



NICS FELLOW 2007

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Implementation Project:

Reducing the use of seclusion in acute inpatient mental health care

Patients in acute psychiatric units identified by staff as being at risk of either harming themselves or others, are sometimes placed in a room which cannot be opened from the inside. This practice is known as seclusion and is an intervention of last resort as it can cause patient distress and result in injury to staff or patients. There is growing evidence that seclusion should be minimised but current rates in Victorian services suggests it is not always an action of last resort.

This project, undertaken at St Vincent's Hospital, Victoria, aims to reduce inappropriate seclusion by introducing a range of alternative strategies and a program of support to inpatient teams. The strategies have been successfully implemented overseas and include organisation leadership and support of the project, use of seclusion data, seclusion reduction tools, consumer involvement and staff training and debriefing.

Implementation Project Progress Report, April 2008:

The Seclusion Reduction project has been under way for 12 months. Core strategies and interventions are based on international evidence, mainly out of North America, where seclusion reduction has been achieved over many years. The project centres on adapting core seclusion reduction strategies to fit with Australian acute inpatient units, within systems of care that differ significantly from services in the US.

Strategy 1: Leadership towards organisational change

Dr Hamilton has engaged executive and other sponsorship for the project, established a project working group including consumer membership and secured additional resources to support change and education for the project.

The National Institute
of Clinical Studies (NICS)

Strategy 2: Using data to inform practice

Dr Hamilton uses an accurate set of base line and ongoing seclusion data to examine patterns of seclusion, to identify staff and consumer variables related to seclusion usage, to set improvement goals and monitor changes in seclusion use. She has developed formal reports and routine communications for internal and external service audiences, as one key element for a sustainable program of activity in the service beyond the project.

Strategy 3: Workforce development

Staff have undertaken a one day program introducing evidence and strategies for seclusion reduction. Local de-escalation training has been adapted to include specific seclusion reduction curricula.

Strategy 4: Using seclusion reduction tools

Dr Hamilton has supported development of local occupational therapy expertise and gained funds for sensory equipment, to support staff in use of alternate strategies to seclusion.

Progress to date confirms significantly reduced rates of seclusion when comparing 2007 quarterly seclusion data with 2006 baseline data, and compared with the Department of Human Services reported 2006 state wide data for all Victorian acute units.

Implementation Project Progress Report, October 2008:

This Seclusion Reduction project is well advanced. Core strategies and interventions are based on international evidence, mainly out of North America, where seclusion reduction has been achieved over many years. The project centres on adapting core seclusion reduction strategies to fit with Australian acute inpatient units, within systems of care that differ significantly from services in the US.

Strategy 1: Leadership towards organisational change

We have engaged executive and other sponsorship for the project, established a project working group including consumer member, and secured additional resources to support change & education for the project.

Strategy 2: Using data to inform practice

We use an accurate set of base line and ongoing seclusion data to examine patterns of seclusion, to identify staff and consumer variables related to seclusion usage, to set improvement goals and monitor changes in seclusion use. We have developed formal reports and routine communications for internal & external service audiences, as one key element for a sustainable program of activity in the service beyond the project.

Strategy 3: Workforce development

70% of staff have undertook initial training introducing evidence and strategies for seclusion reduction. We have adapted local de-escalation training to include specific seclusion reduction curricula and involved

community based staff in the project in their roles as case-managers of clients who have in the past experienced seclusion.

Strategy 4: Using seclusion reduction tools

We have increased local expertise and gained funds for use of sensory equipment, to support staff employing alternate strategies to seclusion. Progress to date confirms we have significantly reduced rates of seclusion. Comparing 2007 quarterly seclusion data with 2006 baseline data, we found that in 2007 seclusion was reduced by 49% (2006 μ per quarter = 32.7; 2007 μ = 16.7, ($p = 0.007$)). This reduced seclusion rate compared favourably with the DHS reported 2006 statewide mean of 34.3 events (/1000 occ. b-d/quarter), for all Victorian acute units.

Funding Partner:

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Project Mentor:

Professor David Castle
Professor of Psychiatry, St Vincent's
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NICS Mentor:

Professor Richard Smallwood
Emeritus Professor of Medicine,
University of Melbourne, VIC

Key Presentations:

Hamilton B, Castle D. Seclusion reduction: Policy drive, gaps in the science and results of a 3-point intervention in a Victorian inpatient unit. The 2008 Congress of the Australian and New Zealand College of Psychiatrists. Melbourne VIC; 2008.

Hamilton B, Mileshekin C. Open doors: Invitation to self govern in acute inpatient psychiatry. World Psychiatry Organisation International Conference. Melbourne; 2007.