Review of Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint

Section 69(2) Mental Health Act 2001

Review of Code of Practice on the Use of Physical Restraint in Approved Centres

Section 33(3)(e) Mental Health Act 2001

November 2008

PROSPECTUS
PUTTING STRATEGY TO WORK
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Executive Summary

Introduction

The Mental Health Commission, established under the Mental Health Act 2001, is an independent statutory body. Its statutory duties are to promote, encourage and foster high standards in the delivery of mental health services and to take all reasonable steps to protect the interests of those detained in approved centres.

Section 69 of the Mental Health Act 2001 obliges the Commission to make Rules providing for the use of seclusion and mechanical means of bodily restraint on a patient. The Act provides for the use of seclusion and mechanical means of bodily restraint for the purposes of treatment or to prevent the patient from injuring oneself or others.

Section 33 of the Mental Health Act 2001 obliges the Mental Health Commission to: "prepare and review periodically, after consultation with such bodies as it considers appropriate, a Code or Codes of practice for the guidance of persons working in mental health services".

In order to meet the above requirements of Sections 33 and 69, the Commission issued a set of Rules governing the use of seclusion and mechanical means of bodily restraint. An accompanying Code of Practice regarding the use of physical restraint in Approved Centres was also developed. Both the Rules and Code of Practice came into effect on 1st November 2006.

Service providers are most supportive of the use of the Rules and Code of Practice to assist with the delivery of services and ensure that the rights of patients[1] are upheld. The Rules and Code of Practice have clearly clarified a range of previous uncertainties for staff working in Approved Centres.

Methodology

A five-phase methodology was utilised to complete this review process.

Phase	Key Tasks
Phase 1 Project Kick-off	Project set up; agreement of roles, responsibilities and key deliverables.
Phase 2 Literature Review / Policy Analysis	Research of international practice, protocols and policy regarding seclusion and restraint.
Phase 3 Stakeholder Consultation	Key stakeholders were invited to contribute using a combination of: one-to-one interviews, focus groups, questionnaires, written submissions.
Phase 4 Analysis & Synthesis of Information	Based on the findings of Phase 2 and Phase 3, an analysis and synthesis of information was completed.

[1] For the purpose of Section 69 of the Mental Health Act 2001 a 'patient' refers to a person to whom an admission or renewal order relates, a child in respect of whom an order under *Section 25* is in force and a voluntary patient as defined by the Mental Health Act 2001.

Phase 5 Finalise Review Document	Draft documents circulated/presented to the project Steering Group for comments.

Legal Framework, Policy Environment & Literature Review

Section 69 of the Mental Health Act 2001 provides that a person shall not place a patient in seclusion or apply mechanical means of bodily restraint to a patient unless "such seclusion or restraint is determined in accordance with the Rules made by the Mental Health Commission to be necessary for the purposes of treatment or to prevent the patient injuring himself or herself".

When restraining a patient, the medical necessity of restraint must be convincingly shown within Irish law. US case law strongly positions the use of seclusion and restraint as a means of last resort. The current stance as per the Council of Europe is that where seclusion and/or restraint are used, the principles of least restrictive environment / least restrictive intervention must be considered.

The policy environment is presently guided by a *Vision for Change* which sets out the model for the development and delivery of mental health services in Ireland. The *Quality Framework* provides a mechanism to assist services to implement national mental health policy. More recently, *Building a Culture of Patient Safety* outlines a range of recommendations to ensure that the safety of patients and delivery of high quality health and social services are further developed in Ireland.

Findings from the literature review suggest that the training requirements of staff are a crucial element to appropriate service delivery. Training programmes should not be provided in isolation according to best practice. Programmes should be used to equip staff with the necessary range of skills to manage an array of situations. It is important that programmes focus adequate attention on communication and prevention techniques.

The literature review also examines the positioning of seclusion and restraint as interventions of last resort. The majority of authors and experts within the field agree that this positioning is correct and should be maintained. However, there is value in using seclusion over restraint in certain circumstances and as a result each decision to seclude or restrain should be taken on the basis of the case at hand.

A range of interventions to minimise the use of seclusion and restraint are considered in addition.

Key Findings from Consultation

A series of one-to-one interviews, a service provider focus group and written submissions received from stakeholders have all been utilised to support the development of recommendations. Questionnaires were developed specifically for service providers, service users and Mental Health Act Administrators. Given the low response rate from service users, it is advisable to treat the results with a degree of caution as the findings may not be reflective of the views of the broader population that have experienced seclusion and/or restraint since the rules and code came into operation.

The findings suggest that:

- Staff working within mental health services are generally satisfied with the detail included within the current Rules and Code of Practice;
- The Rules "have made things more black and white" for service providers;
- The completion of appropriate training programmes and use of appropriate training providers is an area of concern for current service providers, particularly in relation to physical restraint;
- Staff are unsure as regards the range of approaches that fall within the remit of the Rules governing the use of mechanical means of bodily restraint;
- It is appropriate that seclusion and restraint are positioned as approaches of last resort but consideration of whether to use such approaches and when to use them should be given to each case and decided on the basis of the exact characteristics of the situation at hand. This requires that staff are sufficiently trained to make an informed decision as regards the best means to manage a given situation;
- The retrospective authorisation of episodes of seclusion and restraint does lead to certain challenges at times and has the potential to create difficulties within Approved Centres. In order to alleviate this concern, respondents requested that the responsibility to authorise seclusion and restraint be extended to appropriate nursing staff;
- Additional provisions regarding the use of mechanical means of bodily restraint for enduring self-harming behaviour are necessary and should include details as regards principles for use, review requirements and renewal orders.

Recommendations

Recommendations were developed by Prospectus for consideration by the Mental Health Commission. All recommendations are positioned within one of two categories: those which have direct implications for the existing Rules/Code and those which are related to the Rules/Code but are outside their specific scope. We recognise that the majority of the latter recommendations are outside the remit of the Commission. However, Prospectus recommend that the Commission highlights these findings to the relevant organisations in order to progress these further as necessary.

Recommended Changes to the Rules / Code

Include a broader narrative regarding the use of mechanical means of bodily restraint within the preamble to the Rules. This should include general principles for use as follows:

- The procedure being delivered is professional, based within an ethical and legal framework
- It promotes the safety of service users, staff and visitors as being essential and equal
- Its use is based on a thorough risk assessment
- The procedure should be based on best available evidence and contemporary practice
- Ethnic and cultural awareness and gender sensitivity should be demonstrated throughout its use

The rules should include the following provisions regarding the use of mechanical means of bodily restraint:

- The use of mechanical means of bodily restraint should be subject to a second opinion by a medical practitioner, independent of the Centre where the patient is being treated in cases where it is continued beyond one month.
- Independent reassessment every three months should be completed for all cases.
- A clear plan of care should be completed for all patients to demonstrate how the service is attempting to reduce the use of mechanical means of bodily restraint.

Recommended Changes to the Rules / Code (continued)

Amend the existing Rules / Code of Practice to extend the responsibility to authorise episodes of seclusion, mechanical means of bodily restraint and physical restraint to appropriately experienced and qualified nursing staff

Reconsider the existing monitoring and review requirements regarding the bodily restraint of patients using mechanical means

Part 5 of the Rules pertaining to the use of mechanical means of bodily restraint for enduring self-harming behaviour should be expanded to outline the following specifics:

- Principles for the appropriate use of mechanical means of bodily restraint for enduring self-harming behaviour (as outlined in Recommendation 1);
- Responsibilities of relevant staff regarding the reviewing of patients;
- Timeframes for reviewing of patients;
- Requirement that a case be discussed by the MDT before commencing the use of mechanical means of bodily restraint for enduring self-harming behaviour;
- That if this form of restraint is continued beyond one month then it should be subject to independent review by clinical staff not previously involved with the case nor employed by the organisation seeking the review.

Update the definition of physical restraint to include the term “use of minimal physical force”.

Seclusion and restraint should continue to be categorised as approaches of last resort within the preamble. Consideration must/should be provided on a case-by-case basis as regards what approach best meets the needs of a particular patient.

The preamble should make reference to the following in order to set a more appropriate tone for the Rules / Code of Practice:

- Respecting the rights of the patient;
- Promoting a culture of respect within Approved Centres;
- Acknowledgement that the Rules are there to direct practice but do not purport to be all encompassing.

Initiation of seclusion, mechanical means of bodily restraint and physical restraint should fall within the responsibility of medical and nursing staff only. Rules 2.8 / 14.5 and Provision 2.5 within the Code of Practice should be strengthened to clarify this position.

Specify precisely within the Rules (2.10 / 14.10) and Code of Practice (2.10) that where a patient has capacity and does not consent to next of kin notification, that this right should be respected unless within exceptional circumstances.

The preamble to the Code of Practice should emphasise further the use of proportional and minimal force when using physical restraint.

Where a patient is being restrained, the Rules and Code of Practice should specify that he/she must/should have a same sex member of staff present at all times during the episode of restraint.

Rule 4.2 should be expanded to outline what should be completed as part of the written record.

Amend the definition of “direct observation” within the glossary to recommend that the registered nurse remain outside the immediate view of the patient where possible and practicable.

Amend Rule 4.1 to outline that all patients placed in seclusion be under “direct observation” for hour one and reviewed thereafter according to Provisions 4.2 – 4.5.

Rule 4.3 should be updated to specify that “a minimum of 3 staff members” be included.

Rule 16.1 should specify that the ending of an episode of mechanical means of bodily restraint should be “based explicitly on an assessment of the patient”.

The Code of Practice should specify within Section 7 that the completion of staff training should be mandatory for all staff that may have patient contact. This should include training in the prevention and management of violence (including ‘breakaway’ techniques).

Review Rule 5.3 to determine when additional notification should be forwarded to the Inspector of Mental health Services / MHC regarding the repeated use of seclusion.

Remove the inclusion of “care officer” from Rules 2.8 (b) and 3.1.

Related Recommendations

Monitor developments in international practice regarding the provision of education and training programmes for staff with a view to the future introduction of a national system of accreditation and registration for trainers and training providers.

Consider the implications of extending the remit of the Rules to all persons within an Approved Centre with a view to proposing a change to the Mental Health Act 2001.

Commission or seek support for a specific longitudinal study within Ireland on the following:

- The use of alternative approaches to minimise the use of seclusion and restraint;
- The effects of seclusion and restraint on patients/residents and their treatment programmes.

Introduce a governance framework for service providers based on the over-arching principles for governance and accountability as set out by the Commission on Patient Safety and Quality Assurance.

Explore areas of best international practice concerning service user involvement within review/developmental processes to devise an approach to enhance service user involvement in Irish mental health services.

Enhance links with the Health Research Board and other stakeholders as appropriate to support Approved Centres participation in research initiatives.

The register for seclusion should be updated to include the following fields:

- Precise location of the episode – seclusion room, name of unit and name of Approved Centre;
- Next of kin notification (yes / no);
- New episode or continuation episode;
- Secluded in own clothing (yes / no).

The register for mechanical means of bodily restraint should be updated to include the following fields:

- Precise location of the episode – name of unit and name of Approved Centre;
- Type of bodily restraint used;
- Next of kin notification (yes / no).

The clinical practice form for physical restraint should be updated to include the following fields:

- Precise location of the episode – name of unit and name of Approved Centre;
- Summary details regarding the type of restraint used;
- Details as regards what each member of staff, directly involved in the restraint of the resident, was doing.

Monthly reporting audit procedures should be explored further with Approved Centres to agree an approach that maximises the use of available data.

The Mental Health Commission should devise a template and circulate to all Approved Centres outlining the composition of annual reports on seclusion, mechanical means of bodily restraint and physical restraint.

All registers and clinical practice forms should be accompanied by instructions for completions and a glossary detailing all relevant definitions.

All registers and clinical practice forms should have a unique identification number assigned and recorded by the Mental Health Commission.

Minimum requirements should be developed for the design and specification of all new build seclusion rooms.

Complete an environmental audit of all Approved Centres as part of the annual inspection process completed by the Inspectorate.

1. Background to the Review Process

The Mental Health Commission, established under the Mental Health Act 2001, is an independent statutory body. Its statutory duties are to promote, encourage and foster high standards in the delivery of mental health services and to take all reasonable steps to protect the interests of those detained in approved centres.

Section 69 of the Mental Health Act 2001 obliges the Commission to make Rules providing for the use of seclusion and mechanical means of bodily restraint on a patient. The Act provides for the use of seclusion and mechanical means of bodily restraint for the purposes of treatment or to prevent the patient from injuring oneself or others. The key principle underpinning the use of seclusion and/or mechanical means of bodily restraint is that they shall only be used as a last resort when all other options have been considered and shall not be prolonged beyond the period of time that is necessary for their intended purpose.

Section 33 of the Mental Health Act 2001 obliges the Mental Health Commission to: "prepare and review periodically, after consultation with such bodies as it considers appropriate, a Code or Codes of practice for the guidance of persons working in mental health services". As with seclusion and mechanical means of bodily restraint above, the Code of Practice states that physical restraint should only be used as a last resort and shall not be prolonged beyond the period of time necessary for its purpose.

In order to meet the above requirements of Sections 33 and 69, the Commission issued a set of Rules governing the use of seclusion and mechanical means of bodily restraint. An accompanying Code of Practice regarding the use of physical restraint in approved centres was also developed. Both the Rules and Code of Practice came into effect on 1st November 2006.

The Commission has indicated that it intends to review any Rules and Code of Practice it develops within three years from the date of publication. This is in keeping with international best practice.

The purpose of this review is threefold as follows:

1. To determine **the need to revise** the Rules and Code of Practice based on any new evidence that has come to light since the time of publication of these in November 2006;
2. To assess any **practice issues that may have arisen** since the publication and implementation of the Rules and Code of Practice with a view to possibly updating the Rules and Code based on significant or prevalent practice issues that have presented;
3. To identify any **weaknesses** in the existing Rules / Code of Practice.

In order to complete this review, the Mental Health Commission engaged the services of Prospectus Consultants. Prospectus is a specialist healthcare consultancy with a comprehensive track record in dealing with healthcare clients across the health system. A Steering Group was established (see Appendix 1) comprising a range of representatives from the Commission to support Prospectus throughout the duration of the review.

Prospectus utilised the expertise of Dr Colin Dale to assist this review process. Dr Dale is Chief Executive of Caring Solutions (UK) Ltd, a mental health consultancy company based in the north west of England. Dr Dale is the Joint Violence Project Manager for the National Institute for Mental Health (NIMHE) and National Patients Safety Agency (NPSA) and a Senior Research Fellow at the University of Central Lancashire. In 2006 Dr Dale acted as adviser to the National Patient Safety Agency on mental health, whilst in July 2004 he completed a fifteen month interim Executive Director of Nursing secondment to the second largest mental health and learning disability Trust in the west of England. Also during 2006, Dr Dale was commissioned to write the sections of the Mental Health Act Code of Practice for England and Wales in relation to seclusion and restraint. He lectures nationally and internationally on the management of difficult behaviour in psychiatric services. During the period 1992 to 1999, Dr Dale undertook the role of Executive Nurse Director at Ashworth Hospital Authority. Prior to that he served as a Nursing Development Officer for the Special Hospitals Service Authority and worked directly with the three high security psychiatric hospitals of Broadmoor, Rampton and Ashworth.

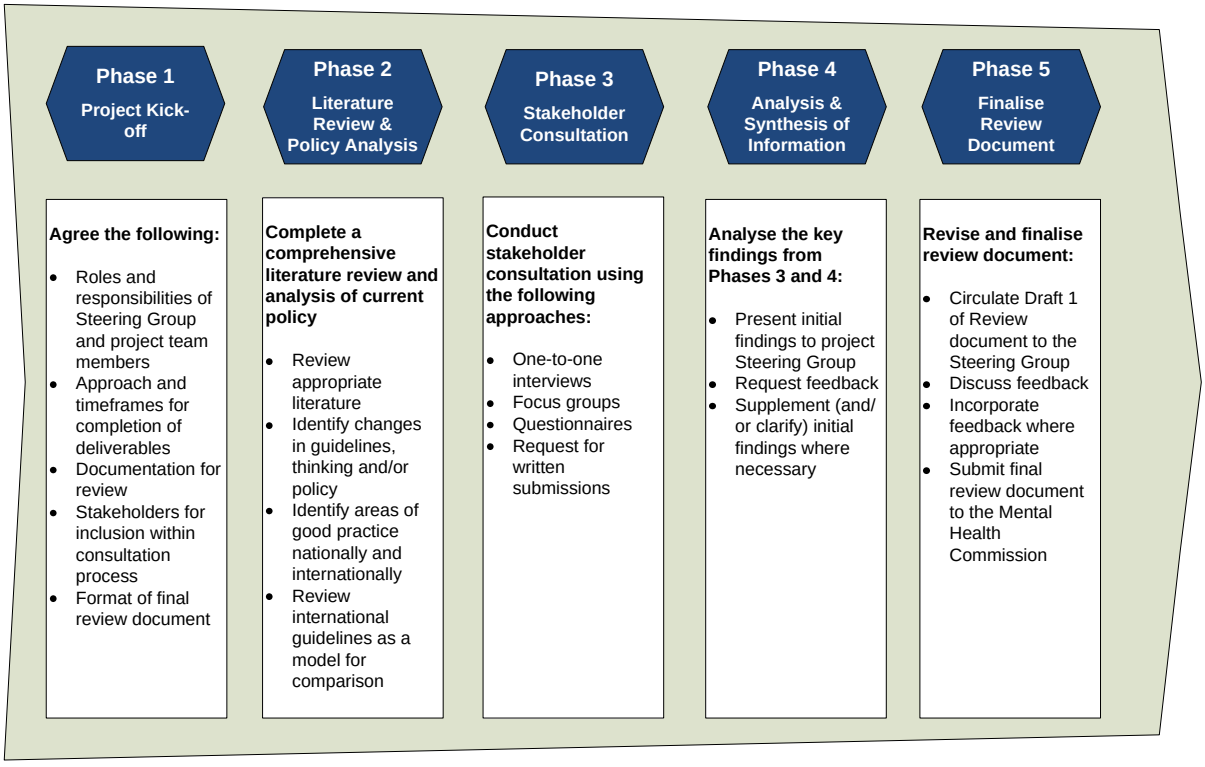
The following section provides a summary of the five-phase approach utilised to complete this review of the Rules and Code of Practice. This was carried out during the period August 2008 to November 2008.

2. Methodology

2.1 Overview

Figure 2.1 below provides a summary overview of the methodology employed to complete this review and the associated sequence of all key tasks for completion.

Figure 2.1 Methodology



2.2 Phase 1: Project Kick-off

A project kick-off meeting was held with the project Steering Group (see Appendix 1) and Prospectus to discuss and agree the following:

1. Roles and responsibilities of the project team, Prospectus and associated external advisors;
2. Approach and timeframes for the completion of all project deliverables;
3. Documentation to include within the literature review;
4. Stakeholders to include within the various consultation approaches;
5. Format of the end product;
6. Project logistics.

2.3 Phase 2: Literature Review & Policy Analysis

International practice, protocols and policy regarding seclusion, mechanical means of bodily restraint and physical restraint were researched to inform the completion of the literature review and policy analysis. All relevant publications of new and updated documents during the period January 2006 to October 2008 were considered. Research studies completed during this period are also included where relevant. Please see Section 3.4 of this document for further details.

The key elements of this phase of the review included:

- A comprehensive review of international literature published, research carried out and policy developments during the period January 2006 to October 2008 inclusive;
- The identification of national/international areas/services of good practice;
- An examination of comparative international Rules and/or Codes of Practice.

2.4 Phase 3: Stakeholder Consultation

The views of associated stakeholders were considered crucial for the completion of this review. The following were targeted and included where appropriate within the various consultation approaches utilised:

- Service users;
- Carers and support groups;
- Mental health professionals;
- Unions and staff associations;
- Professional bodies.

A combination of four different approaches was utilised to gain the views of the above stakeholders:

a) One-to-one Interviews
A total of 13 individuals were interviewed by Prospectus for the purposes of this review. Please refer to Appendix 2 for a full list of those interviewed on a one-to-one basis.

b) Focus Groups
One focus group involving a range of clinicians was held to inform the findings of this review. See Appendix 3 for a listing of those present at this particular focus group. It was the intention of both the Mental Health Commission and Prospectus to hold a focus group involving service users with recent experience of seclusion and/or restraint. Difficulties were experienced in attaining the necessary quorum for this discussion and it did not prove practicable to complete this during the timescale for this review. The Mental Health Commission is committed to continuing to explore options with the National Service Users Executive (NSUE) and may include this as a possible adjunct to the review at a later date.

c) Questionnaires

Three questionnaires were designed and circulated to various stakeholders to capture a further understanding of how the Rules and Code of Practice are currently working and where updates/additions might best be incorporated. Questionnaire 1 was designed specifically for service providers i.e. staff working in mental health services while Questionnaire 2 focussed on service users. The findings from both questionnaires are analysed in Section 4 of this document.

A third questionnaire was designed for the purposes of obtaining feedback from Mental Health Act Administrators regarding the current use of registers, the clinical practice form for physical restraint and other associated documentation.

Please refer to Appendix 5for a copy of the questionnaire templates utilised.

A total of 34 service provider questionnaires were returned. This included the views of 85 staff working within a mental health service in Ireland. In addition, 6 questionnaires were returned from service users with experience of seclusion and/or mechanical means of bodily restraint and/or physical restraint. In relation to the MHA Administrators questionnaire, feedback was received from 16 respondents.

d) Written Submissions

Organisations and associations involved in the delivery of mental health services in Ireland were invited to submit a written submission to the review process. Please refer to Appendix 4 for a list of those contacted. The following organisations utilised this opportunity to return feedback:

- SIPTU;
- Irish College of Psychiatrists;
- An Bord Altranais;
- National Council for the Professional Development of Nursing & Midwifery.

2.5 Phase 4: Analysis & Synthesis of Information

Following the completion of Phases 2 and 3, a synthesis and analysis of all information recorded and attained through the various approaches, as outlined above, was completed. The results of this initial analysis were presented to the project Steering Group at Project Meeting 2. Where clarification or supplementary information was necessary, this was undertaken by Prospectus.

2.6 Phase 5: Finalise Review Document

Outputs from Phases 2 – 4 were utilised to develop a draft review document. This was circulated to the project Steering Group in advance of Project Meeting 3. The final meeting of the project was utilised to agree the precise content of the final review document. Based on the feedback received, Prospectus incorporated comments received from the Steering Group, as it felt appropriate, before finalising the review for the Mental Health Commission.

3. Legal Framework, Policy Environment & Literature Review

The following section of this document outlines the legal framework relevant to use of seclusion and restraint within a mental health setting. The legal framework includes an examination of Irish mental health law and comparative law from other jurisdictions.

Section 3.2 provides an overview of the policy relevant to the provision of safe and high quality mental health services in Ireland.

The key findings of the literature review are detailed in Section 3.4, following a brief summary of the methodology employed to complete this literature review in Section 3.3.

Section 3.5 provides a summary of the key findings from this overall section and highlights the key considerations for the current and future Rules / Code of Practice on the use of seclusion and restraint in Ireland.

3.1 Legal Framework

Irish Mental Health Law

The Mental Treatment Act 1945 legislated for two instances of restraint. This included a provision whereby it was unlawful "to employ a male person in the personal custody or restraint of a female patient" except where the person in charge of the institution adjudges that the urgency of the situation renders it necessary[2]. The second provision detailed that no person may apply mechanical means of bodily restraint to a person of unsound mind unless the restraint was "necessary for the purposes of medical or surgical treatment or to prevent the patient injuring himself or others".

In 1961 the Mental Treatment Regulations provided that seclusion or bodily restraint could not be used except where it is "essential for the safety of the patient or the safety of others and was certified as essential by a medical officer".

Section 69 of the Mental Health Act 2001, which commenced in November 2006, provides that a person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless "such seclusion or restraint is determined in accordance with Rules made by the Mental Health Commission to be necessary for the purposes of treatment or to prevent the patient injuring himself or herself".

According to Reidy (barrister at law), there is an ever growing need for nursing staff to complete training on the medico-legal concepts that impact on their daily interaction with patients[3]. The author contends that few legal challenges could be successfully brought against a healthcare provider and or hospital or approved centre, where (a) the restraint is performed correctly, (b) the patient is monitored carefully throughout the episode and (c) the restraint is used for only as long as is necessary. The author does suggest that not protecting the patient's safety and wellbeing by not using a restraint device/approach when

[2] O'Neill, A.M. (2005) Irish Mental Health Law. Dublin, First Law Limited
[3] Reidy, M (2008). Rights and Wrongs of Patient Restraint. World of Irish Nursing. February 2008, Vol. 16, Iss. 2

such a measure is clinically necessary could result in potential liability for the healthcare provider.

If a court was questioned on whether a failure to restrain could amount to medical or professional negligence, the test applied by the court would be whether the healthcare professional involved breached his/her duty of care to the patient. Consent of the next of kin should also be obtained where possible according to the author.

Herczegfalvy versus Austria, a leading European Court of Human Rights case from 1993 is highlighted by the author. In this particular case, the court ruled that the use of a security bed and handcuffs in order to forcibly administer medication and feeding did breach the threshold of Article 3 of the Convention on Human Rights and therefore constituted inhuman and degrading treatment. The court did hold that where the administration of treatment which was “medically” or “therapeutically” necessary, such an action would not contravene Article 3.

The medical necessity to restrain a patient must be “convincingly shown” to exist before proceeding with a particular restraint approach. The author contends that current systems in place to ensure this is adhered to might prove questionable if a case were to be taken to challenge the lawfulness of the use of restraints in Ireland, particularly in relation to the use of mechanical restraints.

Principles of Restraint and Seclusion in Comparative Law

The Mental Health Act Code of Practice 1999 (England and Wales) contains detailed guidelines in relation to both seclusion and restraint. The Code is not underpinned by legislation. It provides that physical restraint should be used “as little as possible”. The Code further includes that “restraining aggressive behaviour by physical means should be done only as a last resort and never as a matter of course”. Where restraint is used it should:

- Be reasonable in the circumstances;
- Apply the minimum force necessary to prevent harm to the patient or others;
- Be used for only as long as is absolutely necessary;
- Be sensitive to gender and race issues.

In relation to seclusion, the Code specifies that the approach should only be used as a last resort and for the shortest possible time.

US based case law provides that restraint and seclusion may only be used when a person with mental illness could harm himself or others and where there is no less restrictive alternative available to control this danger.

In most Canadian provinces, common law defences of necessity and self defence are relied on to enable the use of reasonable force that is deemed necessary to prevent a patient harming oneself or others.

An exploration of contemporary practice regarding the use of restraint was completed by Paterson in 2006 in light of guidance from the Council of Europe endorsing the principles of

least restrictive environment / least intrusive intervention[4]. In 2004 the Council of Europe adopted the principles of least restrictive environment / intrusive treatment through the Council of Europe Committee of Ministers Recommendation (2004) 10. Article 8 of the recommendations binds member states of the CoE to the principle of least restriction. This requires that: *Persons with a mental disorder should have the right to be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their health needs and the need to protect the safety of others*.

The author contends that when responding to the challenging and dangerous behaviour of persons with a mental disorder, the emphasis must always be on primary prevention but that coercive intervention may not be avoidable in certain circumstances. Within these circumstances, the question of what constitutes the least restrictive / intrusive intervention must be considered. As a lack of comprehensive research exists regarding the perceptions of service users, it is most challenging to develop policy and guidance in this area.

The author further states that "contemporary restraint practice continues to show remarkable diversity reflecting long-standing cultural beliefs that inform judgements as to the reasonableness of least restrictiveness / intrusiveness". As a result, current practice across Europe tends to be largely influenced by tradition and local values as opposed to practice that is evidence- based.

Practice should be informed by an understanding of the relative risk of injury or death associated with the relevant associated approaches. This data is not currently available in Europe but should be managed centrally, similar to the US Joint Commission of Accreditation of Health Care Organisations, through the development of a Europe- wide database of restraint related injuries and deaths.

The Rules governing the use of seclusion and restraint are currently applicable to all persons to whom an admission or renewal order relates, a child in respect of whom an order under Section 25 is in force and a voluntary patient as defined by the Mental Health Act 2001. As a result, the Rules are not applicable to other persons within an Approved Centre under any other form of legislation. This can pose certain difficulties for Approved Centres where patients are admitted/detained in circumstances outside the remit of the Mental Health Act 2001.

3.2 Irish Policy Environment

A Vision for Change (2006)

A comprehensive model for the development and delivery of mental health services in Ireland was concluded in 2006[5]. The framework proposes a holistic view of mental illness and recommends an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems.
The report strongly supports the involvement of service users and their families at all levels of service provision. As a consequence, the report recommends that interventions should be designed to assist the recovery of patients by building on resources available to service

[4] Paterson, B. (2006) Developing a Perspective on Restraint and the Least Intrusive Intervention. British Journal of Nursing, 2006, Vol 15, No 22
[5] Department of Health & Children (2006). A Vision for Change: Report of the Expert Group on Mental Health Policy. Dublin, Stationary Office.

users and within their immediate social networks to facilitate and encourage meaningful integration and participation in community life.

The report recommends that Community Mental Health Teams (CMHTs) should be used to deliver specialist expertise to serve the needs of service users across the lifespan. CMHTs should be self-governed and fully accountable to service users, families and carers according to the recommendations of the report. It is further recommended that CMHTs be established on a regional or national basis to address the complex mental health needs of specific care groups.

The current lack of accurate and timely data to evaluate service provision and ensure service equity is highlighted within the report. Information systems to rectify this are recommended in addition to a recommended increase in the completion of mental health service research. Both developments are necessary in order to improve our understanding of the unique and changing mental health needs of Irish people.

In summary, *A Vision for Change* details an "active, flexible and community-based mental health service where the need for hospital admission will be greatly reduced". Significant investment in mental health services is necessary in order to achieve this transformation. As a result, the report recommends the development of a comprehensive programme of capital and non-capital investment.

Quality Framework: Mental Health Services in Ireland (2007)

A Quality Framework was developed by the Mental Health Commission to provide a mechanism for services to continually improve the quality of mental health services in Ireland. The Framework promotes the utilisation of an empowering approach to service delivery by placing the service user at the centre of service provision. It provides the necessary tools to assist services to implement national mental health policy.

The framework was developed to enable application to all mental health services, regardless of their particular sector and scale. It is also sufficiently flexible to cater for the diverse needs of service users.

The Quality Framework comprises eight themes, 24 standards and 163 criteria. The eight themes are outlined as follows:

1. Provision of a holistic seamless service and full continuum of care provided by a multidisciplinary team
2. Respectful, empathetic relationships are required between people using the mental health service and those providing them
3. An empowering approach to service delivery is beneficial to both people using the service and those providing the service
4. A quality physical environment that promotes good health and upholds the security and safety of service users
5. Access to services
6. Family/chosen advocate involvement and support
7. Staff skills, expertise and morale are key influencers in the delivery of a quality mental health service
8. Systematic evaluation and review of mental health services underpinned by best practice will enable providers to deliver quality services

The Commission believe that attainment of 'buy in' at senior management levels and commitment from associated stakeholders is crucial for successful implementation. In addition, the provision of appropriate resources, effective planning and strong leadership are equally necessary.

The requirement that approved centres comply with the Rules for Seclusion and Mechanical Restraint and the Code of Practice on the use of Physical Restraint is outlined within Standard 2.2 (Service user rights are respected and upheld) of the quality framework. The Rules and Code are stitched into the quality framework and are viewed as the foundations upon which services should build a quality mental health service.

Building a Culture of Patient Safety (2008)

In July 2008 the Commission on Patient Safety and Quality Assurance produced a range of recommendations to ensure that the safety of patients and the delivery of high quality health and personal social services are further developed in a coordinated approach within the Irish healthcare system[6]. The aim of this report was to provide a framework of patient safety and quality which will ultimately lead to effectively governed healthcare facilities, increased involvement of patients and service users in healthcare decision making and the development of local and national leadership with clear accountability and reporting relationships.

The Commission agreed that the vision for the development of a patient safety and quality framework in Ireland should be: "*Knowledgeable patients receiving safe and effective care from skilled professionals in appropriate environments with assessed outcomes*". The values underpinning this framework include openness, patient centredness, learning, effectiveness and efficiency, good governance, leadership, evidence-based practice, accountability and patient/family involvement.

The report recommends that the voice of the patient/service user, carers and family members needs to be integrated into healthcare decision-making. This includes effective listening and engagement regarding the development of policy for service delivery, development and evaluation. The Commission is also of the view that every patient is entitled to open and honest communication regarding his/her healthcare and that every patient should have all the relevant information regarding his/her diagnosis/prognosis, treatment options and the chances of recovery where appropriate.

A clearly defined system of governance and accountability for safety and quality is of crucial importance to achieving the culture and organisational changes required for the achievement of a safe and responsive healthcare system. This involves two critical components according to the Commission: (a) national policy that identifies patient safety and quality as core principles of healthcare delivery and (b) over-arching principles that underpin the development of governance and accountability systems within all healthcare organisations.

The Commission strongly supports the prioritisation of education, training and research on patient safety. All those responsible for the training and continuing professional development of healthcare workers should review the relevant training programmes and ensure that both

[6] Department of Health & Children (2008). Building a Culture of Patient Safety: Report of the Commission on Patient Safety and Quality Assurance. Dublin, Stationary Office.

the appropriate technical and human factors from a patient safety and quality perspective are considered and incorporated within all programmes as appropriate. The report further recommends that systems of lifelong learning and professional development are mandated in order to ensure that all members of the workforce remain competent and appropriately skilled throughout their working lives.

3.1 Literature Review - Methodology

International practice, protocols and policy regarding seclusion, mechanical means of bodily restraint and physical restraint were researched to inform this literature review. All relevant publications of new and updated documents during the period January 2006 to October 2008 were considered. Research studies completed during this period are also included where relevant.

The following databases were utilised to source relevant peer reviewed journals and studies:

- JSTOR;
- Medline;
- PsycINFO;
- BioMED.

A review of available primary literature was also conducted using the Cochrane Social Science Database. Online resources, as provided by various stakeholders (including SIGN, NICE, College of Psychiatrists) were employed to draw on additional information sources. In addition, various internet search engines were utilised to source practice literature.

Key search terms used during this research included: 'seclusion', 'restraint', 'mechanical restraint', 'physical restraint', 'aggression', 'assault', 'violence' 'staff safety', 'patient safety' and 'risk assessment'.

3.2 Literature Review – Key Findings

Introduction

The following literature review provides a summary of key studies and articles completed during the period January 2006 to October 2008. The findings are categorised within themes including training, prevalence, substituting and reducing the use of seclusion/restraint and patient view studies.

The question of including a programme of approaches rather than isolated modules and refresher courses is examined within the discussion on training. A number of options to reduce the use of seclusion and restraint are considered and compared. Seclusion and restraint are generally considered interventions of last resort. This is also examined briefly within the review. As an intervention of last resort, certain alternatives to the use of seclusion and restraint are reflected on. Finally, a summary of relevant patient view studies completed during the period under review is included.

Restraint: Validity, Training and Attitude

Paterson and Duxbury explored how the concept of validity might be interpreted when applied to restraint as an intervention within mental health services[7]. The authors state that if restraint as an intervention is to be considered a valid approach for service providers to use, we must be able to demonstrate that it works. Currently we lack sufficient evidence to answer this question in the opinion of the authors. This is also true in an Irish context as research here is limited, particularly regarding the effects of restraint on a patient or resident.

The authors write that there are "potentially strong arguments in favour of training in restraint as part of wider training in the prevention of violence". Several benefits are associated with the introduction of structured training programmes including an increase in staff confidence, a decrease in the seriousness of assaults / related injuries and a decrease in the level of fear expressed by staff when interacting with patients. However, the authors also outline a number of negative outcomes associated with the introduction of training programmes. This is particularly pertinent where inappropriate training models are imported from non-health services. This tends to lead to an overemphasis on physical intervention according to studies. Furthermore, such programmes typically neglect training interpersonal skills and violence prevention approaches. In addition, the authors state that training staff in restraint procedures consequently increases staff confidence in their ability to manage violence and may encourage them to intervene physically at an earlier stage in the escalation of particular episodes.

The authors conclude that "a programme of multiple activities rather than single isolated interventions such as restraint training" could serve best to manage the complex problem of patient aggression and violence. Restraint reduction initiatives are warranted in the opinion of the authors but it is crucial that restraint is not "driven underground" as such a development would "be the worst of all possible scenarios because something that does not officially exist by implication cannot be supervised or monitored to ensure that maximum safety is assured during its implementation".

The use of restraint will be necessary where the behaviour of service users seriously threatens the welfare of oneself or others and where other interventions are impractical. The lack of clarity and knowledge in terms of what procedures should be / are used; the effect of such procedures on the wellbeing of service users and the risk of injury to service users/providers must be overcome using a nationally coordinated approach according to the authors.

A Dutch study, published in 2008, explored the attitudes of professionals working in mental health services regarding the use of restraint[8]. Specific initiatives have been developed in the Netherlands to reduce the use of seclusion. Despite these, a decreased rate of restraint has not been recorded. The authors developed a specific questionnaire which resulted in the analysis of 540 responses from professionals with experience and expertise in the seclusion of psychiatric inpatients.

[7] Paterson, B., Duxbury, J. (2007) Restraint and the Question of Validity. Nursing Ethics 2007 14(4)
[8] Van Doeselaar, M., Sleegers, P., Hutschemaekers, G. (2008) Professionals' Attitudes Toward Reducing Restraint: The Case of Seclusion in the Netherlands. Psychiatric Quarterly (2008) 79:97-109

A cluster analysis was completed to create a three cluster solution as follows:

a) Transformers
This represented a group of professionals who had little faith in seclusion. Ethical thinking was strongly prevalent within responses received. Individuals within this cluster were strongly in favour of using alternative approaches. Transformers were more often of an older demographic, were more often psychologists and were more often not involved in seclusion as compared to the two other clusters.

b) Maintainers
This cluster rated ethical considerations just slightly more important than confidence in seclusion. The group saw no predominant reason to reduce seclusion, despite some ethical objections. Maintainers were typically in their thirties and most were involved in a seclusion episode on a frequent (monthly) basis.

c) Doubters
This third group were interested in common alternatives but also saw the use and point of seclusion. Doubters were most often younger professionals (under the age of 30), discipline appeared to be a less important consideration and professionals within this cluster were most frequently involved in seclusion.

The results of the study clearly show that while professionals have many ethical questions they are predominantly in favour of continuing to use seclusion as necessary going forward. Seclusion is an appropriate solution in certain situations where a threat to a patient or staff member exists.

The data suggests that professionals have doubts about seclusion at the beginning of their careers, over the course of time their belief in the use of seclusion grows and then as they become older (aged 40 years plus) criticism of seclusion re-emerges. The authors believe that the most likely explanation for this is habituation.

Nature and Prevalence

Foster et al carried out a study to investigate the nature and prevalence of inpatient aggressive behaviour directed at staff and other patients in 2007[9]. This included an examination of the methods used by nursing staff to manage patient self-harm.

Nursing staff located within five acute inpatient wards in one London-based hospital collected data on aggressive incidents using the Staff Observation Aggression Scale. The key findings from the data include:

- 254 incidents of aggression were recorded during the period under review (June 2001 to April 2002);
- Staff were most commonly targeted in these incidents and were involved in 57% of all incidents;
- The most frequent provocation of the aggression (30% of incidents) was the patient being denied something (e.g. leave from the ward);

[9] Foster, C., Bowers, L., Nijman, H. (2007) Aggressive Behaviour on Acute Psychiatric Wards: Prevalence, Severity and Management. Journal of Advanced Nursing 58(2), 140-149

- The most frequent means used by patients was verbal aggression (60% of incidents);
- Verbal interventions were used most commonly (44%) to manage aggressive behaviour;
- When aggression was directed at staff, the most frequently used measures to stop this were talking to the patient (42%) and seclusion (36%);
- When aggression was directed at patients, seclusion of the aggressor resulted in 25% of cases.

The data points to the fact that the majority of aggressive incidents were directed at staff members but when aggression was directed at other patients the risk of physical harm to the intended victim significantly increased. In addition, staff were more likely to use seclusion following aggression directed at staff than following aggression directed at other patients or following self-harm.

The authors conclude that a wealth of previous evidence exists to suggest that staff and patients have very different perceptions regarding the use of containment measures and their function. Training programmes developed to manage and prevent aggressive behaviour within services need to focus on improving methods of communication between staff and patients. The focus of this should be to enable staff to identify adequately the "provoking factors of aggression, recognise the importance of interpersonal factors in provoking such incidents, and thereby reduce the occurrence of aggression".

The frequency and duration of mechanical restraint and seclusion of patients with a diagnosis of F2 ICD-10 (Schizophrenia, schizotypal and delusional disorders) was analysed in seven German and seven Swiss psychiatric hospitals in the year 2004[10]. For the purposes of this study, mechanical restraint was defined as the use of belts to fix a patient to a bed and seclusion was defined as bringing a patient into an empty and locked room without the possibility to leave under one's own free will. 6.6% and 10.4% of admissions were affected by mechanical restraint in Switzerland and Germany respectively. The seclusion rates in Switzerland and Germany were 17.8% and 7.8% respectively.

The results highlight different patterns in the use of seclusion and mechanical restraint across Swiss and German hospitals. In German hospitals more cases were exposed to mechanical restraint, whereas in Switzerland the reverse was true with far more cases of seclusion being recorded.

Restraint and seclusion on a per case basis was on average about three times more common in Germany as compared to that of Switzerland. The duration of an episode of restraint or seclusion was on average about five times longer in Switzerland in comparison to that recorded within hospitals in Germany.

The authors conclude that it is not possible to determine whether clinical practice is better or worse in either jurisdiction. Further research on the use of coercive measures, including the reapplication and duration of these, is advisable. This should include the association of coercive measures with the psychological traumatisation of patients and the security of staff.

[10] Martin, V., Bernhardsgrutter, R., Goebel, R., Steinert, T. (2007) The Use of Mechanical Restraint and Seclusion in Patients with Schizophrenia: A Comparison of the Practice in Germany and Switzerland. Clinical Practice and Epidemiology in Mental Health. 2007, 3:1

Substituting Seclusion for Restraint

A US based study involving a retrospective chart review conducted within an acute adolescent inpatient unit[11] was completed to measure the efficacy of installing a padded seclusion room to decrease the use of mechanical restraints. In the opinion of the authors, mechanical restraints represent a potentially more emotionally traumatic and dangerous intervention than seclusion.

Following the development of the padded seclusion room, the number of monthly mechanical restraint events per 1000 patient days decreased by 93.7% from 21.2 to 1.3. The main finding of this study is that the introduction of a padded seclusion room significantly and consistently reduced the rate of mechanical restraint. The use of the padded room did not increase the time patients spent in seclusion. In addition, it did not increase the summed number of seclusion and restraint episodes.

The data highlights a statistically significant reduction in the rate of mechanical restraint without the rate of seclusion increasing to the same extent. An initial concern existed within the service that the introduction of a padded seclusion room might increase the summed total of seclusion and restraint within the service in question (due to the concern that staff may have viewed the padded seclusion room as a convenient means to de-escalate behaviours without first utilising non-restrictive interventions). This increase did not materialise, nor was there any significant change in the amount of time patients spent in seclusion.

The authors conclude that the use of seclusion or restraint should be interventions of last resort. They add that, in their opinion, there is value in seclusion over mechanical restraint as it is “inherently less dangerous and potentially less emotionally-mentally destructive to patients, their families and staff”. As a result, it is suggested that avoiding mechanical restraint through the provision of safer seclusion facilities is a step in the right direction.

Reducing the Use of Seclusion

Gaskin et al completed a review of peer-reviewed literature on interventions that enable a reduction in the use of seclusion to discover empirically supported interventions that allow such a reduction within psychiatric facilities[12].

The authors examined the following interventions to reduce rates of seclusion:

a) State-level support
   A State Mental Health Authority (SMHA) achieved a reduction in the seclusion rate across 70 institutions within its catchment area by assisting staff to reduce restraint and seclusion through frequent “licensing and contract monitoring visits”. These visits were used to enhance skills in the following:
   - Strength-based care;
   - Individual crisis prevention planning tools;

[11] Larson, T.C., Sheitman, B.B., Kraus, J.E., Mayo, J., Leidy, L. (2007) Managing Treatment Resistant Violent Adolescents: A Step Forward by Substituting Seclusion for Mechanical Restraint? Adm Policy Mental Health 2008 35:198-203

[12] Gaskin, C.J., Elsom, S.J., Happell, B. (2007) Interventions for Reducing the Use of Seclusion in Psychiatric Facilities. British Journal of Psychiatry. 2007, 191, 298 – 303.

- Peer-to-peer support for staff;
- Development of restraint and seclusion ground Rules.

The authors conclude that the reduced seclusion rates appear to have "stemmed from the SMHA providing such support to institutions"

b) State policy and regulation changes
Evidence exists that changes in state policy and regulations can help shape interventions designed to reduce the use of seclusion. The authors provide examples whereby an increased emphasis on having tighter controls on when/how seclusion should be used, a more comprehensive review approach by an independent advocate for patients and the requirement for post seclusion debriefings involving staff and patients can assist to reduce the use of seclusion.

c) Leadership
Chief psychiatrists and community advocates for psychiatric patients play a strong role in influencing the policies and practices of a service and consequently enable organisational change to occur more freely. This is typically achieved using a number of different approaches including the setting of new expectations for staff to reduce the use of seclusion, changing systems of practice to make seclusion reduction a priority and providing staff with the necessary resources to reduce seclusion rates.

d) Examinations of the Practice Contexts
Regular and formalised evaluation tools can assist with the identification of systemic weaknesses that contribute to the use of seclusion within a particular service. The authors suggest that tools such as staff surveys, collecting/analysing baseline data on the use of seclusion, interviews with staff / patients and observations of crisis events within units can play a useful role in helping to develop interventions that can lead to a decrease in seclusion rates.

e) Staff Integration
Increasing the extent of cross-disciplinary collaboration can assist with the reduction of seclusion. The authors refer to a 2003 study that reviewed the effectiveness of an interdisciplinary committee that was established to oversee the development of a programme to reduce the use of seclusion within a given facility. The committee comprised of administrators, counsellors, nurses, physicians, psychologists and social workers. By involving such a range of staff in the process, widespread support for the reform of seclusion and restraint practices was achieved.

f) Treatment Plan Improvement
Enhancing treatment plans can assist in the reduction of seclusion usage. In this particular case, management within a particular hospital established a behavioural consultation team to work with all areas within a hospital to provide input into treatment plans from a behavioural perspective. As a result of input from this team, quality standards for assessing behaviour plans were introduced and assisted in reducing the rate of seclusion within the hospital in question.

g) Increased Staff to Patient Ratios
By increasing the staff to patient ratios, it is possible to provide "more sensitive care" to patients within a service and as a result a safer environment for both staff and patients can be achieved.

h) Monitoring Seclusion Episodes
Analysing available data can be used effectively to detect both general seclusion patterns over a period of time and to identify outlier patients. Patterns typically analysed include inter-hospital comparisons on the use of seclusion, comparison of performance between unit and/or hospital goals and indicators to inform the development of staff education programmes.

An example of using outlier data effectively might involve amending the criteria for reviewing patients with multiple episodes of seclusion or restraint to ensure that patients are subject to review after fewer episodes or less time in seclusion / restraint.

The authors further suggest that reviewing episodes of seclusion / restraint during the actual episode, through the form of observing the behaviours of staff and patients, is a useful exercise to consider. Using data gained from these observations, staff were provided with feedback as regards how the episode was managed and undertaken.

i) Psychiatric Emergency Response Teams
Emergency Response Teams can provide an effective solution to reducing the use of seclusion and restraint within services according to research reviewed by the authors. Staff on such teams must complete additional training to enhance their skills to manage crisis situations and avoid using restrictive procedures when possible. Particular emphasis is given to the use of verbal de-escalation by way of violence prevention skills, therapeutic communication, mediation and conflict resolution.

j) Staff Education
Enhanced training and education programmes for staff, in order to reduce seclusion, formed a central component to much of the research completed by the authors. Education programmes typically focus on one of two different areas:

- The implementation of new models of care
- Alternative behavioural interventions

New models of care tend to involve the development of “high-therapy, low-conflict wards” or collaborative multi-disciplinary problem solving. Alternative behavioural interventions typically involve a combination of components including learning to identify the behavioural indicators of impending violence, collaboration with other team members and verbal de-escalation techniques.

k) Monitoring of Patients
Increased monitoring of patients can be used to assist in the reduction of seclusion and restraint. The authors refer to one particular study whereby the monitoring of patients was increased through the installation of additional CCTV facilities. The findings of this study are not documented.

l) Pharmacological Interventions
The authors excluded all studies where the prime focus was on the evaluation of pharmacological intervention from this research. However the introduction of second generation antipsychotics was alluded to in a range of studies reviewed. One such study highlights the more frequent use of clozapine to control aggressive behaviour.

m) Treating Patients as Active Participants in Seclusion Reduction Interventions
Research exists that psychiatric facilities have enlisted the support of patients to good effect in an effort to reduce the use of seclusion. The staff at one inpatient unit gained support from patients by discussing the goal of seclusion reduction with patients and emphasising the potential positive outcomes from reducing the use of seclusion and restraint within the unit. In a further effort to involve patients and consequently achieve a lower rate of seclusion usage, staff also reviewed therapeutic de-escalation strategies with patients and introduced a reward system for patients based on the number of episodes recorded.

n) Changing the Therapeutic Environment
Making amendments to the therapeutic environment is a common approach to reduce seclusion rates according to the authors. This might involve adopting new therapeutic frameworks to guide practice or shifting the treatment paradigm from one of "staff fear and control to one of patient empowerment and collaborative relationships". In addition, staff have further improved therapeutic environments by increasing the frequency with which they communicated with patients about their needs and their care.

o) Changing the Facility Environment
The option to amend facility environments should also be considered when striving to reduce seclusion rates. This might involve enhancing the physical environment or extending the opening hours of a particular service.

p) Adopting a Facility Focus
By taking a broader look at a service in general, and not simply focusing on reducing the number of seclusion/restraint episodes, it may be possible to attain better results according to one particular study highlighted by the authors. This might involve reviewing how a particular ward/unit currently operates, hosting regular staff meetings to discuss practical issues and using an external facilitator to examine the root causes of particular ward issues. Such approaches can help to decrease the rate of seclusion and restraint within a particular service.

q) Improving Staff Safety and Welfare
A range of approaches, relevant to improving staff safety and welfare, are highlighted by the authors that may assist in the longer term aim of decreasing the rate of seclusion within a service. These include rostering staff between higher and lower dependency units in order to prevent burnout, educating staff further in risk assessment and in techniques for controlling and restraining patients and providing staff with personal alarms.

This review provides a range of evidence that supports the use of interventions to reduce the use of seclusion in psychiatric facilities. However, the authors do contend that it is difficult to assess which interventions are more effective than others. Knowledge in the area of how best to reduce the use of seclusion is limited at present so it is most important that services report where interventions are both effective and ineffective.

A 15-year national follow-up study completed in Finland investigated nationwide trends in the use of seclusion and restraint during the period under review. During this 15 year period, the legislative environment experienced some significant changes with the aim to clarify and restrict the use of seclusion and restraint.

The method utilised for this study involved the collection of data during a predetermined week in 1990, 1991, 1994, 1998 and 2004 from Finnish psychiatric hospitals.

Despite the legal changes implemented, the risk of being secluded or restrained during psychiatric hospital care did not decline over the period under review. The authors report that a rapid deinstitutionalising process has taken place in Finland over the recent past. This has meant that there are now significantly less psychiatric hospital beds in the system. Two other considerations need to be taken into account: (a) The number of patients receiving psychiatric treatment and care did not decrease during this period and (b) The average length of stay of an inpatient did shorten considerably. As a result, the authors contend that it can be assumed "that the patients in psychiatric treatment have become more acutely ill and therefore are more challenging to treat". It is recommended that more knowledge concerning the changes in patients' diagnosis and acuteness is needed.

The data highlights that the duration of seclusion increased threefold during the period under review. The authors contend that this might be "an unintended side-effect of the stricter regulations". The authors add that "when the use of coercion becomes more complicated, patients are not released from seclusion as easily as before because re-seclusion requires more complicated and time-consuming practices of registration".

The study concludes that the reduction of the use of seclusion and restraint can clearly not be achieved solely through systemic measures like the introduction of more restrictive legislation. The authors suggest that educational programmes for staff working within psychiatric hospitals need to be introduced together with legislation to regulate the use of coercive measures.

Alternatives to the use of Seclusion and Restraint

A 2006 Croatian-based study by Margetic et al found that the majority of patients felt that mechanical restraint was "sometimes necessary"[13]. The authors contend that a decline in the use of seclusion or mechanical restraint due to administrative regulation might be dangerous and the reason for increased violence on psychiatric wards.

The authors developed a questionnaire that concentrated on patients' emotional reactions towards the use of mechanical restraints and aggression on psychiatric wards. Data was collected from 71 patients. 86% of patients considered mechanical restraint "sometimes necessary. 59% of respondents felt that mechanical restraint of another aggressive patient reduced their feelings of insecurity.

Of the cohort of patients that had been mechanically restrained in the past, 53% commented that in their case, restraint was (at least once) necessary. 34% of patients had requested mechanical restraint in the past and 38% felt safer during the episode of restraint.

The authors conclude that use of restraints does influence the atmosphere on a ward but that mechanical restraints and seclusion should only be used for the least amount of time possible. Feelings of insecurity among patients in the ward might become the reason for prolonged use of seclusion or mechanical restraint in the opinion of the authors. Therefore inappropriate use of seclusion or restraints could potentially become a feature of a particular

[13] Margetic, B., Aukst-Margetic, B., Matusin A. (2007) Is There an Alternative to Seclusion or Mechanical Restraint? Journal of Clinical Psychiatry 2007;9(3)

unit in order to manage these feelings of insecurity among other patients and such should be avoided.

Research into the use of special observations in both forensic and non-forensic psychiatric settings was completed by Whitehead and Mason in 2006 using a comparative approach to establish if the perceived risk factors leading to the adoption of special observations were similar in both settings[14]. Special observations are predominantly undertaken as an alternative to seclusion and / or restraint techniques.

Nursing staff were requested to undertake the rank ordering of factors that they considered to be the most important in undertaking a risk assessment of psychiatric patients requiring special observations. They also completed an assessment of all patients who had been placed on special observations. Three different settings were used to complete this research:

1. A medium secure forensic psychiatric unit: a locked state of the art, purpose built secure unit;
2. A low secure forensic psychiatric unit: a locked ward within a general psychiatric facility;
3. A non-forensic unit in a general psychiatric hospital: an open ward with general psychiatric facilities.

Staff ranked assault and the threat of assault within the first two major risk elements across all three locations. This is unsurprising in the opinion of the authors as “assault and threat of assault are considered of highest concern in psychiatric settings, both forensic and non-forensic”. The next three major risk factors in the rank ordering, as completed by nursing staff, all referred to the physical integrity of the patient and included suicidal intent, self-injury and the threat of self-injury.

The evidence from this study suggests that both forensic and non-forensic settings are similar in the identification of risk factors but that there is a clear difference in the scores relating to the nurses’ perceptions of the risk factors leading to the implementation of special observations.

Staff within the forensic group were more likely to use special observations because of their perceived risk of danger and/or violence to self or others than their counterparts in the non-forensic group. This has implications for the training of nursing staff working within a forensic psychiatric setting, in the opinion of the authors, as clearly they need a high level and range of skills and competencies to complete risk assessments and clinically engage with such patients.

Patient View Studies

The Commission for Social Care Inspection (UK) completed a study of people’s views and experiences of restraint to gain a greater understanding regarding the use of restraint in the care of older people[15]. The report aims to highlight that the balance between keeping people

[14] Whitehead, E., Mason, T. (2006) Assessment of Risk and Special Observations in Mental Health Practice: A Comparison of Forensic and Non-Forensic Settings. International Journal of Mental Health Nursing 2006, 15, 235-241
[15] Commission for Social Care Inspection (2007) Rights, Risks and Restraints – An Exploration Into the Use of Restraint in the Care of Older People

safe and respecting the rights of people is not just a matter for staff alone to resolve. This is a broader human rights issue where government, regulators, commissioners and care providers all have responsibilities.

Restraint was generally understood by older people as "stopping people from doing what they want or doing things against their will".

Staff were also consulted as part of this study and presented some interesting findings:

- 80% of respondents thought restraint could be justified in exceptional circumstances;
- 59% thought restraint infringed human rights;
- 63% stated that a restraint-free policy would serve as a "good approach".

The Commission concluded that clarity on the associated policy and guidelines regarding what constitutes restraint and how the rights of older people are respected is necessary. Appropriate training for all care staff is also currently lacking and needs urgent attention according to the report. The over arching recommendation stresses that appropriate resources and working conditions should be available in order to enable staff to provide the highest quality of care on a day-to-day basis.

A qualitative study completed to explore and describe the experiences of psychiatric in-patients who were secluded within a specific hospital in Lesotho concluded that the implementation (within this specific setting and context) appeared to be divorced from the treatment intent for seclusion "as a means to reduce disruptive stimulation and provide the client with a contained well-defined space for reassurance and protection"[16]. At the time of conducting this study, mental health legislation in Lesotho did not specifically address seclusion of psychiatric in-patients.

The authors write that the "basic physical, psychological, interpersonal and spiritual dimensions of care and treatment of patients before, during and after seclusion were not effectively adhered to". This resulted in patients experiencing feelings of humiliation and a range of negative emotions.

The views of service users undergoing physical restraint procedures in secure units within the UK were explored by Jones and Stenfert Kroese in a 2007 study[17]. Ten in-patients with mild learning disabilities from two secure units were interviewed. All patients were detained as per the Mental Health Act 1983 and had been restrained once in the previous six months.

The main findings included:

- All 10 interviewees explained restraint as "a process involving restriction of someone's movement";
- All 10 interviewees described restraint in the form of a purposeful goal and related it to physical protection to help prevent people getting hurt. Interviewees alluded to self harm and the protection of staff;
- 50% of those interviewed felt it helped one to calm down. The remaining 50% inferred that restraint made things worse;
- When queried on potential alternative approaches, all alluded to greater communication and/or the use of medication.

[16] Ntsaba, G.M., Havenga, Y. (2007) Psychiatric In-Patients' Experience of Being Secluded in a Specific Hospital in Lesotho. Health SA Gesondheid. Vol. 12, No. 4 - 2007

[17] Jones, P., Kroese Stenfert, B. (2007) Service Users' Views on Physical Restraint Procedures in Secure Settings for People with Learning Disabilities. British Journal of Learning Disabilities 35(1), 50 - 54

- Four participants felt they had experienced abusive restraint procedures;
- Three participants stated that they were not spoken to / ignored by staff members after the episode of restraint. Two participants stated that they had a "positive interaction" with staff after the episode of restraint.

3.5 Conclusion and Implications for the Existing Rules / Code

This section provides a summary of the key findings from the legal framework, policy environment and literature reviews. Items highlighted in bold are included within the Prospectus recommendations.

Legal Framework

When restraining a patient/resident, the medical necessity of restraining a patient must be convincingly shown, as outlined by Reidy. The author contends that current systems might not be sufficiently developed to meet this requirement and as a result may be open to legal challenge.

US case law clearly positions the use of restraint and seclusion as a means of **last resort**. This positioning is also reinforced by the UK Code of Practice (1999).

The stance of the Council of Europe regarding the use of seclusion and restraint acknowledges that the use of these approaches will be necessary within healthcare services but that, where and when this is the case, the principles of least restrictive environment / least restrictive intervention must be considered. In order to assist this, practice should be informed by an understanding of the relative risk of injury associated with the relevant approaches. This has **training and research implications for service providers**. The application of all approaches should be initiated on the basis of informed practice derived from research completed in the area and supported by comprehensive training programmes.

The Rules governing the use of seclusion and restraint are currently applicable to persons to whom an admission or renewal order relates, a child in respect of whom an order under Section 25 is in force and a voluntary patient as defined by the Mental Health Act 2001. The Rules therefore are **not applicable to any other persons within an Approved Centre**. This continues to pose difficulties for some service providers and is an issue that may need to be further reviewed by the legislators.

Policy Environment

A Vision for Change sets out the model for the development and delivery of mental health services in Ireland. It provides a comprehensive 10-year mental health policy framework for Ireland and recommends on how services should be organised across the entire community. A holistic view of mental illness is considered and used to inform the development of an integrated multidisciplinary approach to addressing the myriad of factors that contribute to mental health problems. Special emphasis is given to the need to involve service users and their families at all levels of service provision.

The *Quality Framework* provides a mechanism for services to continually improve the quality of mental health services in Ireland. The Framework places the service user at the centre of service provision and provides the necessary tools to assist services to implement national mental health policy.

Building a Culture of Patient Safety includes a range of recommendations to ensure that the safety of patients and the delivery of high quality health and social services are further developed in Ireland. The report outlines a framework to support patient safety and the delivery of high quality services. **Effective governance systems** and the **increased involvement of patients and services users** are two main goals of the framework. The report strongly supports the prioritisation of education, training and research as a means to achieve the ultimate goal of higher quality service provision.

Literature Review

A range of common themes emerged from the literature review. In particular, the issue of **training requirements for staff** is prominent. Research is rather limited, however, as regards the effects of restraint on a patient/resident and consequently a means to compare and contrast approaches is restricted. The review of literature also suggests that patterns in the use of restraint and seclusion tend to differ significantly between jurisdictions.

Training in communication and prevention is prioritised and considered as important as the act of restraint itself. A focus of all training programmes should be to enable staff to identify the source of aggression and violence of a given situation. This will then allow staff to react using a more appropriate and informed means in order to contain and/or de-escalate situations where the threat of violence exists.

Based on the findings of Paterson and Duxbury, a strong suggestion is included that training should comprise a programme of multiple activities rather than updates on single isolated interventions on an intermittent basis. Using this more comprehensive method, staff will be better positioned to assess a situation and make an informed choice as regards what approach would work best given the precise circumstances of the situation at hand. Alternative behavioural interventions, including the identification of behavioural indicators of impending violence, team collaboration approaches and de-escalation techniques should all be included within any training programme developed. This is best delivered on a nationally coordinated basis in the opinion of the authors.

The Commission for Social Care Inspection (UK) concluded as part of their 2007 study of people's views/experiences of restraint that appropriate training for all care staff working in services for older people is currently lacking and immediately necessary.

Larson et al examine the issue of substituting seclusion for restraint. Both should remain **interventions of last resort** in the opinion of the authors but they do contend that there is value in using seclusion over mechanical restraint in certain circumstances as the former is "inherently less dangerous and potentially less emotionally-mentally destructive". As is outlined later in this document, this view is supported by a proportion of Irish stakeholders consulted with during the review process. Interestingly, the review also points to the suggestion that habituation is a strong influencing factor when considering the use of seclusion.

Gaskin et al provide a summary of a range of **interventions commonly used to reduce rates of seclusion**. Policy and regulations are regularly devised as a means to control the use of seclusion but can clearly not be used solely to reduce the use of seclusion and restraint. Education and training programmes for staff working have a key role to play in this respect. The authors also point to the use of care plans in order to reduce the usage rate. Input from multidisciplinary teams from a behavioural perspective, when formulating plans, can assist staff to manage situations from a more informed basis and consequently reduce the need for seclusion. The role of individual care planning should be utilised to its maximum potential as a result. Gaskin further suggests that by **analysing patterns of the use of seclusion**, much can be learned. This can assist service providers to understand better why and when episodes of violence and aggression can be triggered. With this increased understanding, services are better equipped to introduce effective prevention methods.

Various sources also suggest that there should be greater opportunities for the involvement of staff and service users regarding the development of policies and procedures on the use of seclusion and restraint.

In summary, the key suggestion from the literature review is that appropriate training for staff is vital for the effective use of approaches to de-escalate and manage episodes of violence and aggression. A number of interventions are commonly utilised but staff must be appropriately trained in order to effectively use these in everyday situations.

4. Consultation Key Findings

As outlined in Section 2 of this document, this review comprised of the following consultation approaches:

- **Service Provider Questionnaire**
- **Service User Questionnaire**
- **Mental Health Act Administrators Questionnaire**
- **One-to-One Interviews**
- **Service Provider Focus Group**
- **Written Submissions**

Section 4.1 provides a summary of the key findings derived from the service provider questionnaire. A total of 34 questionnaires were completed and include the views of 85 staff. This provides an examination of Approved Centres that currently use seclusion and restraint and those that do not.

Section 4.2 summarises the key findings from the service user questionnaire. A total of six questionnaires were completed and returned.

Section 4.3 details the relevant findings from the questionnaire completed by Mental Health Act Administrators. Mental Health Act Administrators are primarily responsible for the collation of data for reporting purposes to the Mental Health Commission. A total of 16 questionnaires were completed and returned.

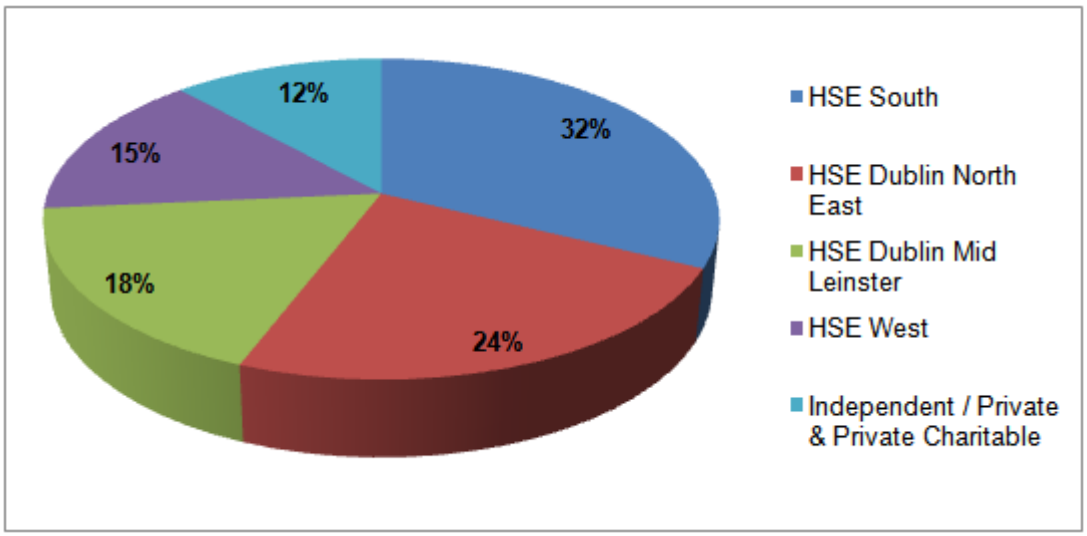
Section 4.4 includes a summary of significant findings obtained from the one-to-one interviews completed, the service provider focus group and the written submissions received.

4.1 Service Provider Questionnaire

A total of 34 questionnaires were submitted by staff working within mental health services in Ireland. The views of 85 staff are included within this consultation approach. Of the questionnaires returned by service providers, 88% of respondents currently work within a centre that utilises seclusion. Regarding mechanical means of bodily restraint, only 24% of questionnaires were completed by staff that currently use this form of restraint. 94% of respondents stated that the centre they currently work within uses physical restraint.

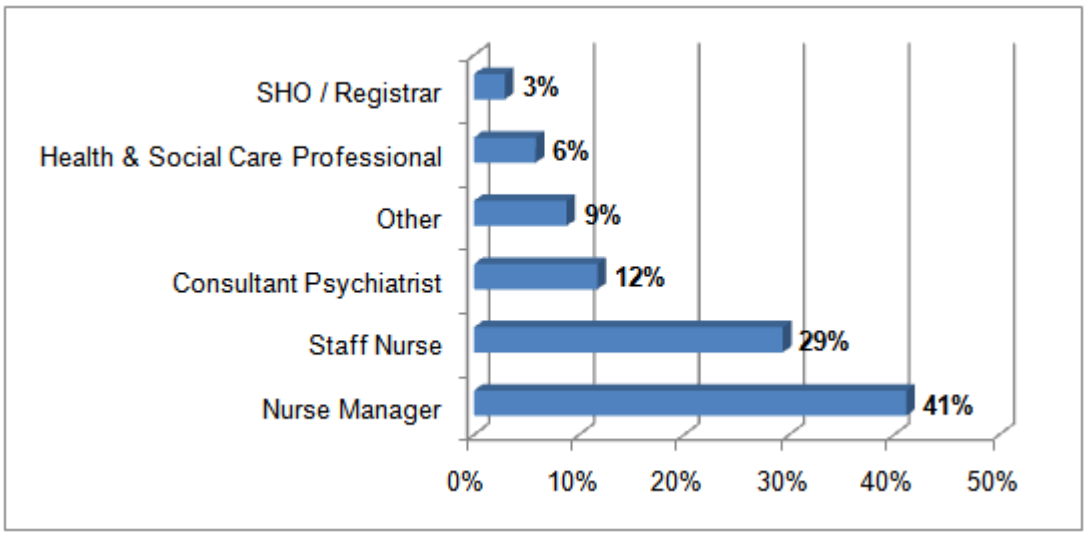
Figure 4.1 below provides an overview of the area that respondents currently work within. 36% of respondents currently work within Centres with a bed count of between 26 and 75 beds. 27% of respondents work in a centre with 76 beds or more.

Figure 4.1 Respondents by Service Type/Location



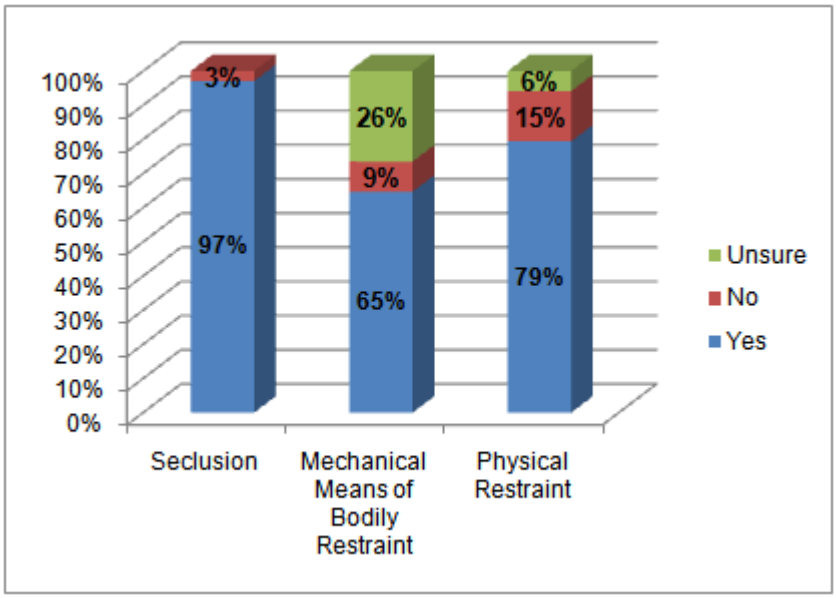
70% of all questionnaires returned were completed by nursing staff. This includes both staff nurses and nurse managers. Consultant Psychiatrists accounted for 12% of all returns. Figure 4.2 below provides a full overview of respondents.

Figure 4.2 Respondents by Profession



Key findings from the questionnaire include:

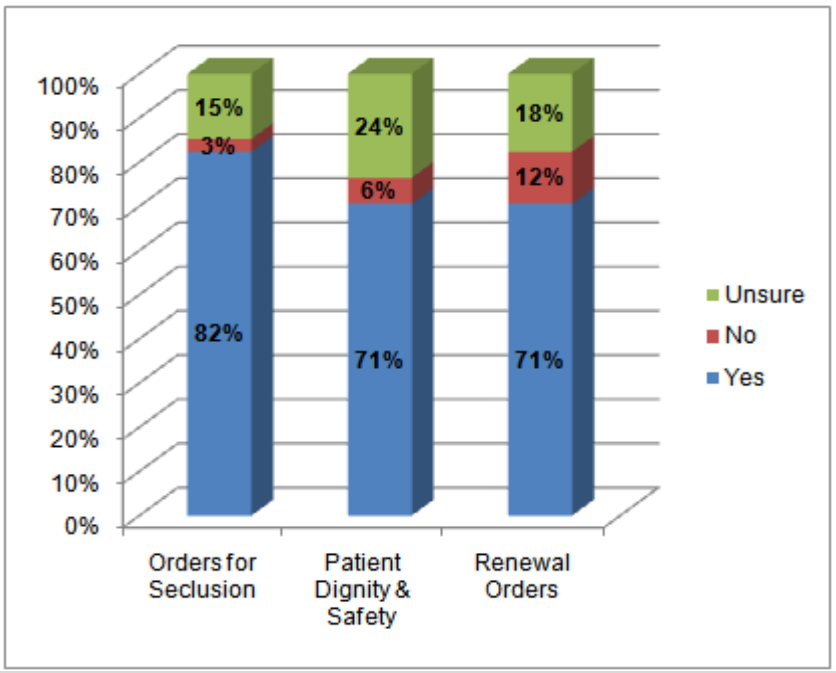
1. Are you satisfied that the current definitions for the following remain appropriate:



A large degree of uncertainty and/or concern surrounds the definition currently being utilised for mechanical means of bodily restraint. In excess of one in every four respondents are "unsure" as regards the current definition. A further 9% of the total respondents are dissatisfied with the definition, with the main criticism being that it is not prescriptive enough and should be supplemented with a list of what is included / excluded.

In excess of one in every five respondents would like to see the definition regarding physical restraint amended. Suggested changes included adding the provision that *minimum* physical force be used and also that the definition should include a commitment to respect the dignity of the resident at all times. Almost all respondents felt that the definition regarding seclusion is appropriate.

2. Do you think that the current provisions in the Rules governing the use of seclusion in relation to the following remain appropriate:



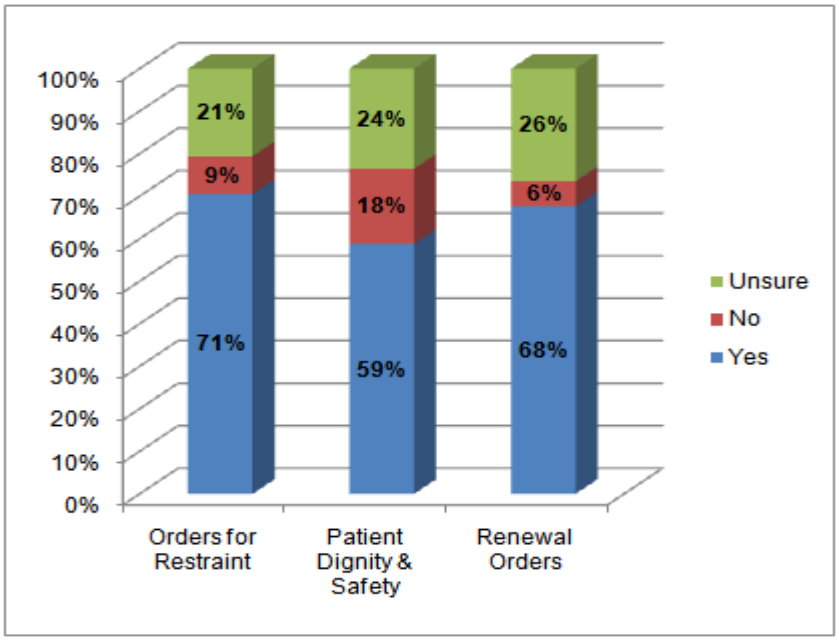
82% of respondents felt that the level of detail included within the Rules pertaining to seclusion orders is appropriate. There are certain concerns regarding the authorisation of seclusion where the emergency Rules were applied. Primarily this concern relates to the requirement that a registered medical practitioner authorises the episode in writing despite having not witnessed the actual sequence of events.

71% of respondents were

satisfied that the provisions governing patient dignity and safety are appropriate, 20% are "unsure" as regards the current provisions but did not take the opportunity to elaborate on their current concerns.

71% of respondents feel that the specification regarding renewal orders is appropriate. Respondents did document some concerns in terms of the repeated use of seclusion. It is not necessary to notify the Inspector of Mental Health Services of the repeated use of seclusion where the patient has not been secluded continuously for 72 hours. In the interests of patient protection, it would be advisable to reconsider this current limitation.

3. Do you think that the current provisions in the Rules governing the use of mechanical means of bodily restraint in relation to the following remain appropriate:



71% of respondents felt that the level of detail included within the Rules pertaining to orders for bodily restraint is appropriate. All respondents that currently use this form of restraint, were satisfied that the necessary level of detail is present.

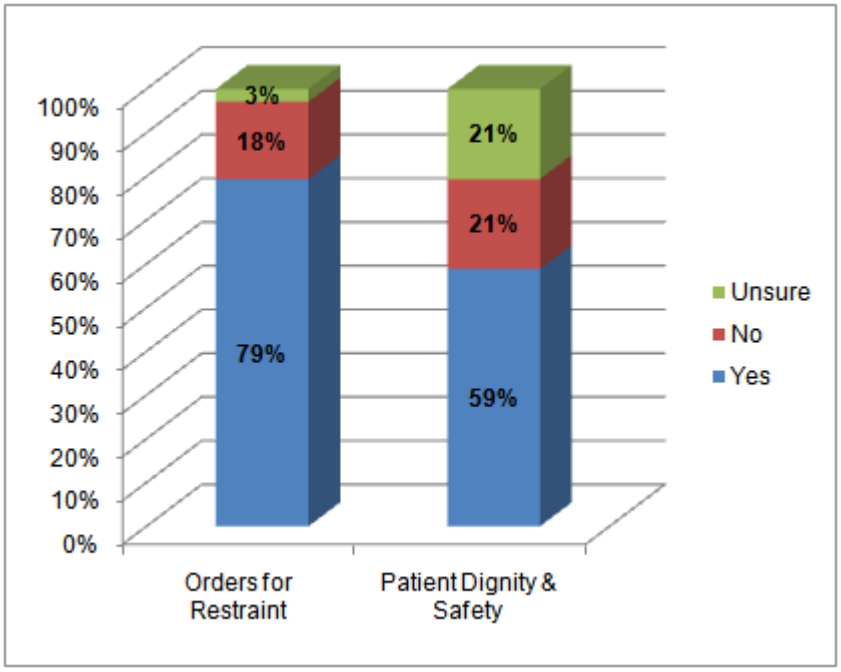
59% of respondents are satisfied that the provisions governing patient dignity and safety are appropriate, the remaining 25% are "unsure" as regards the current provisions. When looking precisely at responses received from service providers that currently use this form of restraint, the level of satisfaction increases to 75%. A frequent concern of respondents was that patients, when being restrained, should have a same-sex member of staff present at all times during the initiation of the episode. Respondents also requested that the requirement that patients be "continually" assessed by defined in line with the type of timeframes provided within the Rules governing seclusion.

68% of respondents feel that the specification regarding renewal orders is appropriate. All respondents from centres that utilise mechanical means of bodily restraint felt that the level of specification is appropriate and sufficiently detailed.

The comparison between the questionnaire findings from Approved Centres (24% of completed questionnaires) where mechanical means of bodily restraint is currently used and the findings from the general population (i.e. all those who completed the questionnaire including those who may not use this form of restraint) deserves further consideration. The findings suggest that, where this approach is currently used to restrain patients, typically, staff are familiar with and satisfied with the associated provisions. However, where staff are

not using this form of restraint many are not familiar with the Rules and remain unsure as regards the suitability of the content. The situation is compounded further by feedback from staff that suggests that Approved Centres were influenced by the alleged lack of clarity within the Rules and consequently took the decision to adopt a policy of not using mechanical means of bodily restraint.

4. Do you think that the current provisions in the Code of Practice on the use of physical restraint in relation to the following remain appropriate:



Of the 18% of respondents that stated that they are not completely satisfied with the provisions regarding orders for restraint, half of these respondents would like to see guidelines introduced on the maximum duration permitted for an episode of physical restraint.

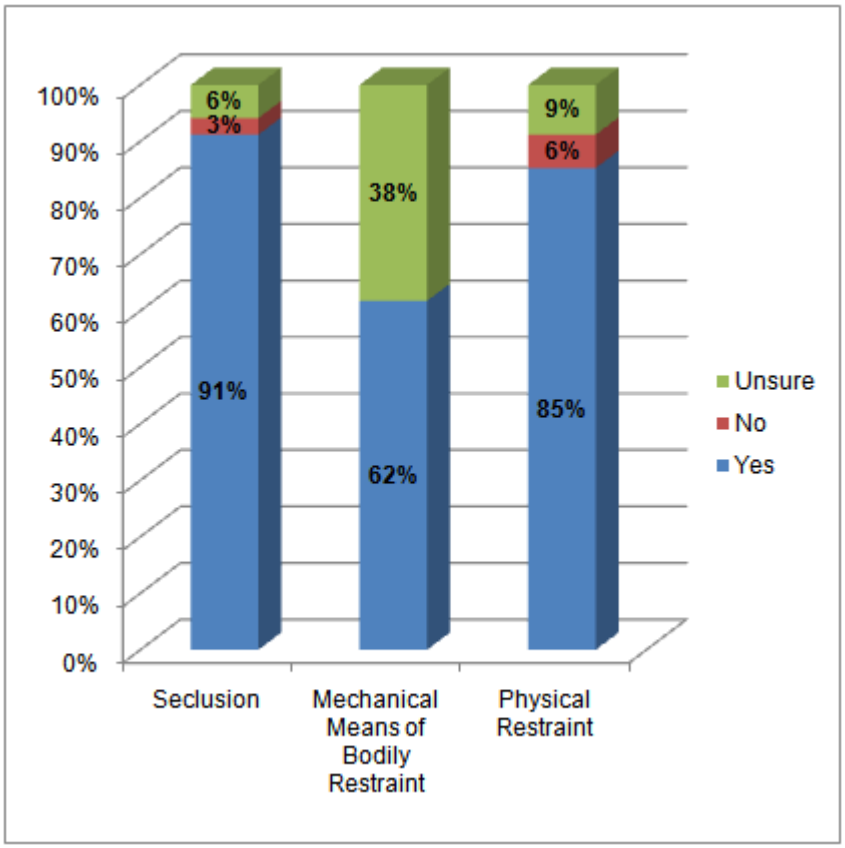
6% of respondents feel that the 3-hour window for the examination of a resident might best be shortened. Ideally respondents would like to see this examination completed within hour one.

Clarity would also be useful as regards the precise meaning of the guidance that a resident be "continually assessed" as per Section 3.3 of the Code.

The necessity of including Section 3.4, and specifically the phrase “intended to deliberately inflict pain” was questioned by respondents. The phrase in question may lead to concern amongst residents and/or their family/relatives.

When restraining a resident, respondents would favour the inclusion of a requirement that a same gender staff member be present for the duration of an episode. This is most important when a female resident is being restrained, in the opinion of respondents.

5. Do you feel that the Rules / Code of Practice are sufficiently prescriptive in terms of the level / form of communication between the patient / resident and relevant staff members both before and after the following:

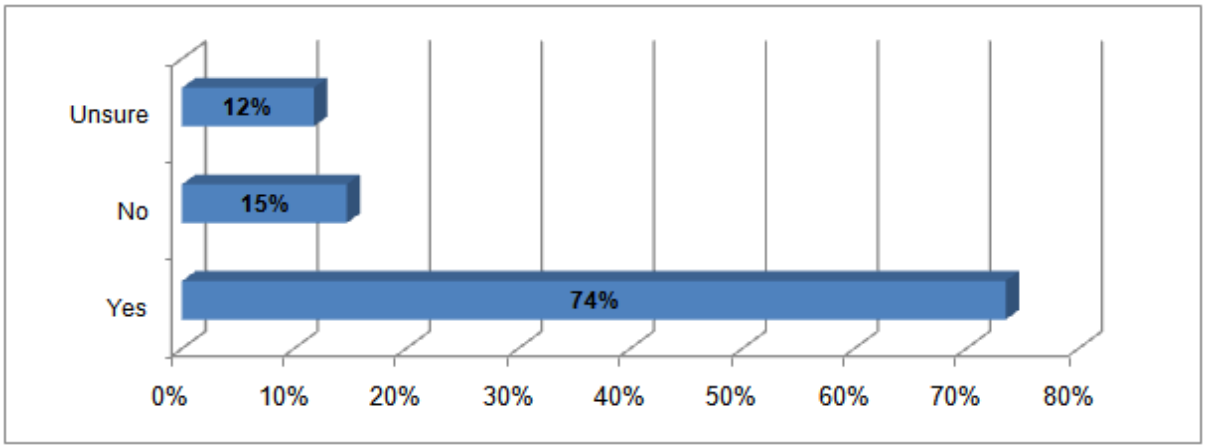


91% of respondents are satisfied that the level and form of communication required by the Rules when secluding a patient is appropriate. This falls to 85% in relation to physical restraint and 62% regarding mechanical means of bodily restraint.

In the case whereby a patient is in the process of being restrained or secluded, informing him/her of the likely duration of the episode is not always possible or appropriate. For certain patients, this information can exacerbate the situation further and needs to be treated with caution in the opinion of respondents.

The Rules and Code of Practice include the provision that this information should be provided "unless the provision of such information might be prejudicial to the patient's mental health". This specification does not appear to be fully understood by staff based on feedback received.

6. Are you satisfied that the timeframes for monitoring patients in seclusion and designated responsibilities of particular professionals in this regard are appropriate:

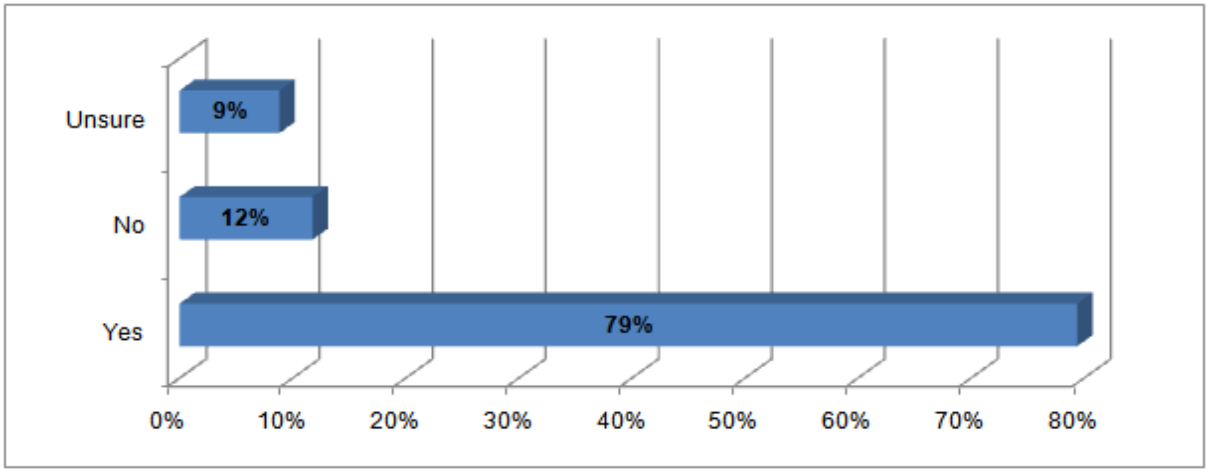


Approximately three out of every four respondents felt that the current timeframes are appropriate. There are two areas that require clarification in the opinion of staff. These include:

a) The scope of the nurse and medical review should be clarified further in the Rules (this should also include the 15 minute record). What exactly needs to be completed as part of these review processes? It was queried by respondents whether a specific risk assessment tool should be developed with assistance from the Commission.

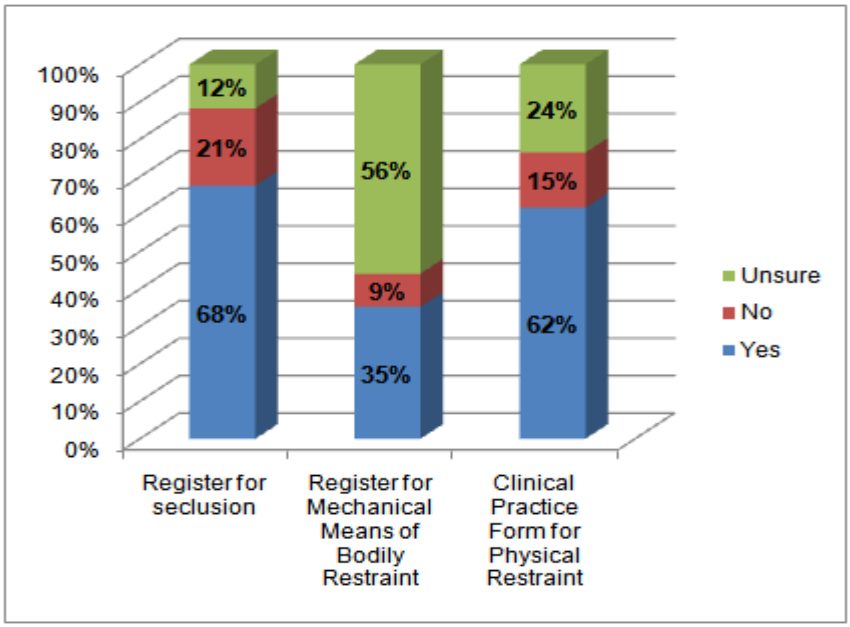
b) Rule 4.1 is being interpreted differently across Approved Centres. Respondents suggested that all patients should be under "direct observation" (as per the definition within the glossary - but this should not require that a nurse stand over the patient, preferably he/she would remain within sight and sound of the patient without being in their direct view) for 'hour one' and that patients should be assessed thereafter as per Rules 4.2 to 4.5.

7. Do you think that the specification for seclusion facilities included within the Rules is adequate?



In general staff are very satisfied that the level of detail provided in relation to seclusion facilities is appropriate. Respondents who were dissatisfied stated that they would like to see some additional provisions to guide service providers in terms of the design and specification of facilities. This should include guidance on room size, features to include within the seclusion room and recommended access arrangement to toilet facilities.

8. In your opinion, do the following capture all essential information requirements:

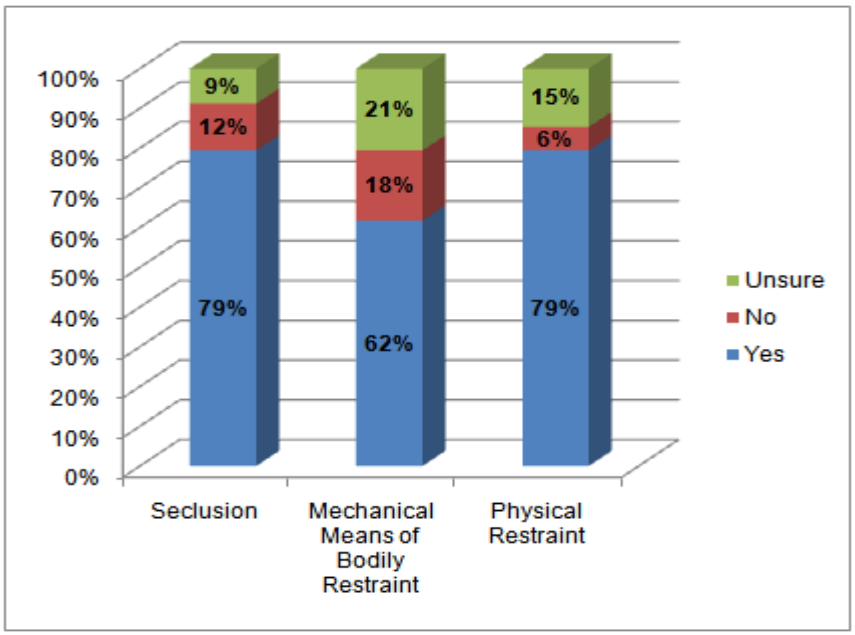


68% of respondents are satisfied with the existing Register for Seclusion. Respondents would favour the differentiation of renewal and new episodes within the register.

35% of respondents (50% from Centres that currently use mechanical means of bodily restraint) are satisfied with the information recorded in the associated register. The majority of criticisms forwarded relate to the range of information recorded regarding the type of restraint. Respondents would like to see the register being far more prescriptive in this regard.

Criticisms of the clinical practice form for physical restraint closely mirror those made in relation to the register for mechanical means of bodily restraint. Sufficient information as regards the type of restraint used and the role of staff members present is not recorded, in the opinion of respondents.

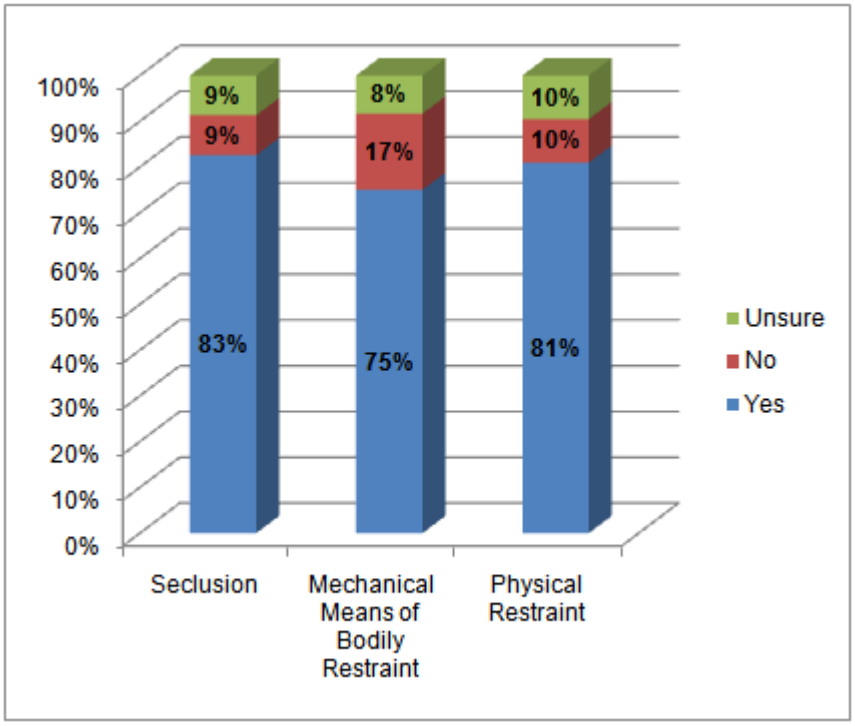
9. Does the Approved Centre within which you currently work have a written policy (including the provision of information to the patient) in relation to the following:



79% of respondents (87% from Centres that use seclusion) stated that they have a written policy in place regarding the use of this approach. 12% of respondents do not have a policy in place, with a further 9% "unsure".

62% of respondents (75% from Centres that use mechanical means of bodily restraint) reported that they have a written policy in place.

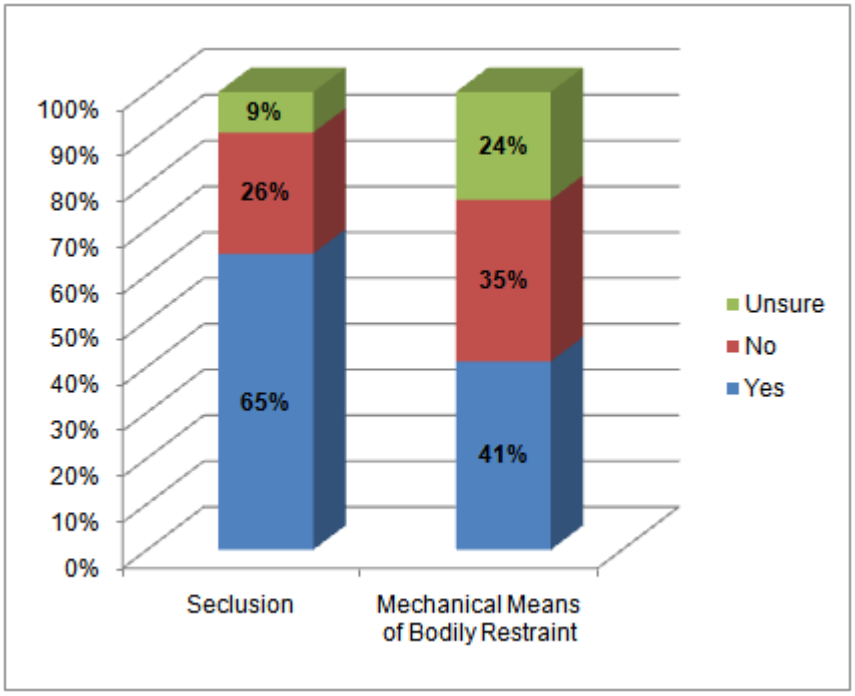
10. In your opinion, are these policies well understood and adhered to:



*Findings only relate to where Approved Centres had a policy in place as per (i) above

Respondents generally commented that this was based on their experiences of working with colleagues as opposed to any formal approach of testing the understanding of a policy in place. It is useful to involve staff in the development of policies as a means to gain understanding and subsequent adherence in the opinion of respondents. In general, three out of every four respondents felt that existing policies were "well understood and adhered to".

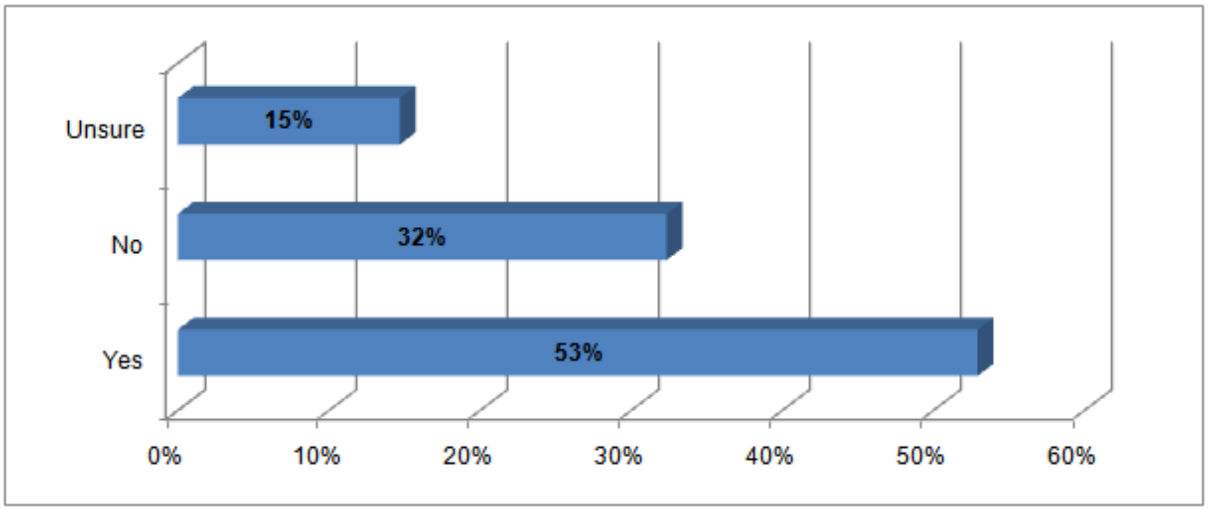
11. Do you feel you have had sufficient training (where necessary) to meet the requirements of the Rules governing the following:



26% of respondents (30% within services that currently use seclusion), felt that they have completed insufficient training to manage and undertake the seclusion of patients.

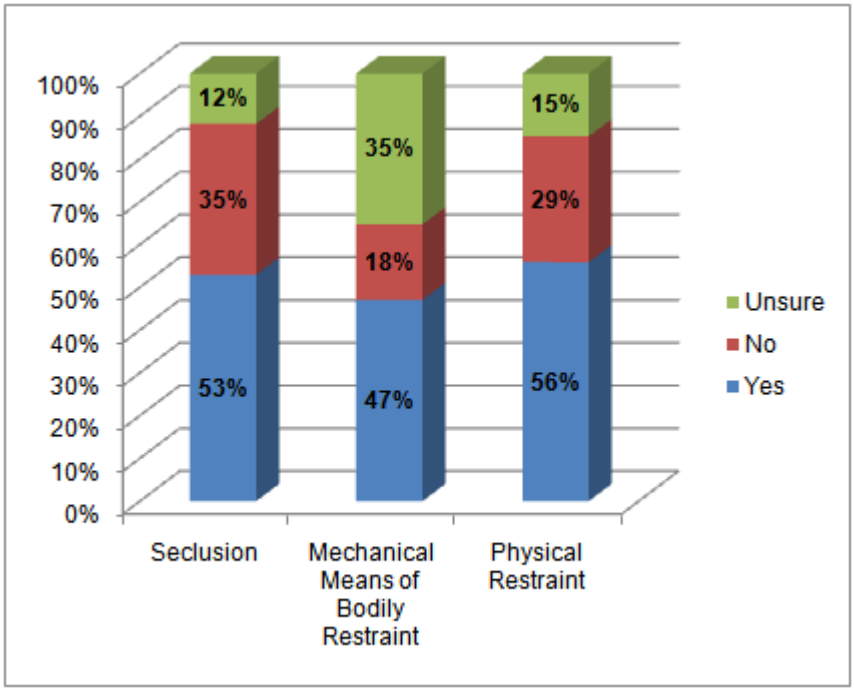
35% of respondents believe that they have completed insufficient training regarding the use of mechanical means of bodily restraint. This increases to 63% of respondents when examining the rate within Centres that currently use this particular method of restraint. In relation to both of the above areas, respondents stated that refresher courses, available on a continuous basis are vitally important to remain competent within a given area.

12. Do you feel you have had sufficient training (where necessary) to meet the requirements outlined within the Code of Practice on physical restraint:



Only 53% of all respondents feel that they have completed adequate training in physical restraint. Respondents were commonly critical of the lack of guidance as regards programmes to complete and who to avail of training from. In addition, a preference for more frequent training updates and refresher courses was evident within the findings.

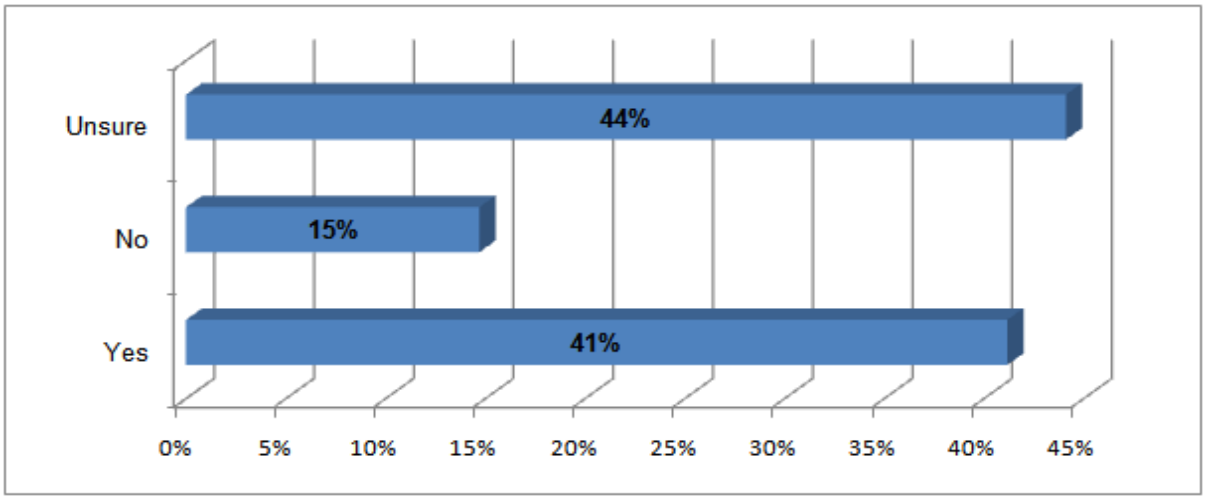
13. Do you think it is necessary for the Rules and Code of Practice to make specific provisions for particular groups of patients including older persons and persons with an intellectual disability:



53% of respondents feel that additional provisions should be developed for specific care groups regarding the use of seclusion. 47% and 56% of respondents believe the same is true regarding mechanical means of bodily restraint and physical restraint respectively.

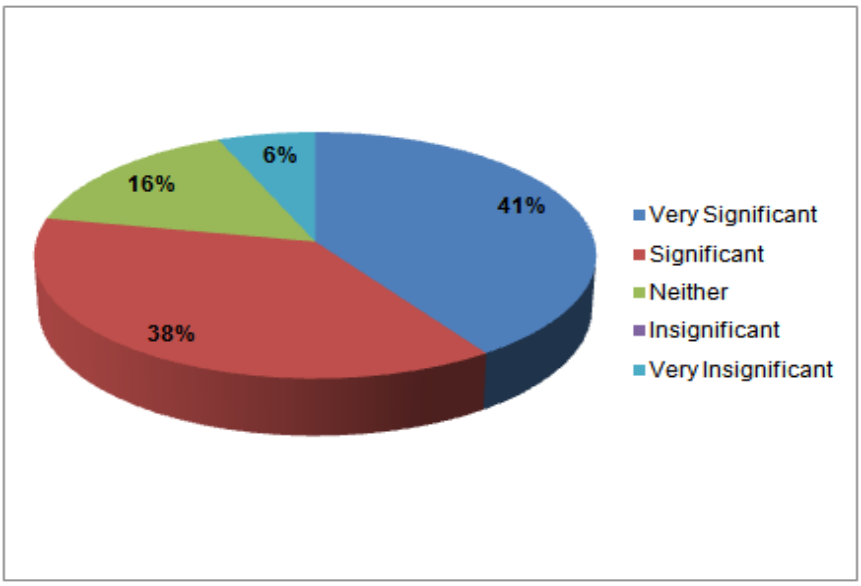
A limited number of respondents felt that it would be useful to include additional considerations in particular for patients with an intellectual disability. The main reasoning for this was that respondents felt that many staff are not sufficiently trained to manage patients with this type of disability. In addition, the review requirements for older persons and patients with an intellectual disability might need to be somewhat more prescriptive for these particular care groups.

14. In your opinion, does Part 5 of the Rules (Use of Mechanical Means of Bodily Restraint for Enduring Self-Harming Behaviour) provide appropriate protection:



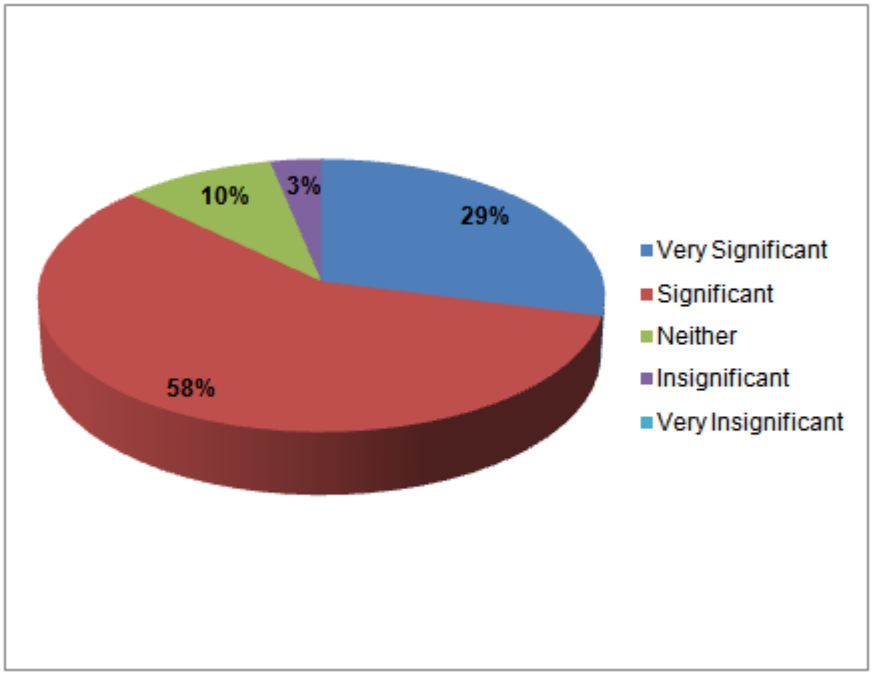
41% of respondents (50% within Approved Centres that currently use mechanical means of bodily restraint) feel that the existing provisions provide appropriate protection. 15% of all respondents feel the existing provisions do not provide the required protection. Where respondents are dissatisfied with the current provisions, their main grievances relate to a perceived lack of detail as regards what is within/outside the remit of Section 5 of the Rules and a lack of detail as regards the monitoring and reviewing of patients. In addition, the Rules should require that a patient's care plan gives consideration to the use of this form of restraint.

15. How significant do you feel the introduction of the Rules for seclusion and mechanical means of bodily restraint have been in terms of fostering high standards in the delivery of mental health services in Ireland and in protecting the rights and interests of those receiving services within approved centres:



79% of respondents felt that the Rules had made a "significant" or "very significant" contribution.

16. How significant do you feel the introduction of the Code of Practice on the use of physical restraint has been in terms of fostering high standards in the delivery of mental health services in Ireland and in protecting the rights and interests of those receiving services within approved centres:



As was found in terms of the Rules, respondents are generally satisfied that the Code of Practice has had a positive impact regarding standards of delivery and the protection of patients. 87% of respondents believe the Code has made a "very significant" or "significant" contribution over the previous two years.

4.2 Service User Questionnaire

The following findings are based on a total of six completed questionnaires. Due to this low response rate, it is advisable to treat these findings with a considerable degree of caution.

	Yes	No	Unsure
1. Were you satisfied that a member of staff sufficiently communicated with you before the episode of seclusion / restraint regarding the reasons for and likely duration of the episode?	1	3	3
2. Were you satisfied that you had an ample opportunity to discuss the episode of seclusion / restraint with relevant staff members soon after the episode had concluded	0	5	1
3. Were you satisfied that staff continuously monitored your well-being throughout your episode of seclusion / restraint and did so on a sufficiently frequent basis	1	4	1
4. Do you feel that the episode of seclusion / restraint was prolonged beyond the period of time that was necessary for its intended purpose?	5	1	0
5. Would you agree that the episode of seclusion / restraint was justified and in your best interests and/or the best interests of fellow patients / members of staff?	1	4	1
6. Would you agree that the episode of seclusion / restraint was the only means available to prevent immediate or imminent harm to you and/or others?	0	4	2

7. Did you experience a loss of trust with staff in the Centre following your episode of seclusion / restraint?	6	0	0
8. Did you feel unsafe within the Centre following your episode of seclusion / restraint?	4	2	0

The above findings would appear to demonstrate a strong level of dissatisfaction amongst the service users responding. Respondents were generally not content with the level of communication both before and after their episode of seclusion / restraint. In addition, the majority of respondents felt that the episode of seclusion / restraint was prolonged beyond the period of time necessary, was not in their best interests and was not the only means available to prevent immediate or imminent harm.

	Yes	No	Unsure
9. Did you feel that staff within the Centre were sufficiently trained and experienced to manage / undertake the episode of seclusion or restraint?	0	3	3
10. Did you feel at any stage that a member of staff was using excessive force in order to commence the episode of seclusion or complete the episode of restraint?	4	2	0
11. Do you agree that seclusion / restraint should only be used as a last resort when all other options have been considered?	5	1	0
12. Based on your experience, do you think that the episode of seclusion / restraint was used too early and before all other suitable alternative approaches were first attempted?	4	1	1

Respondents further commented that they found staff to be “arrogant” and “aggressive”. Four of the six respondents felt that excessive force had been used in order to seclude or restrain the person in question. Four of the six respondents also stated that the episode had been used too early and before other alternative approaches were first attempted.

The majority of respondents (83%) agreed that seclusion and restraint should only be used as a last resort. Two of these respondents specifically commented that restraint should only be used to manage “violent situations”.

	Very Good	Good	Average	Poor	Very Poor
13. How would you rate the seclusion / restraint facilities within the Centre that you experienced this episode?	0	1	2	0	3

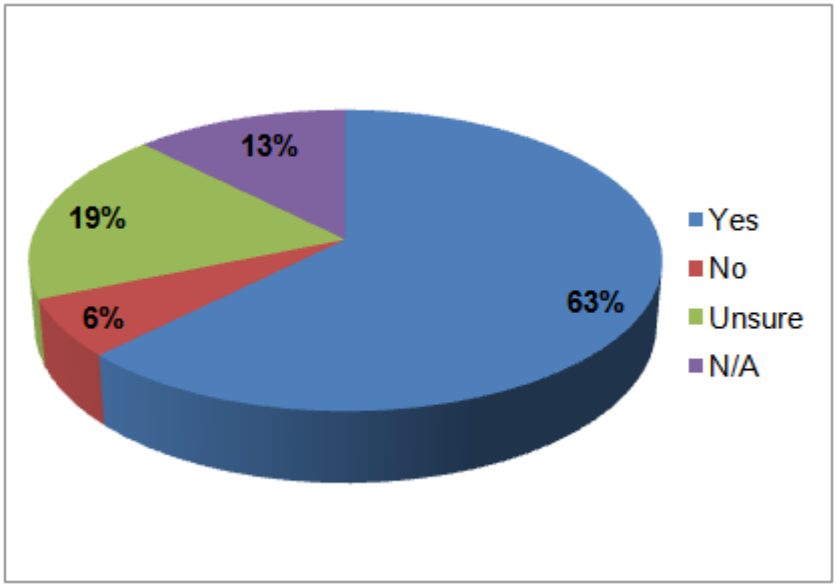
Respondents were also most critical of facilities within Approved Centres. 50% of those that returned a questionnaire categorized the available facilities as “very poor”.

4.3 Mental Health Act Administrator Questionnaire

Sixteen questionnaires were completed and returned for the purposes of the review. 88% of respondents were, at the time of completion, involved in the extraction of data from the Register for Seclusion. The rate of involvement regarding the Register for Mechanical Means

of Bodily Restraint and the Clinical Practice Form for Physical Restraint was 63% and 100% respectively.

1. Does the Register for Seclusion capture the essential reporting information requirements?

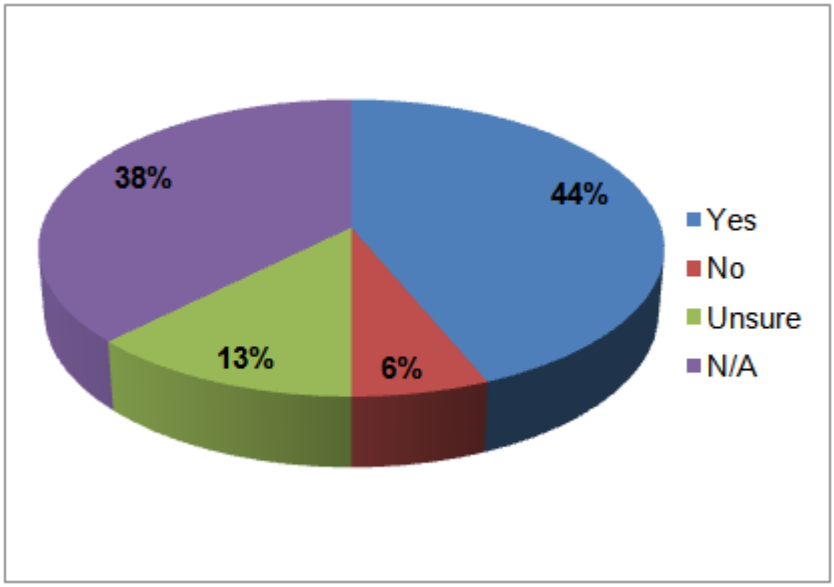


63% of respondents were satisfied that the Register for Seclusion is capturing all the necessary information.

As staff do not have access to records of Department of Social and Family Affairs, acquiring a PPSN for patients is most difficult and time consuming.

Respondents suggested that the Register should include a reminder that each episode of seclusion must have an individual record completed for each and every episode. Respondents also suggested that for each episode of seclusion, it would be useful to record the reasons for restraint and alternatives used/considered prior to seclusion. The register should also differentiate between new and continuation episodes.

2. Does the Register for Mechanical Means of Bodily Restraint capture the essential reporting information requirements?

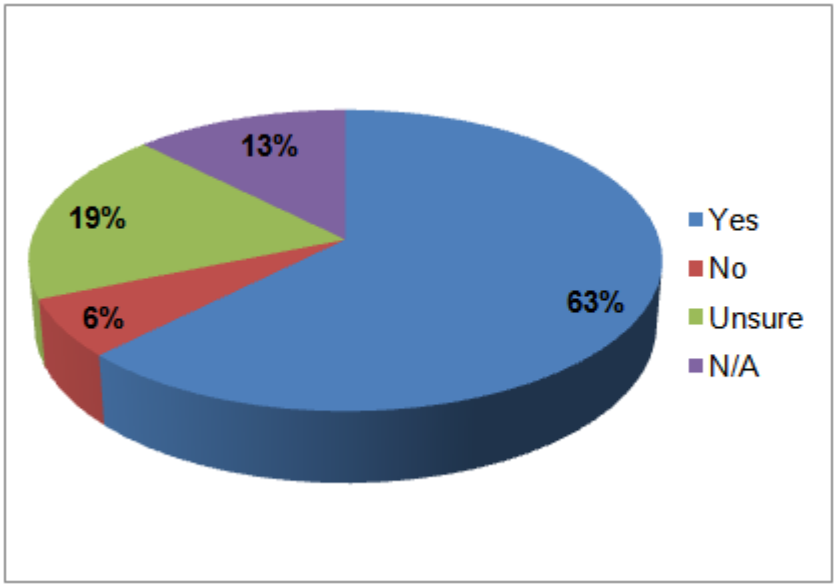


44% of respondents were satisfied that the Register for Mechanical Means of Bodily Restraint is capturing the necessary information.

Respondents would like to have the option to select the type of restraint used from a list of options outlined on the Register.

Reasons for restraint should be recorded, and should also be selected from a pre-defined list if possible.

3. Does the Clinical Practice Form for Physical Restraint capture the essential reporting information requirements?



81% of respondents were satisfied that the Clinical Practice Form for Physical Restraint is capturing all the necessary information.

The wording in Section 15 of the form should be updated, in the opinion of respondents to accommodate the fact that the majority of episodes are authorised retrospectively by a registered medical practitioner. Therefore it should read that "I authorise the use / approve that physical restraint was used".

More specific details should also be recorded within the clinical practice form regarding the type of restraint used and the role assumed by staff members present in order to manage a particular episode of restraint.

4. Please provide recommendations as regards how you would like to see the data collection process improved?

Mental Health Act Administrators would like to see the collection processes utilised to transfer data from the registers/clinical practice form to the Commission updated in order to ensure that processes are time and resource efficient. Ideally, respondents would favour the electronic transfer of data if possible.

In addition, they feel that all registers and clinical practice forms should be accompanied by a set of guidelines for completion. This should include a glossary of terms used. This would serve to ensure that templates are completed on a more consistent basis in the opinion of respondents.

4.4 Supplementary Consultation

This section of the document summarises the key messages received from stakeholders over the course of one-to-one meetings, the focus group and written submissions.

a) General Comments

The introduction of both the Rules governing the use of seclusion / mechanical means of bodily restraint and the Code of Practice on physical restraint was accompanied by a certain degree of apprehension amongst service providers. All services could see the benefit of

applying such tools to practice in Ireland but some respondents were concerned regarding their ability to meet the requirements set down. With the benefit of two years experience since the introduction of the Rules / Code of Practice in November 2006, services are most supportive of the use of defined Rules / Code of Practice to assist with the delivery of services and ensure that the rights of the patient are upheld. The Rules "have made things more black and white for us" was one comment received from a clinician interviewed.

In general, respondents feel the Rules/Code have made clear progress towards their ultimate ambition, to foster high standards in the delivery of services and protect the rights and interests of those receiving services within Approved Centres. A further significant comment recorded during consultation with services providers was that "it is crucial that services respect the rights of patients, particularly the dignity of patients, and the Rules have without doubt contributed to this".

An acceptance was evident among service providers that restraint has to be used to manage certain circumstances. However, staff are somewhat concerned as regards how it should be used and highlighted a distinct need for additional associated training. Respondents would strongly welcome greater clarity regarding the use of mechanical means of bodily restraint and more safeguards in relation to the exclusion of non-qualified staff from initiating an episode of seclusion and/or restraint.

b) Glossary / Definitions

Definition of Seclusion: "*the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving*". The inclusion of the latter phrase "*held in such a way as to prevent the person from leaving*" could be interpreted as was presumably not intended. If the patient is not deprived of social contact (e.g. if a member of staff is standing at a doorway and preventing a patient from exiting a seclusion room) are they secluded was a question posed during the consultation process?

Definition of Mechanical Means of Bodily Restraint: "*the use of devices or bodily garment for the purpose of preventing or limiting the free movement of a patient's body*". A significant degree of confusion exists among service providers consulted with as regards what is included within the remit of this definition and what is excluded. It is not sufficiently prescriptive in the opinion of the vast majority of respondents (in approximately 80% of cases). Service providers would welcome clarification as regards the type and range of apparatus that these Rules were / are intended to govern. The lack of clarity regarding the use of certain restraints and their positioning vis-a-vis the Rules under review has influenced services to not use mechanical means of bodily restraint if possible. Respondents frequently highlighted that they remain unclear as regards the use of a range of different restraints including cot sides and handcuffs.

Definition of Physical Restraint: "*the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident's body*". The second element of this definition (preventing the free movement of a resident's body) is far too open to interpretation according to certain contributors. As it is currently written, one could apply this definition to a range of circumstances presumably unintended by those originally drafting the definition in the opinion of respondents.

The definition of physical restraint should also allude to the use of "minimal physical force" and "respect for the dignity of the patient". Both phrases could be included in the definition with minimum disruption to the sequence and collection of current words as follows:

The use of minimal physical force for the purpose of preventing the free movement of a resident's body while respecting the dignity of that resident

c) Positioning of Seclusion and Mechanical Means of Bodily Restraint Within the Preamble

The preamble to the Rules under review clearly positions the use of seclusion and/or mechanical means of bodily restraint as an approach of last resort. All other options must be considered in advance of secluding a patient or restraining him/her using mechanical means. Respondents believe it is questionable whether this should always be the case. "In certain circumstances seclusion might prove useful to manage an incident before it intensifies" was one particular comment received. It also echoes the majority viewpoint (in excess of 75%) from the focus group specifically held to discuss these Rules. The main reasoning behind this viewpoint is that in certain circumstances seclusion in particular can serve as a safer intervention for the patient, staff and other patients.

As a result, the positioning within the preamble should accommodate this and therefore needs to be updated in the view of respondents. Respondents did also assert though that if this change was to be included, that changes in practice would need to be closely monitored and reviewed to ensure that the rights of the patient are respected and that seclusion was not merely used to overcome any operational difficulties experienced by a particular Centre.

However, a further viewpoint submitted during the review process is that seclusion should be utilised as rarely as possible given "the obvious indignity to the patient".

The preamble further emphasises the view of the Mental Health Commission that the use of seclusion and mechanical means of bodily restraint on a voluntary patient must involve a consideration of whether involuntary admission of the patient on the grounds of mental disorder is warranted. This poses significant compliance issues for Approved Centres and "remains a grey area for staff".

d) Orders for Seclusion / Restraint

Rule 2.1 states that seclusion must only be used "when a patient poses an immediate threat of serious harm to self or others". Respondents questioned the use of seclusion when a patient is in the process of self harming or attempting to do so.

Rule 2.8 states that seclusion may be initiated by a registered nurse or care officer in an emergency situation. Rule 14.5 states that the use of mechanical means of bodily restraint may be initiated by a registered medical practitioner or a registered nurse or a care officer. Provision 2.5 within the Code of Practice states that a registered medical practitioner or registered nurse or a care officer may initiate the physical restraint of a resident. There was a clear view that both Rules and the provision within the Code of Practice should be strengthened to ensure that it is entirely clear that the initiation of restraint should only fall within the responsibility of a professionally qualified clinician. The term "clinician" should be taken to include both medical and nursing staff in this instance. Respondents during this review process were concerned that other staff working within Approved Centres are utilised

to restrain and seclude patients intermittently. This is clearly a dangerous practice for both patients and staff involved in the view of respondents.

Respondents were in agreement that the duration of seclusion and/or restraint must/should only be used for the minimum period of time necessary to prevent immediate and serious harm (Rules 2.4, 14.2, COP 2.2). It was suggested that the Rules and Code of Practice specify that the minimum period of time be based on a patient assessment and/or risk assessment.

Rule 2.8 provides for seclusion in an emergency situation. Respondents stated that when secluding patients, it typically is undertaken in emergency situations. As the Rules are currently constructed, difficulties can potentially emerge if/when a registered medical practitioner is not present to witness the initiation of the seclusion episode. Despite not witnessing the episode, a registered medical practitioner is required to authorise the seclusion of a patient. If s/he disagrees with the initiation of this seclusion episode, what options do medical practitioner and the relevant nursing staff have to resolve the matter. In order to remove this current difficulty, it was suggested by in excess of 85% of those consulted with that appropriately qualified and experienced nursing staff should be able to authorise an episode of seclusion and / or restraint.

The National Forensic Service would like to remove the inclusion of “care officer” from Rules 2.8 (b) and 3.1. This provision is no longer required.

Rule 2.9 provides that when a patient is being secluded that s/he be informed of the reasons for seclusion and likely duration of the episode. It was queried also whether a patient should be informed of the circumstances under which the episode would be discontinued. This might involve outlining what particular behaviour or actions taken by the patient might lead to the discontinuation of a particular episode.

Rules 2.10 and 14.10 (COP 2.10) state that the patient’s next of kin should be informed of the episode of seclusion and/or restraint as soon as is practicable with the patients consent. In the event that a patient lacks capacity and cannot consent, the patient’s next of kin should also be informed. Respondents commented that it would be beneficial to clarify the position where a patient does not consent to next of kin notification. Respondents commented that this is a right that needs to be protected and as a substitute for next of kin notification, it may be appropriate to utilise a patient advocate for this purpose if necessary. Currently service providers tend to notify next of kin regardless of whether consent is provided or not. The Rules should specify precisely that in a situation whereby a patient has capacity and does not consent, then unless within exceptional circumstances, next of kin should not be notified.

Regarding the Code of Practice, the National Forensic Service would appreciate guidance and an inclusion within the Code (if appropriate) regarding the restraint of a patient for the purposes of administering intramuscular medication.

Respondents suggested that proportionality is crucial when using physical restraint. The force applied should not be excessive for a given situation. This should be strongly reinforced within Sections 2 (Orders for Physical Restraint) and Section 3 (Resident Dignity & Safety) of the Code of Practice.

e) Patient / Resident Dignity & Safety

The monitoring and review of patients when restrained by mechanical means should be clarified within the Rules in the opinion of approximately 90% of respondents. Rule 15.3 states that a patient must be "continually assessed" throughout the use of this form of restraint. Clarification as regards what this should precisely involve, who should complete such an assessment and the associated timeframes for completion is required.

Gender consideration is most important when physically restraining a resident. It was advised by respondents that a female member of staff should be present at all times when restraining a female resident, for example, and that the Code of Practice should include this within the guidance.

A degree of concern was expressed by respondents that Provision 3.5 within the Code is in danger of becoming a list of holds / restraints to avoid. The majority opinion was that it would not be advisable to develop such a list.

"Bodily searches", as included within Rule 3.4, should be defined within the glossary.

f) Monitoring a Patient During Seclusion

Based on the consultation completed for the purposes of this review, Rule 4.1 is not interpreted in a consistent manner across services and should be clarified in the opinion of respondents. The rule should specify that when a patient is secluded that (a) s/he be regularly assessed by staff as outlined in Section 4.2 to 4.5 and (b) that a registered nurse be present in the vicinity of the room at all times throughout the duration of hour one and be available to the patient at all times should the need arise. The nurse should be "in sight and sound of the patient" without constantly looking over the secluded patient. If possible, it is best that the nurse is out of the immediate view of the patient.

Respondents also advised that the written record, completed every 15 minutes as outlined in Rule 4.2, should not serve as a mere checklist exercise. It is important that the Rules outline specifically what should be completed as part of this requirement.

Rule 4.3 outlines that during the review of a patient in seclusion, a minimum of two staff members must enter the seclusion room. Respondents commented if it was necessary to restrain the patient then this could not be safely achieved with two members of staff and that typically more than two staff would enter the room as a routine operational procedure. This requirement should be amended to a minimum of three staff members.

g) Renewal of Seclusion Orders

Where a patient is secluded for a total period exceeding 72 hours, Rule 5.3 requires that written notification be forwarded to the Inspector of Mental Health Services and/or the Mental Health Commission. At present, notification is only required where a patient is secluded for a continuous 72 hour period. Respondents suggested that consideration should be given to extending this notification requirement to include patients that are secluded on a regular basis (but where not secluded for a continuous 72 hour period as is presently prescribed). Timeframes for this additional requirement need further consideration as a consensus or majority viewpoint was not reached within this consultation process.

h) Seclusion Facilities

Minimum requirements for the design and specification of new build seclusion facilities should be developed to support Section 7 of the Rules in the opinion of approximately 50% of respondents. This should include size/dimensions, ventilation, natural light, height and heating requirements.

The use of supplementary facilities, including high observation areas, should also be considered for inclusion within the Rules governing seclusion. The Inspector of Mental Health Services was of the view that, in some cases, it may be appropriate to seclude a patient in a location other than a seclusion room. Options in this regard might include the patient's own room, a sitting room or a high-observation room. Furthermore, he considered that in Approved Centres, where the act-of-seclusion rate is very low or likely to be very low, such Centres should not have to build a rule-compliant suite nor should they be cited for a breach of the rules solely on the basis of an absence of such a suite. He asserted that many examples of good practice in relation to seclusion exist in Ireland where there is no seclusion suite.

i) Recording Episodes of Seclusion / Restraint

All registers should have a unique identification number to support good document control/management processes according to respondents.

The following additions should be considered for the associated registers and clinical practice form:

Register for Seclusion:

- The precise location of the episode (unit and centre details where applicable)
- Whether relatives / next of kin were informed
- Whether the episode in question is a new or continuation episode of seclusion
- Whether the patient was secluded in his/her own clothing (if not, reason for same)

Register for Mechanical Means of Bodily Restraint:

- The precise type of bodily restraint used (ticked from a list of defined means)
- The precise location of the episode (unit and centre details where applicable)
- Whether relatives / next of kin were informed

Clinical Practice Form for Physical Restraint:

- Summary details should be recorded as regards the type of restraint/hold utilised during the episode in question
- The above summary should detail how each member of staff supported the restraint episode (record a summation of the precise role of each member involved).

The data collation process at present is a time consuming practice. Respondents would like to see alternative options considered for the transferring of data from forms to the MHC reporting application, the key being to automate the process where at all possible and appropriate.

Obtaining the PPSN for a patient is difficult according to respondents. It was questioned whether this field is entirely necessary and what the precise reason for using this form of identification is.

A limited number of respondents (circa 20%) would like to see some information recorded within the appropriate registers/forms regarding the effects of seclusion and/or restraint on the patient/resident.

It would also be useful, in the opinion of respondents, if options could be provided for regarding (a) reasons for seclusion/restraint and (b) alternatives considered in advance.

Each register and associated documentation to record information pertaining to seclusion and restraint should be accompanied by instructions for completion and a glossary detailing all relevant definitions.

j) Clinical Governance

Each episode of seclusion and restraint should be reviewed within a multi-disciplinary team setting when the episode in question has concluded as per Rules 9.2 / 18.2 and Provision 6.2 within the Code of Practice. This requirement is not typically met by Approved Centres in the opinion of most respondents (90% +). The benefit of involving the full multidisciplinary team is questionable in the opinion of respondents, particularly the inclusion of Allied Health Professionals.

As an example of good practice, the Seclusion Monitoring Group (established within the National Forensic Service) was cited as a possible example to follow. This involves a monthly meeting of key staff to discuss episodes of seclusion (approaches used, outcomes, etc) and to share the learning attained from particular episodes.

Audit approaches for seclusion and restraint should be considered in more detail. The possibility of introducing monthly reporting procedures should be explored and led by the Mental Health Commission in the opinion of respondents present within the focus group setting.

Annual reports on the use of seclusion, mechanical means of bodily restraint and physical restraint are requested within the Rules and Code of Practice. Service providers feel that additional guidance should be provided as regards the structure and content of these reports.

k) Ending the Use of Mechanical Means of Bodily Restraint

The decision to end an episode of mechanical means of bodily restraint is alluded to within Rule 16.1. Respondents suggested that this rule should specify that any decision to terminate an episode of restraint should be based explicitly on an assessment of the patient.

l) Use of Mechanical Means of Bodily Restraint for Enduring Self-Harming Behaviour

A large degree of uncertainty exists regarding the scope of Part 5 of the Rules. Almost all respondents consulted with were generally unsure as regards the type of restraints that can/should be used to mechanically restrain a patient in order to prevent self-harming behaviour. Many of the difficulties experienced with this particular section stem from the

original definition of mechanical means of bodily restraint. For example, clinicians consulted with frequently posed the question “does this section include the use of chairs to restrict movement”? In general, a concern exists that as the section is poorly defined and contains an inadequate level of specification, it does not serve the needs of patients or staff in its current form.

In addition, respondents commented that mechanical means of bodily restraint should only be utilised in cases of enduring self-harming behaviour following the completion of a case discussion by relevant members of the associated multidisciplinary team.

m) Physical Restraint – Staff Training

Approved Centres have developed the required policies and procedures for the training of staff in relation to physical restraint but many admit to being “in limbo” regarding what programmes they should / should not complete and who they should attain training from (circa 95% of respondents). The vast majority of those consulted expressed a wish that the Mental Health Commission (or Health Service Executive) clarify this present ambiguity.

The Code of Practice should specify that the completion of training in physical restraint is mandatory for all clinicians working in Approved Centres in the opinion of respondents. In addition, guidance should be provided regarding the frequency of required refresher courses for all relevant staff. On average, respondents felt staff should complete such an exercise on at least an annual basis.

Staff commented that, given the lack of training programmes available in general, they are typically not aware of the full range of alternative approaches available to de-escalate/manage situations. Where staff are aware of alternative approaches, many remain unclear as regards the suggested sequence to the use of such approaches (as per best international practice). In summary, general concerns regarding the level of training completed and a lack of guidance regarding which training to avail of was a key message received from staff during this consultation process.

n) Physical Restraint – Child Residents

The inclusion of a provision within the Code of Practice regarding child residents was welcomed and valued by those involved in the consultation process. In order to ensure this provision remains adequately prescriptive it was advised that this be informed by the following:

- Guidelines issues by the Social Services Inspectorate
- Child Care legislation and standards

o) Other

The out-dated design of facilities in Ireland is not suitable for modern practice in many cases and significantly reduces the application of modern approaches to manage the requirements of patients and residents. In addition respondents suggested that, given the evidence citing environmental factors as significant contributors to violence and aggression, consideration should be given to recommending that Approved Centres complete an environmental audit.

In addition, a fear exists that due to the availability of seclusion rooms within Approved Centres, other less restrictive methods of crisis-management may not be sufficiently employed.

A national policy on practice and education regarding dignity and safety could serve to strengthen the relationship between the Code, other related professional Codes of practice, professional guidance and related national policy

National guidelines in relation to training content and training provision regarding physical restraint are necessary in the opinion of respondents.

5. Recommendations

Based on the literature / legal review and consultation findings, as outlined in Sections 3 and 4 respectively, the following recommendations have been developed by Prospectus for consideration by the Mental Health Commission. The recommendations are prefaced by a summary of key considerations (below) that have emerged from sections three and four of this document. Recommendations have been grouped in terms of those that contain direct implications for the existing Rules / Code and those that have indirect implications. Each recommendation has been assigned a level of prioritisation; from low to medium to high.

High priority recommendations should be acted upon as a matter of urgency. Recommendations of this type represent the necessary actions to rectify the issues of most pressing concern for stakeholders and the review team. They are also based on the key disparities to emerge between literature review findings and current Irish practice. Medium priority recommendations should be scheduled for completion at the next available opportunity. Low priority recommendations are rated as less essential for the effective operation of the Rules. They should be acted upon following the completion of high and medium priority recommendations.

We recognise that not all recommendations are implementable by the MHC, given its specific remit. In these cases, the role of the Commission will be to highlight such recommendations to the relevant organisations and/or bodies where it determines that it is appropriate to do so.

5.1 Key Considerations

Sections 3 and 4 of this document detail the major findings from the literature review and specific consultation completed for the purposes of this review of the current Rules / Code of Practice. A number of key considerations have emerged and are discussed in more detail below before being addressed within our recommendations.

A key issue that emerged from the literature review and consultation with stakeholders was that of training. Best practice suggests that programmes should be designed to equip service providers with the necessary skills to utilise a range of approaches to manage and/or de-escalate violent or aggressive situations. Therefore it is vital that staff are not merely trained on an approach-by-approach basis. Comprehensive training programmes are required to enable staff to determine which best suits a particular set of circumstances. This should include training on communication and prevention techniques. Respondents to the review process continually highlighted their concern regarding the current uncertainty in relation to what programmes they should complete and who they should seek this training from. Education and training programmes need to be developed and delivered by trainers that have expertise and practice credibility. It is recommended that the Mental Health Commission continue to monitor developments in international practice regarding the provision of education and training programmes for staff. Preparatory steps should be taken for the future introduction of a national system of accreditation and registration for trainers and training providers.

A range of interventions to minimise the use of seclusion and restraint are highlighted within the literature review. Crucial to the appropriate use of these is the provision and completion of suitable training also. Multidisciplinary team input to the development of care / treatment

plans can have a significant impact in formulating plans that are more informed regarding behavioural considerations.
Available data on episodes of seclusion and restraint should be used to its full potential. Accurate reporting and analysis can assist service providers to understand better why episodes of violence and aggression can come to the fore within particular Approved Centres. When triggers are better understood, it becomes easier to develop effective prevention techniques. Research suggests that systemic weaknesses can frequently contribute to the instigation of violence and aggression. However, systemic weaknesses can also lead to a reliance on the use of seclusion and restraint to manage such circumstances.

The issue of retrospective authorisation poses significant difficulties for staff working in Approved Centres. This places both those initiating and those required to authorise an episode of seclusion and/or restraint in an uncertain position at times. At present a registered medical practitioner must authorise all episodes. Having not witnessed the actual initiation and the entire completion of an episode in certain cases, one is expected to authorise an episode. It is questionable whether this represents best practice. Experienced nursing staff should have the necessary authority to authorise all episodes of seclusion, mechanical means of bodily restraint and physical restraint.

The preamble currently positions seclusion and restraint as a means of last resort. Best practice would agree with this arrangement. However, this positioning of last resort should apply to the 'package' that is known as seclusion and restraint. It appears that a proportion of Irish service providers have inadvertently decided that seclusion should not be used until all other approaches have been tried or where other approaches are not appropriate in their professional opinion. These other approaches often include forms of restraint. In many situations, as outlined within the literature review and as alluded to within the summary of the consultation findings, seclusion can present a safer and more appropriate means to manage a particular episode in comparison to restraint. As a result, the preamble should outline that seclusion and restraint remain approaches of last resort but that consideration should be given on a case-by-case basis as regards what approach would best serve the needs of a particular patient.

A large proportion of respondents requested that additional clarification be provided as regards the type/range of restraints that can be used within the Rules governing the use of mechanical means of bodily restraint. Clearly clarification would be useful here as Approved Centres appear to have taken a decision not to use this form of restraint due to the lack of specification outlined. It is not recommended, however, to develop a list of apparatus included and/or excluded. Instead, service providers should be encouraged to question why they are using a particular restraint. The Rules governing the use of mechanical means of bodily restraint are in place to protect the rights of the patient and ensure he/she is safely and appropriately cared for. Where a patient is likely to cause injury to themselves or others, appropriate measures should be taken to prevent this from escalating. Mechanical means of bodily restraint should never be used as a means to merely prevent the movement of patients. It is advisable that this positioning is clarified using a broader narrative within the preamble or introduction. The Rules should specify general principles for use of mechanical means of bodily restraint as a means to further guide service providers regarding the appropriate use of such.

Facilities within a large proportion of Approved Centres are not conducive to the utilisation of many modern day approaches to manage and/or de-escalate violence and aggression. Research suggests that environmental factors can significantly contribute to the instigation of episodes of violence and aggression. Step-up and step-down facilities within a service can prove most useful in assisting patients to be better prepared to return to their typical

surroundings or to provide additional supports to them as necessary when required. For example, the use of high observation areas would support the delivery of improved practices in the opinion of respondents.

The need for additional research in the area of seclusion and restraint is also evident from both the literature review and consultation findings. Knowledge in the use of how best to reduce the use of these approaches, given the range of alternative available, is limited at present. Where particular approaches are effective it is important that success stories are recorded and documented. In addition, limited research is available regarding the effects of seclusion and restraint on patients and their treatment programme thereafter. This is an area that should be prioritised going forward.

Staff consulted with were most satisfied with the level of detail included within the Rules governing the monitoring of a patient during seclusion (Section 4). They would favour the continuation of this level of detail where appropriate within the Rules governing the use of mechanical means of bodily restraint and the Code of practice regarding physical restraint. As both of these documents are used to provide for/guide the use of multiple forms of restraint, it would likely prove most difficult to reach agreement regarding the frequency and type of reviews completed while a patient is restrained. For that reason, it is suggested that the level of detail is explored further and enhanced while remaining sufficiently generic to prove acceptable for the numerous approaches covered by the Rules and Code of Practice.

5.2 Recommended Changes to the Rules / Code

Recommendation		Priority
R 1	Include a broader narrative regarding the use of mechanical means of bodily restraint within the preamble to the Rules. This should include general principles for use as follows: ▪ The procedure being delivered is professional, based within an ethical and legal framework; ▪ It promotes the safety of service users, staff and visitors as being essential and equal; ▪ Is based on a thorough risk assessment; ▪ The procedure should be based on best available evidence and contemporary practice; ▪ Ethnic and cultural awareness and gender sensitivity should be demonstrated throughout its use.	High
R 2	The rules should include the following provisions regarding the use of mechanical means of bodily restraint: ▪ The use of mechanical means of bodily restraint should be subject to a second opinion by a medical practitioner, independent of the Centre where the patient is being treated in cases where it is continued beyond one month; ▪ Independent reassessment every three months should be completed for all cases; ▪ A clear plan of care should be completed for all patients to demonstrate how the service is attempting to reduce the use of mechanical means of bodily restraint.	High

R 3	Amend the existing Rules / Code of Practice to extend the responsibility to authorise episodes of seclusion, mechanical means of bodily restraint and physical restraint to appropriately experienced and qualified nursing staff.	High
R 4	Reconsider the existing monitoring and review requirements regarding the bodily restraint of patients using mechanical means.	High
R 5	Part 5 of the Rules pertaining to the use of mechanical means of bodily restraint for enduring self-harming behaviour should be expanded to outline the following specifics: ▪ Principles for the appropriate use of mechanical means of bodily restraint for enduring self-harming behaviour (as outlined in Recommendation 1); ▪ Responsibilities of relevant staff regarding the reviewing of patients; ▪ Timeframes for reviewing of patients; ▪ Requirement that a case be discussed by a MDT before commencing the use of mechanical means of bodily restraint for enduring self-harming behaviour; ▪ That if this form of restraint is continued beyond one month then it should be subject to independent review by clinical staff not previously involved with the case nor employed by the organisation seeking the review.	High
R 6	Seclusion and restraint should continue to be categorised as approaches of last resort within the preamble. Consideration must/should be provided on a case-by-case basis as regards what approach best meets the needs of a particular patient.	Medium
R 7	The preamble should make reference to the following in order to set a more appropriate tone for the Rules / Code of Practice: ▪ Respecting the rights of the patient; ▪ Promoting a culture of respect within Approved Centres; ▪ Acknowledgement that the Rules are there to direct practice but do not purport to be all encompassing	Medium
R 8	Initiation of seclusion, mechanical means of bodily restraint and physical restraint should fall within the responsibility of medical and nursing staff only. Rules 2.8 / 14.5 and Provision 2.5 within the Code of Practice should be strengthened to clarify this position.	Medium
R 9	Update the definition of physical restraint to include the term “use of minimal physical force”	Medium
R 10	Specify precisely within the Rules (2.10 / 14.10) and Code of Practice (2.10) that where a patient has capacity and does not consent to next of kin notification, that this right should be respected unless within exceptional circumstances	Medium
R 11	The preamble to the Code of Practice should emphasise further the use of proportional and minimal force when using physical restraint.	Medium
R 12	Where a patient is being restrained, the Rules and Code of Practice should specify that he/she must/should have a same sex member of staff present at all times during the episode of restraint.	Medium

R 13	Rule 4.2 should be expanded to outline what should be completed as part of the written record.	Medium
R 14	Amend the definition of "direct observation" within the glossary to recommend that the registered nurse remain outside the immediate view of the patient where possible and practicable.	Medium
R 15	Amend Rule 4.1 to outline that all patients placed in seclusion be under "direct observation" for hour one and reviewed thereafter according to Provisions 4.2 – 4.5.	Medium
R 16	Rule 4.3 should be updated to specify that "a minimum of 3 staff members" be included.	Medium
R 17	Rule 16.1 should specify that the ending of an episode of mechanical means of bodily restraint should be "based explicitly on an assessment of the patient".	Medium
R 18	The Code of Practice should specify within Section 7 that the completion of staff training should be mandatory for all staff that may have patient contact. This should include training in the prevention and management of violence (including 'breakaway' techniques).	Medium
R 19	Review Rule 5.3 to determine when additional notification should be forwarded to the Inspector of Mental health Services / MHC regarding the repeated use of seclusion.	Medium
R 20	Remove the inclusion of "care officer" from Rules 2.8 (b) and 3.1.	Low

5.3 Related Recommendations

Recommendation		**Priority**
R 21	Monitor developments in international practice regarding the provision of education and training programmes for staff with a view to the future introduction of a national system of accreditation and registration for trainers and training providers.	High
R 22	Consider the implications of extending the remit of the Rules to all persons within an Approved Centre with a view to proposing a change to the Mental Health Act 2001.	Medium
R 23	Commission or seek support for a specific longitudinal study within Ireland on the following: ▪ The use of alternative approaches to minimise the use of seclusion and restraint; ▪ The effects of seclusion and restraint on patients/residents and their treatment programmes.	Medium
R 24	Introduce a governance framework for service providers based on the over-arching principles for governance and accountability as set out by the Commission on Patient Safety and Quality Assurance.	Medium
R 25	Explore areas of best international practice concerning service user involvement within review/developmental processes to devise an	Medium

	approach to enhance service user involvement in Irish mental health services.	
R 26	Enhance links with the Health Research Board and other stakeholders as appropriate to support Approved Centres participation in research initiatives.	Medium
R 27	The register for seclusion should be updated to include the following fields: ▪ Precise location of the episode – seclusion room, name of unit and name of Approved Centre; ▪ Next of kin notification (yes / no); ▪ New episode or continuation episode; ▪ Secluded in own clothing (yes / no).	Medium
R 28	The register for mechanical means of bodily restraint should be updated to include the following fields: ▪ Precise location of the episode – name of unit and name of Approved Centre; ▪ Type of bodily restraint used; ▪ Next of kin notification (yes / no).	Medium
R 29	The clinical practice form for physical restraint should be updated to include the following fields: ▪ Precise location of the episode – name of unit and name of Approved Centre; ▪ Summary details regarding the type of restraint used; ▪ Details as regards what each member of staff, directly involved in the restraint of the resident, was doing.	Medium
R 30	Monthly reporting audit procedures should be explored further with Approved Centres to agree an approach that maximises the use of available data.	Medium
R 31	The Mental Health Commission should devise a template and circulate to all Approved Centres outlining the composition of annual reports on seclusion, mechanical means of bodily restraint and physical restraint.	Low
R 32	All registers and clinical practice forms should be accompanied by instructions for completions and a glossary detailing all relevant definitions.	Low
R 33	All registers and clinical practice forms should have a unique identification number assigned and recorded by the Mental Health Commission.	Low
R 34	Minimum requirements should be developed for the design and specification of all new build seclusion rooms.	Low
R 35	Complete an environmental audit of all Approved Centres as part of the annual inspection process completed by the Inspectorate.	Low

6. Conclusion

The introduction of the Rules governing the use of seclusion and restraint in Ireland has clearly had the desired impact of fostering high standards in the delivery of mental health services while protecting the interests of those detained in an Approved Centre. The Rules and Code have provided a more defined approach for service providers and for that the Commission must be commended. Respondents feel the Rules and Code have made clear progress towards their ultimate ambition, to foster high standards i and protect the rights and interests of those receiving services within Approved Centres. A significant comment recorded during consultation with services providers was that "it is crucial that services respect the rights of patients, particularly the dignity of patients, and the Rules (Code) have without doubt contributed to this".

A number of areas have been highlighted for immediate attention. Most notably these include clarification as regards the use of mechanical means of bodily restraint, extending the responsibility of authorisation to appropriately qualified and experienced nursing staff and the provision of education and training programmes for staff working within Approved Centres.

Given the number of *related recommendations* included within this review, it is important that the Commission take these forward to the relevant external organisations as they deem it appropriate to do so.

We recommend, based on the findings of this review, that the all forms of restraint and seclusion remain approaches of last resort. However, when responding to the needs of a patient and managing episodes of violence and aggression within an Approved Centre, it is important that staff consider what approach will work best given the situation at hand. Typically this will vary depending on the patient and staff must be trained appropriately in order to deal with the demands of modern practice. It is crucial that training programmes introduced involve the range of components necessary including communication and prevention techniques.

It is important that the views of service users are heard when evaluating Rules and Codes of Practice. Due to the aforementioned difficulties encountered during this review process, we recommend that the Commission explore innovative approaches that have proved useful elsewhere in this respect. It is vital that the necessary arrangements are put in place to ensure that the opinions of service users are captured using a means that best suits the intended audience.

Prospectus would like thank all those who contributed to this review process in focus groups, direct interviews, submissions or questionnaire responses. We are confident that the engagement of so many stakeholders with the review team has helped to ensure that the Rules and Code will continue to evolve for the ultimate benefit of patients in Ireland.

Appendices

1. Members of Project Steering Group

Name	Job Title
Mental Health Commission	
Patricia Gilheaney (Chair)	Director Standards & Quality Assurance
Derek Beattie	Project Officer
Gerry Cunningham	Director of Tribunals
Pat Devitt	Inspector of Mental Health Services
Susan Finnerty	Assistant Inspector
Deirdre Hyland	Information Officer
Rhona Jennings	Assistant Inspector
Lisa O'Farrell	Policy Officer
Rosemary Smyth	Director of Training & Development
Prospectus	
Vincent Barton	Managing Director
Brian Griffin	Senior Consultant
Colin Dale	External Advisor

2. One-to-one Interviews Completed

Interviewees		Centre / Organisation	Role
1	Ms Eileen Kelly	St Ita's Hospital	Nursing Practice Development Coordinator
2	Mr Pauric Mahon	St Vincent's Hospital	Clinical Nurse Manager 3
3	Mr Des McMorrow	Mental Health Commission	Assistant Inspector
4	Prof Harry Kennedy / Mr Paul Braham	National Forensic Service – Central Mental Hospital	Clinical Director / Director of Nursing
5	Dr Margo Wrigley	St Vincent's Hospital / Mater Misericordiae Hospital	Clinical Director
6	Dr Rita Hughes	St Brendan's Hospital	Clinical Director
7	Dr Brendan Lynch	Kerry Mental Health Services	Clinical Director
8	Ms Dora Hennessy	DoHC	Principal Officer
9	Mr John Flaherty	St Patrick's Hospital	Director of Nursing
10	Dr Pauline Twoomey	St Brendan's Hospital	Consultant Psychiatrist
11	Ms Lucy Scanlon	Roscommon County Hospital	Clinical Nurse Manager 2
12	Dr Pat Bracken	West Cork Mental Health Services	Clinical Director
13	Dr Hibberet Tessema	Adelaide and Meath Hospital, Dublin Incorporating the National Children's Hospital	Senior Registrar

3. Attendees at the Service Provider Focus Group

Name		Centre / Organisation	Role
1	Mr Martin Jennings	St Patrick's Hospital	Clinical Nurse Manager 2
2	Ms Paula McGuire	St Patrick's Hospital	Clinical Nurse Specialist
3	Dr Seamus O'Ceallaigh	St Patrick's Hospital	Consultant Psychiatrist
4	Ms Miriam Delaney	St Ita's Hospital	Clinical Practice Coordinator
5	Ms Rose Bennett	St Ita's Hospital	Nursing Practice Development Coordinator
6	Ms Kelly Mofflin	St Loman's Hospital	Clinical Facilitator
7	Mr Declan Breen	Psychiatric Nurses Association	Industrial Relations Officer
8	Mr Bernard Roe	St Brendan's Hospital	Clinical Nurse Manager 3
9	Ms Barbara Daly	St Brendan's Hospital	Clinical Nurse Manager 2
10	Mr Timothy Lynskey	St Brendan's Hospital	Asst Director of Nursing
11	Dr Rita Hughes	St Brendan's Hospital	Consultant Psychiatrist
12	Mr Kieran Tierney	St Brendan's Hospital	Clinical Nurse Manager 2
13	Ms Pauline Twomey	St Brendan's Hospital	Consultant Psychiatrist
14	Mr Pat Maher	St Lukes Hospital, Clonmel	Staff Nurse
15	Mr Donal O'Malley	National Forensic Service	Social Work Team Leader
16	Ms Jacqui Cahill	National Forensic Service	Clinical Nurse Manager 1
17	Mr Steve Cawley	National Forensic Service	Clinical Nurse Manager 2
18	Mr John Flanagan	Palmerstown View, Stewarts Hospital	Clinical Nurse Manager 2
19	Dr Mary Staines	Palmerstown View, Stewarts Hospital	Clinical Director
20	Dr Stephen Monks	National Forensic Service	Senior Registrar
21	Mr David Timmons	National Forensic Service	Clinical Nurse Specialist
22	Mr Joe Scales	National Forensic Service	Asst Director of Nursing

4. Submissions Requested From

1	Irish Hospital Consultants Association
2	Irish Medical Organisation
3	IMPACT
4	Irish Nurses Organisation
5	SIPTU
6	Psychiatric Nurses Association
7	Irish College of Psychiatrists
8	An Bord Altranais
9	Irish College of Anaesthetists
10	National Council for the Professional Development of Nursing & Midwifery

5. Questionnaire Templates

Questionnaire 1: Service Providers

1. **Please indicate type of response**

   Team ◯ Individual ◯

2. **In the case where this response has been compiled by a team, please provide details regarding the team type and number of members**

   _____
   _____
   _____

3. **Does the approved centre from which you currently work use:**

   a) Seclusion
   Yes ◯ No ◯

   b) Mechanical Means of Bodily Restraint
   Yes ◯ No ◯

   c) Physical Restraint
   Yes ◯ No ◯

4. **Please select the area that you currently work within**

   HSE West ◯
   HSE South ◯
   HSE Dublin Mid-Leinster ◯
   HSE Dublin North East ◯
   Independent / Private and Private Charitable ◯
   Child & Adolescent Services ◯

5. Please enter the approximate number of beds within your approved centre

< 10	◯
10 – 25	◯
26 – 50	◯
51 – 75	◯
76 +	◯

6. Which of the following best describes your current post within this approved centre

Staff Nurse	◯	SHO / Registrar	◯
Nurse Manager	◯	Health and Social Care Professional	◯
Consultant Psychiatrist	◯		
Administration / Management	◯	Other	◯

Where other is selected above, please specify:

_____

_____

_____

7. Are you satisfied that the current definitions for the following remain appropriate:

a) Seclusion

Yes ◯ No ◯ Unsure ◯

b) Mechanical Means of Bodily Restraint

Yes ◯ No ◯ Unsure ◯

c) Physical Restraint

Yes ◯ No ◯ Unsure ◯

If you answered no to any of the above, please explain why and provide a proposed alternative definition.

_____

_____

_____

8. Do you think that the current provisions in the Rules governing **the use of seclusion** in relation to the following remain appropriate:

a. Orders for seclusion (including use in emergency situations)

Yes ◯ No ◯ Unsure ◯

b. Patient dignity and safety

Yes ◯ No ◯ Unsure ◯

c. Renewal of orders

Yes ◯ No ◯ Unsure ◯

Please provide additional comments are required.

_____

_____

9. Do you think that the current provisions in the Rules governing the **use of mechanical means of bodily restraint** in relation to the following remain appropriate:

a. Orders for restraint

Yes ◯ No ◯ Unsure ◯

b. Patient dignity and safety

Yes ◯ No ◯ Unsure ◯

c. Renewal of orders

Yes ◯ No ◯ Unsure ◯

Please provide additional comments are required.

_____

_____

10. Do you believe that the current provisions in the Code of Practice on the **use of physical restraint** in relation to the following remain appropriate:

a. Orders for restraint

Yes ◯ No ◯ Unsure ◯

b. Patient dignity and safety

Yes ◯ No ◯ Unsure ◯

Please provide additional comments are required.

_____

_____

11. Do you feel that the Rules / Code of Practice are sufficiently prescriptive in terms of the level/form of communication between the patient/resident and relevant staff members both before and after the following?

a. Seclusion

Yes ◯ No ◯ Unsure ◯

b. Mechanical Means of Bodily Restraint

Yes ◯ No ◯ Unsure ◯

c. Physical Restraint

Yes ◯ No ◯ Unsure ◯

Please provide additional comments are required.

_____

_____

_____

12. Are you satisfied that the timeframes for monitoring patients in seclusion and the designated responsibilities of particular professions in this regard are appropriate?

Yes ◯ No ◯ Unsure ◯

Please provide additional comments are required.

_____

_____

13. Do you think that the specification for seclusion facilities included within the Rules is adequate?

Yes ◯ No ◯ Unsure ◯

Please provide additional comments are required.

_____

_____

_____

14. In your opinion do the following capture all essential information requirements?

a. Register for Seclusion

Yes ◯ No ◯ Unsure ◯

b. Register for Mechanical Means of Bodily Restraint

Yes ◯ No ◯ Unsure ◯

c. Clinical Practice Form for Physical Restraint

Yes ◯ No ◯ Unsure ◯

If no, please provide suggestions as regards how this could be improved.

_____

_____

15. Does the approved centre within which you currently work have a written policy (including the provision of information to the patient) in relation to the following:

a. Seclusion

Yes ◯ No ◯ Unsure ◯

b. Mechanical Means of Bodily Restraint

Yes ◯ No ◯ Unsure ◯

c. Physical Restraint

Yes ◯ No ◯ Unsure ◯

Please provide additional comments as required.

_____

_____

16. In your opinion are these policies well understood by staff and adhered to?

a. Seclusion

Yes ◯ No ◯ Unsure ◯

b. Mechanical Means of Bodily Restraint

Yes ◯ No ◯ Unsure ◯

c. Physical Restraint

Yes ◯ No ◯ Unsure ◯

Please provide additional comments as required.

_____

_____

17. Do you feel you have had sufficient training (where necessary) to meet the requirements of the Rules governing:

a. Seclusion

Yes ◯ No ◯ Unsure ◯

b. Mechanical Means of Bodily Restraint

Yes ◯ No ◯ Unsure ◯

Please provide additional comments as required.

_____

_____

18. Do you feel you have had sufficient training (where necessary) to meet the requirements outlined within the Code of Practice on physical restraint?

Yes ◯ No ◯ Unsure ◯

Please provide additional comments as required.

_____

_____

19. Do you think it is necessary for the Rules and Code of Practice to make specific provisions for particular groups of patients including older persons and persons with an intellectual disability?

a. Seclusion

Yes ◯ No ◯ Unsure ◯

b. Mechanical Means of Bodily Restraint

Yes ◯ No ◯ Unsure ◯

c. Physical Restraint

Yes ◯ No ◯ Unsure ◯

Please provide additional comments as required.

_____

_____

20. In your opinion, does Part 5 (Use of Mechanical Means of Bodily Restraint for Enduring Self-harming Behaviour) provide appropriate protection?

Yes ◯ No ◯ Unsure ◯

If no, please provide additional suggestions as to how this section might be improved.

_____

_____

21. How significant do you feel the introduction of these Rules for seclusion and mechanical means of bodily restraint have been in terms of fostering high standards in the delivery of mental health service in Ireland and in protecting the rights and interests of those receiving services within approved centres?

Very significant ◯
Significant ◯
Neither ◯
Insignificant ◯
Very Insignificant ◯

22. How significant do you feel the introduction of the Code of Practice on the use of physical restraint has been in terms of fostering high standards in the delivery of mental health service in Ireland and in protecting the rights and interests of those receiving services within approved centres?

Very significant ◯
Significant ◯
Neither ◯
Insignificant ◯
Very Insignificant ◯

23. Please include any additional comments regarding the current Rules, this review process and/or how you would like to see these Rules develop/evolve over the near future

_____

_____

Questionnaire 2: Service Users

1. **Please indicate which of the following your feedback relates to:**
   (In the case where you would like to return feedback on more than one of the below subjects, please take the time to complete a separate copy for each)

   a) Seclusion ◯
   b) Mechanical Means of Bodily Restraint ◯
   c) Physical Restraint ◯

2. **Were you satisfied that a member of staff sufficiently communicated with you before the episode of seclusion / restraint regarding the reasons for and likely duration of the episode?**

   Yes ◯ No ◯ Unsure ◯

3. **Were you satisfied that you had an ample opportunity to discuss the episode of seclusion / restraint with relevant staff members soon after the episode had concluded?**

   Yes ◯ No ◯ Unsure ◯

4. **Please provide any additional feedback that you feel might be relevant, based on your experience, regarding communication with staff before and after the episode of seclusion / restraint**

   _____
   _____
   _____
   _____

5. **Were you satisfied that staff continuously monitored your well-being throughout your episode of seclusion / restraint and did so on a sufficiently frequent basis?**

   Yes ◯ No ◯ Unsure ◯

6. **If the answer to the previous question was "no", please provide some additional feedback regarding your current concern(s)**

_____
_____
_____
_____

7. **How would you rate the seclusion / restraint facilities within the Centre that you experienced this episode?**

d) Very Good ◯
e) Good ◯
f) Average ◯
g) Poor ◯
h) Very Poor ◯

8. **Did you feel that staff within the Centre were sufficiently trained and experienced to manage / undertake the episode of seclusion or restraint?**

Yes ◯ No ◯ Unsure ◯

9. **If your answer to the previous question was "no", please provide some additional feedback regarding your concern(s)**

_____
_____
_____
_____

10. **Did you feel at any stage that a member of staff was using excessive force in order to commence the episode of seclusion or complete the episode of restraint?**

Yes ◯ No ◯ Unsure ◯

11. Do you feel that the episode of seclusion / restraint was prolonged beyond the period of time that was necessary for its intended purpose?

Yes ⬭ No ⬭ Unsure ⬭

12. Would you agree that the episode of seclusion / restraint was justified and in your best interests and/or the best interests of fellow patients / members of staff?

Yes ⬭ No ⬭ Unsure ⬭

13. Would you agree that the episode of seclusion / restraint was the only means available to prevent immediate or imminent harm to you and/or others?

Yes ⬭ No ⬭ Unsure ⬭

14. If your answer to the previous question was "no", please provide some additional feedback regarding your concern(s)

_____

_____

_____

15. Did you experience a loss of trust with staff in the Centre following your episode of seclusion / restraint?

Yes ⬭ No ⬭ Unsure ⬭

16. Did you feel unsafe within the Centre following your episode of seclusion / restraint?

Yes ⬭ No ⬭ Unsure ⬭

17. Do you agree that that seclusion / restraint should only be used as a last resort when all other options have been considered?

Yes ⬭ No ⬭ Unsure ⬭

18. **Based on your experience, do you think that the episode of seclusion / restraint was used too early and before all other suitable alternative approaches were first attempted?**

Yes ◯ No ◯ Unsure ◯

19. **Please include any additional comments regarding the current Rules, this review process and/or how you would like to see these Rules develop/evolve over the near future**

_____

_____

_____

_____

Questionnaire 3: MHA Administrators

1. **Are you currently involved in the extraction of data from the relevant registers associated with the previously outlined Rules and Code of Practice?**

   Yes ☐ No ☐

   If you answered yes to the above, please answer questions 2 – 5 below

2. **In your opinion, do the following capture all essential reporting information requirements?**

   a. **ECT Register**

   Yes ☐ No ☐ Unsure ☐

   b. **Register for Seclusion**

   Yes ☐ No ☐ Unsure ☐

   c. **Register for Mechanical Means of Bodily Restraint**

   Yes ☐ No ☐ Unsure ☐

   d. **Clinical Practice Form for Physical Restraint**

   Yes ☐ No ☐ Unsure ☐

   Where you answered no to any of the above, please provide further details as regards how this could be rectified.

   _____
   _____
   _____
   _____

3. **Have you experienced any difficulties when attempting to extract the necessary data from any of the above due to the design of the register(s)/form**

   Yes ☐ No ☐

   Where you answered yes to the above, please provide further details as regards how this could be rectified.

   _____
   _____
   _____
   _____
   _____

4. **Please provide recommendations as regards how you would like to see the data collection process improved**

   _____
   _____
   _____
   _____

5. **Please include any additional comments regarding the current registers/forms**

   _____
   _____
   _____
   _____

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