that sometimes seclusion just cannot be avoided for the safety and wellbeing of both consumer and staff. I would like there to be a caveat on this goal, that there will be times, despite the best goodwill and clinical practice, when seclusion is the best outcome.*

Many members, staff and consumers, had reservations regarding being able to reduce or even possibly eliminate seclusion. This brought

into clear focus issues of care and treatment and issues of staff and consumer safety. Seclusion as a last resort came into question.

I had been told that this was not possible at the PSU and some part of me believed that. I needed some evidence.

*I had experience with seclusion as a clinician and felt that seclusion had often been a therapeutic care option for consumers who were out of control towards others or towards themselves. I attended my first seclusion review meetings almost feeling as though I was under the microscope from senior clinicians and consumers. I felt a sense of distrust at times, but as time has progressed and my beliefs changed, that trust grew and seclusion was not seen as a necessary evil.*

There was considerable fear and anxiety surrounding setting the meeting up in the first place, challenging the status quo for Mental Health ACT and also the situation for consumers, challenging the conceptions surrounding what makes a 'good' Consumer Representative.

*I empathise with feeling of being out on a limb and being overwhelmed with what we were doing. At times it felt that we were taking great risks, and as a manager, I had concerns that it would all unravel and I would have to spend time picking up the pieces and that seclusion would sky rocket again.*

## **Conflict**

At times I felt I had done ten rounds with Mike Tyson when I came out of the meeting... I believe that this has been the most powerful dynamic of the group.

The 'rub' between the clinician and the consumer has been extremely important and has challenged the status quo of the workings of the PSU.

Ambivalence, dual roles, political correctness and power relations were ongoing themes for consideration and part of what might be termed a liminal space (a space of infinite possibility).

*It was at times difficult not to defend my colleagues on their decisions and actions relating to and involving seclusion incidents. This led to an internal tussle with myself in an attempt to unite both the individual clinician and the collective clinician.*

*Defending the actions of my colleagues... this has proved challenging for me as a consumer as I have not always agreed with what has been proposed by my colleagues, just as I have not always been in agreement with clinicians. I have dealt with this by being vigilant to my position as a consumer and on the occasions when I came close to becoming a 'coconut' (a term used by koori folk to describe an indigenous person gone white on the inside, adopting the ways and means of the dominant (white) culture). It has concerned me, in my efforts to be collaborative, that I cross this line. I don't have a problem with running up against the line but crossing it dilutes the power of a diverse group in collective struggle.*

Early meetings saw frequent 'mini-conflicts' around the table. Consumer reps were seen to have too much say and not enough understanding of the difficulties of clinical management of escalation and ward events, whilst there was frustration for consumer reps that clinicians did not understand the world of the consumer and their pain.

## **Benefit**

The exceptional and mutual goodwill between all members of the SRRM has allowed people to change the way they view not only seclusion, but the why's and how's around the process.

*Staying connected with or dwelling in the emotion, distress or frustration created an environment for creative problem solving, this strengthening empathy, opening avenues for what could be offered to individuals, and in particular, individuals who had been secluded.*

It was identified early in the SRRM that trauma touches us all, not equally, but in particular ways for consumers and for staff. This understanding proved grounding for members and motivating. A sustained effort was required to keep the focus

on people and issues they were dealing with in ways that did not include seclusion and restraint.

*Seeing all seclusion as a failure is a very bold and optimistic statement, even daring - a revolutionary idea and for nurses and clinicians to come on board is quite spectacular.*

Changed mindsets were undoubtedly due to the SRRM's multi-faceted (or liminal) approach to reducing seclusion. Nursing practices have changed due directly to the effects of the SRRM; nurses have had to overcome significant fear and negativity about reducing seclusions, a task they initially saw as impossible. It is also understood that SRRM is part of a bigger process that is occurring in society, leading to perceptions that mental health is like any other health issue, not a big bad concept but something that comes and goes for us all.

*Attitudes in society at large are changing and will change toward mental health; the stigma is being reduced, which is highly significant and important.*

The process of change at SRRM was slow and painstaking but the change was dramatic, with seclusion having been reduced to the point of being the rare exception rather than the rule, with the most hardened advocates for seclusion, having a different perspective and view on the entire process.

*Nurses and Wardies now see themselves not merely as custodians but as carers and helpers.*

*I feel I have not only grown as a person, but also as a clinician.*

## **Rewards**

*I feel very proud and fulfilled as a consumer to be part of this process.*

*To find resolve in myself as a person to push through this and manage those fears within myself.*

*I have permission to do things differently..... practicing what I never thought possible... 'what else do we do' has made me think of hundreds of*

*things that I can do differently in my day to day practice. I have been given the ability to be innovative and creative in my approaches with consumers and with staff... . hugely beneficial.*

The support from this group and the leadership, of various kinds, were key elements. When things felt overwhelming we created an atmosphere where other options became possible. I do not think there is anyone on the unit or involved in this group that does not feel a greater level of personal and professional satisfaction as a result of the changes that have occurred.

*The seclusion review meeting fills me with confidence to continue the journey.*

*The most stunning thing to come out of the seclusion and restraint meetings is overall cultural change.*

Cultural change is about commitment and about changing relationships; being compelled to creatively find other ways and alternatives to seclusion and build real and meaningful therapeutic relationships.

Everyone's opinions were listened to and validated.

This is what made the discussions so rich and valuable.

*I have been able to develop my role as leader beyond what I previously thought imaginable... [hearing]the consumer voice has allowed me to do that but also the collective power of SRM has allowed me to do that. The words Collective Recovery ring very true when describing SRRM.*

## **Celebrations**

*The establishment (the process was showing good results from the start!), maintenance and ongoing progression of the SRRM have proved difficult, exciting and exhilarating, personally and professionally fulfilling. Members attending the research consultations experienced the SRRM as one of the most engaging and promising processes ever taken up. A significant commitment exists both historically and currently to changes made possible by SRRM in practice and culture in a complex and problematic clinical setting.*

*I saw the hope of not choosing seclusion as an option... what helped fan the fire of hope was acknowledging in the SRRM what had been successful, and the times we reflected on therapeutic practices that may not have occurred when we first began reviewing seclusions.*

*What a place to stand! As if on the mountain top and we have seen the other side. Once we've experienced it individually and collectively, we can say that S&R can no longer be a treatment option! What a long way we've come!*

What is striking is the extent to which many clinicians have taken up much broader consumer advocacy roles as an outcome of the SRRM. Consumer Reps are now engaged in collaboration to a much greater extent than was previously possible under a conception that limits consumer roles to that of 'watchdog'. Valuing the lived experience of consumers has promoted a richer landscape, emotionally and practically, for exploring changing and emerging practices. Goodwill, respectful relationships and challenge have been the building blocks for these possibilities.

Members have felt very excited, touched and congratulatory of each other as the success of the SRRM is being considered and enabled in other areas. Even those who had taken leave of the SRRM for periods of time recalled very quickly and vividly our experiences. The felt sense of 'mastery', in relation to SRRM, has prompted many to ask how we can maintain the discomforting elements of the process in order to reap the benefits, to kick start change in other areas, more lately to expand into other restrictive practices.

*I remember the chocolate cake celebration in the nurse's station; there is always time for cake!!*

## **The Third Analysis.**

Two focus groups were conducted towards the end of the research project to support a dialogical/ performative analysis that provides another ‘picture’ of how the SRRM has worked on the group and on individuals and how both have opened to achieve change.

The first consultation was between the consumer members of the SRRM (including the researcher.) Discussion focused on the presence of affect in the meetings to create openings into identity changes. Three distinct relations with affect were acknowledged: to consciously allow personal affect to influence the process of the meeting; to “swallow” personal affect and rationalize it for the meeting; and to witness affect in the meeting.

The acceptance and acknowledgement of affect has been a key factor (along with relationships) in what consumers value in Research environments (Walsh J. and Boyle J, 2009; Woltmann E. and Whitley R. 2010)

The second consultation invited all collaborators in the Definitional Ceremonies and Collaborative Biography sessions. Having been immersed in the research material, the researcher provided collaborators with two particular hypotheses, firstly that both personal and professional roles and identities had shifted as a result of participating in the SRRM, and secondly that sense of humour had been held in a particular way during the meetings. The focus group met to accept, reject or extend on these notions.

In regard to identity all collaborators acknowledged that both our personal and professional identities had shifted in response to attending SRRM.

The challenges encountered during the SRRM, the rawness of material that was the lived and embodied experience of consumers (told by representatives and secluded consumers), expanded the space wherein members of the SRRM could move between a focused gaze, a particularly narrow clinical focus towards seclusion reduction, and more peripheral considerations, that is, inclusion of social, relational and cultural issues and agendas.

This expanding landscape for members using both focused gaze, on why seclusion reduction needed to be achieved, and diffuse gaze on who, how, and what needed to occur in order to do so, was described as an accordion. This metaphor expresses the movement necessary for the music, that is, the creativity, imagination and deep empathy that achieved the extraordinary reduction in seclusion at PSU.

However, and most importantly, when the accordion is locked shut, a metaphor for organisational attempts to streamline the process, to make it formulaic for rollout to other programs, it loses flexibility, fluidity (Raphael, 2011 pers. comm.) and verisimilitude. There is little music.

The accordion metaphor, together with meeting structure and careful commitment to inclusion of all voices, allowed clinicians and consumers to safely “bleed” the edges between personal and professional identities, bringing emotional validity to the project (Nussbaum 2003)

Much of what happened in the SRRM was based on negotiating changes of mind and heart. We learned to support each other whilst questioning the appropriateness of certain ways of working. We found that commitment was needed to re-conceive and reiterate roles over and over in the day-to-day social environment in order to embody change.

In the early days, it was clear that there was a “rub” between consumers and clinicians. Managing that dissonance enabled members to change our own stand-points and attitudes, to the point at which there came a “rub” between the person, our own previous situated personal and professional identities and our preferred futures.

Collaborators acknowledged that despite our attempts we had not entirely achieved a level playing field and that there were considerable barriers, popular understandings, clinical identity categories, internalised stigma, organisational agendas that continued to stand, providing for some anxiety in regard to hard won identity claims.

In contrast, collaborators stated that our identities had shifted through permission to be “artful” in our respective roles towards the “best possible care” (including the elimination of seclusion), having a “better footing”, feeling affirmed and sustained, and leaving the category “non entity” behind.

From this grounding, collaborators agreed that permission had been given for, and members were keen to continue, bringing personal identity categories into our professional roles. For consumers this has meant challenging the idea that consumer representatives speak only for the

larger constituency and leave our own “lived experience” at the door. Collaborators agreed that direct personal and professional experience is the grist for the cultural change mill. We also acknowledged that lived experience needs to be handled with care.

Early in the project it was acknowledged that both consumers and clinicians told “conventional horror stories” about seclusion. Some clinicians used black humour to manage their own feelings around seclusion, and consumers - often out of starvation for anywhere to tell - related stories of horrific seclusion events and used black humour against clinicians. We knew this would have to be held at arm’s length if we were going to have any chance of success.

For the SRRM this meant that sense of humour was necessarily shaped differently to what might happen outside the meeting and at other times. Sense of humour in this context became a swing between relaxation and tension, a moving feast as knowledge of each other increased, only to have tensions increase as new members came and others, including doctors, left.

During establishment, in particular, members held critical awareness around “being flippant”. Not only were we reviewing incidents whose outcomes were understood as traumatising to the individual, but we were also considering a clinical context where consumer representatives had not been included and the consumer voice had little power.

Humour was sometimes an “edge of hysteria” experience where a release of energy happened as a result of a difficult meeting. “Taking the piss” out of systems (as opposed to people) was also used as a debriefing, tension-relieving strategy. Goodwill was maintained with diligence. Humour was experienced by all collaborators as a “quieter pleasure” or satisfaction at achieving through adversity. All agreed that this sense of humour and self-deprecating humour had utility in this context, whereas other forms had little.

Towards the end of the third analysis, collaborators described a tree metaphor that fit our collaborative group identity, with each person’s identity collectively portrayed.

## Recommendations

All indications suggest that the SRRM is a positive addition to Mental Health Services in the ACT. Since late 2009, early in the life of SRRM, Mental Health ACT, in its business planning agenda and documents, identified the consumer/clinician collaboration demonstrated within SRRM as a key strategy for future programs. Since that time Wards-persons have become members of the meeting and Early Support and Intervention Team strategies have been developed that now are utilized across the hospital.

This has been made possible by enduring relationships between consumers, clinicians, allied health staff (and doctors when they were in attendance.) At the writing of this report the registrar for PSU was in attendance at the SRRM, a return to the fold. If the SRRM is to continue, all persons with a stake in the project need to be in attendance, and all voices need to be supported to equal value. It is also recommended, given the findings of this project, that there are times when privileging the consumer voice is entirely appropriate.

Bowland et al (2010) state that “consumer input is imperative to the successful implementation of any work related to systems change to affirm and redirect organizational priorities,” yet consumer-led research languishes beneath a system that increasingly rewards the methods and proofs of the disinterested scientist.

Independent consumer –led research in Australia is virtually non-existent. Serious ongoing discussion and action is required to unpack the cultural and institutional issues that perpetuate the abject positioning of consumers in this regard. Gilfedder (2010) states “experiences of mental illness...became a valuable research asset.”

Wilson and Fothergill (2010) suggest that a user and carer research group established in Wales, UK in 2008 “undertake their own service user and carer-led projects”. They also identify, although not an intended aim, that training and conducting research had “therapeutic potential”.

Research into consumer/clinician collaboration is in its infancy and requires significant further support. Continuing research would seek evidence in settings where collaboration, shared decision making (REF) and the validation of struggle are central features.

Researching these settings would utilise multiple methods that reflect the shape of the researched activities themselves so as to further embed lived experience as continuing and congruent.

## **Conclusion**

Rose and Thomas (2002 in Walsh and Boyle 2009) claim that anyone involved in delivering mental health services would benefit greatly by taking note of the messages given through User (Consumer) led Research. We, the members of the SRRM, hope that this report meets with you, and demonstrates what is important in developing relationships that support change.

## The Experience of Being a Consumer - Researcher

For me the research has been a continuing process of balancing exposure and self care: a recovery process. I identify as someone who is 'recovering' rather than someone who is recovered or cured. This positions me as resisting ideas of cure proposed by the medical model i.e. functioning in the world with an absence of symptoms. As a result of the challenges to my mental health, I experience ongoing impairment to my memory, my ability to structure and hold ideas, and to deal with overwhelm and stress.

*“Just yesterday I was speaking about having attended a series of camps where my resilience has been tested and the threat of collapse has become apparent at day 2,3,4 and 5 consecutively.... I have, during this period, understood my developing resilience as resting upon social and relational underpinnings”*

During the two and a half years that the SRRM has been operating I needed to absent myself from it for a period of 3 months. It took me some time to understand the absence to be about self care and a time for ruminating or accommodating what had gone before, whereas, at the time, I felt pushed away and isolated by the ACTMHCN and somewhat overwhelmed by what we were attempting, too far out on a limb.

*“For my part, as a consumer rep and as Chair of the Network (ACTMHCN) I do remember feeling I had try to be a bridge between the Network office staff in their important roles as coordinating and supporting consumer reps and finding ways to have a role in supporting Bradley’s research effort. This was a tricky new development for all concerned. The good thing is that the time and commitment of all concerned to the process has also healed, renewed and developed organizational relationships. The Network fully supports his valuable work and leadership in this special research work.”*

I initiated this research out of the small budget made available for “education activities” at the close of the Beacon Site Project. I identified the need, the gap was big enough to drive a bus through – there exist only a few examples of independent consumer-led research anywhere in the world. I developed a proposal with the help of my partner and now research assistant and word-smith, Elizabeth Foxlewin (B.A., B.Ed., M.Ed.) who also identifies as a consumer and as someone who cares for me.

My role in the SRRM has changed over time, which in its own way has proved challenging. Some have questioned where I have positioned myself and I have been accused of being ambivalent. *“... his sometimes ambivalence with aspects of it and his dual roles within it which may have been an added challenge for him in some ways. ... There was for him, as a consequence of the multiple roles taken up in support of seclusion reduction, some slippage between the consumer role/perspectives and the later staff role and identification.”*

The research project itself was instrumental in my ongoing journey of Recovery and the development of resilience. Bringing clinicians and consumers together to reflect on what has happened at the SRRM has stimulated much self-reflection, and probably more important a reflexive position which supports being able to read the world.

*“B's unexpected story moved me, as it was not at all apparent to me that he was not fully recovered. He had always seemed fully in control and I would have considered that he was someone who had overcome a problem which had arisen long ago and far away. So I was brought to realise that we are all very much connected in terms of mental health in that I am also, and probably we are all, only a short distance away from being less than mentally healthy. In fact, we probably all take journeys toward and away from mental health without it being identified or acknowledged or diagnosed.”*

Being seen as mentally healthy is at once encouraging, and frightening lest problems arise. This is the ‘exposure’ that has to be balanced by self-care. Being an independent researcher means that I have had to arrange my own supports, at the same time maintaining ethical concern for my research collaborators.

*“B has made a great contribution on many levels in his different roles, including as researcher. He has in his consumer role in particular, also been an invaluable and complementary support for me and other consumers.”*

## **Acronyms used in the text.**

ACT	Australian Capital Territory
ACTMHCN	ACT Mental Health Consumer Network
CMHR	Centre for Mental Health Research
CRG	Consumer Reference Group
CREU	Consumer Research and Evaluation Unit
CRU	Consumer Research Unit
CST	Coping and Safety Tool
MH ACT	Mental Health ACT
PHAMS	Personal Helpers And Mentors
PSU	Psychiatric Services Unit
SRRM	Seclusion and Restraint Review Meeting
VMIAC	Victorian Mental Illness Awareness Council

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## **Appendix 1 - Focus Groups Schedule**

### **Objectives**

Focus groups in the form of Definitional Ceremonies (Epston 2004; Myerhoff 1982; Speedy 2004) is the method utilised at this stage of the research in order to define an inter-subjective performative site where participants relate to themselves and others in an interaction. In Definitional Ceremony participants enter into showing and telling, making meanings together about the processes of identification and cultural change. The process encourages expression of lived experience in regard to participants' own ideas and practices and begins to define and critique cultural stories that constitute our lives. The focus groups also map relationships with reference to social and cultural enablers and barriers, particularly in relation to consumer experiences. This approach is distinct from looking for personal problems or answers to pointed questions. Definitional Ceremony utilises strict teller and witness positions to disrupt conventional forms of conversation ensuring that knowledge claims are not pitted against each other as if in an argument.

Definitional Ceremonies and Collective Biographies engage imagination and have the capacity to disrupt our usual ways of thinking about who we are as consumers, nurses, doctors, psychologists, occupational therapists, setting the scene for thinking about ourselves in un-usual ways.

The objective is as much to canvass acquired knowledge as it is to unveil the process of performing (which will be documented as a series of collective stories) these lived, embodied improvisations and change agency including collaborating in research.

The methods resist the compulsive retelling of individualised (conventional) trauma horror stories (Doane and Hodges 2001) and other conventions that contribute to silencing marginalised voices: everyday conversation, privatisation, isolation, and dislocation. By bracketing out, as much as possible, silencing conventions and by paying attention to these, when they become apparent, the safety and wellbeing of participants is maintained as the highest priority.

### **Methods**

First, a consumer participant will tell a story about their experience of participating in the SRM for a period of about 10 minutes. The researcher

will then ask exploratory questions, seeking out knowledge about what has happened at the SRM that has supported change at both personal and cultural levels. 15-20 minutes

Second, the other group participants, in the role of outsider witnesses, will have an opportunity to retell the story responding in a speculative manner to anything that caught their attention. The role of the researcher here is to witness these tellings in order to retell what he has heard in the third stage, as well as to ask questions that support witnesses to maintain consumer experience at the centre of the consultation, e.g. What is it that Mary (pseudonym) said that prompts you to tell us this further information, or “It appears that you have been moved by something Mary has said and you are telling us something in relation to that, is that so?”

The outsider witnesses (those with insider knowledge in an outsider position) will be supported to tell their experiences using questions similar to the following;

As you listened to the story what did you hear that stood out for you?

Were there particular words or phrases that caught your attention?

What sense did this give you of Mary’s experience at the SRM?

What impression do you get about what might be important to Mary?

Did any mental pictures or anything you heard yourself saying come to mind as you listened to Mary’s story?

Do you know why you were drawn to these things that stood out for you?

Did being here today open up any ideas for you?

Is there any place you might be now that you were not at the beginning of this conversation?

What does this say about what is important to you?

Third, the original teller and the researcher will both have opportunities to speak about what they have heard, in response to the following questions:

What particular things did you hear from the outsider witnesses that caught your attention?

How does hearing these things affect how you understand your contribution to the SRM and the work we are doing together? What does it say about what is important to you?

Can you say something about why you were interested in these particular responses from the witnesses?

Where does this take you in your thoughts or ideas for your work here at the SRM?

In the above ways consumer centred and collaborator specific (expert) cultural maps (relationships and positions) can be construed whilst extending complexity in relation to the particular story being addressed.

Fourth, participants will move into a writing exercise beginning with a preamble and a question for all participants:

Considering what you have heard and your own experiences, please could you write a story about your experience- stories have a beginning, a middle and an end, and often revolve around a conflict or a problem, but not always. Could you please make the story about one of two things, max 300 words;

Something that has been bought up here today?

Or something that remains unsaid but has a connection with the origins of this consultation i.e. the consumer experience/story at the beginning of the session?

20 minutes

Fifth, participants get into pairs (or 3's if there are uneven numbers) and working on one story at a time, each pair attempts to 'finesse' what is being said in each story, to cut away the froth and bubble, cliché, homilies, heady arguments in an effort to get to the kernel of what is being said, the raw embodied experience, if you like, of what it was like to "be there". These pared down stories will be the material worked on in the CB session the following day, or within the next week. Total time = 30 minutes. Each person will be given a thumb-drive and asked to key in their story and bring this to the CB session.

**Collective Biography (each within a week of the DC that precedes it); facilitated by Collaborating Researcher.**

1. Each participant will be asked to bring with them a laptop and a process of moving from chair to chair will be entered into where

participants move one seat to the left 4 times for periods of 15 minutes. This process and the rest of the session will be facilitated by the Collaborating Researcher. At each laptop each participant will be asked to expand, not delete, on the story being told there (pens, pencils and paper will be provided to support creative engagement) 60 minutes.

Tea Break Time 15 minutes

2. Participants will be asked to move again to the left, as many times as there are positions they have not accessed and do the same as step 1, i.e. expand on the story being told there. 60 minutes.

3. Lastly the whole group will enter into an informal conversation about the process, other conversations that may have taken place or conclusions, concerns, frustrations, or celebrations about any part of the activity. This is also a time where participants consider the process, its utility and value, an opportunity to evaluate Definitional Ceremony and Collective Biography as a performative site for research and changes in culture. 30 minutes

After these stories have been collected the researcher will gather them all into one document and distribute these to participants for feedback. The researcher will use this feedback to edit and develop stories so that they become a collection of easily read vignettes that tell the collective experience of the Seclusion Review meeting for publication. These exchanges will require further, up to, 12 hrs reading and collaboration with the researcher around analysis of findings.

A digital notetaker will be used to ensure collection of valuable data from Definitional Ceremonies (to allow the principal researcher to immerse himself in the research data and maintain a consumer perspective around the origins of stories) and the final session of Collective Biographies (again immersion is important towards dialogical/performative analysis)