Mental Health Commission Consultation Seclusion and Physical Restraint Reduction Strategy – PNA Response

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Introduction

The use of seclusion varies between institutions and countries .Seclusion is controversial and many consider it to be an unavoidable reality,[1] while others are committed to reducing or eliminating its use.[2][3][4]. A perusal of the literature reveals a clarion call to end the practice of seclusion, without consideration of feasible alternatives.[5]

In preparation for this submission a committee representing PNA members from across the country were consulted. This submission takes an experiential approach pulling together a conglomeration of experiences related by our members who have direct contact with service users

The PNA continues to identify the urgent need to address the mental health care needs of individuals, families, and groups to improve their access to, and attainment of, quality mental health care in a variety of settings and environments.

We fully endorse the rules and code of practice on the use of seclusion and mechanical means of bodily restraint (Mental Health Commission 2006) and consider ourselves key stakeholders in their establishment. The Commission on Patient Safety in its report Building a Culture of Patient Safety – Report of the Commission on Patient Safety &Quality Assurance 20086outlined the principles and values underpinning its work. This draft Seclusion and Restraint reduction strategy addresses some of the levels of responsibility and accountability in our mental health services

- Openness
- patient centeredness
- learning from mistakes – safety and quality must be embedded in the system
- maximising benefit to patients – effectiveness and efficiency based on good

1 Prinsen EJ, van Delden JJ. Can we justify eliminating coercive measures in psychiatry? J Med Ethics 2009; 35:69-73.
2 Department of Health NSW. Polices on seclusion practices, the use of restraint and the use of IV sedation in psychiatric inpatient facilities, 2007. http://www.health. nsw.gov.au/policies/pd/2007/PD2007_054.pdf.
3Grigg M. Eliminating seclusion and restraint in Australia. Inter J Ment Health Nurs 2006;15:224-5.
4 Glover RW. Reducing the use of seclusion and restraint: a NASMHPD priority. Psychiatr Serv 2005;56:1141-2.
[5] Cleary M, Hunt E G , Walter G, (2010) Seclusion and its context in acute inpatient psychiatric care. Journal Med Ethics 36; 459-462
[6] Government of Ireland (2008) *Building a Culture of Patient Safety – Report of the Commission on Patient Safety &Quality Assurance.* Stationery Office , Dublin

- governance and leadership, modern data management systems and evidence based practice
- accountability
- Patient/family involvement.

Strengthening of governance and accountability arrangements in the Irish Mental Health Services is vital. It is our view that whilst accepting the limitations of the Commission's input with regard to the provision of mental health services. It does have a legal, moral and ethical obligation to protect the interests of patients where there is "*slippage in a number of areas, including staffing, therapeutic services and programmes, recreational activities, privacy and premises."*[7]*. Mental Health Commission Annual Report 2010.At that time the Inspector* of Mental Health Services said that he observed "*regression in the way services were provided*" and how staffing cuts were having a *"disproportionate impact on the development of community mental health teams."* This, he said, is *"causing a reversion to a more custodial form of mental health service".* We (PNA) are of the view that that *"slippage "*has increased since those comments.

Advocating for positive attitudes and values about safety and quality in all services is a key commitment of this organisation (PNA), on principle we are supportive of most the actions or strategies proposed as they are in keeping with international approaches. However not surprisingly they are resource light!!! Almost to the point of non existence and this is unacceptable. We(PNA) are not closeted to the serious economic position we find ourselves , but one could almost express the view that such proposals without a proper cost analysis is naive at best and insulting to both service users and staff at worse.

The implementation of this strategy will require the dedication of resources, financial and human to develop, implement and evaluate inputs, actions, and standardised education and training programmes. Any strategy intending to reduce existence of or remove seclusion rooms form centres, is dependent upon appropriate staffing levels, emphasis needs to be placed on ensuring that services can respond to requirements particularly in terms of having sufficient staff to undertake required development of action plans and undertake training .

[7] Mental Health Commission Annual Report 2010

Mental health legislation has the difficult role of protecting the right of patients to autonomy, the rights of others who may be advisably affected or even injured by the mentally ill person, and the rights of the mentally ill themselves to be protected from their own irrationality. Legislation therefore must balance the interests of the individual with the protection of society. All other interventions to manage a patient's unsafe behaviour before the use of restraint or seclusion must be considered. However seclusion and physical restraint can be part of the reality in mental health services and there are situations where there is an immediate threat of serious harm to an individual or others and regard for the safety of service users, staff and visitors is essential and equal. The documentation and literature reflect the dilemmas and ambiguities inherent in mental health care, the balance of affording fundamental protections and rights for those availing of mental health services with the mental health service's duty to protect that person and other service user's in its care.

The PNA welcomes a proposal to build on previous work aimed at reducing the need for seclusion and restraint in mental health facilities. It is clear that mental health nurses will be at the forefront of this initiative and their safety as well as professional practice standards are of concern to the PNA. In this submission we respond to the series of questions set out in the information paper and conclude with general comments that address some of the other issues associated with seclusion and restraint.

Context

Role of Nurses

The Consultation process within the PNA which informed the preparation of this submission revealed that there is a body of opinion within the membership that on the whole nurses do not want to participate in restraint and seclusion practices. A variety of reasons for this were articulated: such as:

The dignity and safety of patients and staff, the lack of availability of organisational supports for training, data and quality improvement activities, the provision of agreed standards in the provision of training in the use of physical interventions, the adequate numbers of staff to participate in such actions, the lack of suitable regional facilities 30 bed ICRU's as recommended in Vision for Change to cater for individuals with disturbed or difficult to manage behaviour requiring a

level of security. An ill conceived perception that because in the main the culture has pertained whereby it is nurses who ultimately participate in restraint and seclusion procedures that de facto they are enthusiastic participants in the process. Indeed a debate with regard to the role of nurses in carrying out restraint articulated that there is a perception that restraint and seclusion practices were solely an issue for the nursing profession and this is an identified barrier to reducing restraint and seclusion use .Also it has been put forward increasingly by our members, the difficulties particularly in relation to the management of some individuals who appear to present with a mental illness and partake in substance abuse who have seem to have less respect for medical/nursing staff. Therefore Questions were raised by our members as to why the process of seclusion is articulated mostly for the nursing and medical profession .On one hand the Commission refers only to the disciplines of medicine and nursing initiating seclusion episodes but other staff can initiate restraint. See Below:

With reference to the document *Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres* (2009)8 Provision 5.1 states: "*Physical restraint should only be initiated and ordered by registered medical practitioners, registered nurses or other members of the multi-disciplinary care team in accordance with the approved centre's policy on physical restraint"*

Also in relation to Mental Health *Commission Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint (2009)*[9] **page 19 sites:**

a) *Seclusion of a patient must only be initiated by registered medical practitioners and / or registered nurses.*

b)

Page 21 sites in relation to monitoring seclusion:

4.1 a) A patient placed in seclusion must be kept under direct observation by a registered nurse for the first hour following initiation of a seclusion episode.

[8] Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres (2009)8
9 Mental Health Commission Rules Governing The Use of Seclusion and Mechanical Means of Bodily Restraint (2009)

The Mental Health Commission issued an Addendum to the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* in March 2011. The effect of the addendum is to require that a patient in seclusion must now be observed for the duration of a seclusion episode i.e. directly by a nurse for the first hour of a seclusion episode and thereafter either directly or through the use of CCTV.

The literature suggests that the successful reduction of seclusion and restraint requires that all members of the MDT are aware and participate in such a strategy and standardised protocol The leadership of consultant psychiatrists and the contribution of medical and allied health clinicians could make a difference to practice change and reduction efforts, and provide support to inpatient nurse managers and staff. Implementing this strategy will require ALL mental health professionals, service planners and managers, as well as service users, and their carers.

The PNA are also taking the opportunity to reiterate some of their comments in relation to the Review of the 2001 Act in relation to medications with some members recounting that on foot of the tribunal procedures and in some instances the adversarial method the admitting consultant was treated at the tribunal by members of the legal profession, they have found that dosages of prescribed medication are being reduced - whilst this might appear to be a positive consequence, our members report on the contrary that issues have arisen whereby the therapeutic dosage for ameliorating the effects of the illness are not being prescribed due to the inquisitional methods of tribunals on clinicians re high dosages of medication. In addition our members also report the decrease of seclusion for similar reasons which in their opinion are not serving the best interests of the distressed patient on some occasions.

The transfer to the Central Mental Hospital cannot take place until (a) a Mental Health Tribunal has determined that such a transfer would be in the best interest of the health of the patient concerned and (b) until the period of time for the bringing of an appeal to the Circuit Court has expired. If an appeal is made the transfer cannot take place until after the appeal is either determined or withdrawn. In the absence of the regional intensive care rehabilitation units laid down as government policy in *Vision for Change* The time period required by the Act before a patient may be transferred to the Central Mental Hospital is causing difficulties in the approved centres. These

approved centres very often do not have suitable facilities for the detention of a patient who requires treatment in the Central Mental Hospital pending his or her transfer. Containing an individual with aggressive tendencies in unsuitable environments is non therapeutic for the individual and places staff and other patients at risk, whilst all resources are directed towards containing that particular individual.

Service Requirements:

Facilities for Individuals with Dual Diagnosis

Individuals with Dual Diagnosis (e.g. Psychiatric Disorders among people with an Intellectual Disability and Problem Behaviours). The high rate of psychiatric disorders among people with learning disability (Oliver et al. 1987) 10. The requirement for appropriate service delivery as approximately one third of those with an intellectual disability should be served by the mental health of intellectual disability (MHID) team[11]. Indeed A Vision for Change Report of the Expert Group on Mental Health Policy (2006)[12] suggests within the population of people with intellectual disability there is a range of mental health needs, proposing a service model conceptualised by Mansell[13] describing four interrelated sub systems that can operate within the same service or across different service systems:

- Mental health prevention or promotion
- Early detection of mental health problems
- Specialised mental health services and support and long term
- Crisis management of mental health problems

This is especially important with regard to the proposal within Government policy to provide a number of rehabilitation and continuing care beds on a regional basis, for those with severe,

[10] Oliver C., Murphy G. H. & Corbett J. A. (1987) Self-injurious behaviour in people with mental handicap: a total population survey. Journal of Mental Deficiency Research 31, 147–62.
11 Department of Health (1996) Discussion Document on the Mental Health Needs of Persons with Mental Handicap (Mulcahy Report). Dublin: Stationery Office.
12 Department of Health and Children (2006). A Vision for Change Report of the Expert Group on Mental Health Policy. Dublin: Stationary Office.
13 Mansell , J., McGill,P.& Emerson, E. (1994)Conceptualising service provision. In E. Emerson, P McGill J. Mansell (eds) Severe learning disabilities and challenging behaviour , designing high quality services. London: Chapman Hall.

intractable problems. These 10 beds should be delineated in approved centres under the Mental Health Act, 2001[14]. .This is especially important with regard to the proposal within Government policy to provide a number of rehabilitation and continuing care beds on a regional basis, for those with severe, intractable problems. These 10 beds should be delineated in approved centres under the Mental Health Act, 2001[15].

Medication

The use of medication to achieve reductions in the use of seclusion and restraint was also examined in the literature reviews consulted for the purposes of the knowledge review. There is clear evidence that the choice of anti-psychotic medication can influence rates of seclusion and restraint (Smith et al, 2005)16.

The Commission recognises that the administration of medication may be appropriate in certain circumstances and guidance is available on the use of rapid tranquillization as a method of managing violence and aggression (See for example Royal College of Nursing, 2005)17.

The use of medication as restraint includes the use of sedative or tranquilising drugs for purely symptomatic treatment of restlessness or other disturbed behaviour (Mental Welfare Commission for Scotland, 2006). Medication is also used to treat mental illness which may underlie disturbed behaviour although the boundary between these two uses of medication is not always that clear (Mental Welfare Commission for Scotland, 2006)18.

14 Government of Ireland (2001) Mental Health Act. Dublin: Stationary Office Dublin
15 Government of Ireland (2001) Mental Health Act. Dublin: Stationary Office Dublin
16 Smith GM, Davis RH, Bixler EO, Lin HM, Altenor A, Altenor RJ, Hardenstine BD and Kopchick GA (2005), 'Pennsylvania State Hospital system's seclusion and restraint reduction program', in Psychiatric Services, 56, 1115 – 1122.
17 Royal College of Nursing (2005), Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments, (London: RCN & NICE).
18 Mental Welfare Commission for Scotland (2006), Rights, risks and limits to freedom, Principles and good practice guidance for practitioners considering restraint in residential care settings (Edinburgh, 2006).

As the draft strategy concentrates on promoting alternative strategies to seclusion and restraint, the Commission does not consider it appropriate to include an action related to the use of medication as restraint to achieve reductions in the use of seclusion or physical restraint. The reluctance by the Commission to address the use of medication as part of this strategy not as a means of restraint but sometimes necessary in the treatment of mental illness and distress and therefore must be referred to as a component in this strategy

The use of psychotropic medication is highly specialised .Assessing, prescribing and monitoring medication for persons with problem behaviours and mental health problems lies within the domain of either a medical practitioner or nurse in both inpatient and community mental health settings. The use of psychotropic medication should only be administered as part of an overall clinical assessment and monitored only by those professions listed. The prescription of psychotropic medication can only be provided or recommended following the assessment and knowledge base required to consider the context of problem and at risk behaviour and consequently the administration of psychotropic medication can only therefore be determined by registered medical practitioners and nurses.

Psychotropic medications may achieve their best results when combined with other treatment approaches such as e.g. CBT, Solution Focus approaches of which many psychiatric nurses are competent and familiar with. However as per **Recommendation 9 Psychiatric / mental health nursing will improve care by developing new, expanded, specialist and advances roles in response to local need** of A Vision for Psychiatric / Mental Health Nursing – A shared Journey for mental health care in Ireland (2012)[19].This too will require professional and clinical leadership and investment with responsibility for such input outlined as that of DoH/ HSE Corporate MH/ HSE ONMSD/ ABA/ clinical Care Programme/ ECD's and DoN's

Physical environment

A very broad array of specific changes in the individual's immediate personal environment can be an important precipitant to behavioural change. The physical environment and therapeutic milieu is integral to a seclusion physical restraint reduction strategy. A physical environment

19 Health Service Executive HSE (2012) Office of the Nursing & Midwifery Services Director. A Vision for Psychiatric / Mental Health Nursing – A shared Journey for mental health care in Ireland. Health Service Executive. Dublin

that enhances wellbeing and safety, as well as a practice culture that is respectful of the individual's experience, are important aspects of the treatment environment. The ultimate goal of interventions in this area should emphasise reducing the demand for seclusion, rather than just the use of seclusion per se. We need to acknowledge that some aspects of the inpatient environment can contribute to patient distress leading to aggression and the ultimately to seclusion (Duxbury & Whittington, 2005). Protocols for the use of seclusion and for reduction in demand for seclusion need to address those aspects of the inpatient environment that contribute to increased aggression (lack of space, etc) .Environment figures prominently as a predisposing and precipitating factor to problem behaviour. It is incumbent then for this union to comment on the unsuitability on a proportion of the treatment environments in this jurisdiction which year on year have seen their budget decreased, development plans postponed, relocated, to be located again as management considers it acceptable to downgrade services and reduce staff numbers. Coupled with that, mental health services are expected to provide care and services to a range of difficulties and specialisms all within one generic mental health facility, which is in the view of this union (PNA) both scandalous and unethical . It is the experience of our members there are increasing numbers of inappropriate admissions resulting from an absence of appropriate services including admissions to resolve social difficulties, homelessness and acquired brain injury. This is unacceptable and completely incoherent with a positive therapeutic milieu.

Section 3 - Consultation Questions

1. Do you think it would be **useful** to put a Seclusion & Physical Restraint Reduction Strategy in place? Please explain.

Using seclusion to remove an uncontrollable, disruptive individual and safeguard the environment may be justified under the utilitarian ethical framework as it provides benefit to the greatest number of people. At the same time, seclusion does restrict a person's liberty-conflicting with a right to self-determination20.According to Prinsen and van Delden21, respect for autonomy and human dignity, together with the harmful experiences reported during seclusion,2223provides a strong argument to reduce and ultimately eliminate the use of seclusion in order to improve the quality of people's lives24. Generally speaking, staff do not like secluding patients and research has found that they experience distressing emotions in response to seclusion interventions25.The harsh reality is that frontline staff are often held responsible for the faults and shortcomings of the overall system[26] and coercion is linked with professional, attitudinal, ethical, and legal and human rights issues.[27][28]. The PNA welcomes a proposal to build on previous work aimed at reducing the need for seclusion and restraint in mental health facilities. It is clear that mental health nurses will be at the forefront of this initiative and

20 Widdershoven G, Berghmans R. Coercion and pressure in psychiatry: lessons from Ulysses. J Med Ethics 2007; 33:560-3.

[21]

[22] Frueh BC, Knapp RG, Cusack KJ, et al. Patients' reports of traumatic or harmful experiences within the psychiatric setting. Psychiatr Serv 2005; 56:1123-33

[23] Robins CS, Sauvageot JA, Cusack KJ, et al. Consumers' perceptions of negative experiences and "sanctuary harm" in psychiatric settings. Psychiatr Serv 2005; 56:1134-8.

[24] Glover RW. Reducing the use of seclusion and restraint: a NASMHPD priority.Psychiatr Serv 2005; 56:1141-2.

[25] Moran A, Scott PA, Matthews A, et al. Restraint and seclusion: a distressing treatment option? J Psychiat Ment Health Nurs 2009; 16:599-605.

[26] Delaney KR, Johnson ME. Inpatient psychiatric nursing: why safety must be the key deliverable. Arch Psychiat Nurs 2008; 22:386-8.

[27] Kallert TW. Coercion in psychiatry. Cur Opin Psychiatry 2008; 21:485-9.

[28] Wynaden D, Chapman R, McGowan S, et al. Through the eye of the beholder: to seclude or not to seclude. Inter J Ment Health Nurs 2002; 11:260-8.

their safety as well as professional practice standards are of concern to the PNA. We broadly welcome the strategy document. In effect, the 18 actions identified in the document are derived from the available literature and tend to focus on three specific stages of the seclusion process; primary interventions which create therapeutic environments that avoid or minimize conflict, secondary interventions designed to immediately respond to and resolve conflict when it occurs and tertiary interventions which are used post restraint and seclusion to mitigate effects, analyse the event and take corrective action. We do note however that

Key findings described in 2009 by a similar Australian Initiative29 found *"The most critical success factor in reducing the use of restraint and seclusion is the commitment of executive-level leadership to this aim. This commitment could be demonstrated in a range of tangible ways including sponsorship, policy commitment, mentoring and redirection of organisational resources to support practice change and systems improvement."*

[29] Victorian Quality Council, & the Chief Psychiatrist and Quality Assurance Committee (2009) Creating Safety Addressing Restraint and Seclusion Practices project report Department of Human Sciences

Which actions specified in Section 2 above would you prioritise for implementation?

Action 1,

The recommendations of the HSE Strategy for Managing Work-Related Aggression and Violence within the Irish Health Service, Linking Service and Safety (HSE, Dec 2008) that relate to seclusion and physical restraint which pertain to this action are Recc's :

- 19 Minimising Physical Interventions,
- 20 Safety of Physical Interventions
- 21 Regulation of Physical Interventions
- 22 Physical Interventions Guidance

Training and education, and regulation are only one part of a broader workforce development strategy that includes clinical supervision, and staff development opportunities.

We (PNA) fully concur with this Action however we feel it should be more strongly worded stating *"The MHC requires updates……*

Action 3 Presently no one is taking responsibility so again we (PNA) concur. We agree as there is currently no one taking responsibility for this. However any manager must have the necessary experience and expertise. We would advocate a role for a Nurse Consultant, Morrsion et al (2002)[30] to drive such a strategy, merely setting targets without resources or training will achieve little.

Action 4 Dublin West / Sth West Mental Health Services have recently developed a useful Seclusion Pathway which provides a template in which clinical details are recorded along with seclusion /restraint details , a useful format for reviewing nursing observations (0-2hrs)(2-4hrs)(4-6hrs),medical review , variance record and post seclusion review. The pathway developed by one of the nursing and medical staff (Ms Olwyn Cranny A/ CNM1) & Dr Sorcha Mc Manus (Registrar) is used in conjunction with the Rules governing the use of Seclusion, R – S69 (2) / 02/2009 Version 2 Addendum January 2011 and Codes of Practice on the use of Physical Restraint October S33 (3) (e) and Dublin West Sth West Policies. It is the view of this union that this innovative and excellent

[30] Morrison E, Morgan G, Bonner G, Taylor C, Abraham I AND Lathan L (2002), Reducing staff injuries and violence in a forensic psychiatric setting, Archives of Psychiatric Nursing, 16, 108-117

template should be considered by the Mental Health Commission for National rollout (please contact the author re details of same).

It should also include a commitment to regular refresher courses and training as part of the vision, philosophy, roles and responsibilities and overtly articulate this. Employing a CNS to advocate for staff and assist their efforts to reduce levels of violence and aggression and advice in methods to reduce seclusion/restraint and identify training and resource deficits on units.

Action 7 Wholeheartedly concur , this call for an exemption should also come from HSE, College of Psychiatrists, NSUE and IAN This is one target that if met could have an immediate impact on the number seclusion/restraint episodes Donat (2002)[31]. Any strategy intending to reduce existence of or remove seclusion rooms form centres, is dependent upon appropriate staffing levels emphasis needs to be placed on ensuring that services can respond to requirements particularly in terms of having sufficient staff to undertake required development of action plans and undertake training

Action 10, We need clarification in relation to this training and its status in relation to professional development for nurses and portfolio development as per the Nurses Act 2011.We have also made a recommendation re training in relation the Undergraduate Review of Nursing and Midwifery. Recommendation 18 **Education and Guidance Training** of HSE Strategy for Managing Work-Related Aggression and Violence within the Irish Health Service, Linking Service and Safety (HSE, Dec 2008) relates to this Action also.

Action 11

We (PNA) recognize the significance and importance of including the patient and family in assessment, treatment, care planning, evaluating and informing practice. However there are often issues in knowing how to adequately effect this partnership approach with reconciling an individual's "personally chosen advance directives in crisis situations" with the actual event or indeed a risk assessment. This action needs to be reworded taking cognizance of the ethics of balancing duty of care with perhaps a chosen advance directive and make suggestions also in relation to an

31 Donat DC (2002), Impact of improved staffing on seclusion/restraint in a public psychiatric hospital. Psychiatr Rehabil J. 25, 413-416

individual's mental state (e.g. pre discharge when addressing approaching the making of the directive)

Secondly the Action is deemed to be the responsibility of the Clinical Directors & Registered Proprietors. Often it is the nurse who is left dealing with that very same advance directive or indeed the patient may request that "no nurse seclude or restrain them ",

Action 12

We recognise the need and personal benefit of peer led directives however the inclusion of advocates into national, regional and local initiatives must be balanced by the inclusion of staff representatives groups.

2. Which actions specified in Section 2 above would you regard as suitable for **medium-term implementation**?

Action 2,

Action 2 concerns peer-to-peer networking. This is difficult to achieve for a number of reasons including staff time and motivation to engage in such activity, reluctance to share information, and no recognised process to facilitate peer to peer networking. It may be useful for the Commission to fund an annual forum for staff to report progress and discuss initiatives found useful in reducing seclusion. This has been effective in other countries such as Australia which holds a National Seclusion and Restraint Forum each year.

Action 5

In relation to 5 (C) we have difficulty with the prescriptive nature of this wording given the Clinical Director and Proprietor is afforded the responsibility of this action and the culture previously outlined whereby seclusion and restraint practices have been traditionally relegated to mental health nurses. The PNA feels that the current 'actions' should be redrafted to promote involvement of the overall treatment team (i.e., multidisciplinary team) in not only decision making around seclusion and restraint use but also in the process itself.

Discuss the role of nursing (DON) in implementing this action

Action 6

As previously stated not without the proper provision of services as articulated per Vision for Change ICRU's etc

As correctly identified on page 20 of the Knowledge Review, the research base for many of the actions proposed is anecdotal in nature or derived from small scale studies, most of which were conducted in countries outside of Ireland. It is worth noting that while this evidence suggests that the strategies identified are likely to reduce the need for seclusion and restraint, none of the studies report that seclusion and restraint was completely eliminated. In 2008, the Government of Queensland (Australia) implemented an ambitious five-year Plan to *reduce and where possible eliminate seclusion and restraint*. However, the Plan is now in its fifth year and not a single seclusion room has been removed from any of the 19 acute inpatient units in that State. This has implications for Action Point 6 which suggests the removal of seclusion rooms from approved centres. Removal of seclusion rooms, in the absence of alternatives, could place mental health staff at increased risk.

Reducing seclusion in psychiatric facilities is complex and often involves the co-ordination of a range of interventions to meet the needs of such organisations and their staff (Gaskin, Elsom & Happell, 2007)[32]. This highlights the need to tailor suites of interventions to suit specific facilities and the client group treated. Services should not be pressured into adapting actions considered useful by the Commission (e.g., eliminating seclusion rooms) but have the freedom to select actions that best suit their service needs.

Action 9,

There is limited flexibility in the system to support this Action and increasing move towards self staffing of units as services contract and staffing levels reduce, whilst this may not be compatible with this Action, perhaps the MHC along with the other interested agencies could make a stronger case in its argument to realise this Action and whilst doing so refer to the

[32] Gaskin CJ, Elsom SJ, Happell B 2007, 'Interventions for reducing the use of seclusion in psychiatric facilities: review of the literature', Br J Psychiatry, 191: 298–303.

dangerously low level of staffing currently in the system cross referencing Action 7 and reference approaches to deal with stress and debriefing mechanisms for staff exposed to working in the one area for prolonged periods.

Action15,

We (PNA) concur with this action

Action16

The reference to a joint MHC / RCSI research programme appears to be a fate acomplis see page 29 of Knowledge review. The implementation requires further examination due to conflicting data see comments in Action 14.

Action17

Note in that the PNA will be recommending a debriefing process also for staff and this could be integrated as part of Action 18. See also PNA comment in relation to Action 14 the employment of a CNS to advocate for staff and assist their efforts to reduce levels of violence and aggression and advice in methods to reduce seclusion/restraint and identify training and resource deficits .

3. Which actions specified in Section 2 above would you regard as suitable for **longer-term implementation**?

Action 8

In Queensland, all staff involved in patient contact have to attend 5 days of ABM (Aggression Behaviour Management) training to be certified. In addition, they must attend one day of refresher training each year to keep their certification. Non-clinical staff (such as ward clerical staff) have to attend 3 days of training. During the restraint/seclusion process all staff work under the supervision of the most senior nurse involved in the seclusion (so long as that nurse has attended the ABM training).

The PNA are of the view that given the dangerously low levels of staffing on the units that it would not be prudent to implement this Action at this time and requires additional training for staff, increased staffing levels to manage clients out of seclusion and the implementation of recovery based approaches. These elements must be in place before this action is approached and in the interim the MHC should perhaps be advocating that all staff be sufficiently trained in emergency response and that at the commencement of each shift if possible one member of the nursing team co ordinates restraint and seclusion issues.

Effective staff patient ratio is a more effective way of reducing seclusion/restraint.

As the MHC has previously exonerated itself from operational issues in service delivery and firmly place that role back on the HSE, the PNA questions if such an Action is in the gift of the MHC to reccomed.

Secondly this action is devolved to the Clinical Director and Proprietor to implement, given that the majority of the constituents of such teams will inevitably be nursing staff the PNA has a difficulty with non nursing professionals making policy decisions which affect the way our members carry out their duties the role of nursing and Executive DON is conspicuous by its absence in the wording of this action, which is not acceptable to this union.

The employment of a CNS to advocate for staff and assist their efforts to reduce levels of violence and aggression and advice in methods to reduce seclusion/restraint and identify

training and resource deficits on units could also investigate the feasibility of such an approach

Action 14

Data International experience suggests that the variation in the use of restrictive interventions between different areas is likely due to a number of factors. These include:

- Differences in seclusion and restraint practice;
- Geographical variations in the prevalence and acuity of mental illness;
- Differences in admission policies with hospitals in some areas treating more acute patients;
- Ward design factors, such as the availability of intensive care and low-stimulus facilities;
- Staff numbers, experience and training;
- The use of sedating psychotropic medication;
- The frequent or prolonged seclusion/restraint of one patient, distorting figures over a 12-month period; and
- Cultural differences among wards and hospitals (Ministry of Health [New Zealand], 2010[33]; Livingstone, 2007[34]; Stewart et al., 2010[35]).

This action needs to provide for the context and circumstances in which the data is being collected Identifying areas with low levels of seclusion/restraint is flawed because it does not prove that these services have made any impact on their levels through procedural changes or approaches and there is significant anecdotal evidence that there are many services in Ireland that have low levels of seclusion/restraint because they export these type of patients to other services which also has the effect of increasing levels of seclusion/restraint in these services.

In addition the Australian research[36] noted that using statewide data sets alone to track the

[33] Ministry of Health (2010), Office of the Director of Mental Health: Annual Report 2010, (Wellington: Ministry of Health

34 Livingstone A (2007), Seclusion Practice: A Literature Review, (Melbourne: Victorian Quality Council and Chief Psychiatrist's Quality Assurance Committee).

[35] Stewart D, Van der Merwe M, Bowers L, Simpson A and Jones J (2010), 'A Review of Interventions to Reduce Mechanical Restraint and Seclusion among Adult Psychiatric Inpatients', in Issues in Mental Health Nursing, 31:413–424 (2010).

site's performance tended to have a demoralising effect on staff unless they were provided with a narrative about the variables that can influence the results. For example, at one site the lack of an adequate high dependency area was thought to influence their seclusion rates. A further site noted that data can help inform team-specific issues, but it only takes one patient to impact on data. For this reason it is important to look at trends over time rather than view month on month data in isolation. They found that the comparison of statewide trends alone is not sufficient to account for practices owing to the variables attributable to each inpatient unit.

We submit therefore that prior to this action being implemented some of the other actions need to occur such as Staff training and support, leadership. The implementation of the HSE Strategy for Managing Work-Related Aggression and Violence within the Irish Health Service, Linking Service and Safety (HSE, Dec 2008).Increased staff to patient ratios, employing a CNS to advocate for staff and assist their efforts to reduce levels of violence and aggression and advice in methods to reduce seclusion/restraint and identify training and resource deficits on units.

The specific needs of the population treated need to be considered. For example, due to their location, some facilities may treat a greater proportion of clients with complex problems (high acuity). As such, some of the 'actions' outlined in the *Draft Strategy* may be more effective in some facilities and not in others. Due to the contraction of inpatient and community services, individuals are often more acutely ill and distressed on admission. It is inevitable where access to care is problematic or delayed, people can be considerably worse by the time they get seen, thus reducing their chances of full recovery and often increasing the possibility of seclusion and physical restraint when admitted. Vision for Change (2006) aspires to move away from reactive services by detailing early intervention approaches and teams , unfortunately these teams are in the minority and therefore the direction of travel culminates in the individual presenting for admission acutely distressed with very often complex problems with multiple

[36] Victorian Quality Council, & the Chief Psychiatrist and Quality Assurance Committee (2009) Creating Safety Addressing Restraint and Seclusion Practices project report Department of Human Sciences

dimensions , (such as substance abuse) accompanied by often very frustrated families and carers.

Action 18

Staff need to feel respected for the care they provide and the sometimes difficult decisions they are expected to make. The process of restraint and seclusion, reviews and feedback may be quite emotive and a 'no blame' culture can lead to improved outcomes.

4. Are there any actions specified in Section 2 that you consider are **not suitable for implementation?**

Action 13

Absolutely reject this Action in the context of previous discussion re data collection and scarcity of resources

An agreed structure for such a formal review would have to be addressed through proper negotiation channels and only having addressed the proper input of resources and the other major components laid out in this submission.

5. Please explain your responses to the above items:

6. Have you any **other comments or suggestions** you wish to make?

Much of the literature supporting the 'actions' outlined in the Draft Seclusion and Physical Restraint Reduction Strategy is derived from studies conducted in adult settings. There is little acknowledgement of differences in the developmental needs of these patient populations. The determinants of emotional distress and aggression may differ between children and adults. In adult psychiatric units, aggression is frequently associated with psychosis (Steinert et al. 2007) In contrast, aggression is typically the most common reason for referral to child psychiatric units. Underlying diagnoses usually include disruptive behavioural disorders and developmental disorders which are complicated by high rates of abuse and neglect (Dean et al. 2007)[37]. These differences influence the reasons why children and adults are secluded and need to be considered more fully.

We (PNA) are of the view that the Strategy document fails to address the specialist approaches required to consider the following populations, .Children & Adolescents, Individual with an Intellectual Disability and Mental Health difficulty, individuals with a mental health difficulty who have been engaging in substance misuse. Due to the lack of appropriate services they may have to be treated in the General Adult Mental Health Services, which is unacceptable in this union's view but unfortunately a reality at times. If the MHC were to promote such a strategy then an overarching comment with regard to the unsuitability of this situation should also be provided

Note comment from Australian Research38:
Project sites reported that scrutinising restraint and seclusion practices invariably led to the identification of systems issues including clinical pathways of community psychiatry, the emergency department and the mental health inpatient unit experience.
The identified actions appear to emphasise leadership roles and responsibilities almost exclusively in ECD's

[37] Dean, A. J., S. G. Duke, et al. (2007). "Behavioral management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit." Journal of the American Academy of Child and Adolescent Psychiatry 46(6): 711-20

[38] Victorian Quality Council, & the Chief Psychiatrist and Quality Assurance Committee (2009) Creating Safety Addressing Restraint and Seclusion Practices project report Department of Human Sciences

and lay managers. For services to progress critical and self assured people are needed and this strategy needs to build in some recognition of the leadership and change which has come and continues to come from Psychiatric Nursing and members of this union PNA. This union foresees any future seclusion reduction strategy will only succeed in requiring clinical directors, registered proprietors, senior managers and psychiatric nurses to create the conditions for improvement, listen to the service user and work as partners in teams.

Health services need to be aware that any restraint and seclusion reduction strategy will require long-term direction and support for a sustained period of at least three to five years to have an impact on the factors that need to be addressed[39].

We concur with the Commission that seclusion may exert counter-therapeutic effects, and that effective alternatives should be identified. However, we remain open to the possibility that predictable, time limited locked interventions may have therapeutic effects when used within a broader behavioural management program. Cleary (a mental health nurse) and Walter (a psychiatrist) conclude from their review of the literature and their clinical experience that *'it appears difficult – and is perhaps unethical- to ignore the judicious use of seclusion as a treatment option'* (Cleary, Hunt & Walter, 2010; p 461)[40].

The PNA urges a balanced approach to the reduction and possible elimination of seclusion and restraint until adequate alternatives are identified and established. This is likely to involve additional training for staff, increased staffing levels to manage clients out of seclusion and the implementation of recovery based approaches. Moreover, there is a need to consider the establishment of medium secure units to cater for those with severe behavioural problems as is currently the case in the UK and Australia.

We have noted the paucity of research in this area, hence the difficulty in making informed decisions. Policy makers will therefore need to rely on expert and anecdotal evidence. The introduction of this

[39] Victorian Quality Council, & the Chief Psychiatrist and Quality Assurance Committee (2009) Creating Safety Addressing Restraint and Seclusion Practices project report Department of Human Sciences
[40] Cleary, M., Hunt, G., Walter, G. (2010). Seclusion and its context in acute inpatient psychiatric care. Journal of Medical Ethics, 36, 459-462.

approach to seclusion and restraint reduction will provide an important opportunity to engage in research that is so clearly needed.

We would like to thank the Mental Health Commission for the opportunity to provide feedback on this Draft Strategy, we also wish to acknowledge those PNA members who formed part of the committee that informed and contributed to this submission