



QualityRights

Strategies to end the use of seclusion, restraint and other coercive practices

Training to act, unite and empower for mental health
(PILOT VERSION)

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What is the WHO QualityRights initiative?



WHO QualityRights is an initiative which aims to improve the quality of care in mental health and related services and to promote the human rights of people with psychosocial, intellectual and cognitive disabilities, throughout the world. QualityRights uses a participatory approach to achieve the following objectives:

- 1** Build capacity to understand and promote human rights, recovery and independent living in the community.
- 2** Create community based and recovery oriented services that respect and promote human rights.
- 3** Improve the quality of care and human rights conditions in inpatient, outpatient and community based mental health and related services.
- 4** Develop a civil society movement to conduct advocacy and influence policy-making to promote human rights.
- 5** Reform national policies and legislation in line with best practice, the CRPD and other international human rights standards.

For more information: http://www.who.int/mental_health/policy/quality_rights/en/

WHO QualityRights - Guidance and training tools

The following guidance and training tools are available as part of the WHO QualityRights initiative:

Service assessment and improvement tools

- The WHO QualityRights Assessment Tool Kit
- Implementing improvement plans for service change

Training tools

Core modules

- Understanding human rights
- Promoting human rights in mental health
- Improving mental health and related service environments and promoting community inclusion
- Realising recovery and the right to health in mental health and related services
- Protecting the right to legal capacity in mental health and related services
- Creating mental health and related services free from coercion, violence and abuse

Advanced modules

- Realising supported decision making and advance planning
- Strategies to end the use of seclusion, restraint and other coercive practices ←
- Promoting recovery in mental health and related services
- Promoting recovery in mental health and related services: handbook for personal use and teaching

Guidance tools

- Providing individualized peer support in mental health and related areas
- Creating peer support groups in mental health and related areas
- Setting up and operating a civil society organization in mental health and related areas
- Advocacy actions to promote human rights in mental health and related areas
- Putting in place policy and procedures for mental health and related services (in preparation)
- Developing national and state-level policy and legislation in mental health and related areas (in preparation)
- Guidance on CRPD compliant community-based services and supports in mental health and related areas (in preparation)

About this training and guidance

This training and guidance module addresses the use of coercive and violent practices in mental health and related services with a particular focus on seclusion and restraint. It aims to promote a greater understanding of why these practices are used and build practical skills to help end these practices. While the module itself focuses on ending these practices in the health care setting, much of the content can also be applied in other settings where seclusion and restraint occur, for example in the home and in the wider community.

Who is this training workshop and guidance for?

- **People with psychosocial disabilities**
- **People with intellectual disabilities**
- **People with cognitive disabilities, including dementia**
- **People who are using or who have previously used mental health and related services**
- **Managers of general health, mental health and related services**
- **Mental health and other practitioners** (e.g. doctors, nurses, psychiatrists, psychiatric nurses, neurologists, geriatricians, psychologists, occupational therapists, social workers, peers supporters and volunteers)
- **Other staff working in or delivering mental health and related services** (e.g. attendants, cleaning, cooking, maintenance staff)
- **Non-Governmental Organizations (NGOs), associations and faith-based organizations working in the area of mental health, human rights or other relevant areas** (e.g. Organizations of Persons with Disabilities (DPOs); Organization of users/survivors of psychiatry, Advocacy Organizations)
- **Families, care partners and others support people**
- **Other government institutions and services** (e.g. the police, the judiciary, prison staff, law reform commissions, disability councils and national human rights institutions)
- **Other relevant organizations and stakeholders** (e.g. advocates, lawyers and legal aid organizations)

Who should deliver the training?

Training should be delivered by a multi-disciplinary team including people with psychosocial, intellectual and cognitive disabilities, DPOs, professionals working in the area of mental health and related services, families and others with lived and/or professional experience in the area of mental health

The team conducting the training may differ depending on focus. For example, if the training is about addressing the rights of people with a psychosocial disability, it would be more important to have representatives from that group as leads to delivering the training rather than people with dementia, intellectual disabilities, autism or others and vice versa. However, nothing precludes the possibility of having multiple groups leading the training.

Guidance for facilitators

Principles for running the training programme

Participation and interaction

Participation and interaction are crucial to the success of the training. By providing sufficient space and time, the facilitator must first and foremost make sure that the people who are using mental health and related services are being listened to and included. Certain power dynamics within services might make some people reluctant to express their views. In general, the facilitator must emphasize the importance of including the views of all participants.

Some people may feel quite shy and not express themselves. Facilitators should make sure to encourage and engage everyone. Usually, after people have expressed themselves once, they are more able and willing to speak and engage in ongoing discussions. The training is a shared learning experience.

Facilitators are expected to engage participants in a way that draws on the experience and knowledge already existing within the group participating in the training. They will need to supervise and monitor the dynamics and discussions among participants.

Cultural sensitivity

Facilitators should be mindful of using culturally sensitive language and providing examples relevant to people living in the country or region where the training is taking place. In addition, facilitators should make sure that the specific issues faced by particular groups in the country or region (e.g. indigenous people and other ethnic minorities, religious minorities, women, etc.) are not overlooked when carrying out the training.

Open, non-judgmental environment

Open discussions are essential and everyone's views deserve to be listened to. The purpose of the training is to work together to find ways to improve the situation within the service, organisation or association, not to name and blame individuals for their particular conduct in the past. Facilitators should ensure that during the training, no-one is targeted in a way that makes them feel uncomfortable (e.g. attributing the blame to staff or families, etc.). Facilitators should avoid interrupting participants. It is not necessary to agree with people to effectively communicate with them. It may be necessary to withhold criticisms in order to fully understand a person's perspective.

Use of language

In addition, facilitators should be mindful of the diversity of the audience. People participating in the training will have different backgrounds and levels of education. It is important to use language that all participants are able to understand (e.g. avoiding the use of highly specialised medical, legalistic and technical terms, acronyms, etc.) and to ensure that all participants understand the key concepts and messages. With this in mind, facilitators should pause, take the time to ask and discuss questions with participants to ensure that concepts and messages are properly understood.

Operating in the current legislature and policy context

During the training, some participants may express concerns about the legislative or policy context in their countries. Indeed, some of the content may contradict national legislation or policy. For example, the topic on supported decision making may appear to conflict with existing national guardianship laws. Similarly, laws that provide for involuntary detention and treatment contradict

the overall approach of these modules. This can raise issues and concerns, particularly around professional liability.

First, facilitators should reassure participants that the modules are not intended to encourage practices which conflict with the requirements of the law. When the law and policy contradict the standards of the CRPD it is important to advocate for policy change and law reform. In this context it is also necessary to acknowledge that it will not happen immediately. However, an outdated legal and policy framework should not prevent individuals from taking action. A lot can be done at the individual level, on a day to day basis to change the attitudes and practices within the boundaries of the law. For example, even if guardians are officially mandated to make decisions on people's behalf based on a country's law, this does not prevent them from supporting people in reaching their own decisions and from ultimately respecting their choices. In this way, they will be making important strides towards implementing a supported decision making approach.

Throughout the training, facilitators should encourage participants to discuss how the new paradigms, actions and strategies promoted in the training materials can be implemented within the parameters of existing policy and law frameworks. Hopefully, the shift in attitudes and practices, along with effective advocacy, will lead to change in policy and law reform.

Being positive and inspiring

Facilitators should emphasise that the training is not about lecturing people or telling people what to do but to give them the basic knowledge and tools to find solutions for themselves. Most likely many participants already carry out many positive actions. It is possible to build on these to demonstrate that everybody can be an actor for change.

Group work

Throughout the exercises of the training, the facilitator needs to assess carefully whether participants will benefit from being placed in separate groups or in mixed groups that include both people who are using the service, staff, and family and care partners. As noted earlier, feelings of disempowerment, hesitation and fear, which can arise in mixed groups if participants do not feel comfortable in that setting, should be taken into account. Exercises are based on participation and discussion and should allow participants to reach solutions by themselves. The facilitators' role is to guide plenary discussions and when appropriate, prompt with specific ideas or challenges to facilitate the discussion.

Facilitator notes

The training modules incorporate facilitator notes which are in **blue**. The facilitator notes include examples of answers or other instructions for facilitators, which are not intended to be read out to participants. The content of the presentation, questions and statements intended to be read out to participants are written in **black**.

Preliminary note on language

We acknowledge that language and terminology reflects the evolving conceptualisation of disability and that different terms will be used by different people across contexts over time. People must be able to decide on the words that others use to describe them. It is an individual choice to self-identify or not, but human rights still apply to everyone, everywhere.

Above all, a diagnosis or disability should never define a person because we are all individuals, with a unique personality, autonomy, dreams, goals and aspirations and relationships to others.

The choice of terminology adopted in this document has been selected for the sake of inclusiveness.

The term psychosocial disability includes people who have received a mental health related diagnosis or who self-identify with this term. The terms cognitive disability and intellectual disability are designed to cover people who have received a diagnosis specifically related to their cognitive or intellectual function including but not limited to dementia and autism.

The use of the term disability is important in this context because it highlights the significant barriers that hinder people's full and effective participation in society.

We use the terms "people who are using" or "who have previously used" mental health and related services to also cover people who do not necessarily identify as having a disability but who have a variety of experiences applicable to this training.

In relation to mental health, some people prefer using expressions such as "people with a psychiatric diagnosis", "people with mental disorders" or "mental illnesses", "people with mental health conditions", "consumers", "service users" or "psychiatric survivors". Others find some or all these terms stigmatising.

In addition, the use of the term "mental health and related services" in these modules refers to a wide range of services including for example, community mental health centres, primary care clinics, outpatient care provided by general hospitals, psychiatric hospitals, psychiatric wards in general hospitals, rehabilitation centres, day care centres, orphanages, homes for older people, memory clinics, homes for children and other 'group' homes, as well as home-based services and supports provided by a wide range of health and social care providers within public, private and non-governmental sectors.

Learning objectives, topics and resources

Learning objectives

Participants will:

- Define practices in healthcare services that constitute seclusion and restraint;
- Discuss the physical, and psychological impact of seclusion and restraint on service users and mental health and related practitioners and the impact on recovery;
- Understand how seclusion and restraint violate human rights understand the various reasons behind the use of seclusion and restraint in mental health and related services and to challenge the common misconceptions related to these practices, and;
- Build knowledge and skills on the different strategies that can be implemented in mental health and related services in order to avoid seclusion, restraint and other coercive practices.

Topics

Topic 1: What is recovery?

Topic 2: Defining seclusion and restraint

Topic 3: The personal experience and impact of seclusion and restraint

Topic 4: Challenging assumptions about seclusion and restraint

Topic 5: Identifying tense situations and elements of a successful response

Topic 6: Individualised plans to prevent and manage tense situations

Topic 7: De-escalation

Topic 8: Creating a “saying yes” and “can do” culture

Topic 9: Comfort rooms and sensory approaches

Topic 10: Response teams

Topic 11: Action to take for eliminating seclusion and restraint

Resources required

To optimise the learning experience for participants, the room in which the training takes place should be:

- Large enough to accommodate everyone, but also small enough to create an intimate environment conducive to free and open discussions
- Flexible, in terms of enabling the change of seating arrangements (for example movable seats so that people can get into groups for group discussions)

Additional resources needed include:

- Internet access in the room, in order to show videos
- Loud speakers for the video audio
- Projector screen and projector equipment
- 1 or more microphones for facilitator(s) and at least 3 additional wireless microphones for participants
- At least 2 flip charts or similar and paper and pens
- Power Point presentations

- Copies of *Annex 3: Make an individualised plan*
- Copies of *Annex 4: Reflect to reframe* for all participants
- Copies of *Annex 5: Personal actions to eliminate seclusion and restraint* for all participants
- Copies of *Annex 6: Service level change to eliminate seclusion and restraint* for all participants
- Optional: Copies of completed versions of *Annex 1: Coercion Experience Scale* for all participants
- Optional: Copies of *Annex 2: Quotes from people with lived experience of seclusion and restraint* for all participants

Time

2 days (2 x 7 hours)

Number of participants

Based on experience to date, the workshop works best with about 25 people. This allows sufficient opportunities for everyone to interact and express their ideas.

Important reminder:

For exercise 3.1, Option 1: If this option is selected, prior to the session the facilitator will need to identify and invite one or two speakers who can speak about their own personal experience of being secluded or restrained (see below for more details on the topics for speakers to discuss).

For exercise 3.1, Option 2: If this option is selected, prior to the session the facilitator should ensure that the "Coercion Experience Scale" survey available in **Appendix 1** has carried out in one or more services **prior to the session**. The facilitator will also need to make copies of the findings of the survey to distribute for discussion during the session.

For exercise 3.6, Option 1: If this option is selected, prior to the session, the facilitator will need to identify and invite a health staff who has had negative experiences in administering seclusion or restraint and wishes to share his/her experience.

Welcome and Introduction

Give participants an opportunity to explain their own background and their expectations for the day (if relevant; 10mins).

Explain to participants that:

The purpose of this training on *Strategies to end the use of Seclusion, Restraint and Other Coercive Practices* is not to imply that difficult or dangerous situations do not arise within mental health and related service – it is acknowledged that these types of situations do arise.

Instead, this training highlights that:

1. By intervening and providing support early, many challenging situations can be avoided.
2. All efforts must be made to ensure that any intervention in these situations does not rely on the use of seclusion, restraint, or other coercive practices.



Trigger warning: It is important to highlight at the start of the training that this module may provoke difficult emotions for people who may have been through traumatic experiences of non-recovery approaches. Moreover, mental health and other practitioners may feel that they have been responsible for preventing recovery despite good intentions.

Facilitators should be mindful of this and let participants know that they should feel free to step out of the training session if they need to until they feel able to participate again (please refer to *Guidance for facilitators* for more information).

Topic 1: What is recovery?



Presentation 1.1: What is recovery? (10 min.)

This presentation gives a brief overview of recovery in order to set the scene for this whole module on seclusion and restraint. It is important to emphasise to participants that enabling recovery is the main goal of mental health and related services and the use of seclusion and restraint is incompatible with this.

This presentation aims to define the recovery-based approach to ensure that all participants share the same idea of recovery at the start of the module. For more information, see the module on *Promoting recovery in mental health and related services (with handbook and teaching guide)*.

It is important to remember that the objective of mental health and related services is to support people's recovery.

Recovery means different things to different people. Here are some quotes and definitions around recovery:

- “Recovery is a self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members” (1).
- “What matters in recovery is not whether we're using services or not using services, using medications or not using medications. What matters in terms of a recovery orientation is, are we living the life we want to be living? Are we achieving our personal goals? Do we have friends? Do we have connections with the community?” (2)
- “Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment, and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them.” (3)

Recovery-oriented mental health and related services provide hope, support empowerment and respect people's choice allowing them to drive their own care and recovery journey and to live the life they want.

Therefore, the use of seclusion and restraint is inconsistent with a recovery approach.

Topic 2: Defining seclusion and restraint



Exercise 2.1: Meaning of Seclusion and Restraint (10 min.)

Begin with a brief, general discussion of participants' initial ideas about what the terms "seclusion" and "restraint" mean. The purpose of this exercise is to encourage participants to start thinking creatively and critically about seclusion and restraint, practices which for many may constitute acceptable, commonplace, standard procedures within services. Ask participants the following question and invite them to share their thoughts.

What do you understand by the words: "Seclusion" and "Restraint"?

Write down ideas on a flip chart. Do not worry at this point about coming up with complete definitions as these terms will be defined in the next presentation.



Exercise 2.2: Forms of Seclusion and Restraint (10 min)

The aim of this exercise is to discuss various explicit and subtle forms of seclusion and restraint that are commonly used in mental health and related services worldwide.

Some of these examples may initially seem ambiguous. Through discussion with participants, the idea is to clarify what constitutes seclusion and restraint (including its more subtle forms) and what does not. Note that this set of examples can be changed and tailored according to the context in which the training is delivered.

Show the following to participants:

Do the following constitute seclusion, restraint, both or neither?

1. Holding down a person in bed using a belt or chains
2. Keeping a person in a caged bed
3. Tying a person to a tree, bed or a fixed object
4. Holding down a person
5. Forcefully grasping someone's arms to put their clothes on
6. Compelling a person to go to their room
7. Keeping a person in their room with a door open but the person is not allowed to leave
8. Holding someone's hands down in order to feed them because they are under-nourished

- All these situations represent various forms of seclusion and restraint. Some are more subtle than others but all are coercive practices that need to be eliminated from mental health and related services in order to ensure recovery and compliance with the CRPD.
- Some examples (examples 1-4) are obvious cases of seclusion and restraint and may not be disputed by participants such as using caged beds, tying a person down to a tree, bed or a fixed object, and holding a person down using belts or chains.
- However, participants may argue that some of these examples can be considered non-coercive or that some of these practices are better than others. Some practices may be justified, from participants' perspective, as being for the benefit of the person concerned and therefore not seclusion and restraint – for example forcefully holding someone's hands down in order to feed them, because they are under-nourished)). However, as the session proceeds, participants will appreciate that these practices are coercive, harmful, violate human rights, do not benefit the person concerned, impede recovery, and in fact **do** constitute seclusion and restraint.



Presentation: Forms of Seclusion and Restraint (15 min.)

This presentation aims to define seclusion, restraint and various forms that these may take. It highlights what does and what does not constitute seclusion and restraint.

Physical Restraint:

- Physical restraint imposes a manual limitation of a person's movement (whole body or certain body parts) often using force.
- It refers to any "hands-on" control of a service user commonly involving floor control.
- "Prone" or "face-down" restraint is another form of physical restraint. This is when a person is held face-down (or prone) on the floor and is physically prevented from moving out of this position. It is a particularly dangerous form of restraint due the risk of positional asphyxiation and sudden death. (4),(5),(6)

Mechanical Restraint

- Refer to the use of devices to restrict a person's ability to freely move all/part of their body Restrictive devices include belts, ropes, chains, shackles and tightened cloth.

Chemical Restraint:

- Broadly defined as medication which is not part of the person's treatment regimen and is used to restrict the freedom of a person's movement and/or control their behaviour.
- It involves the inappropriate use of a sedating or psychotropic drug such as benzodiazepines, antipsychotics and dissociative anaesthetics.
- Often administered in response to a perceived violent or aggressive act against one's self or others or to control people or make them "easier to manage".

- Chemical restraint is frequently used as an ‘alternative’ to physical and mechanical restraint. However it is important to note that chemical restraint *is* a form of restraint itself, and is **not** an acceptable alternative to other forms of restraint.

Seclusion:

- Broadly defined as isolating an individual away from others by physically restricting their ability to leave a defined space. It may be by locking someone in a defined space (e.g. room, cell) or containing them in a specific area by locking access doors or by telling them they are not allowed to move from a defined space and threatening or implying negative consequences if they do.

Combined coercive practices in healthcare services

- Seclusion and restraint are often used together; for example, in many instances people are physically or mechanically restrained in order to subsequently be taken to a seclusion cell or room.
- Also, physical and mechanical restraint is often used in conjunction with chemical restraint; for example, in many instances, people are forcibly held down (physical restraint) so that they can then be sedated.

Protective Tools and practices: It is important not to confuse protective tools and practices with restraint. Protective actions or devices are different from restraint in that they are acceptable to the person, are non-coercive, and are used with the informed consent of the person. They might include, for example:

- Holding a person’s hand or arm to prevent them from falling.
- Wearing a helmet for head protection by a person with a significant seizure disorder.
- Wheelchair seatbelt worn by a person with a history of falling forward.
- Using a leg or arm splint to maintain proper body positioning or to promote healing (casts or orthopaedic devices).

Eliminating the practices of seclusion and restraint does not imply that you should not make efforts or take steps to stop someone from hurting themselves. There may be situations that require an immediate response – for example to save someone from harm or to save their life. The point is that any such response should be taken in the same way as would be taken for anyone without a psychosocial, intellectual or cognitive disability.



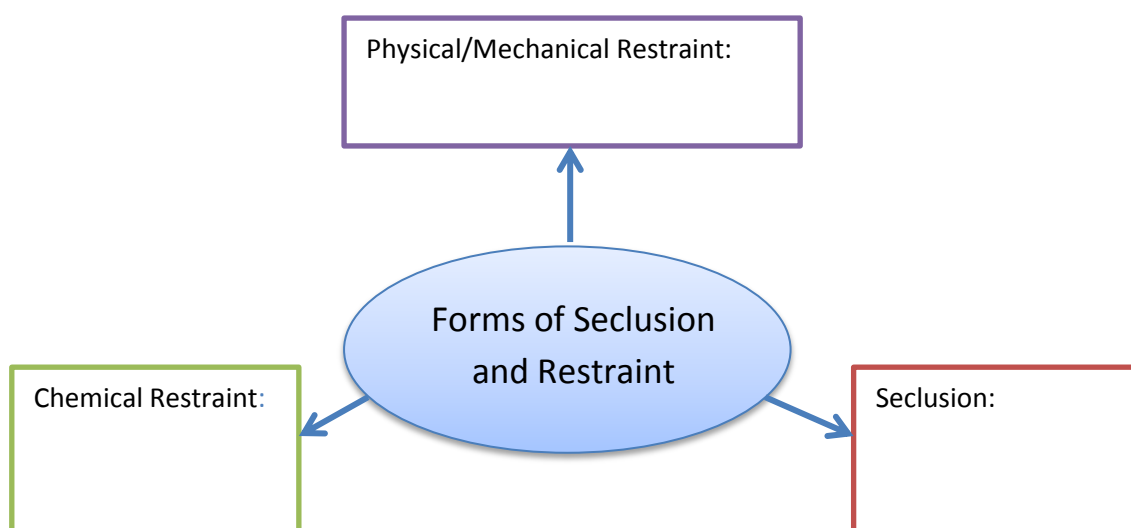
Exercise 2.4: Forms of Seclusion and Restraint (30 min)

Participants will have different ideas about the various forms of seclusion and restraint so it is useful to encourage participants to identify different examples of seclusion and restraint that are used at their own service (for example, it may be the case that some participants have never considered the overuse of psychotropic medication as a form of restraint).

Ask participants the following questions:

1. What examples of seclusion and restraint are used in your mental health or related service?
2. What are the different terms that you use to describe seclusion and restraint in your service?

Draw a graph similar to the example below and write participant's examples in the relevant boxes.



Some possible answers include (but are not limited to):

Seclusion:

- Placing a person in a locked room
- Placing a person in a room with the door held shut
- Requiring a person to stay in their room, even with the door open, in order to prevent them from moving about freely outside of the room
- Separation of a person from other parts of the service and/or other service users, family and staff

Restraint:

Physical/Mechanical:

- Any manual method of limiting someone's movement e.g. holding them down
- Applying any device to a person that physically limits their movement e.g. hand and wrist straps

Chemical

- Sedating a person to control or overpower them
- Giving a person medication to 'manage their behaviour' when it is not a standard treatment or dosage for their condition

Note: Participants may highlight certain seclusion and restraint practices specific to their own cultural contexts but that go under different names: for example the act of physically restraining someone in Indonesia is known as 'Pasung'. In the African context, chemical restraints are often called stoppers



Exercise 2.5: Images of Seclusion and Restraint (10 min)

This exercise is designed to enable participants to view and discuss images of the various seclusion and restraint practices across the world.



Trigger Warning: Remind participants these images may be upsetting to some people.

Go through each of these images with the group and ask them to describe what the pictures display.

Do you see seclusion or restraint in this picture? What Kind?



Presentation: The practice of seclusion and restraint constitutes a human rights violation (10 min.)

Secluding or restraining people violates many human rights, for example, the right to be free from violence and abuse, the right to be free from torture and cruel, inhuman and degrading treatments, the right to integrity of the person, the right to privacy, etc.

These rights are protected by many human rights instruments including:

- The Universal Declaration on Human Rights
 - The International Covenant on Civil and Political Rights
 - The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
 - The UN Convention on the Rights of Persons with Disabilities (CRPD)
- The United Nations Special Rapporteur on Torture has called for “an absolute ban on restraints and seclusion” (7). He has stated that the imposition of solitary confinement “of any duration to persons with mental disabilities constitute cruel, inhuman and a degrading treatment”.(8)

To illustrate the previous presentations, show participants the following video about a man who has been living in a seclusion room for the past 5 years.

Attitude Live, Seclusion (29:10) (9): <http://attitudelive.com/watch/Seclusion> (accessed 18 January 2017)

At the end of the video, give participants the opportunity to share their thoughts.



Presentation: When and why are seclusion and restraint used? (20 min.)

Mental health and related professionals report using seclusion and restraint for many different reasons:

- **To stop harm or danger (real or perceived)**
 - To stop people from hurting themselves or to keep them safe.
 - In response to persons attempts to self-harm, or commit suicide.
- **To control**
 - To control or maintain order in the service environment by firmly handling nonconforming actions, or behaviours. Indeed, many services tend to overemphasise the need to maintain an orderly environment, to the detriment of personalised care. People using services are routinely over medicated, sedated or restrained to ensure that they are “easier to manage” and “under control”.
 - To coerce or oblige a particular action or behaviour from people using services.
 - Some staff perceive the use seclusion and restraint as a necessary means of ‘setting limits’ in order to establish their authority and ‘manage behaviour’ early on in their interaction with them.
- **For convenience:**
 - Staff in many cases feel that it is easier to use coercive methods such as seclusion and restraint, than other non-coercive methods to manage tense situations or support people who are distressed.
- **To punish**
 - As a form of punishment for those unwilling to follow instructions.
 - Sometimes staff do not perceive the use of seclusion and restraint as punishment, but rather, perceive it as a necessary consequence for particular actions or behaviours by people using services.
- **Misconceptions about psychosocial, intellectual or cognitive disabilities**
 - As an automatic reaction to someone who has a perceived or diagnosed mental health, intellectual or neurological condition due to assumptions and perceptions that the person is dangerous or unmanageable.
 - Prejudice and discriminatory attitudes towards certain population groups of service users (such as young people, people of Afro-Caribbean descent, males, etc.) and presumption of violent or dangerous intent.
- **Inadequate service policies, practices and resources**
 - Service level policies often allow for the use of seclusion and restraint and these practices are therefore considered standard procedures.
 - Insufficient staffing and resources in some mental health and related services means that staff resort to seclusion and/or restraint in an attempt to ‘manage’ their service.
 - Service staff feel compelled to use seclusion and restraints in order to implement the often very rigid rules, procedures and schedule of the service.

- lack of resources to adequately support service users and oversee the running of the service.
 - These practices are also used because of a negative culture within services which dehumanises people using the service and desensitizes staff.
- **Inadequate staff knowledge and skills**
 - Sometimes these practices are used as an automatic response to a tense or crisis situation. Staff do not know about alternative practices for managing tense situations or providing support to distressed and agitated people, and don't have the necessary skills, tools and training that would enable them to use non-coercive techniques and creative alternatives when providing care and support to service users.
- **Risk and staff/service liability**
 - Seclusion and restraint methods are often used as a first resort because their outcomes are perceived as being “certain” compared with alternative approaches.
 - Sometimes staff are concerned about being held liable or responsible if an incident occurs (e.g. if someone gets injured) when seclusion and restraint have not been used. This encourages staff to use these coercive practices.

Topic 3: The personal experience and impact of seclusion and restraint



Exercise 3.1: The Personal Experience of Seclusion and Restraint of Service Users (1 hour)

This is designed to help participants understand that seclusion and restraint are violent adverse events that can contribute to mental, emotional and physical harm.

The facilitator may choose between one of the following options or combine them for a more comprehensive exercise.

Please note: The most powerful way of understanding the personal experience of seclusion and restraint is to hear directly from people who have had this experience. Therefore **option one is the preferred option** for this exercise.

Option One: The facilitator should identify one or two speakers with lived experience of seclusion and restraint in mental health and related services and invite them to share their stories with the group. The facilitator should guide the speaker to describe not only what happened to them, but how it happened. They would discuss how their experience negatively impacted them, both emotionally and physically, as well as their ideas about what would have prevented the use of seclusion and restraint in their situation. **The facilitator will need to organise for speakers ahead of this session.**

Option Two: The facilitator should distribute the results of the "Coercion Experience Scale" survey (See **Appendix 1**) carried out in one or more services, and ask participants to discuss the findings of the survey. **The facilitator will need to ensure that the survey has been completed prior to the session.**

Option Three: The facilitator should distribute a hand-out of quotes from people with lived experience of seclusion and restraints (See **Appendix 2**) and ask participants to discuss people's feelings and experiences around the practice of seclusion and restraint.

After hearing about or reading people's experiences of seclusion and restraint or reviewing the results of the CES, ask participants:

- What are your thoughts and feelings on what you have heard and/or read?
- What are the common feelings of people during these experiences of seclusion and restraint?
- What can you say about the emotional and physical impact of seclusion and restraint?
- Would anyone like to comment on what could have been done differently?



Presentation: The impact of seclusion and restraint on service users (15 min)

Evidence has linked the use of seclusion and restraint to many other adverse impacts and outcomes:

IMPACT ON PHYSICAL HEALTH (10),(11),(12),(13),(14),(15),(16),(17),(6)

- Bruises
- Broken bones
- Muscle atrophy
- Coma
- Choking: People placed in restraints where they must remain on their back, are at risk of choking on emesis (vomiting), food, liquid or saliva.
- Circulatory and skin problems: Pressure on the skin by tight restraints and immobilization may interfere with arterial and various circulations. Gangrene can occur when severe disruption to circulation takes place on the upper or lower limbs. It can also lead to skin deterioration and pressure sores.
- Dehydration: People can become severely dehydrated while in restraints or during a struggle over applying restraints. The dehydration, which is usually combined with overheating due to exertion, can produce cardiovascular collapse or even death. People who are restrained can easily become dehydrated because they are completely dependent upon others to provide liquids for them.
- Incontinence: People who are restrained may experience loss of bowel or bladder control when they are not given access to the toilet when needed.
- Self-harm, self-directed aggression including self-mutilation and cutting and suicide attempts
- Death
 - The use of seclusion and restraint can also lead to death.
 - Investigations have shown that the causes of restraint- or seclusion-related death include asphyxia, cardiac complications, drug overdoses or interactions, blunt trauma, strangulation or choking, fire or smoke inhalation, and aspiration.
 - A review of the scientific literature on the adverse impact of physical restraint, identified positional asphyxia (face-down) as extremely dangerous and in particular the ‘forceful prone’ position as hazardous where breathing can be reduced by 15%.(18)
 - Very little recent data exists on numbers of deaths related to seclusion or restraint. However one national investigation across 50 states in the USA estimated that between 50 to 150 people died each year in mental health services and group homes as a direct result restraint practices.

At this point show a short 1 minute BBC video about the use of face-down restraint film.

Video: “I couldn't move. I couldn't breathe’ (19) (52 seconds): <http://www.bbc.com/news/uk-england-37427665>

(Accessed 19 January 2017)

IMPACT ON RECOVERY (13)

- Seclusion and restraint are counter-therapeutic and impede people's recovery.
- They damage therapeutic alliances and are responsible for the break-down of the relationship between service users and healthcare staff.

IMPACT ON PSYCHOLOGICAL AND EMOTIONAL WELLBEING

- The experience of seclusion or restraint results in the subjugation of one's own self to the will and the power of another person. The forceful assertion of another person's will over one's own, along with the loss of control over one's body and environment, can generate very negative emotions and have deep psychological and traumatic impacts on people.
- Many people experience feelings of loss of dignity, degradation, demoralization, dismissal, humiliation, anxiety, disempowerment, helplessness and rejection by the healthcare staff, which can aggravate the situation further.
- Seclusion and restraint can also re-traumatise people who have a past history of sexual or physical abuse, or past psychological trauma.(20)
-



Exercise 3.3: Psychological impact of the use of seclusion and restraint (30 min)

The aim of this exercise is to highlight the grave psychological impact that the use of coercion has on people experiencing these practices.

Explain to participants that:

This video narrates the experience of Naomi Jones who has used services in the UK. This video is about an incident that took place in the UK. It is important to understand that seclusion and restraint practices take place across the globe, in high, middle and low- income countries; however, whatever the context, the psychological trauma and impact on people are the same. .)

The video should start at minute 10.27:

Video – 'Road so far' (21): <https://youtu.be/j405vpdjeUU?t=627> (Accessed 18 January 2017).

(A later video will be shown during exercise 3.4 in order to explore the impact from staff view point

Ask participants the following question:

What do you think of Naomi's experience? What are some of the terms, emotions and feelings that Naomi describes as part of her experience?

Participants should be encouraged to discuss Naomi's testimony.

Use the flipchart to write down the various terms Naomi used to describe her experience.

- Naomi’s experience of restraint includes: fear, confusion, disorientation, trauma, humiliation, anger, frustration, increased distress, punished, and lonely.
- She did not feel helped, comforted or supported, and felt that her recovery was hindered.
- Naomi also describes feelings of trauma and fear that continued for weeks that followed the incident.



Presentation: Drastic impact of the use of seclusion and restraint (5 min.)

The use of seclusion and restraints has been associated with wide-scale death of people using services in emergencies. The inability of people to move or leave the building means that they are trapped and unable to escape.

Below are two examples of the massive death toll that could have been avoided if people had not been restrained.

Participants should be invited to share other examples that they may be aware of.

- Erwadi Fire Incident (22)
 - 6 August 2001
 - Ramanathapuram, Tamil Nadu, India
 - At least 25 people killed
 - When a fire broke out, all service users burned alive because they were in restraints.
- Moscow Ramensky Fire (23)
 - 26 April 2013
 - Ramensky, Russia
 - 38 people killed
 - A fire in the middle of the night killed service users who are thought to have been physically and chemically restrained.



Presentation: The impact of seclusion and restraint on mental health and related practitioners and services (10 min.)

The use of restraint or seclusion can also have a negative impact on practitioners.

- Evidence indicates that the use of coercive methods is linked to staff physical injuries. For example one study attributed at least 50% of mental health staff injuries to the use of seclusion and restraint.(24),(13)
- Mental health and related practitioners who employ coercive measures such as seclusion and restraint can also experience trauma. (25)

- The use of force and coercion breeds resentment, frustration and loss of trust between the service users and staff which negatively impacts their therapeutic relationships. (26)
- People who have already experienced coercive practices such as seclusion and restraint and the associated feelings of loss of control, fear and humiliation, may feel that they have very little choice but to defend themselves, even violently, against a renewed coercive intervention. “If we want people to stop acting violently, perhaps we need to stop treating them violently”. (27)
- The use of these practices can also lead to civil and criminal lawsuits against services and/or staff for example on the grounds of excessive use of force, medical malpractice, failure to protect, assault and battery and failure to maintain a safe environment for service users. (28)
- Despite a common misconception that the use of seclusion and restraint is cost-effective, this claim is not substantiated by research data.
 - The use of force and coercion drives increased costs such as: staff time, increased supervision, sedatives and tranquilizers, insurance, investigations, disruption of services, litigation and injuries. (13),(29)
 - In fact research shows that the reduction and/or elimination of the use of force and coercion reduces service costs. One study showed that a 91% reduction in the use of restraint in an adolescent mental health service in one year resulted in a 92% decrease in cost associated with the use of restraints.(30)
- Research also indicates that reduction and elimination of these practices also increases job satisfaction, reduces staff turnover and hence reduces training and human resources costs.



Exercise 3.6: Psychological impact of the use of seclusion and restraint on service staff (30 min)

The aim of this exercise is to encourage participants to think about the negative impact of using seclusion and restraint.

There are two options for this exercise. Option one is the preferred option.

Option one:

Prior to the session, the facilitator needs to identify a practitioner who is comfortable sharing negative experiences associated with using seclusion and restraint. The person should be invited to share their stories with the group.

After the speaker’s presentation of their negative experience of administering seclusion and/or restraints, the facilitator may, through a series of question and answers, guide the speaker to discuss:

- the context of the situation that led to the use of seclusion and/or restraint
- the impact of administering seclusion and restraints, including emotions and discomfort they may have felt and discomfort they may felt.
- The negative impact this may have had in the therapeutic relationship with service user(s).
- What could have been done differently to change the course of events and prevented the use of seclusion and restraint?

Allow the participants the opportunity to ask the speaker questions related to the talk.

Option two:

If it was not possible to organise a speaker prior to the session, share this 11 minutes video about the experience of a psychiatrist ordering restraint of a service user.

Finger prints and Foot prints (31) (11:07):

https://www.youtube.com/watch?v=R_Nnet1tbBQ&feature=youtu.be (Accessed 09/06/2016)

Then, invite participants to share their opinions about this video. Ask participants:

- What do you think of this experience?
- What are some of the terms, emotions and feelings that are used by the speaker when describing his experience?
- What are some of impacts on the recovery of the person who experienced the coercion as well as on the therapeutic relationship?
- What could have been done differently to change the course of events and prevented this situation from happening?

Topic 4: Challenging assumptions about seclusion and restraint



Presentation: Challenging the assumptions about seclusion and restraint (25) (20 min.)

What are the assumptions that need to be challenged with regard to seclusion and restraint?

- 1. Assumption 1: Seclusion and restraints can be used for the therapeutic benefit of people using mental health and related services.**
 - There is no evidence-based research that supports the idea that seclusion or restraints are therapeutic. On the contrary, evidence points out that these practices can be damaging to a person's physical and mental wellbeing.

- 2. Assumption 2: Seclusion and restraints keep people safe.**
 - Seclusion and restraints cause physical, emotional and mental harm. As we have seen, restraints sometimes cause physical harm such as broken bones and even death. Also, the psychological impact and trauma of seclusion and restraint is profound and long-lasting.
 - Research evaluating the impact of the Pennsylvanian programme of reduction of seclusion and restraint showed that significantly reducing the use of seclusion and restraint in state and forensic psychiatric hospitals did not result in an increase in assaults on staff and in some cases, the number of assaults on staff actually decreased (32),(33). Other reports also indicate that reductions in coercive measures are associated with reduced staff injuries (34).

- 3. Assumption 3: Seclusion and restraints prevent violent behaviour**
 - Evidence shows that seclusion and restraint can make feelings of frustration and anger worse, resulting in more harmful behaviour.
 - People using services unsurprisingly tend to view seclusion and restraint as punitive (for example for not doing 'what they are told' including failing to follow instructions to take their medication) and this can increase feelings of frustration towards mental health and related staff or others. The use of these practices also entrenches a culture of 'them and us' (13).

- 4. Assumption 4: Staff can accurately recognise potentially violent situations**
 - The belief that it is possible to accurately predict potentially violent behaviour and situations is also a reason why practitioners resort to seclusion and restraint.
 - However in reality predicting future violence and harm accurately is extremely difficult.
 - Often staff are not able to differentiate between unpredictable/unexpected behaviour and risky/dangerous behaviour. They also often correlate agitation and distress with aggression
 - The uncertainty with which risk of harm or violence to self or others can be anticipated by practitioners has resulted in a culture of overly defensive practices and increased use of coercive practices (35),(36).

5. **Assumption 5: People with psychosocial, intellectual and cognitive disabilities are often irrational, violent and unpredictable**
- There is a common misconception that people with psychosocial disabilities are governed by their psychosis and/or hallucinations which makes them violent, unpredictable and irrational.
 - Substantial evidence exists showing that they are not more violent than the rest of the population and in fact are more likely to be the victims of violence rather than the perpetrators (37),(38),(39),(40).
6. **Assumption 6: There are circumstances in which the use of seclusion and restraint can't be avoided.**
- This is one of the key assumptions about seclusion and restraints. We will explore this assumption in detail in the next exercise.



Exercise 4.2: Challenging the assumption of exceptional circumstances as valid reasons for using seclusion and restraint (20 min)

The assumption – that there are exceptional circumstances in which seclusion and restraints need to be used - is one of the most delicate issues in relation to efforts to end the use of seclusion and restraint in mental health or related services, and facilitators should be prepared to discuss this exhaustively with the group.

Some participants may express the view that sometimes certain practices, such as seclusion and restraint, can't be avoided. For example, some participants may argue that if someone is acting dangerously and violently, seclusion and restraint may be inevitable to avoid harm to the person and to others. The exercise below is intended to dispel this misconception.

Now show the following statement/misconception:

There are circumstances when the use of seclusion and restraints cannot be avoided.

Ask participants the following questions and encourage them to discuss their answer directly with each other:

1. Do you agree or disagree with this statement? Why?
2. Under which circumstances do you think seclusion and restraint cannot be avoided?

Ideas can be written down on a flip chart.

Some of the circumstances participants agreeing with the above statements could bring up include (but are not limited to):

- People using services being considered responsible for abusive acts, such as during times of violent or aggressive behaviour.
- People using services needing immediate hospital care and treatment because their life is at risk (for instance a person with diabetes needing immediate treatment, a person at high risk of suicide).

- People using services resisting medication even though mental health and related practitioners believe that they need it.

After the discussion, show the following:

- 1) Seclusion and restraint for people with psychosocial, intellectual and cognitive disabilities are never justified, even in extreme circumstances.**
 - Seclusion and restraints are not interventions of last resort.
 - Seclusion and restraint are never justified, even in extreme circumstances (such as when individuals behave violently, are at potential risk of harm etc.).
 - Alternatives to seclusion and restraints should always be sought in order to protect people's wellbeing.
- 2) Staff believe that in some cases it is impossible to find alternatives to seclusion and restraint and this is why seclusion and restraint are used in the service.**
 - We should always consider the use of seclusion and restraints, not as a treatment option, but as a "treatment failure", a bad outcome, even when it seems that all the alternatives to these practices were implemented before resorting to them.
 - There are always alternatives to seclusion and restraint.
 - Some of those alternatives will be discussed in the next session.
- 3) The use of seclusion and restraints is also a service failure, the failure of a whole system and it could also be a failure of individual staff members.**

The statement "The use of seclusion and restraints is always a service failure" could be seen as accusatory towards staff members. It is important to highlight that.

- Service failures happen in health care practice (as in the case of suicide or death of a person using health services).
- Individual members of staff need to reflect on their own contribution to the service failure.
- The use of seclusion and restraint is sometimes a criminal act.

The use of seclusion and restraint constitutes a service failure, and a failure of the whole system. Service failure can happen in health care practice (as in the cases, for instance, of the suicide or the death of a service user) but everything should be done to avoid it. Somewhere in the process a reflective space needs to be made for each individual member of staff to think through whether they themselves could have played a part in the trajectory which resulted in the use of restraint or seclusion. Consideration also needs to be given as to whether the use of seclusion or restraint was a criminal act.

Each failure should be considered a sentinel event

- It should be seen as an opportunity to understand what went wrong.
- It should push staff to review all the strategies that have been put in place to avoid seclusion and restraint.
- It should be an incentive to do better next time.

4) A report should be written on the specific incident.

- In this report, the person who experienced the seclusion or restraint should be offered the opportunity to communicate their perspective:
 - of the events that led to the use of seclusion and/or restraint
 - of the use of seclusion and/or restraint itself

- about what they believe needs to be done to prevent the use of these practices from happening again.
- If they need support to communicate their perspective, a family member or other supporter should be requested to help the person to do so.
- With the person's consent, this report should be made accessible to all service staff involved, other people using the services, the person's family members and supporters and, if appropriate, with external advocates such as organizations working in the area of human rights, disability, mental health, in order to improve ways of dealing with challenging situations in the future.
- The report should also be shared with senior management of the service.

5) A general report should be written on the use of seclusion and restraint within the service

- The report should document all cases of seclusion and restraint in the service during a specific period (e.g. 1 year). It should also describe and analyse strategies in place to eliminate them.
- The information contained should be de-identified – ie. not include the identity of the people concerned.
- These service reports on the use of seclusion and restraint should be made publicly available. This will allow people to make more informed choices concerning their health care provider, enable organizations or individuals to challenge the use of these practices before the court, and incite government to investigate services that have particularly high rates of seclusion and restraint.
- Fostering a culture of transparency through regular reporting is likely to motivate management and staff to change and improve their practices.



Exercise 4.3: Is it possible to change the course of events leading up to the use of seclusion and restraints? (30 min)

This exercise focuses on what can be done to prevent crises from evolving and explores lost opportunities to intervene along the way.

Show and read the following scenario to participants:

SCENARIO 1: TOM'S EXPERIENCE

Tom is staying in an inpatient service. He wants to make a phone call to his mother to inform her about the progress he has been making in his recovery and needs to get a phone card from the nurse to be able to place his call. The nurse says that she will handle his request in a minute because she is very busy.

Because the nurse is stretched and overloaded with various tasks, Tom has to wait for over an hour. He gets increasingly agitated and angrily bangs on the door of the nursing office. The nurse asks him to "calm down" which results in a deepening sense of frustration for Tom.

The nurse then responds by saying: "if you are in this frame of mind I will not be able to allow you to make your phone call."

Tom starts pacing up and down in the corridor and gets more and more agitated, kicking the door and verbally abusive to staff walking past him.

Tom's agitation results in his being physically and chemically restrained. This was justified by the service staff as necessary for his own and others' safety.

Ask participants to answer the following questions:

- 1. What do you think of this case?**
- 2. How common is it in your service?**
- 3. Was the use of restraint inevitable in Tom's case? What could have been done to prevent it?**
- 4. Whose responsibility was it? Was it only the nurse's responsibility?**
- 5. What impact do you think this incident had on Tom's wellbeing and recovery?**

After the discussion, show participants the following:

Reflections on Tom's scenario:

- The outcome of this scenario is quite common in many mental health and related services around the world, yet it could have been avoided.
- The outcome could be attributed to the failure of the service management to hire sufficient numbers of staff to avoid overloading existing staff members and to give them more opportunities to prioritise the personal needs of people using the services over their administrative and routine tasks.
- In this case, the nurse should have prioritised Tom's needs above other tasks that could have been delayed for a few minutes, to provide Tom with the telephone card. The crisis could have then been avoided.
- Other doctors, nurses, health care assistants walked past Tom perhaps knowing he was waiting to make a telephone call and would have noticed early signs of agitation due to the unnecessary wait. It would have taken perhaps five minutes of their working day to help Tom, but instead no staff member assisted him. In the end, the crisis cost the health staff significantly more time.
- The use of physical and chemical restraints are likely to have adversely affected Tom (powerlessness, re-traumatisation, loss of control, fear, dehumanisation, etc.), delayed his recovery, increased the costs for the service, and increased time-demands on the service staff.

- Each person who looked away when they could have taken action to help Tom could be considered to have been personally responsible for escalating the situation leading to the crisis.
- By highlighting these failings, the intent is not to blame service staff but rather to reinforce the point that people can and should proactively take steps to influence the course of events whenever possible in order to avoid a crisis. Everyone has a role to play in preventing crises that may eventually lead to the perceived inevitability of the need to use force or coercion.
- Tom was let down – by the service which allowed seclusion and restraint and also by the service staff who ignored his very legitimate needs and basic human rights.

SCENARIO 2: FATIMA'S EXPERIENCE

Fatima is a first-year medical student who is sharing a house with other students. She is sleep deprived because she has been studying long hours to pass her exams. She is increasingly anxious that she might fail.

She goes to her doctor and expresses concerns that she is having problems sleeping, that she is experiencing stomach pain and panic attacks and also that she is finding it more and more difficult to get out of bed in the morning.

The doctor refers her to a psychologist but because her situation is not seen as a priority compared to other people she has to wait 3 weeks to get an appointment.

By this time she becomes very unwell, increasingly anxious and distressed. She misses her appointment with the psychologist, but nobody follows up.

One day her concerned housemates call the police because she is not letting them come into the house and is not answering their phone calls. They fear that Fatima may be having thoughts of suicide and may hurt herself if nobody enters the house.

The police arrive and break down the door. A scuffle between Fatima and the police officers ensues, and Fatima is then put in restraints and involuntarily admitted to an inpatient mental health service.

After reading this scenario, ask participants the following questions:

What do you think of this scenario?

How common do you think this scenario is?

Was the use of restraint inevitable in Fatima's situation? What could have been done to prevent it?

Once participants have had the opportunity to share their thoughts, show the following:

Reflections on Fatima's case:

- The system failed Fatima. The lack of human resources meant that she was not provided with care and support when she requested it and before her situation deteriorated.
- There were opportunities throughout Fatima's trajectory in which she could have been provided with support.
- The police also let Fatima down by restraining her, instead of using non-coercive techniques to help her (e.g. talking to her calmly through the door, explaining that they were there to make sure she was ok, asking her if there was anything they can do for her, asking if she would allow them to come in etc.). Their use of coercion increased her distress and agitation.
- The restraints are likely to result in adverse affects for Fatima (powerlessness, re-traumatisation, loss of control, fear, dehumanisation, etc.), delays in her recovery, increased costs for the service, and increased time-demand on the service staff.
- And finally, the mental health service system further let her down by involuntarily admitting her.



Presentation: Spectrum of lost opportunities (10 min.)

- Resorting to coercion is a system and service failure but also can be an individual failure.
- Everyone has a role to play to change the course of events.
- Crises are often avoidable by being responsive to people's needs, and providing support early on to stop negative spirals.
- It is important for mental health and related practitioners to recognise the spectrum of lost opportunities along the way.
- Practitioners also need to recognise their personal responsibility in being responsive, compassionate and in providing support to a person early on so that situations don't escalate into a crisis.



Presentation: What have we learned so far? (10 min.)

Ask participants:

What are key points that you have learned from the previous topics?

Follow this question with the following:

- Types of Seclusion and Restraint
 - Seclusion,
 - Physical restraint
 - Mechanical restraint
 - Chemical Restraint
- Seclusion and restraint are traumatic and have negative impacts on people
- Seclusion and restraint hinder recovery
- Seclusion and restraint can result in injury, psychological trauma and death
- Seclusion and restraint also has negative impact on health staff

- Seclusion and restraint is not a form of treatment
- Seclusion and restraint must be avoided in all circumstances
- The use of seclusion and restraint is a failure of the system and service and can also constitute a personal failure by staff
- Finding alternatives to seclusion and restraint. This will be explored in greater detail in the next topics.

Topic 5: Identifying tense situations and elements of a successful response



Reflection from the previous topics: seclusion and restraint in Somaliland (15 min)

Invite participants to share their thoughts and reflections from the previous session.

Ask the group:

How has your opinion about seclusion and restraint changed?

How can we stop people resorting to seclusion and restraint?

After the discussion, play the following video which shows one perspective and experience of seclusion and restraint: It is a powerful summary of the use of seclusion and restraint and their impact on individuals and families.

Chained and Locked Up in Somaliland (41):

https://www.youtube.com/watch?v=19B8_qYJ5tU&feature=youtu.be (3:05).

At the end of the video, ask participants to share their thoughts. This is an opportunity to revisit some of the issues discussed previously.



Presentation: Identifying Tense Situations, and Elements of a Successful Response (10 min)

Introducing strategies to prevent and avoid seclusion and restraints

There are some key strategies to effectively manage tense situations and end the use of seclusion, restraint and other coercive practices. They include:

1. Individualized plans to identify and manage triggers and early warning signs
2. De-escalation
3. Creating a “saying yes” and “can-do” culture
4. Sensory approaches and comfort rooms
5. Response teams

Each of these strategies will be discussed in more detail later in this training.

Before exploring these, it is important to have an understanding of how to recognise and address triggers and early warning signs in tense situations, which, if not addressed, can escalate into a crisis.

Recognising and responding to triggers and early warning signs

- Seclusion and restraint are often (but not always) used in response to tense and challenging situations.
- Tense and challenging situations result from many causes, including miscommunications and misunderstandings or people ‘playing their roles’ (e.g. staff role to keep control and maintain

order in the service). They often arise when someone feels they are not being listened to or that their wishes are not being respected.

- Identifying and responding to those situations early (in a non-coercive way), before they escalate into a crisis is a way to avoid people resorting to the use of seclusion and restraints.

To prevent tense or challenging situations, it is necessary to identify people's triggers and early warning signs.

Triggers

- A trigger is a behaviour, event or emotion (such as fear or anger) that sets off an action, process or series of events.
- Triggers are different for everyone: A trigger for one person might not be one for another person
- They can be caused by internal thoughts or feelings that the person has.
- Triggers can also be caused by external events and the behaviours of others which affect the person's own thoughts or feelings. Internal triggers are usually more difficult to anticipate than external ones.
- Multiple triggers occurring within a short space of time can escalate a situation and lead to a crisis.

Some examples of triggers include, for example:

- Hearing shouts or yells, or being shouted/yelled at
- Not being listened to
- People getting too close
- People talking disrespectfully to you
- Feeling pressured to do something you don't want to do
- People interfering with your personal belongings
- Noise
- Agitation around you
- People speaking too quickly
- Not understanding what is happening around you or to you
- Being isolated
- Not having choice, control or input
- Feeling lonely and loss of family contact
- Recalling bad memories
- Lack of privacy
- Darkness
- Arguments
- Being stared at

Early warning signs

Physical signs of distress can signal a possible tense situation, which are generally unique to each person. However some common examples include (42):

- Restlessness
- Agitation
- Pacing
- Shortness of breath or rapid breathing
- Tightness in the chest
- Sweating

- Clenched teeth
- Crying
- Wringing hands
- Rocking
- Withdrawal, fear, irritation
- Prolonged eye contact
- Increased volume of speech
- Aggression,
- Threatening harm



Exercise 5.1: Discussion: Understanding Triggers (30 min.)

This exercise will help participants realise that many people have similar triggers regardless of their mental health, and that it is important to manage triggers with patience and empathy.

Begin by inviting participants to think on their own about what makes **them** feel scared, upset, angry, anxious or stressed.

Ask the group the following question and make a list of ideas on the flip chart.

What makes you feel scared, upset, angry, anxious or distressed, which could cause you to act in a way that might be challenging to others (e.g. losing your temper, crying, becoming confrontational etc.)?

After 1 or 2 minutes of individual reflection, invite participants to share their ideas. Make a list of responses on the flip chart.

Participants may give examples which are similar to those of the previous presentation.

Once participants have provided answers, explain that all people have triggers, which may sometimes be very similar irrespective of their mental health and that understanding these triggers is key to dealing with or avoiding the development of tense situations.



Exercise 5.2: Calming Actions (15 min.)

Begin this exercise by inviting participants to think on their own about specific actions that can be taken to help them calm down in tense situations. Ask the group the following question:

What actions would you like to take or be taken to help you calm yourself in moments when you are frustrated or upset?

After 1 or 2 minutes of individual reflection, invite participants to share their ideas. Make a list of responses on the flip chart. Some ideas may include but are not limited to the following:

- Going for a walk
- Listening to music

- Talking to someone who will listen

Once participants have had the opportunity to provide answers, emphasise that taking the time to understand what helps us or others to calm down is a key way of avoiding or dealing with tense situations.



Exercise 5.3: Triggers and warning signs (10 min)

This exercise gives participants a chance to apply the concepts covered in the previous presentation.

Susan

1. Read through the following scenario

Susan is a young woman with a diagnosis of bipolar disorder who has a history of being abused. She has just admitted herself into an inpatient service for a few days because she is feeling unwell. When she feels particularly unwell, she becomes frightened of enclosed spaces. She often becomes distressed and agitated before going to bed. She covers her ears with her hands, stops listening, and sometimes talks aggressively to staff and others in the service.

2. After reading the scenario discuss the following questions with participants.

- *What are Susan's triggers?*
- *What are her warning signs?*
- *What are a few suggestions about calming strategies or ways to avoid distressing Susan further?*

When discussing the third question about calming actions, be sure to emphasise that calming strategies should be identified in partnership with the person who is experiencing distress or agitation. This question is meant to encourage participants to think of different options that might help the person in each scenario.

3. After the discussion, read the strategies that were identified and used:

After discussion with staff, Susan identified the following strategies for helping her to manage her triggers:

- She is not required to go to bed; she decides when is the right time for her (For this to work, staff realised the importance of adapting the service routines).
- Staff enable her to watch TV in the common room until she feels tired, calmer and ready to go to bed.

Repeat the exercise with Robert's story.

Robert

1. Read through the following scenario:

Robert is a 62 year old man who has a diagnosis of dementia. He is unsteady on his feet and is prone to falling down. He enjoys walking around the halls and the grounds of the care home, and becomes combative when he is told he cannot wander around freely. When he becomes agitated, he yells at staff and walks around in a frustrated manner.

2. Discuss the following questions with participants:

What are Robert's triggers?

- *What are his warning signs?*

- *What are a few suggestions about calming strategies?*

3. After the discussion, read the strategies that were identified and used:

Robert and staff at the home were able to identify the following strategies to support Robert and avoid distressing him.

- He is given a walking frame so that he can walk around freely and un-assisted within the care home and its grounds.
- The staff also organise for volunteers from a local peer support group to go out on walks around town with Robert once or twice a week.

Topic 6: Individualized plans to prevent and manage tense situations



Presentation: Individualised Plans to prevent and manage tense situations (25min)

This presentation focuses on the development of individualised plans to prevent and manage tense situations. It builds upon the previous introductory session which highlighted the need to identify, understand and manage triggers and early warning signs that could potentially lead to a crisis.

- In the previous topic we examined how to recognise and address triggers and early warning signs.
- Now we are going to explore the different strategies that are useful in order to end seclusion and restraint and other coercive practices.
- The first strategy is around developing individualized plans to prevent and manage tense situations.

What is an individualised plan to prevent and manage tense situations?

- A plan outlining actions that can be used to help a person to calm themselves down in times of escalating anxiety, distress or frustration.
 - Plans are unique to each person.
 - Plans focus on the needs of the individual above the needs of the service
 - They are based on discussions about people's triggers, early warning signs and risk factors for frustration, anger, stress or distress.
 - These plans include strategies to identify signs of an emerging crisis and and manage triggers/ risk factors before the situation escalates.

Who are individualised plans for?

- It may not be relevant to develop specific individualised plans for all people. However, for some, developing individualised plans is a key means of avoiding or de-escalating tense or challenging situations in a way that is respectful of the person, their wishes and preferences.
- Individualised plans are not only for people with psychosocial, intellectual and cognitive disabilities. The use of individualised plans applies equally to staff members, families and care partners, as they do to the people using services.
 - Everyone, including staff, families and care partners have triggers than can affect their behaviour in challenging situations.
 - They must be able to understand their own triggers and calming methods when dealing with challenging situations.
 - Therefore, it is also important for staff and families, relatives and care partners to also develop their own individualised plans.

Why are individualised plans useful?

- Individualised plans are critical for understanding what makes someone feel distressed, agitated, anxious or angry. They can:
 - Help resolve tense situations more effectively.
 - Contribute to the elimination of restraint, seclusion or other coercive practices against the person concerned.
- When an individualised plan is made well, it can benefit everyone concerned and create a better environment within mental health and related services or in the home.

How should an individualised plan be developed and used?

- Developed collaboratively and agreed upon by the person concerned and mental health and related practitioners. If the person wants, the plan can be developed with the support of key people in their life.
- Decisions on what goes into the plan should be made BY and WITH the person concerned, not FOR them.
- The plan should not be developed during the actual crisis but rather at a time when the person is in a calm or relaxed frame of mind (i.e. before or after a crisis).
- Where useful, the plan can be integrated into a person's overall recovery plan (see module on *Realising Supported Decision Making and Advance Planning*).
- Plans should be continually reviewed and updated, because a person's triggers and early warning signs as well as calming strategies can change over time.
- Plans should be easily accessible to health staff, response teams, and other relevant people during tense situations (e.g. medical records kept in the service, online registry, etc.).
- After a crisis situation, staff and the person should discuss any changes that should be made to the plan to help prevent and better handle similar situations in the future.

Making an Individualized Plan:

1. Identifying triggers and early warning signs

- The person should be supported to make a list of what makes them feel frustrated, angry, and agitated and could lead to challenging behaviour or a crisis (e.g. not being listened to, loud noises) as well as of their early warning signs (e.g. restlessness, agitation, pacing)

2. Managing triggers and early warning signs

- Once triggers and early warning signs have been identified, it is possible to put in place a number of strategies to avoid and diffuse potentially challenging situations. These strategies will be different for everyone, but some examples include:
 - Going for a walk
 - Having someone acknowledge their feelings
 - Taking slow, deep breaths
 - Squeezing a ball or blanket
 - Being able to yell or cry
 - Spending time in the comfort room
 - Calling a friend or family member

3. Finding solutions

- The steps taken to help a person overcome their distress, anger, frustration or anxiety must always be on a voluntary basis and never forced on them.
- Calming actions should be tailored to each individual: something that works for one person might not work for another.
- Creativity is important: creative, simple solutions often work better than complicated ones.
- The process of developing individualised plans can also be a good opportunity for staff and service users to build trust and mutual respect.



Exercise 6.1: Make an Individualised Plan (20 min.)

Everyone including health care workers, people using services and care partners, need to identify their own triggers.

Have the group divide into pairs and distribute to participants copies of Appendix 3 (Making an individualised plan).

Invite each pair to complete the table represented below for each person.

1. Begin the exercise with one person in each pair interviewing the other **about what makes them feel frustrated, anxious, angry, distressed or agitated.**
2. Then, both partners discuss **what helps the person calm down** during stressful or challenging situations.
3. Finally, the pair should identify **steps to take to help the other person calm down during tense situations.**

After this first round, have the partners switch roles and repeat the exercise.

| My Plan to Manage My Triggers | | |
|---|--|--|
| What are My Triggers? | What Calms Me Down? | What Can I Do to Manage my Triggers? |
| <i>e.g. Feeling overwhelmed by noise and people around me</i> | <i>e.g. Slowing down my breathing and taking some time to be by myself</i> | <i>e.g. Practice slow breathing: find a quiet place where I can be by myself until I feel calmer</i> |
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Topic 7: De-escalation



Presentation: De-escalation: definition, guidelines and main domains (30 min.)

Definition

De-escalation is a technique to manage situations in which people may be feeling distressed or agitated in a crisis. It involves a three-step approach that engages the person, establishes a collaborative relationship and diffuses the situation and helps the person concerned find a way to relieve their distress or agitation with the support of others (43):

- When de-escalation methods are utilised instead of coercive ones, the person concerned is given a sense of control, calm, and security.
- Some people naturally possess the skills to de-escalate crisis situations using these techniques. Even if people don't have these skills, de-escalation is nevertheless something that everyone can learn.
- De-escalation requires patience and training to be done correctly and effectively in order to produce safe and satisfying outcomes.
- De-escalation involves practicing active listening. Active listening is a structured form of listening and responding that focuses the attention on the speaker. In active listening, the listener focuses their full attention on the speaker, and then repeats, in the listener's own words, what they think the speaker has said. Active listening is about being attentive to what someone else is saying in order to be able to understand their views and feelings. It is about having a dialogue (rather than a monologue) with the person concerned and valuing their feelings, thoughts and ideas. (For more information on active listening, please refer to the module on *Promoting Recovery in Mental Health and Related Services*).
- Body language is key to the ability of engaging successfully in de-escalation.
- When interacting with a person who may be distressed or agitated, people need to monitor their own emotional and physical responses so that they remain calm and capable of performing de-escalation.
- Contrary to common beliefs that coercive practices such as seclusion and restraint save time, coercion is in fact usually time consuming and requires additional resources. On the other hand, de-escalation can be less time consuming for staff (43).

The 10 domains of de-escalation (44)

The ten domains below provide steps that should be respected and implemented when attempting to de-escalate a situation.

1. Respect personal space
 2. Do not be provocative
 3. Establish verbal contact
 4. Be concise
 5. Identify wants and feelings
 6. Listen closely to what the person is saying
 7. Agree or agree to disagree
 8. Be clear about expectations and limitations
 9. Offer choices and optimism
 10. Debrief the service user and staff
-

Domain 1: Respect personal space

- Respect a person's personal space: This is very important because getting too close to a person who may be experiencing distress, anxiety, anger or frustration can exacerbate these feelings.
- Avoid enclosed spaces (e.g. small rooms) while managing a tense situation to ensure that the person does not feel trapped, cornered or confined, which can also exacerbate their distress.

Domain 2: Do not be provocative

- Demonstrate body language that shows you have no intention to harm the person e.g. hands should be visible at all times demonstrating that there is nothing to hide.
- Stand at angle so as not to appear confrontational when people do not like to be faced directly. If this is the case,
- Do not stare and ensure that you break eye contact regularly (e.g. when you are thinking) with people who may perceive excessive eye contact and staring as hostile or aggressive.
- Do not use language that can be perceived as provocative, humiliating or condescending – in other words be polite, respectful, and talk to the person as an equal at all times.

Domain 3: Establish verbal contact

- Establishing verbal contact with the person concerned is an important part of deescalating a situation.
- When trying to engage the person and establish verbal contact:
 - Introduce yourself and explain your role to the person.
 - Inform the person that you wish to support them and will not do anything against their wishes or anything to harm them.
 - Assess the correct degree of formality or informality required. Being overly formal can increase the person's discomfort, distress and agitation. On the other hand, being too informal can falsely suggest that you are being condescending.
 - Do not take anything the person says personally and make efforts to remain calm and controlled.

Domain 4: Be concise and repeat yourself:

- Keep sentences or statements simple and precise. A person experiencing distress may find it difficult to comprehend complex and long sentences or statements. In addition, complex sentences can lead to confusion and frustration which can exacerbate the situation.
- Repeat the main points of the conversation to ensure that everyone is 'on the same page' and that the information communicated is being understood. .
- Do not rush the person, and to give them time and space to process what have just been said and to respond.

Domain 5: Identify wants and needs:

- Ascertain the reason(s) behind the distress or agitation of a person and determine what the person needs or wants. Ask the person directly about the reason(s) for their distress and ask them if there is anything that can be done to support them in order to relieve them of their distress.
- Sometimes the requests can be granted but in some cases this may not be possible. Either way, ask the person directly what their requests are using clear language: 'It is important to know what you expect from us'. 'Even if we can't immediately satisfy your need/request, it is important to know what would help you so that we can work on this together'.

Domain 6: Listen closely to what the person is saying

- It is important for people practicing de-escalation to listen closely and attentively to what the person is saying.
- Use active listening – i.e. listen attentively and repeat what the person has said in your own words in order to verbally acknowledge that you have understood what has been said.

Domain 7: Agree or agree to disagree

- Try to find room for agreement with what the person concerned is saying.
- Do not dismiss what the person is saying 'out of hand' just because you do not agree with everything they are saying. Even if you don't agree with everything the person is saying, try to find areas on which you can agree.
- If you are unable to agree with the person on a certain issue, then it is ok to agree to disagree.

Domain 8: Be clear about expectations and limitations

- Clearly communicate to the person what they can and cannot expect in terms of help and support from others.
- Set out clearly, reasonably and respectfully these expectations and limitations.

Domain 9: Offer Choices

- Giving a person choices is important and a useful way of de-escalating a situation.
- Ask the person what would help them feel better and propose different options and choices (e.g. going to a quiet room to try and reduce their distress, speaking to a friend or a family member, etc.).

- Do not promise what you cannot or do not intend to deliver. Choices must be realistic and must be honoured.
- Ask the person what course of action can be taken in order for them to feel better and for the crisis to be resolved.
- Facilitate access to people that the person knows and trust (e.g. peers, relatives) and who can support the person to calm down and feel better.

Domain 10: Debrief the person concerned, Staff Members and others

- Involve the person concerned, staff members and others in evaluating the course of events that took place and ways to improve actions taken if a similar situation should arise in the future.



Exercise 7.1: De-escalation (30 min.)

Ask participants to watch the following video of a role play concerning de-escalation:

Understanding Agitation: De-escalation (45) (9:14, starting at 3:27):
<https://youtu.be/6B9Kqg6jFel?t=207> (Accessed 20 January 2017)

At the end of the video, ask participants to share their thoughts on the techniques they have seen.

Ask the group:

What are your thoughts on the techniques explained in this video?

Give participants enough time to discuss the video.

Topic 8: Creating a “saying yes” and “can do” culture



Presentation: Creating a “saying yes” and “can do” culture (10 min.)

- On admission to a service, people using services in many cases surrender control to the service and staff. They are away from their day to day life, their family, friends, social networks, belongings and so on. This ‘loss of control’ and ‘dependency’ on staff for their comfort, security, safety and wellbeing can cause distress, anxiety and frustration. This is particularly true when staff are not responsive to their needs and requirements.
- Healthcare staff often say ‘no’ to people’s requests or delay meeting these requests. This may be due to heavy workloads, staff shortages, poor training, service regulations or a culture of unresponsiveness in the service more generally.
- The frustration, distress and dependency felt by the person concerned can be misperceived by staff as challenging behaviour and can ultimately lead to a conflictual or crisis situation in which staff resort to coercive measures such as seclusion and restraint.
- In order to avoid these situations, a key strategy is to create a “saying yes” and “can do” culture within a service. This involves creating a non-judgemental space to think through how decisions are reached and whether it is possible to say ‘yes’ rather than ‘no’ in response to a request from people using the services. This will help service staff put people, as well as their needs and requirements first.
- Before saying an automatic ‘no’ to requests from a person using the service, staff practitioners should first R.E.F.L.E.C.T on the request. Think about (46):
 - R – Reframe: What would it take to say yes?
 - E – Easy: Is “no” the easy option?
 - F – Feeling: What would it feel like for the person if I say ‘no’?
 - L – Listen: Have I really listened to the person concerned and what they are asking?
 - E – Explain: Can I explain to the person concerned why I am unable to meet their request?
 - C – Creative: Are there creative ways I could use to try and find a way to meet the request of the person?
 - T – Time: Am I giving enough time to consider the request?
- Even in situations where practitioners have already said ‘no’ to a request, it is useful to R.E.F.L.E.C.T on the motivations for having said ‘no’
 - R – Reframe: What would it have taken to say yes?
 - E – Easy: Was “no” the easy option?
 - F – Feeling: What would it have felt like?
 - L – Listen: Did staff listen to the person concerned?
 - E – Explain: was an explanation given to the person concerned?
 - C – Creative: Was creativity used to try and find a way to meet the request of the person?
 - T – Time: was enough time taken to consider the request?

- Reflecting on these questions encourages participants who are practitioners to think in more depth about their practices and how they can reverse this situation to develop a culture of “First say yes”.
- Another important practice is to provide the necessary resources to allow people using the services to be more autonomous and self-reliant and thus less dependent on the service and staff. So another important question to be considered by practitioners is:
 - “Can I give the resources to the person so that they do not need to make this request and become more autonomous?”.



Exercise 8.1: Creating a “saying yes” and “can do” culture in our mental health or service (15 min)

This exercise is designed to help the group come up with a list of steps that can be taken to create a “saying yes” and “can do” culture in a mental health or related service.

Hand-out to participants **Appendix 4 - Reflect To Reframe** to support the participants in this exercise.

Ask mental health and related practitioners, and people using services, and care partners/families each the following questions.

- **Question for mental health and related practitioners:** Think about the last time you said “no” to the request of a person using the service? What could you have done differently?
- **Question for care partners/families:** Think about the last time you said “no” to the request of your family member? What could you have done differently?
- **Question for people using services:** Think about the last time a staff member or care partner/relative said ‘no’ to your request. How did it make you feel?

After writing down on the flipchart the various responses from participants, ask them the following question, and record their ideas on the flipchart.

- What is needed to create a culture of ‘saying yes’ in a mental health or related service?
- How could practitioners, people using the service, families and care partners or others be involved in this process?
- Which skills would be needed to create or improve a ‘saying yes’ culture?

Topic 9: Comfort rooms and sensory approaches



Presentation: Comfort Rooms (30min.)

Comfort Rooms (47),(48),(49)

A comfort room provides a sanctuary from stress and allows a person to “experience feelings within acceptable boundaries.”(47)

- They may be useful to help people calm themselves and reduce the use of seclusion and restraint
- A comfort room is not an alternative to a seclusion room. It is a preventive tool that can help calm someone in distress, before the situation escalates.
- These rooms should always be used on a voluntary basis and with the informed consent of the person.
- Staff can suggest its use and they can use it themselves as a place where they can go to calm down and reduce their own stress.
- It is useful to normalise the use of comfort rooms so that they are not perceived or used as seclusion rooms. One useful way of normalising these rooms is to make them available to people using the service as well as staff, for the purpose of activities involving relaxation and rest.

Setting Up a Comfort Room

- Make a plan for the creation of a comfort room
- Staff and people using the service should work together to develop a plan for the creation of a comfort room. It is essential that people using the service inform the process and design of the comfort room.
- Discuss and decide
 - which room (or rooms) will be used
 - how will it be furnished (donated items that are in good condition can be used whenever possible)
 - how will it be paid for
 - who will be in charge of maintaining the room, etc.
- Include the comfort room in individualised plans to prevent and manage tense situations where relevant.
- When designing the room, the safety of people using the room should be an important consideration. Consider whether it is useful to remove glass items, flammable objects, and light-weight objects that can easily be thrown around. Considerations for the design might include:
 - Avoiding fixed furniture as this may give a sense of detention.
 - The possibility of using a room with multiple exits so that the person using the room as well as others do not feel trapped which can add to a stressful situation.
 - The use of special doorknobs to prevent self-harm e.g. by hanging.

Using sensory approaches in comfort rooms (50)

- Including calming and soothing sensory stimulation in comfort rooms can be useful for focusing the attention away from distress and onto something else. Again, sensory approaches must always be voluntary.
- Examples of sensory approaches that can be integrated into a comfort room include:
 - Warm water
 - Soft blankets, carpets or pillows
 - Calming colours
 - Low lighting
 - Rocking chairs
 - Quiet, calming music or sounds
 - Flowers, incense, scented candles
 - Aromatherapy
- Sensory approaches should be individualised. Staff should work with the person to try different sensory approaches to see what works for each person.
- What is calming for one person might be agitating for another.
- Some people might prefer to sit quietly with little or no sensory stimulation.



Exercise 9.1: Sensory approaches (15 min.)

Begin this exercise by inviting participants to think individually of some sensory approaches that could be used in a comfort room within their service. Make the following statement, or some variation of it, to the group:

- On your own, try to think of some specific sensory approaches that can be used in a mental health or related service. After a few minutes we will come back together and make a list of our ideas.

After 5-10 minutes of individual thinking time, invite participants to share their ideas with the group. Make a list of ideas on the flip chart.

Some examples of ideas may include, but are not limited to:

- Flowers and plants
- Soft lighting
- Warm drink (e.g. tea)
- Soft blanket
- Calming music
- Incense, lavender, or other aromatherapies
- Salty, sour, or sweet foods
- Fish in an aquarium



Presentation: Comfort rooms in emergency departments in general hospitals or in other places of acute care (10 min.)

- Emergency departments in general hospitals or in other places of acute care are often the first place that people go to or are taken to when experiencing distress, agitation or a crisis
- The conditions can be busy and chaotic, with abundant triggers and stimuli such as noisiness, overcrowding and long waiting times, that can exacerbate people's distress, anxiety and agitation (51).
- Also, staff are seldom trained in non-coercive techniques to support people experiencing agitation or distress. As a result, in many cases staff resort to the use of seclusion and restraint.
- Surveys have shown that the use of seclusion and restraint in emergency departments is very common (52),(53).
- Creating a comfort room within an emergency department is therefore a useful means of ensuring that people don't have to wait in noisy, overcrowded and sometimes chaotic waiting rooms, but rather, that they can wait in a calming environment away from negative stimuli.



Exercise 9.2: Comfort Rooms in the Service (15 min.)

This exercise is meant to help the group come up with a list of steps that could be taken to create a comfort room in their service.

Ask the following questions and record ideas on the flip chart:

What must be done to create a comfort room in a mental health or related service?

- Which room will be used?
- What can be included in the room?
- How to gather and incorporate suggestions from people using the service and staff when creating the room?
- How will it be funded?
- Will the room be open so that everybody (people using the service and staff) can use it when there is a need or will its use be managed by staff?

Topic 10: Response teams



Presentation: The creation of a Response Team (RT) (54),(32),(33),(55),(56) (30 min.)

This presentation provides an overview of how response teams can be used to manage tense or challenging situations without using coercive strategies: the creation of a Response Team (RT).

What is a Response Team?

- A response Team (RT) is a core group of experienced and committed people (for example, around 7 members) who embrace the non-restraint approach and who are responsible for intervening/responding when there is likely to be a crisis or emergency considered to be difficult or “un-manageable” by those present at the scene.
- Response teams have different names in different countries and services, for example Crisis Response Teams (CRT), Psychiatric Emergency Response Team (PERT).
- RTs can be effective at managing a crisis by using good communication, de-escalation and violence-prevention skills to diffuse and safely resolve a crisis or emergency (57).
- RT members serve as examples for other staff on effective crisis management response skills, and on positive practices and interaction with people using services.
- They help and assist during a crisis situations, but can also perform proactive crisis prevention by working with people in order to identify and implement strategies that are helpful in times of distress, frustration and agitation (e.g. developing individualised plans to prevent and manage tense situations).
- It is important to note however, that the intervention of a Response Team is only necessary in certain crisis situations where other strategies are not appropriate or have not worked. In many instances, people may simply need some time and space to overcome their distress on their own or with support from staff and others.

The purpose of the team is to always respond to challenging situation in a non-violent and non-coercive way. It is important to ensure that the RT does not evolve over time into a team that itself uses coercive and violent measure to manage tense and crisis situations.

Objectives of a Response Team:

- To provide a safe resolution to a crisis based on the development of non-coercive and non-confrontational approaches that are designed to help and support the person rather than to control them.
- To reduce the potential for injury or harm during a crisis.
- To provide an organized team approach and leadership with all emergencies involving people in crisis.
- To train and share experiences and knowledge with others on non-coercive crisis management skills and techniques
- To undertake post-crisis discussions with the individual concerned, identifying with them useful measures for preventing or managing crises in the future and communicating these with staff within the service

The composition and role of the RT

The response teams should include:

- Mental health and related practitioners (aides, nurses, doctors, and others) who are committed to non-coercive approaches in care and services. There is a risk of crisis escalation if the person in crisis is unfamiliar with the personnel on the RT. RTs should include staff or others whom the person in crisis has a good relationship with and trusts.
- Teams should also include other members, for example people with psychosocial, intellectual and cognitive disabilities, people who use services, peer workers, community advocates and family members.

Role of various RT members:

- Team members should have clear and specific roles to avoid confusion and duplication under duress.
- At least one core group should be assigned to the mental health or related service on a day-to-day basis.
- There can also be “on-call members” outside of the service:
 - They do not stay permanently at the mental health or related service.
 - They are called on a needs basis.
 - They can be called on at short notice and report to the emergency location in a short period of time.

RT team leaders

- RT should have a team leader. This should be an individual with effective leadership and de-escalation skills and experience in supporting people in crisis. They should be screened by the management at the service prior to their engagement on the team.
- An effective RT Leader:
 - promotes the safety of the person in crisis, staff, families and others around them;
 - is a service user advocate who promotes a non-violent approach to the resolution of a crisis;
 - keeps up to date with, and shares, new research on non-coercive approaches a
 - is competent with verbal and non-verbal communication skills;
 - listens to advice and coaches others on safety issues and non-coercive practices;
 - questions unsafe decisions and practices;
 - takes a leadership role in crisis situations and delegates roles and responsibilities to other team members (eg. clearing the area, ensuring there are no potential harmful or dangerous objects etc.);
 - is responsible for the response and all post event debriefing.

Training of RT members

- RT members (both professional and non-professional) should be trained in crisis management.
- Mental health and related services should upgrade the quality and quantity of their training on crisis management, making it an annual requirement for all RT members.
- The RT should be trained together, have clear defined roles and have working relationships so that they can respond together as a team and prevent any miscommunication or lack of coordination in crisis situations.
- Training for RT should include how to support people with special needs and requirements during a crisis e.g. pregnant women, people with a physical impairment, etc.

- Training should simulate the stress of ‘real-life’ situations that result in the use of seclusion and restraint thus enabling RT members to practice keeping calm under duress.
- All staff at the service should also be trained in the RT approaches to crisis situations.
- As response teams gain more experience on the ground, their effectiveness in diffusing crises increases over time.

Response Team in Action:

1. Prior to a potential crisis

- When a crisis occurs the staff member at the scene alerts the RT members calling them to the location of the emergency by radio, pagers, emergency lights, (e.g., Code Orange) etc.
- When RT members are alerted, they stop what they are doing and report to the area.
- The response team needs to come to the area where the crisis is occurring in a short period of time (less than 5 min).

2. Responding to a crisis or an emergency

- As team members arrive they are met by the RT leader, who identifies which measures to take in the particular situation, based on dialogue with the person in crisis, past experience of effective measures, personal observation, advance plans or Individualised plans (where these are available), etc.
- Mental health staff on the response team should determine whether there are underlying medical reasons for the distress or agitation of the person concerned, and if they have any pre-existing conditions (eg. cardiac problems, history of trauma, drug use etc.) which the team should be aware of.
- All team members should have clear and defined tasks during the time of crisis to avoid confusion and duplication under duress.
- The RT leader designates one person to take charge of the response. This should be a team member who knows and has the best relationship with the person concerned, knows their triggers, what the person finds helpful in crisis, etc.
- RT members work alongside the person concerned, working with them to understand the immediate circumstances and relevant background that precipitated the crisis and identifying means of overcoming it. This will lead to a relationship based on shared knowledge that will, in turn, enable RT members to put themselves into the person’s shoes.
- When necessary, one or more RT members should lead people not involved in the crisis (e.g. nonessential staff or service users etc.) away from the area.
- RTs should ensure that other staff members are providing the necessary support to other service users and that other units are taken care of (to avoid spreading of chaos/crisis).
- Response teams should take action to calm the environment (e.g. reduce harsh lighting, , reduce any noise pollution/loud noises etc.), and to remove any potentially harmful objects (e.g. furniture, medical implements etc.).

- RTs should not overwhelm the person in crisis for example by talking at the same time or adapting an “all-hands” or “gang” approach, because this may increase the potential for injury and trauma to people and staff.
- Even during a crisis situation it is important to be mindful of ways in which the relationship with the person can be enhanced and to avoid saying or doing things that hinder this relationship.
- A successful team response is when the crisis has been resolved without using seclusion, restraint or other coercive methods.

3. Once the crisis has been resolved

- A post-incident review should be conducted as soon as possible and no later than 72 hours after the incident.
- A debriefing session is held with members of the RT to discuss the response and review the outcome and determine what worked, what didn’t work and how things can be managed better the next time a crisis emerges.
 - Discuss with any staff involved about what led up to the situation, how it was handled, and what could be done to prevent a similar situation from occurring in the future.
 - The purpose of a review is to learn lessons, support staff and service users, and encourage a positive therapeutic relationship between staff and service users in the service.
- A separate debriefing session is conducted with the persons who experienced the crisis, when they feel ready, in order to better understand what led up to the situation, what they went through, what their triggers were, and how appropriately the RT dealt with the situation.
 - This is also an opportunity to develop or review individualised plans to prevent and manage tense situations (as already discussed in this training) for diffusing crises in the future.
 - The person concerned should have the opportunity to write their own personal perspective of the incident and indicate how they think any potential future incidents should be prevented.
- In addition, a formal external post-incident review should also be undertaken soon after the crisis (eg. within 3 days). Recommendations should be made as part of the review, highlighting actions that could be taken in the future to improve the ability of the service to handle crises. Results of this review should be shared with the mental health and related service staff/teams and service management leadership as needed.



Exercise 10.1: Creating a Response Team (20 minutes)

This exercise is meant to help the group come up with a list of steps that can be taken to create a Response Team (RT) in their service.

Ask the following questions and record ideas on the flip chart.

What can be done to create a Response Team to respond to crises in your service?

- Who could you involve?
- How could people who are not staff members be included as part of the RT (e.g. can they be available at the service on a day to day basis or could they be 'on call' to come quickly to the service to support the service users and staff in a crisis situation?)
- How could you organize the training for this team?
- If funding is needed, how could it be funded?



Reflective exercise (10 min)

The reflective exercise gives the participants an opportunity to further think about what has been learned in today's lesson.

Below is a question to reflect on after the session. You can either write down your answer to discuss at the next session or simply think about your answers.

What can you do as an individual to help eliminate the use of seclusion and restraint in your service?

Topic 11: Action to take for eliminating seclusion and restraint



Exercise 11.1: Current practices for managing challenging behaviour and crises in the service (15 min, Slides)

This is a brief discussion exercise designed to encourage participants to talk about what they currently do in challenging and potential crisis situations within the service.

Ask participants the following question:

- How does this service currently manage crisis situations?

Allow 15 minutes for participants to share their thoughts on this.



Exercise 11.2: Personal action to eliminate seclusion and restraint (20 min.)

This exercise is intended to encourage participants to discuss implementing alternative strategies outlined in the training. This is meant to encourage the group to commit to eliminating seclusion and restraint through personal action.

Start with individual reflection followed by a group list-making exercise on possible personal actions. Write ideas on the flip charts.

Begin by inviting participants to think on their own about some specific individual actions mental health and related practitioners can take to eliminate seclusion and restraint.

Ask the group:

What are some personal actions staff can take to eliminate the use of seclusion and restraint in a mental health or related service?

After 5-10 minutes of individual reflection, invite participants to share their ideas with the group. Make a list of responses on the flip chart. Some examples may include (but are not limited to):

- Take a breath before approaching a tense situation in order to allow myself time to think before rushing to address it.
- If I see someone demonstrating challenging behaviour, try to lower my voice and project calm, kindness, and understanding.
- When approaching a tense situation, think about how the other person might be feeling and how I can address the situation keeping in mind that person's triggers.
- When I see a staff member struggling with a tense situation, respectfully offer to help.
- Report the use of seclusion, restraint or other coercive practices to supervisors.

- Talk with other staff members about what kinds of strategies can be used to diffuse tense situations peacefully.
- Work with service users to make individualised plans with them.
- After a crisis has been resolved, talk with everyone involved, particularly the person concerned, about what was done well and what could be done better in the future.

After making the list, help the group select five actions from the list to which they can collectively commit (i.e. the whole group selects five or more personal-level actions that every person at the service will commit to). Invite them to write these actions in the table hand-out (see Annex 5).



Exercise 11.3: Service level action to eliminate seclusion and restraint (1 hour)

Next have the group make a list together of four or five changes that need to be carried out at the service level to end the use of seclusion and restraint at their service, including the specific actions that need to be taken in order to implement those changes. You can draw a table on the flip chart (see below) and record these changes in that table. Invite participants to write these changes on the Service Level Changes hand-out (see Annex 6).

Ask participants the following questions:

What are some changes that can be implemented at the service level to eliminate the use of seclusion and restraint?

(Record these in the “Service Level Change” column)

What actions need to be taken in order to implement these changes?

(Record these in the “What Needs to Be Done” column)

Example table to draw on the flip chart:

| Service level change | What needs to be done |
|--|--|
| <i>E.g. Develop a service policy aimed at eliminating the use of seclusion and restraint</i> | <i>E.g. Action 1: Convene a meeting of staff and service users to start developing the service policy for eliminating seclusion and restrains Action 2: etc.</i> |
| | |
| | |
| | |
| | |
| | |
| | |

Some example of “changes and actions” may include (but are not limited to):

- Change: Develop a service policy aimed at eliminating the use of seclusion and restraint;
- E.g. Action 1: Convene a meeting of staff and people using the services to start developing the service policy for eliminating seclusion and restraint
- Action 2: etc.

- Change: Staff should all have skills in how to avoid and manage crises:
- Action 1: Hold training sessions for all staff on strategies to avoid and manage crises
- Action 2: etc.
- Change: Introduce individualised plans to manage triggers for service users for systematic use in the service
- Action 1: Develop and distribute individualised plans
- Action 2: Work with people using the service and staff members to complete the plans
- Action 3: etc.
- Change: Establish a comfort room within the service
- Etc.



Presentation: Service level actions to eliminate the use of seclusion and restraint (XX min)

To sum up the discussions of the previous exercise show participants this short presentation.

As we have seen in the previous exercise, actions to eliminate the use of seclusion and restraint can be taken at the individual level but also at the service level through services policy and cultural changes.

Examples of actions at the service level include:

- Develop a service policy aimed at eliminating the use of seclusion and restraint;
- Establish a service based policy to ensure that staff are not held responsible or liable when accidents or incidents have occurred if they have followed all correct non coercive strategies, procedures and protocols.
 - Very often staff resist finding alternatives to seclusion and restraint because they fear they will held accountable for damages or lose their jobs. Removing this liability is key to eliminating seclusion and restraint.
- Train all staff on how to avoid and manage crises;
- Introduce individualised plans to manage triggers for service users for systematic use in the service;
- Establish a comfort room within the service.

The Pennsylvania State Hospital System's Seclusion and Restraint Reduction Programme (54),(32),(33),(55)

In the 1990s, the Pennsylvania Department of Public Welfare instituted an active programme to reduce and ultimately eliminate seclusion and restraint in mental health and forensic hospitals. All the hospitals have been seclusion free for several years and are approaching zero-use of restraint.

The programme was realised through a combination of training, monitoring, policy revisions, cultural change, data transparency, the use of response teams and by adopting a recovery approach to providing mental health and related services.

Research evaluating the impact of the programme from 2001 to 2010 showed significant reductions in the use of seclusion and restraint over this period across the State. During the span of the study, the use of unscheduled medication an indicator of the use of seclusion and restraint, also declined.

Furthermore, contrary to fears, there was no increase in assaults on staff; in some cases, the number of assaults on staff even decreased. Overall the program illustrated that it is possible to create environments that are safe and provide support to everyone involved in the service, without further traumatising the individuals using the mental health service.

Conclusion: What Have We Learned?



Presentation: Wrapping Up (10min)

Ask participants:

What are the 3 key points that you have learned from this training?

[Follow this question with these key take home messages.](#)

- Seclusion and restraint are human rights violations and are harmful.
- There are many strategies that can prevent and help manage tense situations without resorting to seclusion and restraint.
- Everyone has a role to play in ending seclusion, restraint and other coercive practices.
- By ending these practices, everyone will benefit!

Annexes

Annex 1: Coercion Experience Scale

Reproduced from: Bergk, J., Flammer, E. & Steinert, T. (2010). "Coercion Experience Scale" (CES)--validation of a questionnaire on coercive measures. *BMC Psychiatry*, 10, 5.

Name: _____ Date of birth: _____

Questionnaire

Dear service user,

This questionnaire should help to assess the stressors which were induced by a previous coercive measure. Thank you very much for being so kind to participate in this survey. If possible, please take a few moments and try to recall the situation before and during the coercive intervention. It is best if you make your ratings spontaneously.

1. **How well do you recall the coercive measure?**
 Please mark your capacity for remembering with a tick on the dashed line:
 Not at all x-----x Completely
 0 -- 10 -- 20 -- 30 -- 40 -- 50 -- 60 -- 70 -- 80 -- 90 -- 100

2. **How stressing did you experience the measure in total?**
 Please mark with a tick on the dashed line:
 Not at all x-----x Extremely
 0 -- 10 -- 20 -- 30 -- 40 -- 50 -- 60 -- 70 -- 80 -- 90 -- 100

| | To what extent did you experience due to the intervention ... | Not at all | A little | Moderate | Severe | Extreme | Factor |
|----|---|------------|----------|----------|--------|---------|--------|
| 3. | ... adverse effects on your human dignity? | | | | | | 1 |
| 4. | ... restrictions of your ability to have contact with staff? | | | | | | 3 |
| 5. | ... restrictions of your ability to move? | | | | | | 1 |
| 6. | ... coercion? | | | | | | 6 |
| 7. | ... restrictions of your freedom to decide things? | | | | | | 1 |

| | | How did you experience the following stressors? | | | | | Factor |
|-----|--|---|---------------------|------------|-----------------|----------------------|--------|
| | | Not unpleasant | A little unpleasant | Unpleasant | Very unpleasant | Extremely unpleasant | |
| 8. | The restriction of contact with staff was ... | | | | | | 3 |
| 9. | The restrictions of my ability to move was ... | | | | | | 1 |
| 10. | The applied coercion was ... | | | | | | 6 |
| 11. | The restrictions of my freedom to decide things was ... | | | | | | 1 |
| | | How stressing were the following circumstances for you? | | | | | Factor |
| | | Not at all | A little | Moderate | Severe | Extreme | |
| 12. | I feared not getting enough air. | | | | | | 4 |
| 13. | I suffered pain. | | | | | | 2 |
| 14. | I felt my dignity taken away. | | | | | | 1 |
| 15. | I was not able to sleep well. | | | | | | 4 |
| 16. | The decor or lighting of the room was unpleasant. | | | | | | 4 |
| 17. | I had to obey the orders of others. | | | | | | 1 |
| 18. | The room was too cold or too warm. | | | | | | 4 |
| 19. | I was afraid I would be killed. | | | | | | 5 |
| 20. | Others made decisions about me without my consent. | | | | | | 1 |
| 21. | Using the bathroom was shameful. | | | | | | 2 |
| 22. | I did not know what to expect. | | | | | | 1 |
| 23. | Using the bathroom was uncomfortable. | | | | | | 2 |
| 24. | I could not understand why I was being treated that way. | | | | | | 1 |
| 25. | I couldn't move freely. | | | | | | 1 |
| 26. | I had to bathe whilst being observed by aids or staff. | | | | | | 2 |
| 27. | I was afraid I would die. | | | | | | 5 |
| 28. | The air in the room was poor. | | | | | | 4 |
| 29. | I felt I was treated like an animal. | | | | | | 1 |
| 30. | I feared the measure would last forever. | | | | | | 1 |
| 31. | My wishes were not taken into account. | | | | | | 1 |

Name: _____ Date of birth: _____

Evaluation

| Factor Number | Item | Value |
|---|-----------|-------|
| Total stress | 1 | |
| | | |
| Factor 1: Humiliation | 3 | |
| | 5 | |
| | 7 | |
| | 9 | |
| | 11 | |
| | 14 | |
| | 17 | |
| | 20 | |
| | 22 | |
| | 24 | |
| | 25 | |
| | 29 | |
| | 30 | |
| | 31 | |
| | Sum F1 | |
| | Sum F1/14 | |
| | | |
| Factor 2: Physical Adverse Effects | 13 | |
| | 21 | |
| | 23 | |
| | 26 | |
| | Sum F2 | |
| | Sum F2/4 | |
| | | |
| Factor 3: Separation | 4 | |
| | 8 | |
| | Sum F3 | |
| | Sum F3/2 | |
| | | |
| Factor 4: Negative Environment | 12 | |
| | 15 | |
| | 16 | |
| | 18 | |
| | 28 | |
| | Sum F4 | |
| | Sum F5/2 | |
| | | |

| Code | |
|----------------------|---|
| Not at all | 0 |
| A little | 1 |
| Moderate | 2 |
| Severe | 3 |
| Extreme | 4 |
| | |
| Not unpleasant | 0 |
| A little unpleasant | 1 |
| Unpleasant | 2 |
| Very unpleasant | 3 |
| Extremely unpleasant | 4 |

| | | |
|--|-----------------|--|
| Factor 5: Fear | 19 | |
| | 27 | |
| | Sum F5 | |
| | Sum F5/2 | |
| | | |
| Factor 6: Coercion | 6 | |
| | 10 | |
| | Sum F6 | |
| | Sum F6/2 | |
| | | |
| | Total | |
| | Total/29 | |
| | | |
| Total number of stressing items | | |

Annex 2: Quotes from people with lived experience of seclusion and restraint

Reproduced from: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), (2005) *Roadmap to seclusion and restraint free mental health services*. DHHS Pub. No. (SMA) 05-4055. Rockville, MD: SAMHSA. http://www.asca.net/system/assets/attachments/2661/Roadmap_Seclusion.pdf?1301083296 (Accessed 20 January 2017)

The big problem I have with restraints is that you start feeling vulnerable and you start thinking imaginary things like the people are going to hurt you, especially like the staff. Since they are required by law to always chart you, you are always seeing them staring at you through the window while you are lying there like, you know and it's scary. Very scary.

—Male

As an adolescent, age 12, I was put in a psychiatric unit for adolescents. I was there for abuse situations and the duration of my stay I was put into seclusion, which we called the padded room. I was put in there and stripped down, to nothing, and I was forced to stay there for 5 hours because I refused to watch a sexual assault video. Instead of letting me stay in my room and talk to my nurse at that time, they said if I don't follow the rules this is where I have to go.

—Female in seclusion and restraint as an adolescent

I think they should talk to you when you want them to talk to you. Basically you are a human being, not an animal. Even an animal being strapped down flat on the floor the Humane Society would have a fit with that.

—Male

They say act like an adult. If they want me to act like an adult, they should treat me like one. The way I should be treated and the way you would want to be treated.

—Female

I have been in seclusion about seven times. I've had experiences where I've had 7 or 8 people take me down and I've had experiences where I have had less. It's very degrading because when they put you there even as a girl or woman, all you're left is your underwear and a paper gown and a mattress that has nothing on it.

—Female

Fear basically is a big thing. You're vulnerable. Seclusion room is sometimes used as a punishment not as a therapy. I don't think treating someone like an animal is really a therapy. I think a lot of the staff are scared of the patients. And they react to that fear by controlling the patients and not trying to treat the patients.

—Male

The only way to survive in there is to turn inward and that just made me more angry.

—Female in seclusion and restraint as an adolescent

Then they have these restraints; they really are kind of sadistic in a way. You are spread-eagled so you really can't move. You can't have any circulation. You can't do anything. And they do and when they do it on your stomach lying down, you really can't even breathe. And the human instinct when you are spread-eagled is to get up so you are constantly fighting these things.

—*Male*

I've heard about people trying to pull their feet out of restraints and getting hurt. I've never tried that, my feet are too big and I was afraid I might lose them.

—*Male*

I usually would end up hurting myself more because of what they had done, instead of less.

—*Female*

It's the fear factor. I get paranoid and that's why I sign myself into a place like that. I get more paranoid while I go through the process 'cause basically because of my energy level I scare people. I'm not a mean person. I don't hurt people. I don't pull wings off flies. I'm a nice guy; I don't even hunt or fish. I don't even put worms on hooks; it's not my thing. But I am very loud and very energetic and it does frighten people. And I am fairly big and that also frightens people. But unless I want to go on a starvation diet and get my vocal chords cut, lose my legs just so they can treat me well at a State hospital when I am paranoid.

—*Male*

They said as soon as I stopped being angry, they would let me out. Meanwhile you are naked on your bed, strapped down with your door open and they wondered why you weren't mellowing out.

—*Female as an adolescent in restraint and seclusion*

Seclusion room, same thing with the people viewing you. They are always looking at you with them beady eyes. It's very frightening; it's very frightening.

—*Male*

After they unlocked the door and they dragged me in there, they said, well you can't keep your clothes for danger issues. And they made strip me down. They kept a video on me the whole time. For a girl who is awkward and is in there for issues of abuse at home, all that did was extend my hate.

—*Female in seclusion and restraint as an adolescent*

I know it deepened my fear. I was in there to get help so I wouldn't injure myself anymore and become a better person. It just made me more angry and didn't help nothing.

—*Female*

If I was really harsh I would say that it's a form of lazy and harmful practice that achieves a similar effect, so if you can't lock someone in a small room you can medicate them to the point that they can hardly move and have the same kind of effect." -*Female*

Annex 4: Reflect to reframe

Reproduced from: Manaan Kar Ray & Sarah Rae. 'No Audit: Reflect to Reframe' in *Power to empower Lies beyond Binaries*. PROMISE: PROactive Management Of Integrated Services & Environments. Cambridge University Health Partners. Available at http://www.promise.global/2016_01_29_sp_no_audit.pdf (Accessed 20 January 2017)

No Audit: Reflect to Reframe

Theme: Reflective Space

Objective:

- Empower staff to be creative in saying yes and embed a can do culture
- Create reflective space to explore the balance between the needs of one service user against those of the others
- Put patients first, capture hope and decrease frustration

Concept: From time to time staff members say no to patients. Each instance is an opportunity to REFLECT. Capturing and creating a non-judgemental space to think through how we came to the decision and whether we could have said yes helps us put the service user first.

We think about:

R – Reframe: What would it have taken to say yes?

E – Easy: Was 'no' the easy option?

F – Feeling: What would it have felt like?

L – Listen: Did we listen?

E – Explain: Did we explain?

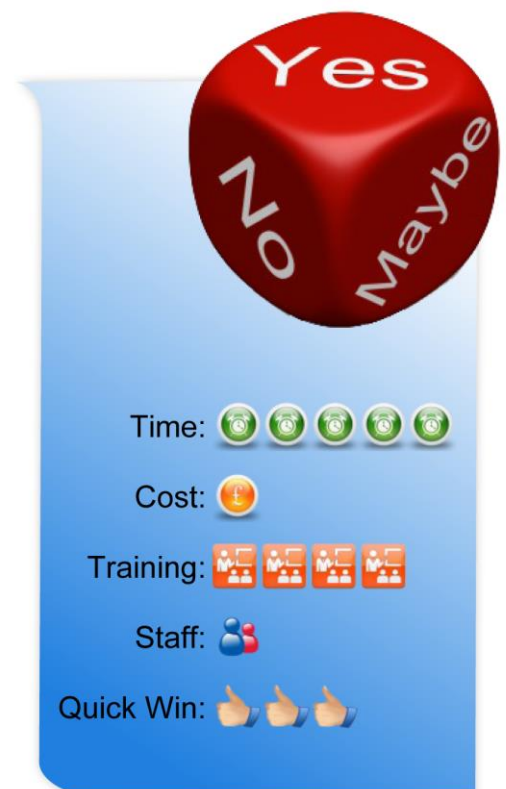
C – Creative: Where we creative enough?

T – Time: Did we take the time?

Reflecting on these questions encourages staff to think more about their practice and how we can continue to improve. This leads to a culture of "First say YES". When we do say "no" our responses are kind and considerate. Patients can understand where we are coming from and get a sense of what would need to happen for us to have said "yes". E.g. leave from the hospital contingent on improvement they make.

Pragmatics:

- Set up a collection box for 'no slips'.
- Encourage reporting by putting up a poster above the collection box saying we like to say yes, tell us if we have said 'no' to you.
- Keep the 'no slips' simple – if we said no to you to please tell us about it
- For this to be embedded in every day practice, build it into your reflective practice sessions, supervisions and handovers etc.
- Evolution of recurring themes, the quality of the discussion and less incidents will allow you to monitor progress over time.



Top Tip: Maintain a non-judgemental stance at all times and create ownership and delegate responsibility of the process to the frontline staff by encouraging open and honest reflections and dialogue.

Note: This is not about discarding policies and procedures as they have been put in place for a reason, however when policies override common sense and clinical judgement, staff are encouraged to take a view and put patients first while at the same time keeping an eye on what it means for the rest of the patients.

Examples / Quotes:

A. Service user asked to paint a wall in her bedroom on the ward. Staff said ‘No this is a hospital not your home, you can’t do that.’ When we thought about this further there were lots of reasons why it was actually a good idea:

- It is a good distraction technique
- It made her feel useful and valuable
- It encouraged patients to respect and improve their surroundings
- A personal space where patients feel safe is likely to aid recovery
- It made the patients feel ownership of the ward and believe they could make positive changes
- Just because it wasn’t usual didn’t mean it couldn’t be done

Quotes:

- ‘I feel I was listened to’
- ‘I felt I had achieved something’
- ‘I felt pride which I hadn’t felt in a long time’
- ‘I was doing something normal’
- ‘I felt like my opinions counted’
- ‘I wasn’t dismissed’

B. On admission to one of our wards a service user expressed the desire to bring his own pillow in as he had neck problems and found his own pillow soothing. Fire safety and infection control regulations state that on the hospital premises all bedding used must be pre-approved. So the answer was a “no”, but on reflection staff felt that the pyjamas the service user was wearing were just as inflammable as his pillow. They exercised their judgement and brought the patients distress levels down by allowing the pillow and then sought the necessary permission.

Acknowledgement:

- The idea of No Audit originated on Mulberry 2, Fulbourn Hospital, Cambridge, UK and was led by Jane Poppitt and Terry Hill.
- Video: No Audit by Sarah Rae: <https://youtu.be/hlElv1ZdKiU> More examples from the space programme at: http://www.promise.global/9pc_4.html

Annex 5: Personal actions to eliminate seclusion and restraint

(More rows may be added to this table as necessary)

| Personal Actions to Eliminate Seclusion and Restraint in My Service |
|--|
| <i>E.g. Work with service users to make individualised plans with them</i> |
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Annex 6: Service-level changes to eliminate seclusion and restraint

| Service Level Change | Actions to be taken |
|---|--|
| <i>E.g. Develop a service policy aimed at eliminating the use of seclusion and restraint.</i> | <ul style="list-style-type: none"> ○ <i>Eg. Action 1: Convene a meeting of staff and service users to start developing the service policy for eliminating seclusion and restraints</i> ○ <i>Action 2: etc.</i> |
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