



Mental Health Commission

Seclusion and Physical Restraint Reduction

Knowledge Review and

Draft Strategy

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1. Introduction

This document presents the Mental Health Commission Draft Seclusion and Physical Restraint Reduction Strategy which has been developed having regard to the Commission's mandate to *"promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres"* (Mental Health Act 2001, Section 33(1)). The purpose of the strategy is to achieve significant reductions in the use of seclusion and physical restraint while also ensuring patient and staff safety. Reductions in the use of seclusion and restraint refer to decreases in the number of seclusion and restraint episodes and decreases in the duration of these episodes.

The Mental Health Commission considers that a number of developments make it appropriate for it to commence such an initiative. In particular:

- The Commission already plays a lead role in the regulation of seclusion and restraint and encourages services to try and reduce the use of these interventions;
- The Commission has published data on seclusion and restraint from 2008 to 2010 and continues to monitor data on seclusion and restraint;
- Concerns have emerged internationally over the safety and effectiveness of restrictive interventions and of their impact on patients;
- Seclusion and restraint reduction initiatives have taken place successfully in other countries; and
- One of the strategic priorities outlined in the Commission's Strategic Plan 2009 -2012 commits it to embedding human rights *"in all aspects of Commission and mental health service providers' policy and practice"*.

We provide more detail on the background to the development of this draft strategy in Section 2. Section 3 outlines the methodology which we used to formulate the strategy. Section 4 is the core of the knowledge review where we identify the primary interventions that emerge from the literature as being effective in reducing levels of seclusion and restraint. We discuss the literature in an Irish context in Section 5 before including specific actions that comprise the Commission's draft strategy to reduce seclusion and restraint. We also outline our approach to implementation in Section 6.

2. Background

2.1 Regulation of Seclusion and Restraint in Ireland

The Mental Health Act 2001 provides for the use of seclusion and mechanical restraint for the purposes of treatment or to prevent the patient from injuring himself or herself or others. In line with Section 69(2) of the 2001 Act, the Mental Health Commission published *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (MHC, 2009d) which regulate the use of seclusion and mechanical restraint in approved centres. The Commission also published a *Code of Practice on the Use of Physical Restraint in Approved Centres* (MHC, 2009a) which contains best practice guidance on the use of physical restraint for persons working in approved centres. Updated versions of both the Rules and Code of Practice came into effect in January 2010 following an independent review of their provisions which was carried out in 2008. The Inspector of Mental Health Services assesses compliance with the Rules and Code of Practice as part of the annual inspection process for approved centres.

The provisions of the Rules and Code of Practice make clear the Commission's belief that these are not standard interventions but emergency measures which should be used "*in rare and exceptional circumstances and only in the best interests of the patient when he or she poses an immediate threat of serious harm to self or others*". Provisions within both documents also encourage approved centres to focus on preventative measures that eliminate or minimise the use of restrictive interventions. For instance, Rule 10.2 of the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* states that "*Each approved centre must have a written policy in relation to the use of seclusion. The policy must include a section which details how the approved centre is attempting to reduce the use of seclusion, where applicable*" (MHC, 2009d). A similar provision is contained in the *Code of Practice on the Use of Physical Restraint in Approved Centres*.

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

Seclusion is defined by the Mental Health Commission as "*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*" (Mental Health Commission, 2009d). The Commission defines physical restraint as "*the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident's body when he or she poses an immediate threat of serious harm to self or others*" (Mental Health Commission, 2009a). The exact definitions of seclusion and physical restraint that are used in other countries vary but are broadly similar to those in use in Ireland.

2.2 Data Collection

The Commission collects data on the use of seclusion, mechanical restraint and physical restraint in approved centres and has published three annual reports on the use of these interventions. These reports describe the use of seclusion and restraint nationally, regionally and in individual services (MHC, 2009d; MHC, 2011b; MHC, 2012). They highlight substantial variation in the use of seclusion and restraint between approved centres and between different regions in Ireland. Data collected during 2010 show that 5,370 restrictive interventions were used in all approved centres in that year. Of the 14 super- catchment areas into which Ireland's mental health services are geographically organised, the use of seclusion varied from a rate of 1.2 episodes per 100,000 population in the super catchment area of North Lee & North Cork in 2009 to a rate of 168.6 episodes per 100,000 population in the Dublin North Central & North West region. There was also substantial variation in the duration of seclusion episodes (MHC, 2012). In St Joseph's Intellectual Disability Services at St Ita's Hospital, 99.7% of seclusion episodes lasted for less than 4 hours. Conversely, 48.8% of seclusion episodes in the Central Mental Hospital lasted for longer than 16 hours.

The variation that is evident in Ireland is in line with findings from other countries. A 1992 review of the frequency of seclusion in the United States reported that its use varied from 0 - 66% of admissions (Browne and Tooke, 1992). More recently, an analysis of data collected by the New Zealand Ministry of Health for forensic services in New Zealand showed that the rate of seclusion events ranged from 3.8 per 100,000 population in the Capital and Coast District Health Board to 252.3 events per 100,000 population in the Otago District Health Board (Ministry of Health [New Zealand], 2010).

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

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

2.3 Related Irish Developments

A Vision for Change and Quality Framework

Ireland's national mental health policy document, *A Vision for Change* (Department of Health & Children, 2006), stresses that the range of interventions offered in Irish mental health services should be comprehensive and should reflect best practice for addressing any given mental health

problem. It also states that a “recovery” approach should inform every level of service provision. International literature on seclusion and restraint reduction suggests that the recovery approach demands a reduction in the use of restrictive interventions carried out against a patient’s wishes (Smith et al., 2005; Huckshorn, 2004).

Ireland’s national standards for mental health services, the *Quality Framework for Mental Health Services in Ireland* (MHC, 2007) provide clear guidance to service users, their families/chosen advocates, service providers and the public as to what to expect from a mental health service and compliment the recommendations outlined in *A Vision for Change*. A number of the standards in the Quality Framework should clearly inform any consideration of and actual use of these interventions. Standard 4.1 states that “Service users receive care and treatment in settings that that are safe, and that respect the person’s right to privacy and dignity” and Standard 7.3 states that “Learning and using proven quality and safety methods underpins the delivery of a mental health service”.

Strategy for Managing Work-Related Aggression and Violence within the Irish Health Service

The HSE launched a Strategy for Managing Work-Related Aggression and Violence within the Irish Health Service in December 2008. *Linking Service and Safety* (Mc Kenna, 2008) used four best-practice approaches from organisational and health disciplines to address the problem of work related aggression and violence. These were:

- A contextual understanding of aggression and violence within healthcare;
- An integrated balanced organisational response;
- A public health preventive approach; and
- A partnership ethos of working.

The strategy addressed *inter alia* seclusion and restraint practices and recommended that “the HSE proactively aspire to provide services which are ‘seclusion and restraint minimised’ at philosophical, organisational and operational levels (Mc Kenna, 2008)”.

The strategy’s other recommendations come under the following headings:

- The Extent of the Problem of Work-Related Aggression and Violence;
- Its Impact and Response;
- Health Safety Quality and Risk;
- Education and Training;
- Physical Interventions¹;
- Supporting Staff;
- Organisational Security Responses; and
- Organisational Policy.

¹ Physical Interventions refers to all interventions employed for the purpose of managing potential or actual work-related aggression and violence, but excludes the functional physical contacts customarily involved in care delivery. This definition therefore includes both seclusion and physical restraint.

2.4 International Seclusion and Restraint Reduction Initiatives

A number of seclusion and restraint reduction initiatives have been undertaken in different states in recent years, mainly prompted by concerns over the high number of deaths of patients in seclusion and restraint (Weiss, 1998; Huckshorn, 2005) and revelations about the trauma that is experienced by some patients who are subject to these interventions (Frueh et al., 2005; Robins et al., 2005). A Cochrane systematic review of seclusion and restraint which was carried out in 2000 also found that there was no evidence base for their effectiveness (Sailas & Fenton, 2000).

A particularly successful seclusion and restraint reduction initiative was undertaken in Pennsylvania in the United States where the number of seclusion and restraint incidents in state hospitals was reduced by 74% between 1990 and 2000 with no associated increase in either the frequency or the severity of staff injuries (Smith et al., 2005). We detail some of the strategies associated with this successful initiative in Section 4. More recently, seclusion and restraint reduction strategies have commenced in other jurisdictions. A *Policy statement on reducing and where possible eliminating and reducing seclusion and restraint* in Queensland mental health services was commenced in October 2008 for example (Queensland Health, 2008) and in the same year, the Ministry of Health in New Zealand, introduced the Restraint Minimisation and Safe Practice Standard (RMSP). The intent of the standard is to reduce restraint in all its forms and to ensure that, when practiced, it occurs in a safe and respectful manner (O'Hagan M, Divis M and Long J, 2008).

2.5 Mental Health Commission Draft Seclusion and Physical Restraint Reduction Strategy

Having regard to all of the above developments, the Commission decided to complete a knowledge review on effective international seclusion and restraint reduction interventions. This knowledge review is presented in Section 4. After undertaking the knowledge review, we decided to develop an associated strategy with the aim of reducing the use of seclusion and physical restraint within approved centres in Ireland.

The Commission regulates the use of three restrictive interventions – seclusion, physical restraint and mechanical restraint. In 2010, seclusion and physical restraint together accounted for 99.7% of all restrictive interventions in approved centres which were reported to the Commission. Therefore, as mechanical restraint is rarely used in approved centres, this draft strategy focuses on addressing decreases in the use of seclusion and physical restraint.

3. Methodology

3.1 Methodology

For our initial literature review, which took place in March 2011, we carried out electronic searches of the Psychinfo, PubMed and Cochrane databases to identify research articles published since 1990. The key search words chosen were: (mental health OR psychiatr*) AND (seclu* OR restrain*) AND (reduc* OR decrease*). The selected abstracts were then reviewed to identify those articles which were relevant for our purposes. We excluded articles that did not relate to in-patient psychiatric services or reduction strategies.

Among the articles identified were a number of literature and systematic reviews in the area. These included three reviews which were published during 2010 (Scanlan, 2010; Johnson, 2010; Stewart et al., 2010). After we examined seven reviews in detail, we considered that very little added value would accrue from undertaking our own in depth literature review, such was the comprehensiveness of the material.

At this stage, we decided to summarise the findings from the literature reviews and to issue relevant recommendations to form part of the Commission's draft strategy to reduce the use of seclusion and physical restraint. Where we wished to obtain more information than was presented in a review, we also read individual research articles which were referenced in literature reviews. Table 1 summarises the literature reviews from which we identify the main interventions detailed in the next section. The table shows the author (s), the aims of each literature review, the inclusion and exclusion criteria and the number of papers that were included as part of the review.

Note: A follow-up search carried out in June 2012 showed that no relevant reviews had been published since the original literature search carried out in March 2011.

Table 1: Summary of Literature Reviews on Seclusion &/or Restraint Reduction Initiatives

Author(s)	Review Aims (s)	Inclusion and Exclusion Criteria	No. of Papers Included in Review
Johnson ME (2010)	<p>1. To compare and contrast the design, content, and outcomes of programs aimed at reducing seclusion/restraint or aggression/violence; and</p> <p>2. To identify trends in design, content, and outcomes of seclusion/restraint and aggression/violence reduction efforts.</p>	<p>To be considered highly relevant, the studies or projects needed to be conducted on inpatient psychiatric units, published in the English language, and published in a peer-reviewed journal.</p> <p>Published abstracts and dissertations, reports of studies in non-psychiatric or forensic settings, and studies using nursing students as participants were not included.</p>	46
Stewart D, Van der Merwe M, Bowers L, Simpson A and Jones J (2010)	Review of Interventions to Reduce Mechanical Restraint and Seclusion.	<p>Post-1960 empirical studies in English of interventions to reduce the use of mechanical restraint and seclusion among adult psychiatric in-patients.</p> <p>Exclusion of studies relating to children, eating disorders, diet, dementia and the elderly.</p>	36
Scanlan JN (2010)	Analyses evidence available from evaluations of single seclusion and/or restraint reduction programmes.	<p>Site-specific programmes implemented to reduce seclusion and/or restraint in in-patient psychiatric settings.</p> <p>Exclusion criteria = editorials or opinion pieces that were not related to inpatient psychiatric services or were not related to reduction strategies.</p>	29
Gaskin CJ, Elsom SJ & Happell B (2007)	To find empirically supported Interventions that allow reduction in the use of seclusion.	<p>Papers published in English and in peer-reviewed journals between 1988 and 2007 in which the authors reported on interventions to reduce seclusion rates in psychiatric facilities.</p> <p>Opinion-based papers (e.g. commentaries, letters to editors) were excluded, as were papers in which the interventions were solely based on changes to medications, and those in which seclusion rates pre and post-intervention were not provided.</p>	16
Delaney KR (2006)	Studies were reviewed and critiqued that related to programmes of restraint reduction, restraint reduction methods, and aggression management.	Inclusion criteria were: studies less than 10 years old, data based, addressing restraint and seclusion or aggression management of children, and written in English or a translation was available.	Not stated

Author(s)	Review Aims (s)	Inclusion and Exclusion Criteria	No. of Papers Included in Review
Sailas EES &Wahlbeck K (2005)	The review summarises recent research on the use of seclusion and restraint, and measures taken to reduce their use.	<p>Seclusion and restraint in adult psychiatric care.</p> <p>The review of the literature spans covered many years but focused in particular on papers published in 2004.</p> <p>Articles for the review were obtained from peer-reviewed scientific journals.</p>	Not stated
Livingstone (2007)	To re-evaluate the literature on seclusion as a follow-up to a previous literature review and retrospective study of seclusion in 2002.	Prospective and retrospective studies, case studies and series, theoretical formulations, position statements, opinion focused papers, investigative reports and community-oriented websites.	134

Five of the seven literature reviews detailed in Table 1 group the variety of interventions that have been used to reduce seclusion and restraint into different categories. For instance, the category of training and education includes a number of interventions in this area, including training on attitudes to the use of seclusion and restraint, training in crisis management skills and education on new models of care such as the principles of recovery and trauma –informed care. Our summary of the literature findings in Section 4 also groups interventions into different categories. None of the reviews used the same categorisation of interventions to reduce the use of seclusion and restraint and we have adopted one which we feel is best suited to Irish mental health services.

We complimented the electronic search of research databases with an electronic search for grey literature, including best practice documents and accounts of seclusion and restraint reduction in other states. After summarising the literature, we then considered its implications for practice in Ireland and developed recommendations to form part of an effective strategy to reduce the use of seclusion and physical restraint in Ireland.

4. Interventions to Reduce the Use of Seclusion and Restraint

Our knowledge review has identified nine major categories of interventions to reduce the use of seclusion and restraint.

These are:

- a) Policy and regulation changes;
- b) State level support;
- c) Leadership;
- d) Staffing changes;
- e) Training and education;
- f) Patient, family and advocate involvement;
- g) Using data to monitor seclusion and restraint episodes;
- h) Review procedures/Debriefing; and
- i) Medication.

We describe each of these in turn.

4.1 Policy and regulation changes

This occurs when states or regulatory agencies such as the Mental Health Commission introduce new or altered policies or regulations that relate to seclusion or restraint. These changes can mandate or alternatively encourage the development of seclusion and restraint reduction initiatives at a local level (Scanlan, 2010; Gaskin, Elsom and Happell, 2007; Smith et al, 2005).

Gaskin, Elsom and Happell reviewed two studies where the involvement of the state in seclusion practices had changed. This led to:

- An increased emphasis on having tighter controls on when and how seclusion may be used;
- Greater oversight of seclusion episodes through the appointment of an independent advocate for patients;
- The introduction of a recovery approach to caring for patients; and
- The requirement for post-seclusion debriefings with staff and patients (Gaskin, Elsom and Happell 2007).

Tighter controls over the use of seclusion were introduced by the Health Care Financing Administration (HFCA) in the United States in 2001 through new rules which required all patients who were restrained or secluded to have a face-to-face evaluation by a physician or other licensed, independent practitioner within an hour of the start of the seclusion or restraint event. Two studies of single psychiatric hospitals which were carried out shortly after the rules were introduced found that the introduction of the rules appeared to reduce levels of restraint and seclusion (Belanger, 2001; Currier & Farley-Toombs, 2002).

4.2 State level support

Le Bel et al. (2004) detailed the efforts of a State Mental Health Authority (SMHA) in the United States to reduce seclusion and restraint in child and adolescent services. The authority had regulatory powers over 70 psychiatric institutions and the initiative concentrated on child and adolescent facilities and used a strength based-care approach. A strength-based care approach emphasises the positive resources and abilities that children and families have rather than focusing on problems and weaknesses.

The support that was provided by the SMHA mainly consisted of:

- A series of licensing and monitoring visits, in which strength-based care was outlined to staff;
- Assisting the development of peer-to-peer support networks for staff at the different facilities to change workplace cultures and implement interventions to reduce seclusion and restraint;
- Organising a best practice conference on restraint and seclusion reduction;
- Requiring staff at each facility to develop a strategic plan incorporating strength-based care;
- Facilitating restraint and seclusion themed visits, in which conference presentations were made and SMHA staff assisted facility staff to develop their strategic plans and strength-based approaches;
- Linking with other state agencies serving children and adolescents; and
- Enhancing supports for children and adolescents with histories of trauma (Gaskin, Elsom and Happell, 2007).

Seclusion and restraint episodes decreased across all unit types during the 22 month period. Decreases of 73%, 47% and 59% in the number of seclusion and restraint episodes was achieved on child units, adolescent units and on mixed child/adolescent units respectively. As the SMHA did not make any changes to its regulations or policies during the initiative, it appears that it was the supports described above that lead to the reductions in seclusion and restraint rates (Le Bel et al., 2004; Gaskin, Elsom and Happell, 2007).

4.3 Leadership

In the context of strategies to reduce the use of seclusion and restraint, leadership refers to a strong commitment to and support for seclusion and restraint reduction efforts among senior staff at mental health facilities and those in key positions in government, regulatory and other stakeholder organisations. Much of the literature on the successful seclusion and restraint reduction programme in Pennsylvania identifies the leadership of Charles Curie, the state's then deputy secretary for the State Office of Mental Health and Substance Abuse Services (OMHSAS) as being especially significant. He introduced new standards that further restricted the use of seclusion and restraint, publicly declared that these interventions amounted to "*treatment failure*" and challenged services to find more positive ways of supporting persons in crisis (Smith et al, 2005).

Delegations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) have also reported that when management at psychiatric facilities adopt an active and alert role towards the use of restraint, this usually leads to a decrease in its use (CPT, 2006). Huckshorn (2004) links clear leadership to the development of a specific plan which targets a reduction in the use of these interventions. Such a plan should include a mission statement, clearly articulate the facility's philosophy about seclusion and restraint reduction and describe the roles and responsibilities of all staff.

Other leadership behaviours have included:

- Reducing the maximum time period for which seclusion and/or restraint can be ordered (W.A. Fisher, 2003; Hellerstein *et al.*, 2007);
- Setting targets for reducing seclusion and restraint (Singh *et al.*, 1999);
- Removing seclusion rooms (Lehane & Rees, 1996);
- Setting new expectations for staff to reduce the use of seclusion (Sullivan *et al.*, 2005),
- Reviewing seclusion policies (Kalogjera *et al.*, 1989; Fisher, 2003),
- Public calls for the reduction of seclusion (Fisher, 2003; Sullivan *et al.*, 2005),
- Changing systems of practice to prioritise the reduction of seclusion (Schreiner *et al.*, 2004),
- Providing staff with resources such as education and training to reduce levels of seclusion (Schreiner *et al.*, 2004),
- Implementing data collection initiatives (Taxis, 2002);
- Modelling crisis de-escalation techniques for staff (Schreiner *et al.*, 2004); and
- Marking the commencement of a reduction strategy with a launch or 'kick-off' event (Huckshorn, 2004).

4.4 Staffing Changes

A number of different strategies in which some aspect of the intervention related to staffing changes have been attempted in order to reduce seclusion and restraint. These have included:

- Increased staff to patient ratios;
- Changes to staffing roles and structures; and
- The introduction of Psychiatric Emergency Response Teams (PERTs).

Increased staff to patient ratios

Increasing the staff to patient ratio was one of a number of measures introduced at a public psychiatric hospital in Virginia in the United States between 1997 and 2002. The staff to patient ratio increased from 2 to 1 in July 1997 to 3.3 to 1 in June 2002 and coincided with a decrease of 75% in the use of seclusion and restraint over the 5 year period in which this and other interventions were used (Donat, 2003). These staff to patient ratios included all staff that were employed at the hospital. A dramatic reduction in the use of seclusion and restraint occurred in a number of psychiatric hospitals in Pennsylvania State between 1990 and 2000. During this time, the number of

patients on a typical unit decreased from 36 to 32 and the number of staff on each unit increased from one licensed nurse and three psychiatric aides to two licensed nurses and four psychiatric aides (Smith et al, 2005).

The manner in which increasing the patient-to-staff ratio leads to reductions in the use of restrictive interventions is not clearly understood but it is assumed that it results in there being more time available for the direct care of patients which might be expected to reduce the likelihood of conflict occurring in units. Increased staffing should also assist with the implementation of other strategies outlined in this document and which are also designed to reduce the use of seclusion and restraint.

Changes to staffing roles & structures

Staffing roles and structures have also been changed in an effort to reduce the use of restraint and seclusion. Some examples include:

- Employing a new nurse consultant to advocate for staff and to assist their efforts to reduce the levels of violence on wards (Morrison et al., 2002);
- The rotation of staff to ensure that nurses work with a range of patients so that burnout is reduced among staff that work continuously with acutely unwell patients (Sullivan, Wallis, & Lloyd, 2004); and
- Increasing multi-disciplinary collaboration in reduction efforts (Donovan et al, 2003).

Psychiatric emergency response teams

Psychiatric emergency response teams are usually teams of nursing staff that have been created specially to provide a quick and co-ordinated response to crisis situations on a ward (D’Orio et al., 2004; Smith et al., 2005). Members of these teams are trained in verbal de-escalation, violence prevention skills, therapeutic communication, mediation and conflict resolution to enable them to deal with crisis situations. They may consist of staff from other units and staff typically serve on-call as members of the team on a rotating basis throughout the week. Psychiatric emergency response teams formed part of the successful seclusion and restraint reduction programme in Pennsylvania between 1990 and 2000 and were credited with eliminating the use of seclusion and dramatically decreasing the use of restraint in one of Pennsylvania’s in-patient psychiatric facilities, Allentown State Hospital (Smith et al, 2005).

4.5 Staff Training & Education

Three main types of staff training and education can be identified from studies of seclusion and restraint reduction:

- Training that focuses on promoting attitudinal change among staff;
- Training to support the development of skills in crisis management including alternatives to seclusion and restraint ; and
- Training on the implementation of new models of care.

Attitudinal Change

Two recent studies suggest that without substantial attitude changes among staff, it is unlikely that reductions in the use of seclusion and restraint will ever be achieved (Curran, 2007; van Doeselaar et al, 2008). In particular, traditional views about the value of seclusion and restraint in promoting safety and compliance among patients must be tackled (Busch & Shore, 2000; Delaney, 2001; Schreiner *et al.*, 2004; Singh *et al.*, 1999; Taxis, 2002). Some of the myths identified by a number of authors in the literature include:

- Seclusion and restraint keep people safe;
- Seclusion and restraint are only used when absolutely necessary;
- Staff know how to recognise and de-escalate potentially violent situations;
- Seclusion and restraint interventions are based on empirical knowledge; and
- Seclusion and restraint are used without bias and only in response to objective behaviours.

It is also maintained that misinformation and inaccurate assumptions have sustained these beliefs (Holzworth & Willis, 1999; Mildred, 2002; Mohr and Anderson, 2001; NETI, 2003; Stilwell, 1991).

Schreiner et al. (2004) suggest that key decision makers i.e. staff who largely decide whether or not seclusion or restraint are used, should be the focus of training initiatives.

Crisis Management Skills

The majority of training strategies that are referenced in the literature have focussed on improving the ability of staff to manage crisis events. This frequently includes training in de-escalation techniques and other non-violent interventions (Gaskin, Elsom and Happell, 2007; Scanlan, 2010; Stewart et al, 2010). Taxis (2002) provides a detailed description of a training programme in a psychiatric facility which was one of a number of interventions used to bring about reductions in the use of seclusion and restraint. It consisted of a number of half hour sessions in which training was delivered on verbal de-escalation techniques, collaboration, one-to-one discussions, crisis intervention and diversion techniques, anticipation of violence, therapeutic interventions with personality disorder patients, ethics, the use of medication with aggressive patients and documentation. Training at this facility was also designed to address areas of concern highlighted through the monitoring of data. Overall, a 94% reduction in the rate of seclusion and restraint was achieved at this facility over a 42-month period.

In another study, a 14% reduction in the use of seclusion and a 50% decrease in the duration of seclusion occurred in an urban psychiatric hospital in which training was the primary intervention (Forster et al, 1999). The training consisted of a one – day assault prevention course and was compulsory for all staff.

New models of care

New models of care in which staff have been trained include the development of high-therapy, low-conflict wards (Bowers et al, 2006) and collaborative problem-solving (Greene et al, 2006). Trauma informed care i.e. a model of care that recognises that many patients have been negatively affected

by traumatic life events has also been identified as pivotal to reducing seclusion and restraint (Fallot & Harris, 2002; NETI, 2003).

4.6 Involving patients, family members & advocates in seclusion and restraint reduction programmes

Service users, family members, advocates and members of the public are becoming increasingly involved in health and social care services in Ireland and internationally (Health & Social Care Regulatory Forum, 2009). Many seclusion and restraint reduction initiatives have also sought to include patients, family members and advocates. This has included:

- Collaborative development of crisis management strategies (Hellerstein *et al.*, 2007; Jonikas *et al.*, 2004; Pollard *et al.*, 2007; Visalli & McNasser, 2000);
- Debriefing (Delaney, 2001; W.A. Fisher, 2003; Jonikas *et al.*, 2004; Visalli & McNasser, 2000);
- Including the patient and family in treatment planning and as part of the treatment team; (Donovan *et al.*, 2003; Greene *et al.*, 2006; Kalogjera *et al.*, 1989; Taxis, 2002)
- Advocacy efforts (Smith *et al.*, 2005); and
- Patient Education.

We describe some of these strategies in turn.

Collaborative development of crisis management strategies

The development of a crisis management strategy usually focuses on newly admitted patients. For instance, one study reported on a coping agreement questionnaire which was issued to all new patients. It sought information on personal triggers, typical responses and patients' treatment preferences which included the possible use of restrictive interventions (Hellerstien *et al.*, 2007). This study reported a significant reduction in the number of patients secluded and in the duration of seclusion but not for the use of restraint (Hellerstien *et al.*, 2007). Patient preferences can also be incorporated into treatment plans or crisis management plans (Jonikas *et al.*, 2004; Sullivan, 2004).

Debriefing

We discuss debriefing as a separate critical strategy below (section 4.8).

Including the patient and family in treatment planning and review processes and as part of the treatment team

Donovan *et al.* (2003) describe a performance improvement programme known as "ABCD" which was introduced at a large child and adolescent in-patient facility in Connecticut in the United States (Donovan *et al.*, 2003). "ABCD" consisted of four core elements i.e. autonomy, belonging, competence and doing for others. It led to a number of changes such as an increased emphasis on positive relationships between patients and staff and the encouragement of patients to become

involved in the in-patient community by taking responsibility for group tasks and mentoring new patients. One method of involving patients in treatment planning and review processes as they pertain to seclusion and restraint reduction is through the use of advance directives which are then integrated into the service user's care and treatment plan (Delaney, 2001). The perspectives of service users and nurses on restraint events are often different (Outlaw & Lowery, 1994) and so seclusion and restraint reduction efforts should be informed by the documenting of service user's experiences in restraint. Getting patient's feedback on a service is a further approach to reducing seclusion and restraint. People are less likely to get agitated or aggressive if they are happy with the mental health service (O'Hagan et al., 2008).

Advocacy Efforts

Service user advocacy groups have played influential roles in past successful reduction efforts. Advocacy organisations in Pennsylvania complained about the misuse and overuse of restraint and were assisted by that state's assignment of independent advocates to each psychiatric hospital (Smith et al., 2005). At a state level, advocacy organisations regularly raised questions about the use of the interventions, requested reports and demanded more staff training. The efforts of advocates on this issue were credited with addressing individual patient issues and pressuring the state mental health organisation to monitor and reduce the use of seclusion and restraint. Where advocates are employed at the mental health service, it is especially important that their role is respected and is a genuine and not tokenistic initiative (Huckshorn, 2004).

Patient education

Patient education aims to improve patients' skills in dealing with their anger and other emotions (McCue et al., 2004; Taxis, 2002). Such programmes have consisted of regular, structured group sessions and informal one-to-one interactions with nurses.

4.7 Using data to monitor seclusion and restraint episodes

The use of data to monitor restrictive intervention episodes is also highlighted in a number of the reviews that informed our findings. Data have been collected by mental health facilities and are then used for different purposes which include:

- Identifying general seclusion patterns which facilitates benchmarking with other hospitals and wards;
- Identifying outlier patients who can then be targetted with strategies such as the initiation of reviews after less episodes of seclusion (Schreiner et al., 2004; Donat, 2003);
- Identifying issues of concern which can then be addressed through staff training and education;
- Identifying staff members and individual units that have successfully reduced seclusion and restraint in order to ensure that learning can be shared (Huckshorn, 2004).

O' Hagan et al. (2008) outline a series of data items which should be collected in order to effectively monitor the use of seclusion. They are:

- Total seclusion events;
- Total seclusion hours;
- Total number of service users secluded, including demographics;
- Total number of seclusion events and total hours for each service user secluded;
- The use of alternative restraints to replace seclusion e.g. medication or one to one time with staff;
- The use of non-restraining methods to replace seclusion;
- The number of injuries sustained by service users and staff;
- The days and shifts the seclusion events occurred;
- The staff member (s) involved in each seclusion event;
- Analysis of both the themes and outcomes of debriefings; and
- Analysis of trends in use of seclusion, and of non-restraining methods (O' Hagan et al. , 2008).

Huckshorn (2004) recommends that data are not used to discipline staff members.

4.8 Review procedures/Debriefing

Review procedures for seclusion and restraint events have taken different forms. One of the more common approaches has been the establishment of a review committee to analyse episodes of restrictive interventions in detail and recommend steps to prevent future events. One study from 2003 found that the use of such a committee accounted for 34% of the variance in the reduction of seclusion events (Donat, 2003). In other instances, reviews took place during regular team meetings or involved senior staff monitoring and reviewing the frequency of restraint and seclusion. (Donat, 1998, 2003; Hellerstein et al., 2007; Taxis, 2002) Both of the latter methods also achieved notable reductions in their use. Review procedures can also focus on an individual patient with the goal of reducing seclusion or restraint for that patient (Fisher, 2003; McCue et al., 2004; Sullivan et al., 2004).

A particular type of review of the seclusion or restraint of an individual patient is debriefing which occurs after a restrictive intervention episode and may involve staff (Forster et al., 1999; Khadivi et al., 2004; Schreiner et al., 2004) or staff and patients or their families (Delaney, 2001; W.A. Fisher, 2003; Jonikas et al., 2004; Visalli & McNasser, 2000). Debriefing mainly focuses on the events leading up to a seclusion or restraint episode. Where it involves the patient, it provides clinicians with an opportunity to explain their rationale for initiating a restrictive intervention episode and allows patients to explain their behaviour and emotions prior to the episode. This should help with formulating strategies for how seclusion and restraint can be prevented for the particular patient in future. Huckshorn (2005) and O' Hagan et al. (2007) agree on the need for an immediate debriefing to be followed by a formal debriefing or critical incident review.

4.9 Medication

The use of medication to achieve reductions in the use of seclusion and restraint was also examined in the literature reviews and there is clear evidence that the choice of anti-psychotic medication can influence rates of seclusion and restraint (Smith et al, 2005). In the literature reviews that we examined, medication refers only to the use of second generation anti-psychotics. In particular, clozapine has been found to lead to reductions in the use of restraint (Chengappa et al., 2002; Mallya, Roos & Roebuck-Colgan, 1992; Ratey et al., 1993). Mixed results have been found for other atypical anti-psychotics (Stewart et al, 2010).

4.10 Interpreting the Evidence

It is important to consider the nature of the evidence that supports the use of all of the interventions identified. In particular, there are a number of limitations associated with the research that has been carried out in this area.

Firstly, there are ethical and practical difficulties associated with carrying out randomised controlled trials in in-patient mental health facilities and very few controlled studies have been undertaken that examine the effectiveness of the strategies highlighted above. Most of the studies have a time series design and compare levels of seclusion and restraint before and after the introduction of an initiative. By their nature, these studies are less controlled which means that the reported reductions in seclusion and restraint use could be caused by factors other than the introduction of the interventions. In addition, many of the studies that are reported in the literature used a number of interventions to reduce the use of seclusion and restraint and did not assess the effectiveness of each individual intervention. This makes it difficult to identify which intervention(s) was/were responsible for the reported decrease in seclusion and restraint rates.

These challenges have lead authors, policy makers and researchers to advocate seclusion and restraint reduction strategies composed of multiple interventions.

Most of the literature which we summarised in this section applies to research undertaken in general adult and child and adolescent mental health facilities. However, seclusion and restraint reduction initiatives utilising many of the strategies we highlight above have also been successfully carried out in forensic mental health facilities (Ching et al., 2010; Qurashi et al., 2010). Qurashi et al.'s study of a seclusion reduction initiative undertaken in Ashworth Hospital, a high security hospital in the UK, highlighted a steady fall in the number of seclusion episodes from 54 per month in January 2002 to 18 per month in January 2007. The main components of the initiative were: a) the use of information and transparency; b) the effective use of audit and peer reviews; c) positive risk management; d) patient involvement; e) education and training; and f) enhanced clinical leadership. The authors also found no evidence of an increase in adverse incidents over the study period.

The recommendations and actions outlined in Section 5 as part of the Commission's draft strategy to reduce seclusion and physical restraint apply to all types of approved centre that use these interventions.

5. Discussion and Actions

This section sets out the actions that make up the Mental Health Commission Draft Seclusion and Physical Restraint Reduction Strategy. This follows a consideration of the literature's implications and the current context for applying the learning from it in Ireland. In particular, we must bear the following in mind:

- Most of the literature comes from outside Ireland and from the United States in particular. A different cultural context applies in Ireland where mechanical restraint is rarely used for instance.
- Implementation Issues. This includes factors such as the current economic climate and the Moratorium on Recruitment and Promotion in the Public Services which will hinder the implementation of any initiatives that have increased human resource implications.
- Existing regulation in mental health services. Many of the interventions highlighted in the literature are already partly or wholly addressed in the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* and the *Code of Practice on the Use of Physical Restraint in Approved Centres*. Therefore, the Commission will examine issuing further guidance to compliment the implementation of these rules and provisions.
- Related work programmes in the area of seclusion and restraint. A clinical scientist has commenced a PHD programme in the area of seclusion as part of a partnership programme between the Mental Health Commission and Royal College of Surgeons of Ireland (RCSI). There should be scope for this candidate to support the implementation of this strategy in areas such as data collection and analysis. Furthermore, the HSE's Strategy for Managing Work-Related Aggression and Violence within the Irish Health Service, *Linking Service and Safety*, is also relevant. The Mental Health Commission recognises that the implementation of this HSE strategy would facilitate realising some of the objectives of the Commission's seclusion and physical restraint reduction strategy. Therefore, our first action states that the Commission should request regular updates on the implementation of those aspects of *Linking Service and Safety* that relate to seclusion and physical restraint reduction.

We now discuss the literature under each of the main intervention categories highlighted in Section 4.

5.1 Policy and regulation changes

The literature included examples of successful seclusion and restraint reduction strategies where reductions in the use of these interventions were achieved through making changes to seclusion and restraint policies and to the manner in which these interventions are regulated. Seclusion and physical restraint are largely regulated through the requirements of the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* and the provisions of the *Code of Practice on the Use of Physical Restraint in Approved Centres*. Both publications also inform the content of local policies on the use of these interventions.

The introduction of the Rules and Code of Practice in 2006 brought about significant regulatory changes. A large majority of mental health services staff (79%) who participated in a review of the Rules in 2008 considered that the Rules had made a “*significant*” or “*very significant*” contribution to 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 (Prospectus, 2009).

It has not been possible to accurately assess the impact of the introduction of the Rules and Code of Practice on levels of seclusion and physical restraint use because of a lack of baseline data prior to the introduction of the Rules and Code in November 2006.

As the literature describes how regulatory changes can bring about reductions in the use of restrictive interventions, the Mental Health Commission must consider if there is a need to amend the Rules and Code of Practice governing the use of seclusion and physical restraint. In this context, it is important to note the CPT’s comments in its report on its visit to prisons and approved centres in Ireland in 2010. It stated that “*in general, the Mental Health Commission’s Rules Governing the Use of Seclusion & Mechanical Means of Restraint correspond closely to the CPT’s standards as set out in its 16th General Report*” (CPT, 2011, p. 64).

The Commission welcomes the comments of the CPT in relation to the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*. The Commission continues to recognise that the rules, codes of practice and standards should be kept under periodic review with a view to being updated with best practice guidance as the need arises.

The Commission also recognises that its regulatory role in relation to seclusion and physical restraint extends beyond imposing requirements on services through the Seclusion Rules and provisions of the Code of Practice on Physical Restraint. For example, there is scope for the Commission to issue guidance to assist with the implementation of certain Rules and Code provisions. The Commission can also request information from services that relates to its regulatory role. Furthermore, where the Inspectorate of Mental Health Services informs the Mental Health Commission that it has concerns that Commission Rules, provisions of Codes of Practice, guidance or aspects of the final strategy are not being complied with, the Commission will consider using its regulatory powers to impose conditions on the registration of approved centres.

The draft strategy’s action points that relate to policy and regulation changes consist of guidance to assist with the implementation of specific rules and provisions in the Rules and Code. The

Commission includes guidance on the areas of training (Action 10) and debriefing (Action 17) for instance which reflects the content of successful seclusion and restraint reduction programmes that were highlighted in Section 4. The draft strategy also includes an action related to the preparation of a seclusion and restraint reduction plan by each approved centre (Action 4).

5.2 State Level support

Most ideas on state level support that can be provided to assist with reducing seclusion and restraint emanate from Le Bel et al.'s (2004) article on a successful seclusion and restraint reduction initiative which consisted of a range of supports provided by a regulatory body in the United States. These supports included licensing and monitoring visits, the organisation of conferences and assistance with the development of peer-to-peer support networks. This initiative suggests that there are some supports which could be provided to approved centres to assist them to decrease the use of restrictive interventions.

In particular, support could be provided to approved centres to develop their seclusion and physical restraint reduction plans through the provision of guidance and templates (Action 4). The HSE and independent mental health service providers should lead out on this action with support from the Mental Health Commission. Some of the supports that were provided by the SMHA in the United States may, however, be more appropriately undertaken by mental health services themselves in Ireland. The HSE is solely responsible for the provision of mental health services in the public system in this country and is therefore better placed to implement an initiative that involves organising peer-to-peer networking between services that report relatively high overall uses of seclusion and physical restraint and those that report relatively low overall uses of these interventions (Action 2).

5.3 Leadership

The draft strategy's action points that relate to leadership focus on leadership behaviours to be carried out by the Commission and senior management in approved centres and which are consistent with the findings from the literature. For example, we include an action that the HSE allocates responsibility to senior managers within the Executive for the implementation of this strategy (Action 3). This is intended to demonstrate a commitment to seclusion and physical restraint reduction at the top level of management within the HSE.

Some of the leadership behaviours identified in Section 4.3 already take place. There are requirements/provisions in the Rules and Code that require approved centres to review their policies on the use of seclusion and physical restraint for instance. Furthermore, the maximum time period for which physical restraint can be ordered was revised to 30 minutes in 2010 when the *Code of Practice on the Use of Physical Restraint in Approved Centres* was updated.

One of the core components of this strategy consists of a seclusion and physical restraint reduction plan, which the Mental Health Commission will request from all approved centres that use these interventions and whose content will be suggested by the literature (Action 4). The implementation

of such a plan should be directed by the Clinical Director and Registered Proprietor of the approved centre. The Commission will request approved centres to provide it with an update on the implementation of this plan on an annual basis.

One study noted in Section 4.3 reported on how seclusion rooms were successfully removed from psychiatric facilities (Lehane & Rees, 1996). Of the 67 approved centres that returned seclusion data to the Mental Health Commission for 2010, 37 (55.2%) reported that they do not use seclusion. This includes a number of approved centres providing acute services and the Commission considers it appropriate that all Clinical Directors examine the feasibility of removing the seclusion room from the approved centre (Action 6).

5.4 Changes to Staffing

All of the staffing related initiatives to reduce the use of restrictive interventions identified in Section 4.4 must be considered in the context of current staffing shortages in the mental health services. The Inspector of Mental Health Services reported that 20% of nursing staff have been lost in some areas in the last year or two due to staff retirement (MHC, 2011). The Moratorium on Recruitment and Promotion in the Public Services means that most of these staff will not be replaced in the near future. In such a situation, it would be unrealistic for the Commission to include an action related to increased staff-to-patient ratios.

Nevertheless, it is clearly stated within both the Rules and the Code of Practice on Physical Restraint that seclusion and physical restraint should never be used to ameliorate operational difficulties including where there are staff shortages. As the literature indicates that increased staff-to-patient ratios are associated with a reduction in the use of seclusion and restraint, we can infer that decreased staff-to-patient ratios may lead to an increased use of these interventions. In order to ensure that staff shortages do not lead to the inappropriate use of seclusion and physical restraint, the Mental Health Commission calls for the replacement of those staff who are retiring from mental health services such that current staff-to-patient ratios are not reduced (Action 7). The Commission will also request approved centres to examine the feasibility of establishing psychiatric emergency response teams and to report the outcome of this examination to the Commission (Action 8).

Some of the initiatives related to altered staffing roles and structures as suggested by the literature are already in place. There is some multi-disciplinary involvement in reduction initiatives for instance through the review of seclusion and physical restraint episodes that take place after these events as required by the Rules and Code of Practice. However, the draft strategy includes an action which states that staff rosters should be arranged to ensure that staff are not working continuously with acutely unwell patients (Action 9).

5.5 Training and Education

General staff training and education is already addressed in existing Mental Health Commission regulations and standards. Standards 7.1 - 7.4 of the Quality Framework already address the area of staff skills and expertise and the Commission is of the view that the implementation of these standards can contribute significantly to seclusion and physical restraint reduction.

The Rules and the Code of Practice also contain specific requirements relating to the need for each approved centre to have a policy and procedures for training staff in relation to seclusion. However, the specific rule/provision does not address the content of training programmes as the Commission understood that this area was being addressed separately by the HSE through its Managing Violence and Aggression in the Workplace Initiative. In light of the findings from the literature identified in Section 4.5 regarding training programmes, the Commission is issuing guidance to services on training in seclusion and physical restraint (Action 10).

5.6 Involving patients, family members and advocates in seclusion and restraint reduction programmes

Patients, advocates and carers have become more directly involved in Irish mental health services in recent years and this trend has been encouraged in Ireland's major mental health policy, *A Vision for Change* (Expert Group on Mental Health Policy, 2006), and in Ireland's national standards for mental health services as outlined in the *Quality Framework for Mental Health Services in Ireland* (Mental Health Commission, 2007). Theme 3 of the Quality Framework focuses on achieving an empowering approach to service delivery for those using services and those working in them. Where these standards are complied with, service users should be directly involved in mental health services, including best practice initiatives such as a seclusion and physical restraint reduction programme.

Risk assessment is currently addressed in Provision 15.1 of the *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre*. The Commission considers that crisis management strategies such as advance directives should be developed collaboratively following a risk assessment and include such an action (Action 11).

Advocacy organisations and service user representative organisations such as the Irish Advocacy Network and NSUE campaign on behalf of service users in Ireland so there is potential for them to become directly involved in seclusion and physical restraint reduction initiatives as is suggested by the literature. The draft strategy includes an action which acknowledges that advocates and service user representative groups should be involved in initiatives to reduce the use of seclusion and physical restraint at national, regional and local level (Action 12).

5.7 Using data to monitor seclusion & restraint episodes

The Mental Health Commission has been monitoring the use of seclusion, mechanical restraint and physical restraint through the collection and analysis of seclusion and restraint data since 2008 and it has published three annual reports on the use of these interventions (MHC, 2009; MHC, 2011b;

MHC, 2012). These reports have described the use of seclusion and restraint in each approved centre in the state. National seclusion and restraint patterns have been identified and the reports have highlighted differences in the use of seclusion and restraint and the duration of seclusion and restraint episodes between approved centres and different super-catchment areas.

The data that are used to compile these reports are submitted to the Commission by approved centres on a quarterly basis. All data are extracted from a Register for Seclusion and a Clinical Practice Form for Physical Restraint, which are used to record all episodes of seclusion and physical restraint, as required by the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* and the *Code of Practice on the Use of Physical Restraint in Approved Centres*.

A number of the strategy's actions relate to data collected on these registers and the Mental Health Commission reports generated from them. As the Commission will shortly have gathered data on seclusion and restraint use over four years, it will be in a position to jointly set targets for seclusion and restraint reduction for all approved centres in consultation with mental health services (Action 13).

We also include an action which states that approved centres should carry out additional analysis on seclusion and restraint data that are collected on the Registers but which are not returned to the Commission (Action 14). This should support clinical audit and include an examination of issues such as seclusion and restraint episodes initiated by different staff members.

The Commission intends to examine the feasibility of developing electronic registers which would allow it to report on additional items that are not currently available, such as total seclusion and restraint hours and total number of patients secluded and restrained (Action 15). In addition, it is planned that the clinical scientist who is undertaking research in the area of seclusion as part of the MHC/RCSI joint PHD research programme will examine the feasibility of collecting additional data on seclusion and restraint use that will assist in monitoring their use and assisting in achieving reductions in their use (Action 16).

5.8 Review procedures/Debriefing

The Mental Health Commission *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* and the *Code of Practice on the Use of Physical Restraint in Approved Centres* contain provisions in relation to review procedures and debriefing. There is therefore scope for the Commission to issue guidance to facilitate the implementation of these rules/provisions so that debriefing and review procedures reflect best practice as outlined in Section 4.8.

Debriefing is addressed in Rule 7.4 of the Seclusion Rules and Provision 7.2 of the Code of Practice and Rule 10.3 of the Seclusion Rules and Provision 9.3 of the Code of Practice concern the review of seclusion and restraint events.

The guidance that the Commission includes to assist with the implementation of the rule and provision on debriefing (Action 17) clarifies that the debriefing should involve an advocate, carer or family member participating on behalf of the patient where he or she declines to participate and where appropriate i.e. with the patient's consent. Furthermore, the guidance also clarifies that during the debriefing, the events leading up to the seclusion/restraint event should be discussed and lessons are learnt from these so that future episodes of seclusion and restraint can be avoided.

The guidance that the Commission includes to assist with the implementation of the rule and provision on review procedures (Action 18) clarifies that the formal review procedure should take place after the debriefing of the patient, advocate, carer or family member and that the chairperson of the review meeting should not be someone who was involved in initiating the seclusion or restraint episode

5.9 Medication

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

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

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

As this draft strategy concentrates on promoting alternative strategies to seclusion and physical restraint, the Commission does not consider it appropriate to include an action related to the use of medication as restraint to achieve reductions in the use of seclusion or physical restraint.

5.10 Actions

This section sets out the actions that make up the Mental Health Commission Draft Seclusion and Physical Restraint Reduction Strategy. We also identify the person or agency that the Commission considers should take responsibility for the action in question and the intervention category to which each action belongs.

Actions

1. The MHC should request regular updates on the implementation of those aspects of the HSE Strategy for Managing Work-Related Aggression and Violence within the Irish Health Service, *Linking Service and Safety* (HSE, Dec 2008) that relate to seclusion and physical restraint.
Action: MHC **Intervention Category:** Policy and regulation changes
2. Peer-to-peer networking should be organised between mental health services with a particular emphasis on creating links between services that report relatively high overall uses of seclusion and physical restraint and services that report relatively low overall uses of seclusion and physical restraint.
Action: HSE & independent mental health service providers **Intervention Category:** Leadership
3. Responsibility should be allocated to HSE senior managers for the implementation of this strategy in all publicly funded mental health services. Responsibility should be allocated for the implementation of this strategy to senior managers within each approved sector in the independent sector that uses seclusion and/or physical restraint.
Action: HSE & independent mental health service providers **Intervention Category:** Leadership
4. (a) A seclusion and physical restraint reduction plan should be developed for each approved centre that uses seclusion and/or physical restraint. It should:
 - Include a mission statement;
 - Clearly articulate the approved centre's philosophy about seclusion and restraint reduction and the expectations that this places on staff;
 - Identify the role of the Clinical Director and senior management in directing the overall plan;
 - Describe the roles and responsibilities of all staff and indicates how they will be accountable for their responsibilities;
 - Commit senior management to creating a collaborative non-punitive environment to facilitate the reduction of seclusion and restraint in the approved centre;
 - Indicate how the approved centre intends to make use of data on seclusion and physical restraint to assist in reducing the use of both interventions;
 - Indicate how staff training and education will assist in realising the goal of seclusion and restraint reduction;
 - Support clinical audit;
 - Be developed in consultation with staff, service users and advocates; and
 - Be reviewed on an annual basis.
- (b) The Commission should be provided with an update on the implementation of this plan on an annual basis.
Action: HSE & independent mental health service providers
Intervention Category: Leadership

Actions

5. A commitment to the implementation of the seclusion and physical restraint reduction plan should be demonstrated in each approved centre. This should include but is not limited to:
- Making seclusion and physical restraint reduction a standing item on the agenda of multidisciplinary staff meetings;
 - Setting up a staff recognition project which recognises staff for their work towards achieving reductions in the use of seclusion and physical restraint use on an ongoing basis;
 - Clinical leadership communicating to staff that they will be expected to reduce the use of seclusion and physical restraint;
 - Reviewing seclusion and physical restraint policies; and
 - Formally marking the commencement of the plan's implementation.

Action: Clinical Directors and Registered Proprietors

Intervention Category: Leadership

6. An examination of the feasibility of removing the seclusion room from each approved centre that uses seclusion should be undertaken and a report on its outcome should be forwarded to the Mental Health Commission.

Action: Clinical Directors and Registered Proprietors

Intervention Category: Leadership

7. There should be a call for an exemption from the moratorium on recruitment in the public sector to facilitate the replacement of staff who are retiring from mental health services to ensure that current staff to patient ratios are not further reduced leading to a possible increase in the inappropriate use of seclusion and physical restraint.

Action: MHC & HSE

Intervention Category: Staffing

8. An examination of the feasibility of establishing psychiatric emergency response teams in every approved centre that uses seclusion and/or physical restraint should be undertaken and a report on its outcome should be forwarded to the Mental Health Commission.

Action: Clinical Directors and Registered Proprietors

Intervention Category: Staffing

9. Staff rotation should be arranged to ensure that staff are not working continuously with acutely unwell patients.

Action: Senior management and persons with delegated responsibility for staff rostering

Intervention Category: Staffing

Actions

10. The following Mental Health Commission guidance on training on seclusion and physical restraint should be followed to support achieving compliance with Section 19 of the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (Staff Training) and Section 10 of the *Code of Practice on the Use of Physical Restraint in Approved Centres* (Staff Training).

“Each approved centre’s policy on training in the use of seclusion and policy on training in the use of physical restraint should address the following:

- *attitudes to the use of seclusion and physical restraint;*
- *crisis management skills including de-escalation and negotiation;*
- *new models of care including trauma informed care and training in the principles of recovery; and*
- *the role of (i) policy and regulation (ii) support from the Mental Health Commission (iii) leadership (iv) changes to staffing (v) the involvement of service users, family members and advocates (vi) data (vii) review procedures/debriefing and (viii) medication in reducing the use of seclusion and physical restraint”.*

Confirmation that this guidance has been implemented in the approved centre should be forwarded to the Commission six months after the commencement date of this strategy.

Action: Clinical Directors and Registered Proprietors

Intervention Category: Training and Education

11. Provision 15.1 of the *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre* (initial assessment on admission) should be complied with to ensure that that each resident of an approved centre has an adequate assessment following admission, including a risk assessment. This risk assessment should aim to identify individual triggers for each patient and include personally chosen advance directives to be implemented in crisis situations. The outcome of this assessment should be integrated into the patient’s individual care and treatment plan.

Action: Clinical Directors and Registered Proprietors

Intervention Category: Patient/Family/Advocate Involvement

12. Advocates and service user representative groups should be involved in national, regional and local initiatives to achieve reductions in the use of seclusion and physical restraint. This may include but is not limited to taking part in the development of a seclusion and physical restraint reduction plan and representing patients in debriefing episodes, where appropriate i.e. with the patient’s consent.

Action: IAN, NSUE, MHC & HSE

Intervention Category: Patient/Family/Advocate Involvement

13. Seclusion and physical restraint reduction targets for each approved centre in which seclusion and/or physical restraint are used should be jointly set by the Mental Health Commission and mental health services. These targets should be publicised along with an approved centre’s progress on reaching the target on the Mental Health Commission website.

Action: MHC, HSE & independent service providers

Intervention Category: Using data to monitor seclusion and restraint episodes

Actions

14. Additional data analysis using data collected on the Register for Seclusion and the Clinical Practice Form for Physical Restraint but which are not returned to the Commission should be carried out on a quarterly basis. The additional data which are analysed should support clinical audit and include:

- Seclusion and physical restraint episodes and hours by shift, day, unit and time;
- Seclusion and physical restraint episodes initiated by different staff members.

Arising out of this analysis, staff, wards and shifts which are recording high levels of seclusion and physical restraint use and who may benefit from training and education in seclusion and restraint reduction should be identified.

Action: Clinical Directors and Registered Proprietors

Intervention Category: Using data to monitor seclusion and restraint episodes

15. The feasibility of developing electronic versions of the Registers and Clinical Practice form to replace the hard copy format should be examined. This would allow for data returns to be extracted directly from the Registers without manual collation and allow additional data to be reported on, including total seclusion hours.

Action: MHC with assistance from HSE and independent services

Intervention Category: Using data to monitor seclusion and restraint episodes

16. The feasibility of collecting additional data on seclusion and physical restraint use that will assist in monitoring their use and achieving reductions should be examined.

Action: MHC & clinical scientist who is undertaking research into seclusion as part of the MHC/RCSI joint PHD research programme

Intervention Category: Using data to monitor seclusion and restraint episodes

17. The following Mental Health Commission guidance should be followed to support achieving compliance with Rule 7.4 of the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (Debriefing) and Provision 7.2 of the *Code of Practice on the Use of Physical Restraint in Approved Centres* (Debriefing).

“A debriefing should take place with a resident after an episode of seclusion or physical restraint. A resident’s advocate, carer or family member should be granted the opportunity to participate in the debriefing with the resident, or, on his or her behalf, if the resident declines to do so and where he or she consents to the participation of others. A debriefing should include a discussion of the events leading up to the episode of seclusion or physical restraint and address how the use of seclusion or physical restraint can be avoided in the future. The outcome of the debriefing should be documented in the resident’s individual care and treatment plan. Approved centres should develop policies and procedures on debriefing that conform to this guidance”.

Confirmation that this guidance has been implemented in the approved centre should be forwarded to the Commission six months after the commencement date of this strategy.

Action: Clinical Directors and Registered Proprietors

Intervention Category: Review Procedures/Debriefing

Actions

18. The following Mental Health Commission guidance should be followed to support achieving compliance with Rule 9.3 of the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (Review Procedures) and Provision 10.3 of the *Code of Practice on the Use of Physical Restraint in Approved Centres* (Review Procedures).

“A formal review of an episode of seclusion or physical restraint should take place after the debriefing of the patient, advocate, carer or family member. The staff member who chairs a review meeting should not have been someone who was involved in initiating the episode of seclusion or physical restraint. Approved centres should develop policies and procedures on review procedures that conform to this guidance”.

Confirmation that this guidance has been implemented in the approved centre should be forwarded to the Commission six months after the commencement date of this strategy.

Action: Clinical Directors and Registered Proprietors

Intervention Category: Review Procedures/Debriefing

6. Implementation

Following consideration of the draft strategy, the Mental Health Commission, mental health services and other key stakeholders should move towards planning the implementation of this strategy. In its analysis of the implementation of the mental health policy *A Vision for Change, From Vision to Action*, the Commission identified twelve factors which are essential to effective implementation. These are:

- Make implementation an important consideration during policy design;
- Involve as many stakeholders as possible in policy formulation process;
- Disseminate the policy;
- Generate political support and funding;
- Appoint a leader and an implementation team;
- Establish an implementation structure;
- Provide the necessary resources;
- Prepare a plan;
- Communicate;
- Include stakeholders and promote stakeholder interaction;
- Support interdepartmental co-ordination; and
- Put in place a governance structure (MHC, 2009b).

The Commission and mental health services should use the above framework to guide implementation. The Commission will now commence a consultation process with key stakeholders on the draft strategy which will include consideration of the strategy's implementation.

Experience from seclusion and restraint reduction strategies in other states suggests that significant reduction in the use of these interventions typically takes two or three years (O'Hagan et al., 2008). The timeframe that we have assigned to this strategy is from late 2012 through to the end of 2015.

7. Useful Links/Resources

Substance Abuse and Mental Health Services Administration, *Roadmap to Seclusion and Restraint Free Mental Health Services* (SAMHSA, 2005).

<http://store.samhsa.gov/home>

You must enter “Roadmap to Seclusion and Restraint Free Mental Health Services” in the search box and then download all of the manuals individually.

Huckshorn KA (2005), *Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool* (Alexandria [VA], NASMHPD).

http://www.nasmhpd.org/general_files/publications/ntac_pubs/SR%20Plan%20Template%20with%20cover%207-05.pdf

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Appendix

Seclusion and Physical Restraint Reduction Plan

Name of Approved Centre	
Timeframe of Plan	

Mission Statement

Example:

This approved centre is committed to removing all unnecessary uses of seclusion and physical restraint and only using restrictive interventions based on the best available evidence and contemporary practice.

Philosophy of Care

Example

This approved centre adheres to the following value statements:

- Seclusion and restraint are used in rare and exceptional circumstances and only in the best interests of the patient when he or she poses an immediate threat of serious harm to self or others.
- Seclusion and mechanical means of bodily restraint are not prolonged beyond the period which is strictly necessary to prevent immediate and serious harm to the patient or others.
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Staff Roles & Responsibilities

Example

Clinical Director: The Clinical Director has overall responsibility for implementing the contents of this plan in the approved centre for this calendar year. He/she will also report to the Executive Clinical Director on a quarterly basis on progress in implementing this plan. The Clinical Director's responsibility for specific actions is indicated in the action plan below.

Director of Nursing:

Other Staff:

Seclusion/Restraint Data

	2011	Year to Date	Target for 2013
No. of Seclusion Episodes			
No. of Physical Restraint Episodes			
Hours of Seclusion			
Hours of Physical Restraint			

Other ways this approved centre will use data to reduce seclusion and restraint:

Example:

- Publish seclusion and restraint data for each unit in the approved centre and discuss same at staff meetings
- Publish seclusion and restraint data for similar approved centres alongside our own to benchmark our use of seclusion and restraint with other facilities

Elements of Action Plan			
Goal	Action Steps	Who Is Responsible	Date of Completion
<p>Example: Organise staff training on seclusion and restraint reduction. This aims to develop the knowledge & skills among key staff in the following areas: a) attitudes to the use of s&r b) crisis management skills c) new models of care and d) the other key components of the MHC s & r reduction strategy.</p>	<ul style="list-style-type: none"> • Analyse s&r data to identify who are the main initiators of s&r in this service. • Commission in-house training for staff identified through the data analysis • Carry out in-house training for same staff • Organise training for all other MDT staff through the MHC e-learning module. 	<ul style="list-style-type: none"> • Joe Bloggs • Clinical Director • ABC Training with support of Director of Nursing • Director of Nursing with support of CNM1. 	<p>December 2012</p> <p>February 2013</p> <p>April 2013 – July 2013</p> <p>April 2013 – July 2013</p>