Mental Health Commission

Seclusion and Physical Restraint Reduction Strategy

Consultation Report

Executive Summary

The Mental Health Commission approved a Draft Seclusion and Physical Restraint Reduction Strategy in November 2011 on the basis that it would issue for wider consultation. The draft strategy consisted of 18 actions which it was proposed to implement to reduce the use of seclusion and physical restraint in approved centres. The 18 actions were grouped into seven intervention categories:

- State Policy and Regulation Change;
- Leadership;
- Staffing;
- Training and Education;
- Patient, Family and Advocate Involvement;
- Using data to monitor seclusion and restraint episodes; and
- Review Procedures/Debriefing.

A written consultation exercise commenced on 12th June 2012 and ran for three months until 12th September 2012. The Commission's consultation document[1] asked stakeholders to identify the draft actions that they considered should be prioritised for implementation, those actions that they considered appropriate for medium-term implementation and those matters that were suitable for longer term implementation. Stakeholders were also asked to identify those actions that they considered were not suitable to include as part of the final strategy. General views were also sought on the usefulness of the strategy.

Fifty-two respondents made submissions as part of the consultation exercise. Respondents were representative of all major stakeholder groups. We would like to thank everyone who took the time to participate in the consultation.

Responses to Consultation Document Questions

Almost all (97.9%) respondents stated that it would be useful to put a seclusion and physical restraint reduction strategy in place.

Respondents also fed back on the different actions outlined in the draft strategy. This summary outlines stakeholder views on each action using quantitative data and supplementary comments that were presented for each action.

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[1] The consultation document can be accessed at the following web address:
http://www.mhcirl.ie/Consultations/Previous_Consultations/

Intervention Category – Policy and Regulation Changes

Action 1 - Linking Service and Safety
More than half (18/33) of respondents stated that this action should be prioritised and over one quarter (9/33) indicated that it was appropriate for medium-term implementation. Five submissions (15.2%) considered that it was suitable for long- term implementation.

A submission from the Project Joint Governance Committee *of Linking Service & Safety* which has responsibility for overseeing its implementation, informed us that they would be "*pleased to provide updates on the implementation of the Linking Service & Safety Strategy*".

Intervention Category: Leadership

Action 2 – Peer to Peer Networking
A majority (21/39) of respondents stated that peer to peer networking was appropriate for medium-term implementation. One quarter (10/39) considered that it should be put in place as a priority action and 15% of respondents (6/39) suggested that it should be realised in the long-term.

Action 3 – Responsibility for Implementation of Strategy
A large majority of over 77% (28/36) of respondents indicated that this action should be prioritised. One in six (8/36) respondents considered that it should be realised as a medium-term action.

Action 4 – Seclusion and Restraint Reduction Plan
A substantial majority of more than nine in ten respondents (34/37) indicated that the development of a seclusion and restraint reduction plan should be prioritised. Three submissions (8.1%) expressed a preference for implementing it in the medium-term.

Action 5 – Demonstrate Commitment to Implement Reduction Plan
Almost eight out of ten (31/39) respondents supported prioritising this action. Seven submissions (18%) indicated that it was appropriate for medium-term implementation.

Action 6 – Examine Feasibility of Removing Seclusion Rooms
Two-fifths (14/36) of respondents considered that it was most appropriate to examine the feasibility of removing seclusion rooms in the long term. Eleven per cent (4/34) of respondents suggested that this action was not suitable to implement. One quarter (9/36) of responses stated that it should be a priority action and the same proportion supported implementing it in the medium-term.

Comments on Leadership Actions

In general, respondents recognised the critical importance of leadership to the success of the strategy. This was reflected in the strong support for prioritising three of the five leadership actions. A recurring theme in several submissions related to where responsibility for implementing these actions was allocated. A large number of respondents stated that it was insufficient to allocate responsibility for actions to senior managers, Clinical Directors and Registered Proprietors. It was suggested that there needed to be more multidisciplinary involvement and a key role assigned to senior nurses in particular.

Reflecting preferences for implementing peer-to-peer networking as a medium-term action, many submissions stated that more consultation with stakeholders was needed before it could be implemented. Many respondents felt that this action assumed that services with low uses of seclusion and restraint were best practice services and that this was erroneous.

Though only one fifth of respondents stated that the proposal to examine the feasibility of removing seclusion rooms was not suitable to include in the strategy, most commentary on this action reflected strong concerns over implementing this action. It was suggested that it was impractical in the absence of alternatives and that it risked alienating staff members and reducing good will towards a strategy.

Intervention Category: Staffing

Action 7 – Call for Exemption from Moratorium on Recruitment

Almost seven out of ten respondents (27/39) considered that a call for an exemption from the Moratorium on Recruitment for the mental health services should be prioritised. Close to one quarter (9/39) of submissions stated that it should be implemented in the medium-term.

Action 8 - Psychiatric Emergency Response Teams (PERTs)

Four out of every ten respondents (16/39) considered that the development of psychiatric emergency response teams (PERTs) should be put in place in the medium term. Just over 10% (4/39) of respondents supported prioritising the action. Eleven (28.2%) submissions considered that this action should be realised in the longer-term. A relatively large proportion (20.5%) of respondents did not support including this action in the strategy.

Action 9 – Staff Rotation

More than one-third (12/33) of submissions indicated that staff rotation should be prioritised. Three out of ten (30.3%) respondents stated that it should be implemented in the medium-term and one quarter (24.2%) considered it appropriate for longer-term implementation.

Comments on Staffing Actions

Comments reflected the strong support for prioritising the action related to a call for an exemption from the Moratorium on Recruitment in the Public Service. It was frequently reported that it was simply not feasible to introduce a strategy if there were further reductions in staffing numbers in services.

Some comments were supportive of the development of PERTS and of the proposal to rotate staff but the majority of commentary identified concerns regarding including these actions in the final strategy. A recurring theme was that there were simply too few staffing resources at present to contemplate putting either action in place. A number of respondents considered that both actions may lead to the deskilling of staff. It was also suggested that PERTS were not suitable for Irish mental health services as they were mainly associated with services in the United States.

Intervention Category: Training and Education

Action 10 – Additional Guidance on Training
More than four out of five (31/39) respondents supported implementing additional guidance on training as a priority. Six respondents (15%) supported implementing this action in the medium term.

Many respondents reflected on the lack of standardised training addressing seclusion and restraint use in Ireland. Staffing and financial shortages were identified as a barrier to realising this action. Others felt that the strategy also needed to address how the prevention and management of violence and aggression are addressed in third level curricula.

Intervention Category: Patient, Family and Advocate Involvement

Action 11 – Assessment Following Admission
Seven out of ten (70.3%) respondents supported implementing this action as a priority. Almost one quarter (9/37) of submissions stated that it should be realised in the medium term.

Action 12 – Advocate and Service User Involvement in Reduction Initiatives
Over one half (20/39) of respondents supported prioritising this action. Almost two-fifths (15/39) of submissions supported implementing this proposal in the medium-term.

Comments on Staffing Actions
Involving service users, family members, carers and advocates in reduction initiatives was almost universally recognised as a welcome development. A number of services commented on their positive experiences of working with service users and advocates currently. Much support for including the action related to an assessment talking place following the admission of a patient, including a risk assessment, was based on the fact that this is already expected of services as a provision of the *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre*. Common challenges associated with implementing advance directives were, however, noted.

Intervention Category: Using data to monitor seclusion and restraint episodes

Action 13 – Seclusion and Restraint Reduction Targets
The inclusion of seclusion and restraint reduction targets as a medium-term action was favoured by 36.4% (12/33) of respondents. Around one quarter (8/33) of respondents stated that it should be a priority action and approximately one-fifth (6/33) indicated that it should be realised in the longer term. A relatively large percentage of 21.2% of respondents considered that this action should not be implemented.

Action 14 – Additional Data Analysis on Seclusion and Restraint Episodes
Just under one half (16/35) of respondents wanted to include the action related to the undertaking of additional data analysis on seclusion and restraint use. One quarter (25.7%) of responses supported carrying out this action in the longer term and one sixth (17.1%) stated that it should be prioritised.

Action 15 – Examine Feasibility of Developing Electronic Registers
Just over 44% (15/34) of respondents supported the implementation of this action in the long term. Around one-third (12/34) of respondents considered that this action should be executed in the medium term. Five (14.7%) submissions indicated that it should be a priority action.

Action 16 – Examine Feasibility of Collecting Additional Data on Seclusion and Physical Restraint Use
Close to 42% (13/31) of respondents favoured implementing this action in the medium-term and 38.7% (12/31) stated that it should be included in the strategy as a long term action. One in six (5/31) respondents believed that this action should be prioritised.

There was much less support for prioritising all actions related to the use of data to monitor seclusion and restraint episodes than for all other actions. It was frequently observed that it was more appropriate to consider additional actions initially because data collection was already taking place. Common concerns related to these actions were that they would be difficult to implement because of staff shortages, costs, insufficient ICT systems and poor ICT infrastructure. Commentary on our proposals revealed strong opposition to the proposal to introduce seclusion and restraint reduction targets in particular.

Intervention Category: Review Procedures/Debriefing

Action 17 – Additional Guidance on Debriefing
Almost three-quarters (29/40) of respondents wanted to prioritise the inclusion of additional guidance on debriefing. One quarter (10/40) considered that it should be put in place in the medium term.

Action 18 – Additional Guidance on Review Procedures

A large majority of almost seven in ten (25/36) respondents supported prioritising the inclusion of additional guidance on review procedures. Around one quarter (8/36) of respondents wished to implement this action in the medium term.

A large number of respondents who supported the speedy implementation of guidance on debriefing and review procedures linked their support to the fact that these issues were already covered by guidance outlined in the Commission Rules and a Code of Practice. Debriefing and review procedures were both identified as valuable reflective learning experiences.

Other Comments and Suggestions

The final consultation question asked respondents to indicate any additional comments or suggestions that they had on the strategy. These included:

- **Omissions from the draft strategy** such as the role of the physical environment, the administration of medication and increased staff-to-patient ratios;
- **The scope of the draft strategy**. There was a wish to extend the strategy to other locations where restrictive interventions are used such as penal institutions and settings where services are provided to people with intellectual disabilities;
- **Implementation of the strategy**; Challenges posed by the shortage of resources were noted. Suggestions included a request for clarification on the timeframes associated with each action.
- **The Knowledge Review**. Suggestions were made regarding additional literature that could be perused, in particular literature related to people with intellectual disabilities and older people;
- **Contextual Developments** including the inappropriate placement of some patients in approved centres; and
- Matters which were considered **outside the scope** of the consultation.

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1. Background

1.1 Introduction

The Mental Health Commission regulates seclusion and restraint in Irish approved centres in the form of *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*. Linked to this regulatory role, the Commission developed a Draft Seclusion and Physical Restraint Reduction Strategy during 2011. The draft strategy consists of 18 actions which were formulated following the completion of a knowledge review on seclusion and restraint reduction.

In addition to our regulation of the use of seclusion and restraint, the Commission considered it appropriate to develop a strategy for other reasons:

- We already collect data on the use of these interventions and publish annual reports on the extent of their use;
- Doubts persist over the safety and effectiveness of seclusion and restraint and of their impact on patients; and
- Successful seclusion and restraint reduction strategies have been implemented in other countries.

The Mental Health Commission approved the draft strategy in November 2011 on the understanding that it would issue for wider consultation before implementation. This consultation exercise took place from 12th June 2012 until 12th September 2012. This report summarises what we heard during the consultation exercise.

The Commission would like to acknowledge its appreciation to everyone who participated in the consultation exercise. It is clear that a lot of effort and resources were involved in preparing submissions which we are especially grateful for.

1.2 Consultation Process

The consultation required stakeholders to express views on 18 specific actions included in the draft strategy. These were best considered following an examination of the knowledge review which informed the development of the strategy. The Commission therefore considered that a written consultation exercise was the most appropriate means for stakeholders to submit feedback as a detailed consideration of the relevant issues was required. We prepared a consultation document to facilitate the consultation process which can be accessed at the following web address:
http://www.mhcirl.ie/Consultations/Previous_Consultations/

The consultation document includes background information on the development of the draft strategy and specifies the 18 actions that it consists of. Seven consultation questions were included that aimed to elicit respondents' views. Stakeholders were asked about the

usefulness of putting a strategy in place and to prioritise the different actions. Participants prioritised the draft strategy's actions by identifying those that they would prioritise for implementation, actions that they considered were suitable for medium-term implementation and actions that were regarded as appropriate for longer-term implementation. Respondents were also asked to indicate which actions they considered were not suitable to implement.

A three-month period was chosen for the written consultation exercise in order to allow stakeholders sufficient time to consider the consultation document and knowledge review. This is in line with the guidance outlined in the *Framework for Public and Service User Involvement in Health and Social Care Regulation in Ireland (2009),* which was produced by the Health and Social Care Regulatory Forum, of which the Commission is a member. Responses could be returned by email or by post.

Some individuals and organisations made requests to submit feedback after the end date of 12th September 2012 and these were facilitated. Appendix 1 includes details of all of the organisations and groups that made submissions as part of the consultation process.

Details of the consultation were also posted on the Commission's website for the duration of the consultation period. Information on the consultation was also provided on the websites of other organisations and included in some health sector publications. All queries received in relation to the consultation were responded to. All submissions were also logged and analysed by the Commission.

## *1.3 Overview of Respondents*

The Commission received 52 responses as part of the consultation. Figure 1 illustrates the breakdown of submissions by a number of respondent type categories. It shows that the largest group from which submissions came were nurse managers and nurses. These 12 respondents included individual nurses, groups of nurses, nurse instructors in the Professional Management of Aggression and Violence (PMAV) and nursing practice/policy development committees.

Submissions made by other respondent types also reflected a nursing focus. Three submissions were made by nurse lecturers and academics, three responses were received from staff associations/trade unions representing nurses and we also received feedback from An Bord Altranais, the professional regulatory body for nurses and midwives.

The second largest number of submissions came from specific mental health services and these also incorporated the views of many nurses. These 9 responses were received from approved centres, general adult mental health services, a mental health service for older people and the national forensic service. Though submissions from services largely reflected the input of nurses and consultant psychiatrists, eight of these nine submissions, nevertheless, included the opinions of other multidisciplinary team members and additional relevant persons. Views were therefore also provided by occupational therapists, social workers, psychologists, behavioural therapists, social care workers, advocates and managers.

Submissions were also made by two intellectual disability services and a joint submission was received on behalf of a mental health service and an intellectual disability service.

Figure 1: Overview of Responses to Consultation by Respondent Type
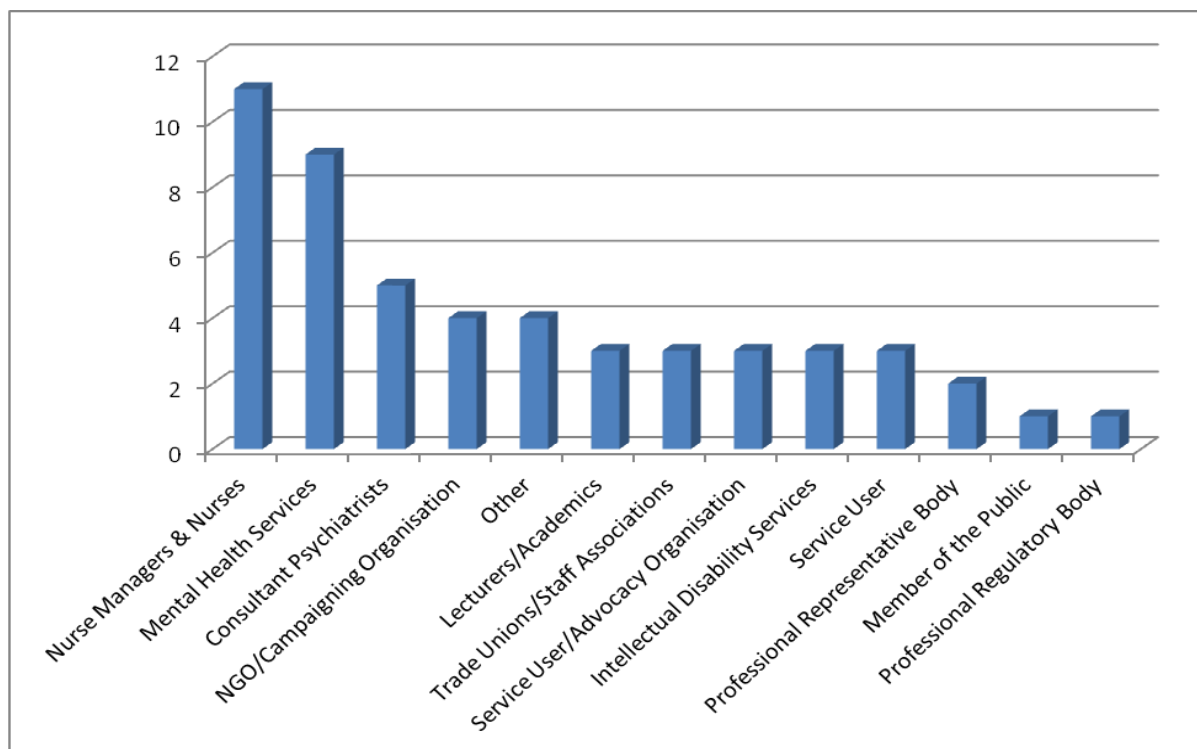
n = 52

Five consultation submissions were made by individual consultant psychiatrists or groups of consultant psychiatrists. This included one submission from the group of 15 Executive Clinical Directors. The two submissions from professional representative bodies included feedback from the Faculty of General Adult Psychiatry at the College of Psychiatry of Ireland. The other submission from a professional representative body was made on behalf of the Association of Occupational Therapists of Ireland (AOTI) Special Interest Group in Mental Health.

Feedback on the consultation was also provided by four non-governmental organisations (NGOs) or campaigning organisations. These were Mental Health Reform, Amnesty International Ireland, Barnardos and Children in Hospital Ireland.

Three further submissions were made by service user or advocacy organisations. These responses were made on behalf of the National Service User Executive (NSUE), the Irish Advocacy Network (IAN) and Shine. Three responses also came from individual service users.

Of the 52 submissions, 40 were joint submissions and 12 were made by individuals. Joint submissions were either organisational submissions or responses on behalf of a number of people.

2. Consultation Findings

The report presents the findings for all of the questions contained in the consultation document. We first summarise what we heard in responses to the first question as we asked stakeholders to comment on the usefulness of putting a strategy in place.

Findings in respect of the next five questions are then considered together. Questions 2-5 addressed the 18 specific actions included as part of the draft strategy and asked respondents to differentiate between actions by indicating which actions they would prioritise for implementation and which actions they regarded as suitable for medium-term and longer-term implementation. Participants were also asked to identify any actions which were not suitable for implementation. The sixth question in the consultation document asked respondents to explain their responses to each of the above questions. As responses addressed many of the eighteen actions in a number of the above consultation questions, we considered it appropriate to present the consultation feedback from all of the above questions for each action separately.

The findings section concludes by presenting an analysis of responses to the final question where respondents included any other comments and suggestions that they had on the strategy.

Some respondents included feedback on some questions that upon analysis, we felt was more appropriate to consider alongside responses to different questions. The presentation of the findings also reflects this.

2.1 Findings for Consultation Question 1: Usefulness of Strategy

The consultation document's opening question asked respondents: *Do you think it would be useful to put a Seclusion & Physical Restraint Reduction Strategy in place?*

Forty-eight of the 52 submissions included a response to this question. The overwhelming majority (97.9%) of these submissions indicated that it would be useful to put such a strategy in place although some respondents qualified their response by highlighting challenges or necessary pre-requisites before such a strategy could be implemented. Typical responses indicated that "*I definitely think that it would be useful*", that "*A strategy is essential*" and that "*we welcome the strategy*".
"Ideally we would like to see seclusion removed from all acute admission units and fully support the development of a strategy for reduction" – **[Faculty of General Adult Psychiatry, College of Psychiatry of Ireland].**

One service user emphasised that implementing a strategy would be useful "*only if and when individuals are given their human rights entitlements to have a say on their treatments*".

A more complete analysis of responses showed that respondents identified the following benefits of putting a strategy in place:

- A strategy will provide an opportunity to **review current practices** and encourage staff and services to **explore alternative intervention approaches**. The review of seclusion and restraint interventions would allow for a "*critical eye*" to be cast on the use of seclusion and restraint.

- It would **raise awareness** of the use of seclusion and physical restraint. Some respondents considered that a strategy would focus attention on the use of restrictive interventions on **distinct service user populations** which was especially welcome. These distinct populations included people with intellectual disabilities, older people, children and adolescents and persons using forensic mental health services.

- A strategy would encourage a **standardised approach** to the use of seclusion and restraint.

- A number of submissions noted that a strategy would ensure that a **human rights approach to mental health care** would be adopted.

- A reduction strategy should create **a more therapeutic environment** within mental health services.

- A strategy should also facilitate the creation of a **safe caring and work environment**.

- A strategy should lead to **more collaborative working**. This would occur within teams and also with service users.

- A Seclusion and Physical Restraint Reduction Strategy should lead people to **explore the values and beliefs underpinning attitudes to the use of seclusion and restraint**.

- It would correctly **shift focus away from compliance with Rules and Codes towards achieving reductions in the use of both interventions**.

- Reducing the use of seclusion and restraint would assist with **removing stigma** from people who use mental health services. It was suggested that practices such as seclusion and physical restraint could be seen as a confirmation of all society's fears and stereotypes around mental illness.

- Putting in place such a strategy would **require commitment from senior management** i.e. ownership of the strategy at the highest levels and encourage managers to manage more creatively.

- It provides an **opportunity to improve data collection and analysis**. Some respondents stated that a strategy would allow for more meaningful comparisons to be made between approved centres using restrictive interventions.

Other benefits associated with implementing a strategy which were expressed were that:

- It would reduce the danger of retraumatising service users who have already been subject to traumatic life events;
- It should reduce aggression and violence in services;
- It would highlight the responsibility of the individual practitioner to be accountable for his or her actions;
- It was compatible with the Commission's mandate under the Mental Health Act 2001;
- It should lead to a process of continuous quality improvement;
- It should achieve financial savings;
- It should lead to improved patient and staff satisfaction;
- It would complement existing good governance procedures and practice regarding the use of these interventions; and
- It would encourage services to review the environment in which care is provided.

Many submissions highlighted implementation challenges associated with this strategy in their responses to this question. These included a **lack of staffing and financial resources** and **the relevance of some of the actions for Irish psychiatric services** in particular. These issues are considered in more detail in the analysis of comments on specific actions and in the section where we present the findings of the responses to the final question.

Current Involvement in Reduction Initiatives

The Commission found it very useful to receive feedback from respondents on their **current involvement in reduction initiatives** and related good practice initiatives. A submission from a group of consultant psychiatrists in South Tipperary Mental Health Services observed for instance that:

"*In South Tipperary our experience has been that by reviewing, auditing, educating and promoting discussion the use of seclusion and restraint within the service reduced significantly and became more standardised. We also decommissioned seclusion rooms*".

Reflecting on some of the limitations of the literature from the United States, the National Forensic Service noted that their local strategy had addressed some of these shortcomings by including a range of restrictive practices in addition to seclusion and restraint.

The Psychiatric Nurses Association (PNA) recommended that consideration be given to rolling out a seclusion pathway that is in use in Dublin West/South West Mental Health Services. Another respondent commented on his involvement in the implementation of a very successful trauma informed care strategy in an acute patient setting.

The National Federation of Voluntary Bodies also provided details on initiatives that are in place in some of the intellectual disability services provided by its 62 member organisations. These included Multi-Element Behaviour Support Plans (MEBS) and Rights Review Committees.

Finally, the commitment of some services to commence reviewing their use of restrictive interventions immediately was especially welcome.

2.2 Findings for Specific Actions Included as part of Draft Seclusion and Physical Restraint Reduction Strategy

The four questions to which respondents provided most feedback on the draft strategy's individual actions were Consultation Questions 2 to 5. They were as follows:

> *Which actions specified in Section 2 above [which outlined the 18 actions] would you **prioritise for implementation**?*

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

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

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

The sixth question in the consultation document asked respondents to explain their responses to each of the above questions.

Quantitative information is presented which shows how submissions ranked each action in order of priority. It is important to note that the information presented in graphs identifies how each submission ranked each of the draft strategy's eighteen actions. **The presented data analysis does not distinguish therefore between responses that came from a single respondent and those which were submitted by an organisation or group of respondents.** We consider, however, that the data as presented still allows for an assessment to be made of how key stakeholders assessed the different components of the strategy.

For each action, the quantitative data that we present is accompanied by a summary of written comments and feedback that were also submitted.

2.2.1 Intervention Category: Policy and Regulation Changes - Action 1

Action 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

Four of the 34 recommendations set out in the HSE strategy which it has formally adopted as an organisation wide approach to addressing aggression and violence in the workplace are of particular relevance to our draft strategy's first action. Recommendations 19 – 22 are set out in Table 1 below.

Table 1: Recommendations 19-22 of HSE Strategy, *Linking Service and Safety*

19.	Proactively aspire to provide services which are 'seclusion and restraint minimised' at philosophical, organisational and operational levels.
20.	Establish the practice safety and fitness for purpose of physical interventions currently in use as a priority.
21.	The use of physical interventions be subject to standards and regulation at least comparable to those applying to other patient focussed interventions.
22.	Standards governing the training in and the use of physical interventions be developed as a matter of priority.

Thirty-three submissions addressed the first action. Figure 2 indicates how the different submissions prioritised this action. Eighteen or just more than half (54.5%) of these respondents stated that the proposal regarding the request of regular updates on the implementation of *Linking Service and Safety* should be prioritised. More than one quarter (27.3%) of submissions indicated that it was appropriate for medium-term implementation. Five submissions (15.2%) considered that it should be realised in the long- term.

Figure 2: Analysis of Responses to Consultation Questions for Action 1 - *Linking Service and Safety*

n = 33
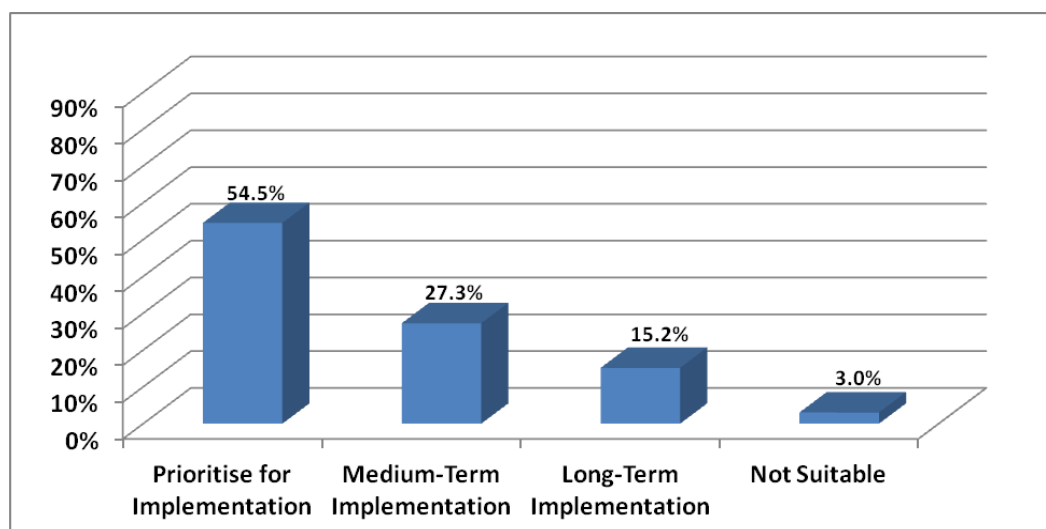
Comments on Action 1 – Linking Service and Safety

Submission from Project Joint Governance Committee of *Linking Service and Safety*
We wish to draw attention to a submission that was received from the Project Joint Governance Committee of *Linking Service and Safety*. The Project Joint Governance Committee highlighted ongoing work in relation to Recommendations 21 and 22 in particular. It was acknowledged that the implementation of these recommendations would require engagement with a number of agencies, including the Mental Health Commission. The Commission is a member of the Multi Agency forum whose role is to provide a platform for the Governance Committee to actively consult and collaborate with key stakeholders in implementing key elements of the strategy.

The Project Joint Governance Committee clarified that they "*would be pleased to provide updates on the implementation of the Linking Service & Safety Strategy*".

Support for Action
Other respondents identified the implementation of *Linking Service and Safety* as pivotal to achieving reductions in the use of restrictive interventions. Respondents noted the similarities between the aims of *Linking Service and Safety* and the Commission's draft strategy.

Suggested Amendments to Action
A number of respondents suggested changes that should be made to the current wording of the draft actions. It was proposed for instance that:
- The action states that the Commission "*requires updates from the HSE*";

- The action specifies an appropriate timeframe for receipt of these updates and that this should occur on a six-monthly basis;
- *Linking Service and Safety* should be integrated into existing service policies in order to ensure its implementation in a seamless way;
- An "easy read" version of *Linking Service and Safety* should be made available;
- The monitoring of *Linking Service and Safety* should take place by examining the HSE corporate response to the strategy; and
- The action clarifies that the Commission would examine the organisational issues associated with violence and aggression identified in *Linking Service and Safety*.

<u>Challenges to Implementing Action</u>
Respondents who believed that this action should only be implemented in the long-term outlined a variety of different reasons for this view. Concern was expressed that monitoring the implementation of the HSE strategy would perhaps become "*a paper exercise*" and that monitoring the strategy might have no impact if there was no progress implementing *Linking Service and Safety*. There was also a concern that the MHC requests for information would impact on front-line staff who are already obliged to complete a lot of paper work.
One submission noted the slow implementation of the HSE strategy which was linked by the respondent to the Moratorium on Recruitment and Promotion in the Public Services. Finally, one respondent considered that this action was not suitable to implement because it was unlikely to have any impact.

## 2.2.2   Intervention Category: Leadership - Actions 2-6

Action 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

Peer-to-peer networking was commented on by 39 respondents. More than half (53.9%) of submissions stated that the identified action was appropriate for medium-term implementation as can be seen in Figure 3. Ten submissions (25.6%) considered that peer-to-peer networking should be put in place as a priority action and six (15.4%) suggested that it should be realised in the long-term.

Figure 3: Analysis of Responses to Consultation Questions for Action 2 – *Peer to Peer Networking*

n = 39
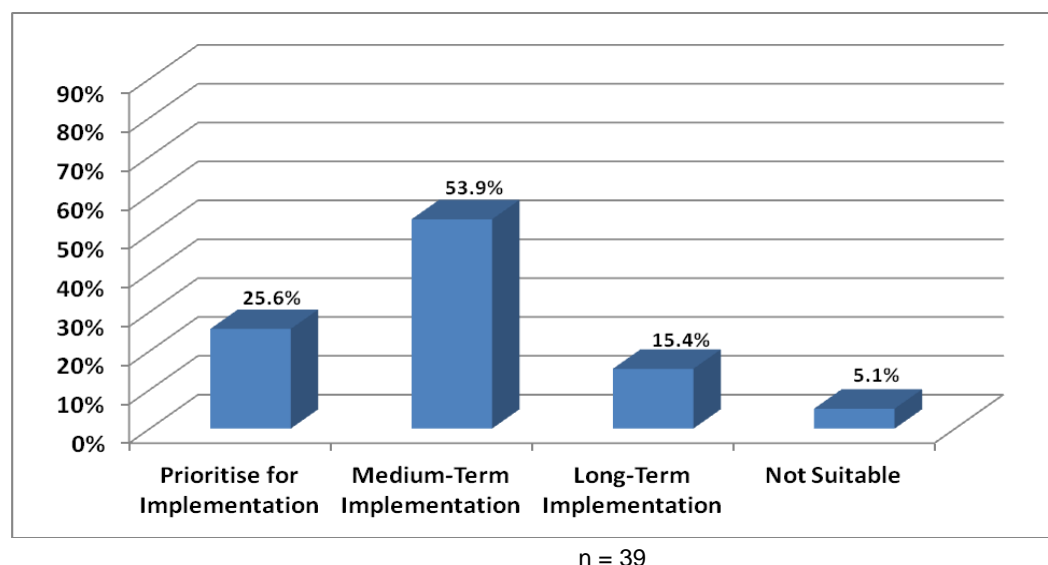
Comments on Action 2 – *Peer to Peer Networking*

Support for Action

Many respondents commented on the benefits of this particular initiative. It was noted that peer-to-peer networking could help to foster better practice across services as staff could learn from other services where the use of restrictive interventions has reduced. This should occur through discussing and thinking through alternative strategies to seclusion and restraint. One respondent stated that this action should be prioritised because HSE training budgets have been reduced or frozen.

Other respondents identified their rationale for including peer-to-peer networking as a medium-term objective. Some consultation participants commented that consultation with stakeholders was needed before implementing this action meaning that it was not best suited for immediate implementation. It was also noted that adequate local planning and preparation was firstly needed to ensure that those involved in peer to peer networking had a foundation to work from.

Variations in the Use of Seclusion and Physical Restraint

A recurring theme in comments on this action was concern over interpretations of the variations in the use of seclusion and restraint in Ireland. Several respondents stated that it was erroneous to assume that services with low overall uses of seclusion and restraint were necessarily models of best practice. One respondent reported that he contacted two approved centres in which the use of restraint and seclusion had decreased significantly as reported in the Mental Health Commission's annual activity reports. He was told that this was due to the discharge of particular patients and not to the implementation of any reduction initiatives. Two submissions reported that many services in Ireland "*export*" and "*ship*"

challenging patients to other services which skews the data that are collected on the use of these interventions.

Many respondents highlighted factors that contribute to varying levels of seclusion and restraint in services. These included:

- Diverse catchment populations;
- The presence of areas of deprivation;
- The physical environment in approved centres;
- Recording practices;
- Different levels and formats of training;
- Different staffing levels;
- Access to secure units:
- Levels of involuntary admission; and
- The existence of emergency response procedures.

Challenges to Implementing Action

Among the challenges associated with implementing this action were the time that would be required to participate in networking events, staff motivation, and a stated lack of a recognised process to facilitate peer to peer networking.

Respondents also voiced concern that this initiative could be misinterpreted and lead to a league table mentality which risked alienating staff.

Suggestions regarding Implementing Action

Several suggestions were made as to how peer-to-peer networking could be best organised. These included the following proposals:

- The Mental Health Commission should take a lead in this area and highlight examples of good practice;
- An annual forum should be established to report progress and discuss initiatives found useful in reducing seclusion. This was similar to an Australian model that has worked well and it was suggested that the Commission could fund such a forum; and
- The Commission should develop a learning hub to allow good practice to be shared between services; and
- Peer-to-peer networking should match services with similar services in order to ensure that fair comparisons are being made.

Commitments and Proposals from Services

St Joseph's Intellectual Disability Service made a specific commitment to establish links with similar services in other jurisdictions as it was acknowledged that there may be no other similar service in Ireland. A submission from a group of psychiatric nurses working in the National Forensic Service proposed that this service should be used as a resource for such networking as they stated that the service has already significantly reduced its use of seclusion and restraint by employing research based interventions.
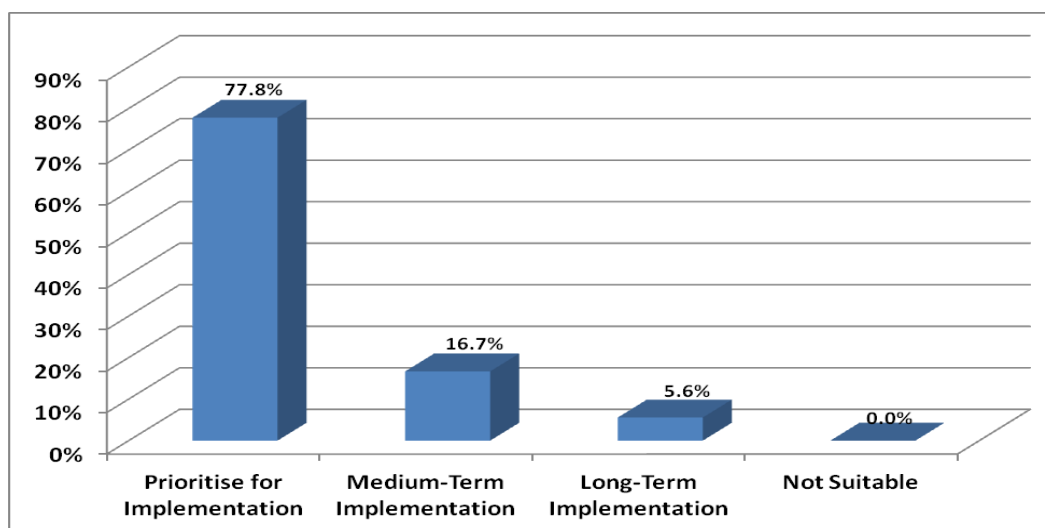
Action 3

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

Thirty-six submissions addressed this action. Figure 4 shows that a large majority (77.8%) of responses considered that this action should be prioritised. Six submissions (16.7%) suggested that it was appropriate for executing in the medium-term.

Figure 4: Analysis of Responses to Consultation Questions for Action 3 – *Responsibility for Implementation of Strategy*

n = 36

Comments on Action 3 – *Responsibility for Implementation of Strategy*

Allocation of Responsibility to Senior Managers
The vast majority of comments on this action made observations on the allocation of responsibility for implementation to senior managers. Some support was expressed for this with a number of respondents noting for instance that senior management responsibility was necessary to achieve a truly successful outcome and that it would focus attention on the issue at a high level.

Other submissions that expressed support for this idea noted additional requirements to senior management responsibility or qualified the support. Doubt was expressed by some respondents as to the appropriateness of allocating responsibility to senior managers who

did not have clinical experience and expertise in the area for example. Two submissions considered that it was not at all clear who was being referred to by the term "*senior managers*" and that the Commission needed to be more specific as to where responsibility for implementation fell.

Many submissions stated that it was not sufficient to allocate responsibility solely to senior managers. It was noted that this risked ignoring the knowledge and skills at all levels of an organisation and the commitment and buy-in required from front-line staff.

"*The identified actions appear to vest leadership roles and responsibilities almost exclusively in clinical directors, registered proprietors, senior managers etc. In doing so it fails to recognise the contribution to leading, managing and implementing change that comes from all mental health professionals*" - **[School of Nursing, Midwifery and Health Systems, University College Dublin].**

Nursing Role in Implementation
A frequent suggestion outlined in submissions was that a senior nurse should have key responsibilities for implementation. This comment was made by individual nurses, groups of nurses, a trade union representing nurses, some mental health services and also by two consultant psychiatrists. This role was variously described as a nurse consultant, a nurse manager, a clinical nurse specialist and an advanced nurse practitioner and one submission suggested that it should be the role of a CNM2. It was also suggested that PMAV trainers could play an important role implementing the strategy.
This comment was typical of these responses:

"*As nurses are the primary group in contact with people experiencing acute mental illness and distress, they are central to organizational commitment, development and implementation of a seclusion and physical restraint reduction strategy*" - **[West and East Galway Mental Health Services in conjunction with the Mental Health Research Cluster, National University of Ireland, Galway.].**

The Commission's attention was drawn to the existence of such roles in other countries, including Australia, and it was stated that such a role provided the crucial link between senior managers and staff on the ground who have responsibility for such crucial tasks as de-escalation, de-briefing, and training. One respondent suggested that a nurse manager should have responsibility for all aspects of seclusion and restraint in each catchment area in addition to other duties and should be supported by a designated consultant psychiatrist. This had the advantage of not requiring additional resources. Two submissions proposed that each area should have a "*champion*", who was identified as an individual responsible for local implementation and who would be supported by senior management.

Caution regarding Implementing Action
Finally, some respondents introduced a note of caution. Shine noted for example that: "*a commitment for change and leadership of that change is required before any actions can be implemented*". A number of respondents also commented that the strategy could not be implemented quickly.

Action 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

Forty-two submissions addressed the seclusion and restraint reduction plan. Figure 5 graphs the 37 responses from consultation participants that addressed the two elements of this action as five submissions gave separate rankings for Parts A and/or Part B rather than for the action as a whole. Here, a substantial volume of support emerges for designating this action as a priority. Of the 37 submissions that responded together for Parts A and B, an overwhelming majority (91.9%) indicated that the development of a seclusion and restraint reduction plan should be prioritised. Three submissions (8.1%) deemed that it was appropriate for medium-term implementation.

Of the five submissions that considered Part A separately, four stated that it should be prioritised.

Figure 5: Analysis of Responses to Consultation Questions for Action 4 – *Seclusion and Restraint Reduction Plan*

n = 37
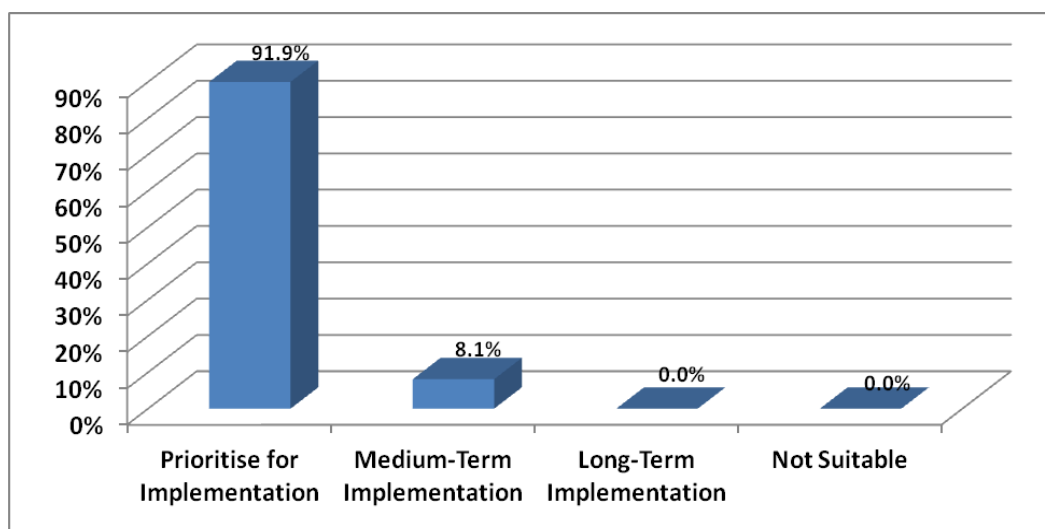
Comments on Action 4 – *Seclusion and Restraint Reduction Plan*

Support for Action
Comments received which addressed the usefulness of implementing this action reflected the broad support for prioritising this action. It was frequently described for example as a "*critical*" or "*essential*" element of any strategy. A submission from the Mid West Mental Health Services insisted that: "*it should happen without delay and be given the attention that any other high risk intervention would be. It is cost neutral and requires only organisational commitment to put in place a system for the plan*".

The description of this action as cost and resource neutral was repeated by a number of respondents. Conversely, one respondent stressed that adequate resources needed to be made available to facilitate this action because of concerns that it may merely result in more administrative work for frontline staff.

Who Develops the Seclusion and Restraint Reduction Plan?
A large number of submissions addressed the issue of who should develop the plan. Many of these comments reflected concerns that had been expressed in relation to where responsibility for implementation of the strategy fell. Some respondents believed that a reduction plan needed to be developed locally by frontline staff. This should ensure that a "*one-size fits all*" approach is not adopted and allow for ownership of the strategy by those tasked with its implementation.

Other submissions proposed that all relevant stakeholders should be involved in the plan's development, including service users, carers and advocates. In line with other proposals regarding responsibilities for implementation, two submissions proposed that a clinical nurse

specialist with key responsibilities for implementing the strategy should be involved in developing the plan.

<u>Suggested Amendments to Action</u>
Many respondents identified specific areas that should be addressed in a service's reduction plan. A number of these proposals reflected content which was already set out in the draft action or addressed areas such as reviews and debriefings which are identified in some of the draft strategy's other actions. Among the other suggestions made were:
- There should be clear guidelines to assist with preparation of the plan;
- An annual update on the plan's implementation was not sufficient. The Commission should receive information bi-annually; and
- The reduction plan should be a regulatory requirement monitored by the Inspectorate of Mental Health Services.

Action 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 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

Thirty-nine respondents addressed the fifth action. Figure 6 illustrates that this was another action which a large majority (79.5%) of the 39 submissions addressing it deemed should be implemented as a priority. Of the remaining eight submissions, seven (18%) considered that it should be realised in the medium-term.

Figure 6: Analysis of Responses to Consultation Questions for Action 5 – *Demonstrate Commitment to Implement Reduction Plan*

n = 39
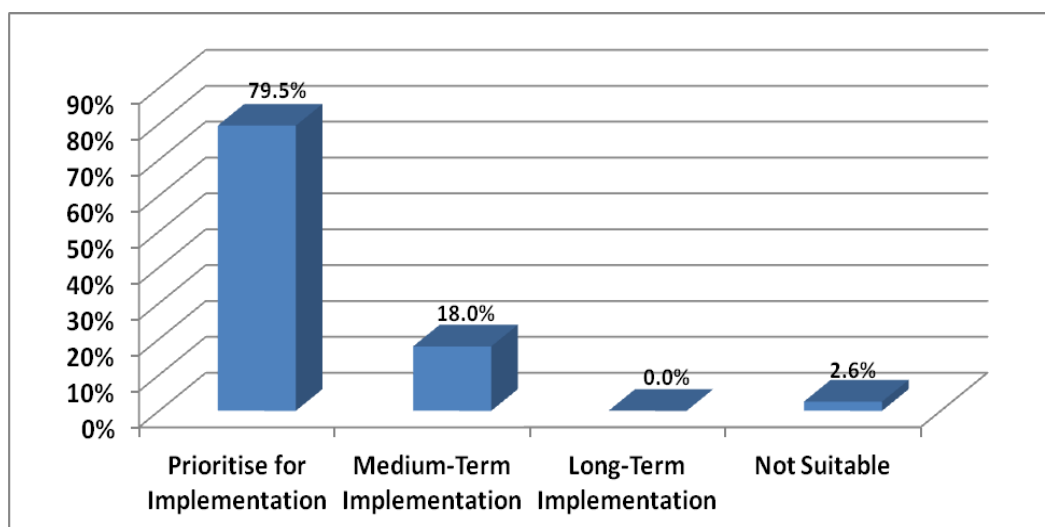
Comments on Action 5 – *Demonstrate Commitment to Implement Reduction Plan*

Support for Action

Many respondents who supported this action saw it as a natural follow-on from the development of a seclusion and restraint reduction plan. It was suggested that it should help ensure that plans would actually be implemented and not become just a paper exercise.

Concerns regarding Implementing Action

The draft action cited examples of how a commitment to implementing a seclusion and restraint reduction plan could be demonstrated. One respondent expressed support for the staff recognition project as it was considered that this would allow staff to take ownership of positive outcomes and recognise good care planning. Three submissions, however, did not support this idea. Consultation participants noted that informal recognition already takes place and that if this was formalised, staff may avoid dealing with crisis situations. Further identified risk was that it would lead to the underreporting of seclusion and restraint and unfairly identify staff. Recognising individual staff members was regarded as inappropriate by another respondent who pointed out that staff should be working as a team to reduce seclusion and physical restraint.

Responses from the nursing sector also voiced strong concerns over the statement included in the action that clinical leaders would tell staff that they would be expected to reduce the use of seclusion and restraint. One respondent noted that this may be used by some Clinical Directors and/or Registered Proprietors to place undue pressure on staff to take unnecessary risks in order to meet unrealistic targets. Another submission did not support the prescriptive nature of the wording used because responsibility was allocated to Clinical

Director and Registered Proprietors in spite of the fact that seclusion and restraint practices are largely the responsibility of mental health nurses.
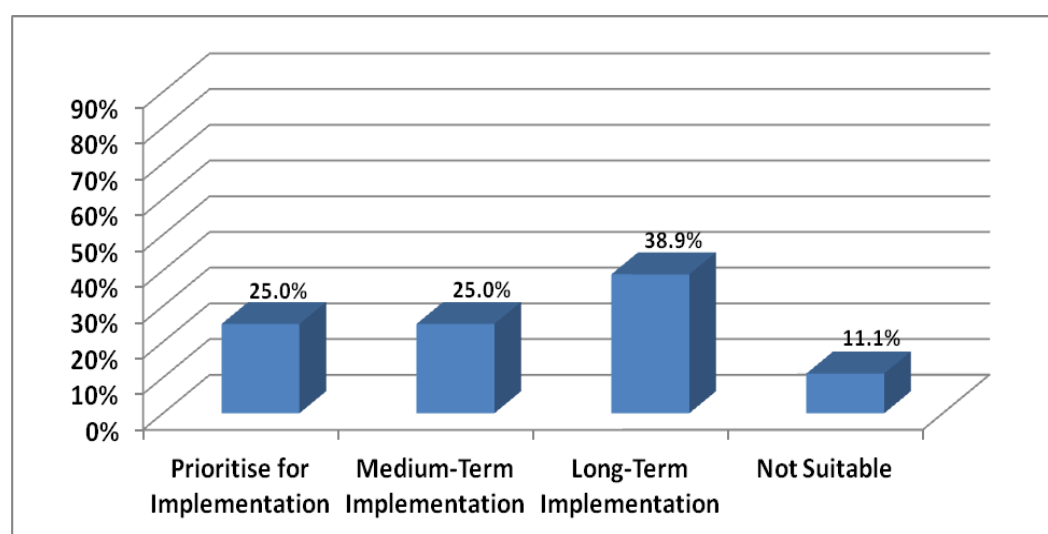
Action 6

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

There was less support for prioritising this action for implementation than for other actions. Of the 36 submissions that assessed this action, close to two-fifths (38.9%) considered that it should be realised in the longer-term. A little over one in ten submissions (11.1%) suggested that it was not suitable to implement. Support for prioritising this action and for executing it in the medium-term was similar with exactly one quarter of respondents supporting each of these positions.

Figure 7: Analysis of Responses to Consultation Questions for Action 6 – *Examine Feasibility of Removing Seclusion Rooms*

n = 36

Comments on Action 6 – *Examine Feasibility of Removing Seclusion Rooms*

Concerns regarding Implementing Action
Respondents frequently pointed out that the removal of seclusion rooms was desirable but not practical at the moment. The following comments were also received:

- Some services would still require seclusion rooms in emergencies;

- Some patients could suffer if seclusion was not available;
- If seclusion rooms are removed too quickly, staff may feel unsafe in the working environment;
- The reduction in in-patient beds and stricter admission criteria will result in a profile of in-patients for whom seclusion and physical restraint would still be needed as interventions.

Many respondents stated that seclusion rooms could only be removed if adequate alternatives were put in place. Among the necessary alternatives noted were:
- Comfort or relaxation rooms;
- Quiet areas;
- Low stimulus therapeutic environments;
- Adequate education and training and
- Full implementation of *A Vision for Change*, including the Psychiatric Intensive Care Rehabilitation Units.

Comments from Respondents considering the action was not suitable to implement

Although just over one in ten respondents indicated that this action was not suitable to implement, many of the comments received indicated that those who were of this view were strongly opposed to including it in the strategy.

It was suggested that removing seclusion rooms would lead to an increase in the use of seclusion and physical restraint and to some approved centres "exporting" their problems to other areas. The latter risk would lead to an artificial increase in the number of episodes of restrictive interventions in other areas. One submission from a specific mental health service commented on how removing the seclusion room would simply not be feasible at present for that service. The service noted that such a move would give them the highest risk score on the current risk assessment template that they use.

Some submissions cautioned that proceeding with this action could alienate staff members and also reduce goodwill towards the strategy.

Support for Action

Support was nevertheless expressed for this action in other submissions. Some services drew the Commission's attention to the absence of seclusion rooms in particular services or elements of a service. It was suggested that a feasibility report could serve as a useful exercise to reflect on practice in a service. One submission which supported prioritising this action suggested that it should be carried out immediately to ensure the timely removal of those seclusion rooms which could be eliminated.   Another respondent suggested that it would be appropriate to develop a feasibility report in any areas involving new builds or modifications.

## 2.2.3   Intervention Category: Staffing - Actions 7-9

Action 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

Figure 8 below shows how the 39 consultation respondents who ranked this action wished it to be prioritised. A clear majority of almost seven out of ten submissions (69.2%) approved of making it a priority action. More than one-fifth (23.1%) of submissions identified it as appropriate for medium-term implementation.

Figure 8: Analysis of Responses to Consultation Questions for Action 7 – *Call for Exemption from Moratorium on Recruitment*

n = 39
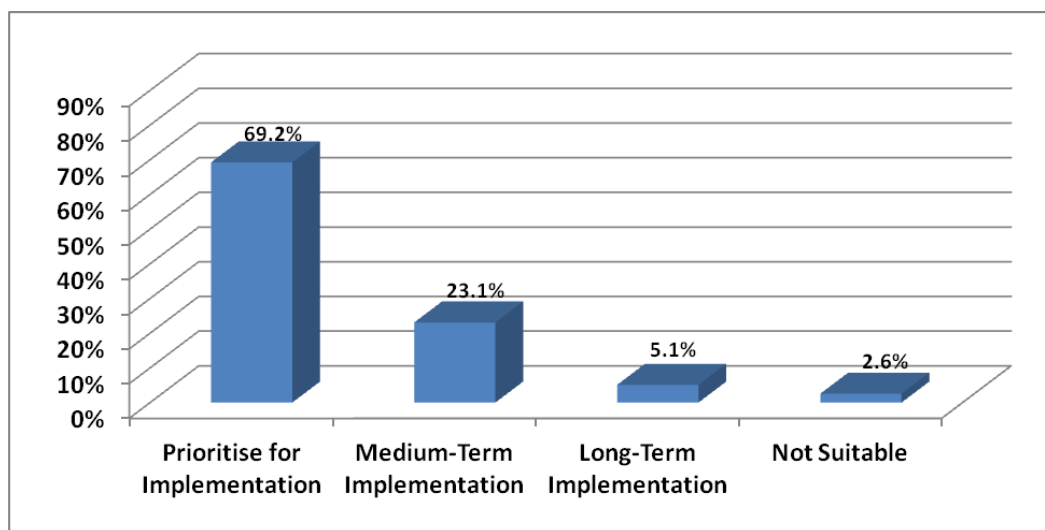
Comments on Action 7 – *Call for Exemption from Moratorium on Recruitment*

<u>Support for Action</u>
A large number of comments received on this action point noted that it was a crucial element of any strategy. Typical comments included SIPTU's statement that an exemption from the moratorium on recruitment is "*essential to allow any improvement in the use of restraint and seclusion*".

Respondents noted that reduced staffing levels often lead to higher risk ratings, made it difficult to maintain good practices and to adequately manage current levels of violence and aggression in approved centres.

Some respondents welcomed this action point on the basis that an end to or exemption from the moratorium on recruitment in the public sector has been and continues to be a priority for their particular service.

<u>Suggested Amendments to Action</u>
Among the suggested amendments to this action outlined by respondents were:
- The Commission should set out appropriate staffing levels for different types of inpatient settings, below which seclusion and restraint are more likely to occur;
- The action should be strengthened. A call for an exemption is not sufficient as more people are leaving the mental health service than are coming in;
- The call from an exemption from the moratorium should also come from the HSE, the College of Psychiatry of Ireland, the National Service Users Executive and the Irish Advocacy Network.

<u>Caution regarding Implementing Action</u>
A word of caution with regard to this action was noted by one respondent. It was stated that staff should not be removed from the community to ensure adequate staffing in approved centres.
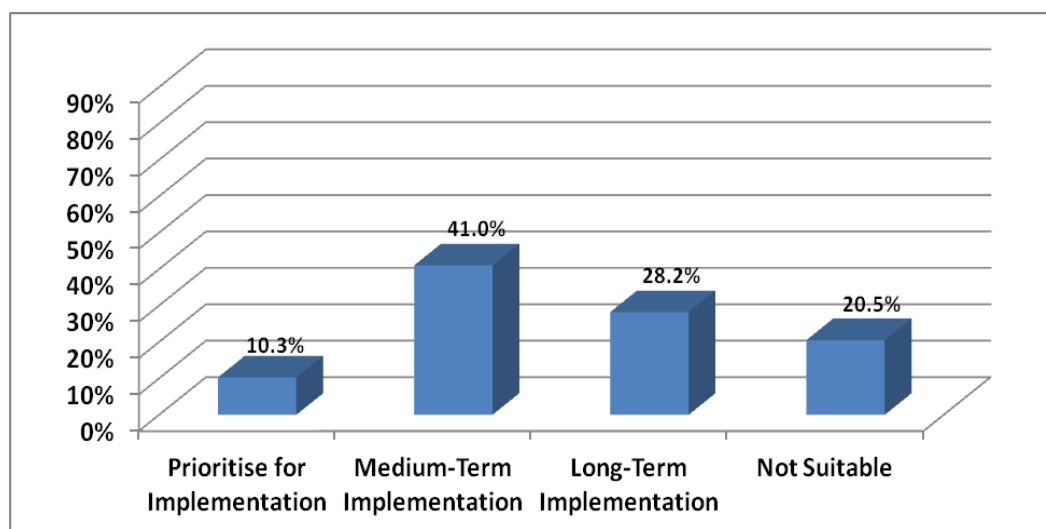
Action 8

> 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

Compared to many of the draft strategy's other actions, consultation responses indicated a low level of support for prioritising this action. Figure 9 below illustrates that just 10.3% of the 39 respondents ranked it as a priority action. Support for implementing this action in the medium term was indicated in 41% of the submissions. Eleven (28.2%) submissions considered that examining the feasibility of establishing psychiatric emergency response teams in approved centres should be realised in the longer-term. One-fifth (20.5%) of responses indicated that such an action was not suitable to implement.

Figure 9: Analysis of Responses to Consultation Questions for Action 8 - *Psychiatric Emergency Response Teams*

n = 39

Comments on Action 8 – *Psychiatric Emergency Response Teams*

Concerns regarding Implementing Action

Almost all comments received in relation to this action identified concerns over including it as part of the strategy. Many of the consultation responses observed that introducing psychiatric emergency response teams at this juncture was not feasible because of the staffing resources that the proposal entailed. The concept implied the availability of additional staff at very short notice which just was not possible at present.

No such teams presently exist in Ireland and establishing them would carry significant training and staffing allocations at a time when finances are stretched in terms of providing the current service – **[Acute Psychiatric Unit, Tallaght, Dublin West/South West Mental Health Services].**

Another respondent pointed to the difficulties experienced finding resources for assisted admissions to highlight the challenges that would be involved.

Additional concerns noted were that:
- The establishment of teams could lead to the deskilling of staff which risked increasing the use of seclusion and restraint;
- PERTS were less appropriate to implement in Ireland where a different context applies than in the USA. In-patient facilities in Ireland are much smaller in size and mechanical restraint is rarely used here;
- Such teams were not appropriate for general hospital units as an emergency response team would consist of the bulk of the available staff.
- PERTS were not appropriate for rural services and geographically dispersed services.

- PERTS were not suitable for older service users and may in fact worsen situations in patients with Behavioral and Psychological Symptoms of Dementia.

Suggested Amendments to Action

Among the amendments to this action that were proposed was a suggestion that the Commission should advocate that all staff should be adequately trained in emergency response and that one member of the nursing team could co-ordinate issues relating to the use of seclusion and restraint at the beginning of each shift.

Emergency Procedures in Ireland

It was helpful for the Commission to hear about emergency procedures that are currently in use in services. St Brendan's Hospital noted for example that although they do not have an identified team to respond to emergencies, there is a system in place such that responses are received from other units in the approved centre after alarms are activated.

Support for Action

Where support was expressed for including this action as part of the strategy, it was noted that the composition of the emergency response team could be an important safeguard for service users. One respondent noted that this was contingent however on there being multidisciplinary involvement in such teams.
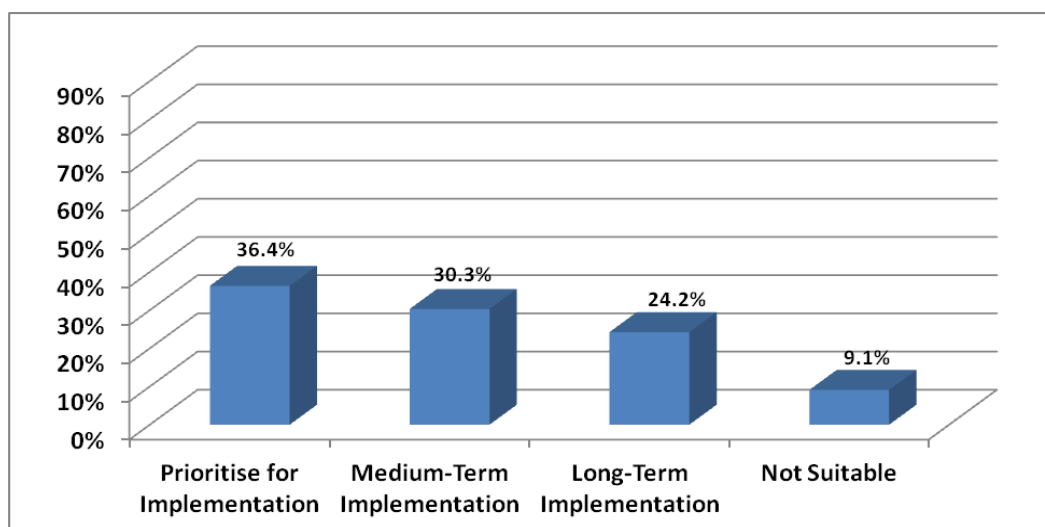
Action 9

> 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

An analysis of the views of the 33 consultation participants who ranked this action shows that none of the priority categories were clearly preferred over the others. As illustrated in Figure 10, more than one-third (36.4%) of submissions indicated that staff rotation should be prioritised. Three out of ten (30.3%) respondents stated that it should be implemented in the medium-term and one quarter (24.2%) considered it appropriate for longer-term implementation. Slightly less than one in ten (9.1%) submissions indicated that this action should not be part of a seclusion and restraint reduction strategy.

Figure 10: Analysis of Responses to Consultation Questions for Action 9 – *Staff Rotation*

n = 33

Support for Action
The majority of consultation respodents indicated support for the objective behind staff rotation i.e. preventing staff burnout but they were at the same time cautious about its feasibility at present. Comments from trade unions representing nurses indicated that the current staff shortages within mental health services meant that such an action may not be possible now. The loss of allowances for staff who move to work in other areas was also identfied as an impediment to realising this action in two submissions.

Some respondents infomed the Commission that staff rotation already happens in their service. St Brendan's Hospital practices rotation for instance in order to prevent staff working continually in an acutely stressful environment.

Risks Associated with Action
A frequent observation made in submissions was that staff rotation risked undermining continuity of care and the development of special skills which are important when working with patients demonstrating challenging behaviour.

Another respondent considered that this action was not appropriate to implement because of its potential to undermine the development of team-working within community teams by disrupting the complement of staff on a regular basis.

A response from the School of Nursing and Midwifery in Trinity College identied a risk that staff rotation could lead to increased stigma by identifying certain sectors of the mental health services as difficult to work in. This submission, and other respondents, suggested that training and education for persons working in acute settings may be more appropriate.

2.2.4   Intervention Category: Training and Education - Action 10

Action 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

Thirty-nine submissions addressed the tenth action. Figure 11 illustrates that a large majority (79.5%) of the 39 submissions considered that it should be implemented as a priority action. Fifteen per-cent of responses stated that it should be realised in the medium term.

Figure 11: Analysis of Responses to Consultation Questions for Action 10 – *Additional Guidance on Training*

n = 39
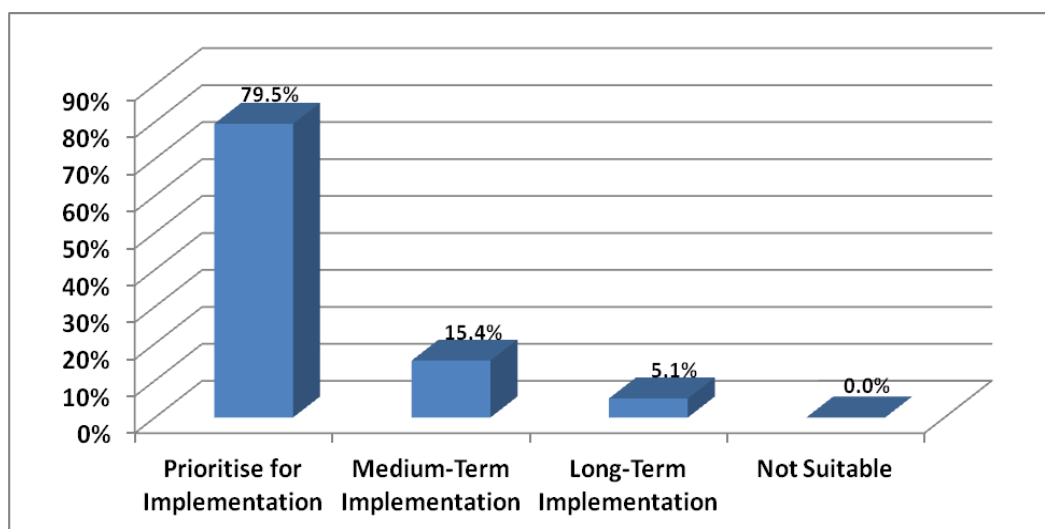
Comments on Action 10 – *Additional Guidance on Training*

Support for Action

Appropriate training was frequently noted as being critical to the success of the strategy. Respondents drew attention to the importance of skills specified in the guidance, including de-escalation, debriefing and attitudes to the use of seclusion and restraint. Some submissions observed that many of these skills had improved in particular services following the undertaking of specific training.

Standardised Training

By far the most common observation made in relation to this action was that there is currently no standardised national training model related to the management of aggression and violence. There are currently a number of providers offering different training in the area. A standardised approach would be welcomed by many respondents and offer the best means of enusring that specific areas and skills referenced in the draft action can be put in place nationally. It should also assist securing the release of staff to attend such training. *This group should recommend the type of training and the fact that it should be mandatory for all staff of the mental health services* – **[National Service User Executive].**

A number of suggestions were received as to how standardised training should be implemented. Three submissions specifically recommened that PMAV training should be considerd as the standardised training model. It focussed on many of the areas specified in the draft action and had the additional advantage that it could be delivered based on a specific service's features and needs.

Other proposals were that the Commission should arrange a best practice conference on seclusion and restraint, at which stakeholders would discuss and agree on a standardised

approach. Donegal Mental Health Services offered, where possible, to support the Commission to carry out an audit of existing models of care and training in order to benchmark and develop a national standardised training model.

Additional Suggestions

Respondents made a number of additional suggestions regarding the role of training in reducing the inclidence of seclusion and restraint. These included proposals that:

- The Commission should provide a training programme on "*alternatives to seclusion*";
- There should be national guidance on the regulation of physical intervention programmes and trainers;
- A guidance document should be issued for those who commission training in the area;
- Training should be based on national learning outcomes, be integrated into all professional training curricula and be appropriately accredited;
- Consultant psychiatrists needed training in the area as they are required to authorise episodes of seclusion and restraint;
- Advance nurse practitioners should have a role in delivering training content in the area; and
- A minimum qualification should be established for those who may be involved in the use of seclusion and restraint,

Challenges to Implementing Action

Some respondents commented that releasing staff for training was already difficult and that staff in some services have not received any training. In light of this, executing this action which included additional training would create even further challenges. Challanges related to finding resources to finance additional training were also frequently noted.

Professional Education

Other respondents noted that the whole area of training needed to be considered alongside professional education that takes place in undergraduate and graduate programmes. One submission stated that undergraduate curricula do not address the prevention, management or treatment of challenging or antisocial behaviour in any strategic detail.

2.2.5 Intervention Category: Patient, Family and Advocate Involvement - Actions 11 & 12
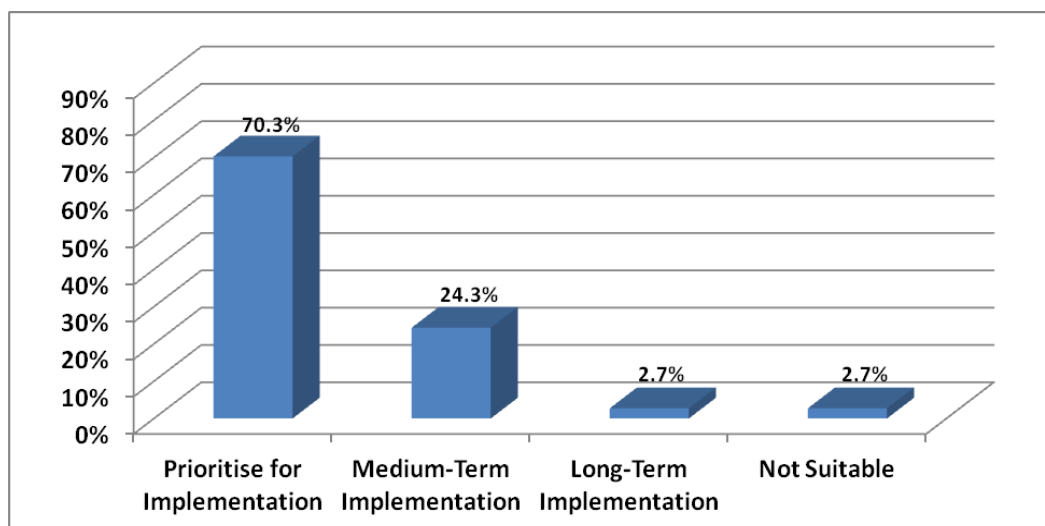
Action 11

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

A large majority (70.3%) of the 37 submissions that assessed this action indicated that it should be implemented as a priority. Almost one quarter (24.3%) of responses supported realising the action in the medium term. Only one (2.7%) submission considered that it should be implemented in the long-term. One respondent (2.7%) stated that it was not suitable to implement.

Figure 12: Analysis of Responses to Consultation Questions for Action 11 – *Assessment Following Admission*

n = 37

Comments on Action 11 – *Assessment Following Admission*

Support for Action
Comments received on this action reflected the large volume of support for its speedy implementation. Among the benefits associated with the action's implementation were:

- It assists services to achieve compliance with Commission codes of practice;
- It assists with care planning; and
- It supports a management culture whereby issues are considered proactively rather than reactively.

Suggested Amendments to Action
A number of suggestions to enhance the action were also put forward by consultation participants. These included:

- A pre-admission assessment should accompany each patient;
- The risk assessment should cover early warning signs and indications of relapse;
- An agreed care plan should include approaches to use for violent behaviour, such as Time Out, the use of a Comfort Room and rapid tranquilisation;
- Advance directives selected by patients should be agreed with the primary nurse and be risk assessed; and
- Advance directives need to be balanced with the duty of care;

One respondent stated that responsibility for implementing such an action which was currently assigned to Clinical Directors and Registered Proprietors needed to reflect the reality that nurses are often the staff with responsibility for dealing with advance directives. Another respondent commented that the draft action could not solely be considered as a proposal related to patient, family and advocate involvement. It was felt that it needed to be recognised that this was also a leadership and training issue.

Challenges
Challenges associated with the use of advance directives for some service users were noted. It was felt that adequate consideration needed to be given to a person's mental state at the time advance directives are chosen. It was also noted that issues of decision making capacity complicates the use of advance directives for service users with intellectual disabilities. Solutions to the difficulties that are often encountered such as using communication supports and familiar staff were noted however as ways to assist with maximising a service users' decision-making capacity.
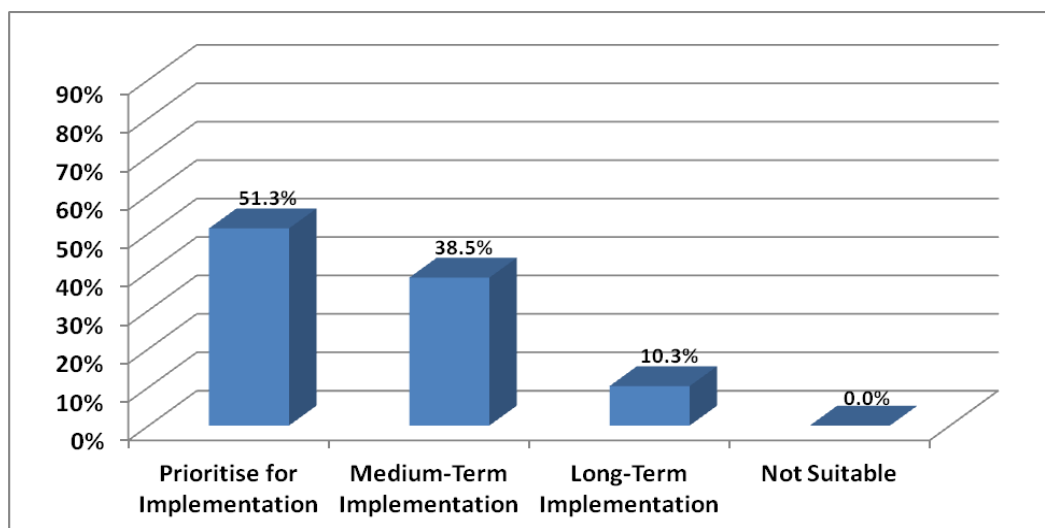
Action 12

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

Figure 13 shows that half (51.3%) of the 39 respondents addressing this action considered that it should be prioritised. Almost four in ten (38.5%) submissions supported its implementation in the medium-term. Ten per-cent of respondents indicated that it was appropriate to realise in the longer term.

Figure 13: Analysis of Responses to Consultation Questions for Action 12 – *Advocate and Service User Involvement in Reduction Initiatives*

n = 39

Comments on Action 12 – *Advocate and Service User Involvement in Reduction Initiatives*

Support for Action
Several submissions considered this action to be an essential component of a seclusion and restraint reduction strategy. Some responses from services reflected on the benefits of involving service users and advocates that have already been experienced such as the important role carried out by advocates in providing peer support to residents who have been secluded or physically restrained. A submission from the Multidisciplinary Restrictive

Practices Group based in St Joseph's Intellectual Disability Services commented on the work of a parents and friends group which inputs views into the use of restrictive practices and is regarded as "*very useful*". One respondent supported such involvement because it facilitated interpretations of a service user's challenging behaviour that were alternative to those supplied by nurses and doctors. One other respondent drew attention to the fact that such involvement is mandated by the UN Convention on the Rights of Persons with Disabilities.

The National Federation of Voluntary Bodies informed us that they wished to explore the development of peer-to-peer support for people with intellectual disability and mental health difficulties.

<u>Suggested Amendments to Action</u>
Among the suggested amendments made regarding this action were:
- Local service user groups should be involved in addition to IAN and NSUE
- Advocate and service user involvement needed to be balanced by the inclusion of staff representative groups in reduction initiatives;
- Service users and advocates could be included in a verification process to ensure that the correct seclusion and restraint procedures were followed; and
- Advocates, carers and family members could be educated about the provisions included in Commission Rules and codes of practice so that they could understand that a structured process is in place which includes the exploration of alternative options before restrictive practices are used.

2.2.6   Intervention Category: Using data to monitor seclusion and restraint episodes - Actions 13-16

Action 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

When submissions ranked this action, divergent views were apparent. The most popular option selected was medium-term implementation, which was chosen by 36.4% of respondents whereas support for the other options was more evenly spread. One quarter (24.2%) of the 33 submissions stated that it should be prioritised, one-fifth (21.2%)

considered that it was not suitable to implement and just under one-fifth (18.2%) indicated that it should be realised in the longer term. The proportion of responses that indicated that seclusion and restraint reduction targets were not appropriate to implement as part of the strategy at just over 21% was the highest percentage indicating that any action was not suitable to execute as part of the consultation.

Figure 14: Analysis of Responses to Consultation Questions for Action 13 – *Seclusion and Restraint Reduction Targets*

n = 33
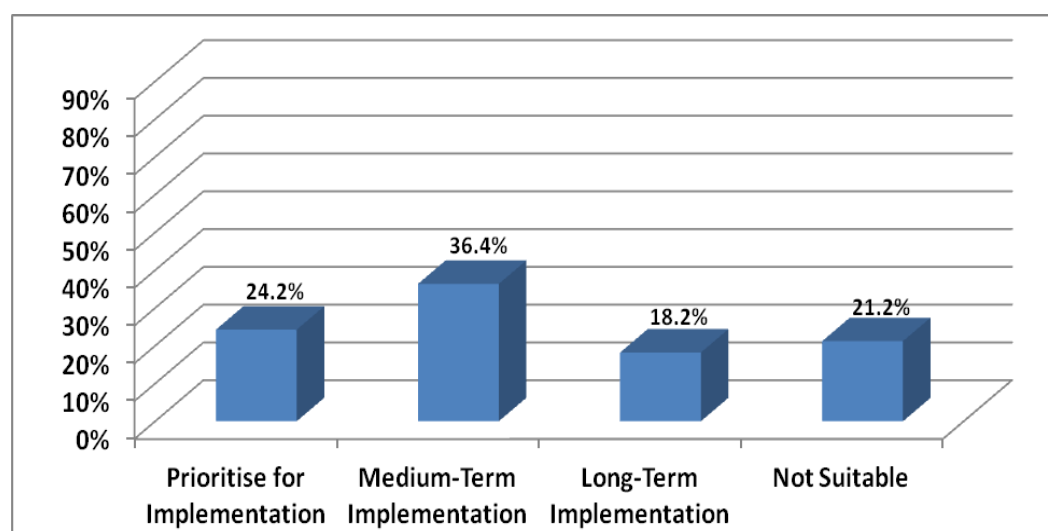
Comments on Action 13 – *Seclusion and Restraint Reduction Targets*

Support for Action
Those respondents who supported prioritising this action noted that data collection and the setting of targets were vital parts of the planning process for launching any strategy.

Other respondents, nevertheless, felt that such an action was more appropriate for medium or longer term implementation because any reduction in the use of restrictive interventions would not happen overnight and that the development of targets was dependent on the realisation of other actions initially, such as those associated with improved data collection. Additional reasons given for identifying this action as a medium term priority were that it posed challenges and needed to be handled sensitively but was still worthwhile to pursue.

Sugessted Amendments to Action
A suggested amendment to the draft action made in three submissions related to the focus of the targets. It was recommended that the targets should also relate to national and local support structures that help those working in mental health services to develop more creative and humane approaches to helping people who are acutely unwell. Another

respondent proposed that an analysis of the reasons for success or otherwise of reduction initiatives should be included alongside published data on targets.

<u>Concerns regarding Implementing Action</u>
Comments noted in numerous submissions regarding this action, however, reflected concerns that it should only proceed in the longer term as well as strong views that it just was not appropriate to implement as part of the strategy. Among the concerns highlighted in submissions were:

- Data returns can be very cyclical and heavily influenced by factors outside of a service's control such as the admission of a particularly acutely unwell patient; and the absence of intensive care rehabilitation units;
- A league table mentality could be created which would be inappropriate because many services are so different, catering for specific populations and providing services in radically different physical environments for example;
- Not reaching targets could have a very demoralising impact on staff who were genuinely trying to introduce good practices;
- Targets could lead to the non-reporting of some episodes of seclusion and restraint;
- Managers may focus too much on meeting targets to the detriment of the needs and safety of patients and staff;
- Targets were inappropriate to put in place in the absence of an adequate data collection infrastructure and staffing resources;
- Targets place a focus on ticking boxes when what is really needed in services is a change in vision, culture and practices.

Action 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

Thirty-five respondents ranked the draft strategy's fifteenth action. Figure 15 shows that the most popular option selected regarding implementing this action was that it should be put in

place in the medium-term. Just under one half (45.7%) of submissions considered that this action should be prioritised in this way. One quarter (25.7%) of responses supported realising the collection of additional data in the longer term with one sixth (17.1%) suggesting that it should be implemented as a priority. Just over one in ten (11.4%) submissions stated that it was not suitable to implement.

Figure 15: Analysis of Responses to Consultation Questions for Action 14 – *Additional Data Analysis on Seclusion and Restraint Episodes*
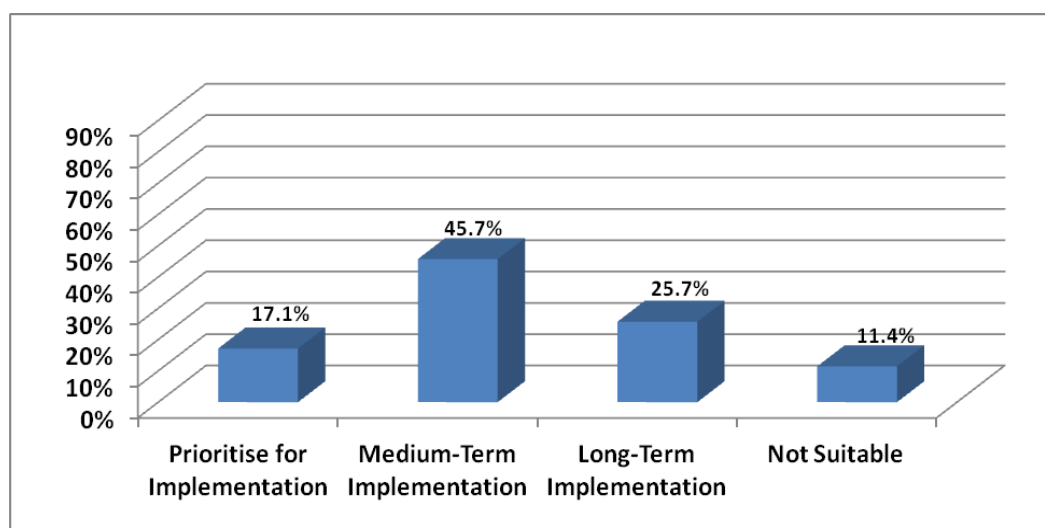
n = 35

Comments on Action 14 – *Additional Data Analysis on Seclusion and Restraint Episodes*

Support for Action
Support for implementing this idea was evident in some submissions from some services. Additional data analysis using information that is already collected was considered a good idea which could influence positive changes in practice. In commenting on why this action should be put in place in the medium term, respondents noted that when other actions were implemented initially, additional data collection made sense to facilitate reporting on the success or otherwise of such initiatives.

Challenges and Concerns regarding Implementing Action
Several consultation responses, nevertheless, pointed out challenges to realising this and other actions associated with the collection and analysis of data. Staff shortages and poor IT systems and infrastructure were the main barriers identified by most respondents.

Data collection is essential but given the lack of electronic systems available to the health service, data collection at the level currently being done is probably all that can be managed in already stressed services – **[Consultant Psychiatrist].**

Many respondents identified concerns related to the draft action's proposal to use additional data analysis to identify staff who may benefit from training in the use of the interventions. The difficulties involved in comparing data collected on the use of seclusion and restraint were highlighted again. Other specific comments which were received included:

- Staff should have the necessary resources and infrastructure to enable them to reduce their use of seclusion and physical restraint before their performance in doing so is evaluated and published;
- Identifying particular staff as frequent users of restraint and seclusion may not be positive and could in fact be counterproductive;
- Some staff volunteer to work with particular patients meaning that they would be unfairly associated with episodes of seclusion and restraint;
- Some staff work mainly at night and would not appear in statistics looking at this issue;
- Staff who show up in statistics as frequent initiators of seclusion or restraint may actually be acting appropriately and making correct decisions;
- Data should not be used in a punitive manner; and
- Isolating training to individuals was flawed as all staff should receive training in the area.

A number of submissions took the opportunity to suggest additional data items that could be collected: These include data on:

- The physical characteristics of approved centres;
- If the admission of a person who was secluded/restrained was an assisted admission;
- If medication was administered during a seclusion and restraint episode;
- The last date of training of staff involved in seclusion/restraint;
- The deaths, injuries and costs associated with the use of seclusion and restraint; and
- The levels/degrees of physical restraint used as recognised in PMAV training.

Other proposals made were that the Commission could provide a tool to facilitate the capturing of additional data and that any additional data should be collected and analysed by a clinical nurse with responsibility for seclusion and restraint.

Action 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

The draft strategy's fifteenth action concerned the Register and Clinical Practice Form used to collect data on seclusion and restraint. They also form the basis for the data returns that are made to the Commission on the use of restrictive interventions. It proposes that:
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.

The draft strategy also proposes that the MHC take responsibility for this action with assistance from the HSE and independent services.

Thirty-four consultation submissions addressed this action. Just over 44% of these submissions supported implementing this action in the long term. More than one-third (35.3%) of respondents considered that this action should be realised in the medium term. Five (14.7%) submissions stated that Action 15 should be prioritised.

Figure 16: Analysis of Responses to Consultation Questions for Action 15 – *Examine Feasibility of Developing Electronic Registers*
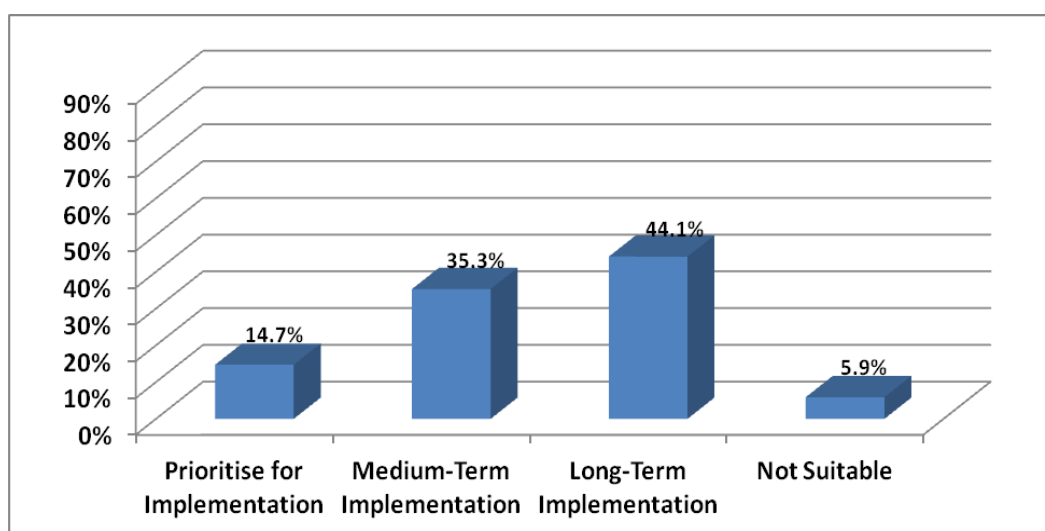
n = 34

Comments on Action 15 – *Examine Feasibility of Developing Electronic Registers*

Support for Medium and Longer Term Implementation of Action
Many responses indicated that ideally, this action would be in place in all services as electronic systems facilitate data collection and analysis. In the long run, it was acknowledged that electronic systems should also save time and money. St John of God Hospital noted that they may be able to assist with executing this action because of the service's use of an electronic mental health information system.

Challenges to Implementing Action
As is the case for all actions related to data collection and analysis, many submissions highlighted challenges associated with implementing this action. The main challenges were:

- Services operating with fewer administrative and clinical staff;
- Access to Information Technology;
- Data Protection Issues; and
- Costs associated with this initiative.

Concern was expressed by one respondent that electronic registers would dilute the meaning associated with recording information on restrictive practices. It was suggested that hard copies of registers should still be completed which could then be integrated with an electronic system.
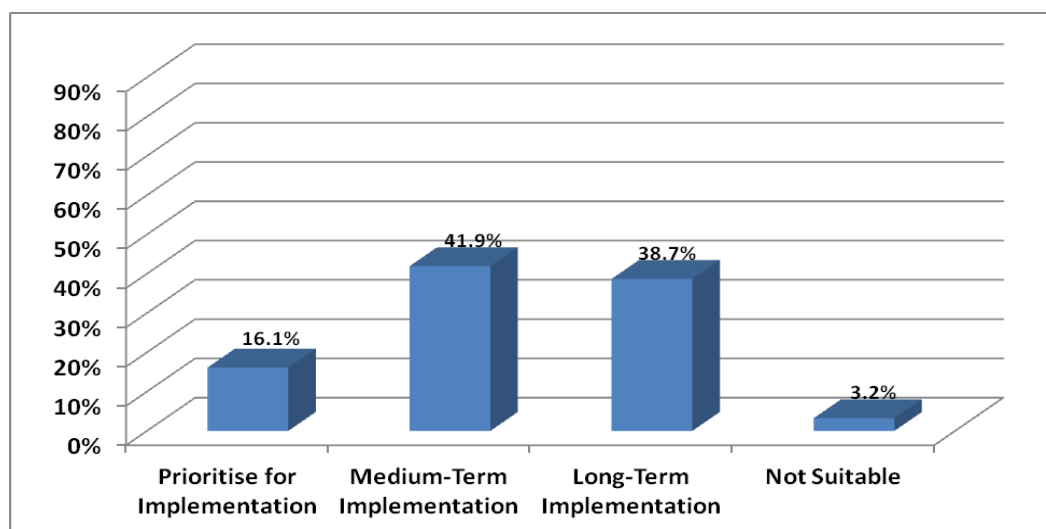
Action 16

> 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

Figure 17 shows that the proportion of submissions indicating support for implementing this action in the medium term and the proportion considering that it should be put it in place in the longer term was close. Almost 42% of respondents stated that it was appropriate for medium-term implementation and 38.7% suggested that it should be included in a reduction strategy as a long term action. One-sixth of respondents believed that this action should be prioritised.

Figure 17: Analysis of Responses to Consultation Questions for Action 16 – *Examine Feasibility of Collecting Additional Data on Seclusion and Physical Restraint Use*

n = 31

Comments on Action 16 – *Examine Feasibility of Collecting Additional Data on Seclusion and Physical Restraint Use*

Submissions which considered that this action should be put in place speedily noted that the strategy would be assisted by the quick availability of more information. Others observed that as data collection was already taking place, it was more appropriate to consider other actions initially. Challenges related to resources, IT infrastructure and the comparability of data that were noted in respect of other actions were again identified in commentary on this action.

2.2.7 Intervention Category: Review Procedures/Debriefing - Actions 17 & 18

Action 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

Figure 18 demonstrates that there was large support for prioritising the inclusion of this additional guidance in the strategy. More than seven out of ten (72.5%) respondents ranked the action in this way. One quarter felt that it should be put in place in the medium term.

Figure 18: Analysis of Responses to Consultation Questions for Action 17 – *Additional Guidance on Debriefing*
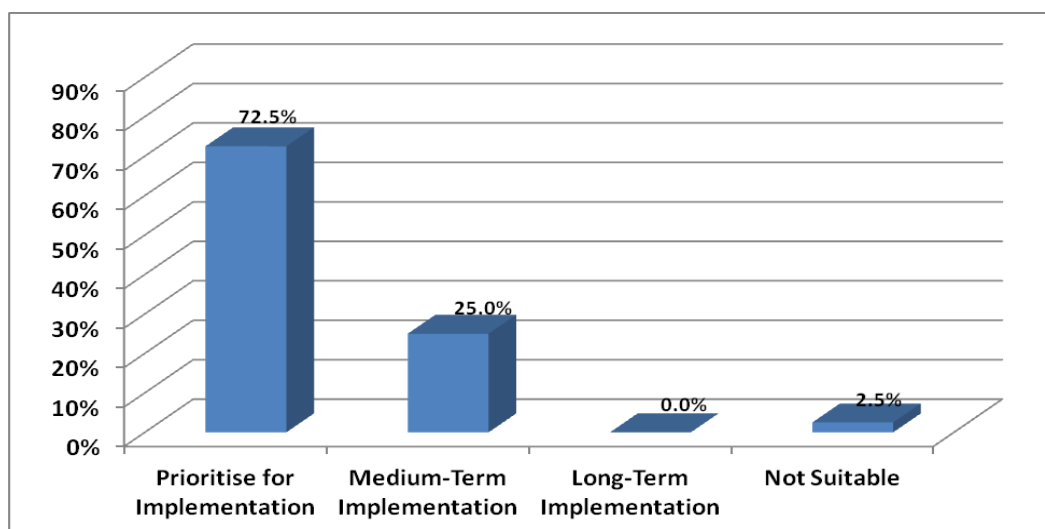
n = 40

Comments on Action 17 – *Additional Guidance on Debriefing*

Support for Action
The most common response outlined in submissions that wished to prioritise this action was that such additional guidance should be implemented immediately because it addressed issues that services should already be complying with as a result of provisions within Commission Rules and a Code of Practice.
Among the benefits of debriefing noted were:
- It improves practice;
- It facilitates stress reduction for staff; and
- It leads to learning for everyone;

Dialogue between patient and staff (and where appropriate advocates and family) sharing their respective perspective of the events will help improve understanding of all parties and potentially produce alternative solutions in the future – **[Shine]**.

Three submissions emphasised that the wishes of the service users with respect to the involvement of others in the debriefing process had to be respected.

Suggested Amendments to Action
Many proposals were received in relation to this action. Some respondents suggested that the additional guidance should be included directly within the Rules and the Code of Practice in order to give it more weighting than guidance.

The following additional suggestions were made regarding how debriefing could operate more effectively:
- There was a need to highlight the people responsible for the different actions, the timeframes for the completion of debriefing, and the associated documentation which would show that the guidance was being followed;
- Consideration should be given as to what are appropriate professional boundaries and which professionals should appropriately be involved in a therapeutic process; and
- Visual material should be used with service users with an intellectual disability to ensure a more appropriate process.

Four submissions identified a need for staff debriefing which it was felt would recognise that staff often needed support after involvement in a crisis situation.

Clarification Regarding Roles at Debriefing Session
Two respondents sought clarification regarding the role of advocates at the debriefing session. One respondent requested this clarification because they did not regard debriefing as an evidence-based approach. Another respondent asked for clarity around the status of

the advocate or service user at the debriefing session. It was considered important that they were regarded as equal participants.

Action 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

Including the final action as a priority action was supported by a clear majority of the 36 respondents who ranked this action. Almost seven out of ten (69.4%) submissions indicated that it should be prioritised. Eight (22.2%) respondents preferred implementing it in the medium.

Figure 19: Analysis of Responses to Consultation Questions for Action 18 – *Additional Guidance on Review Procedures*

n = 36
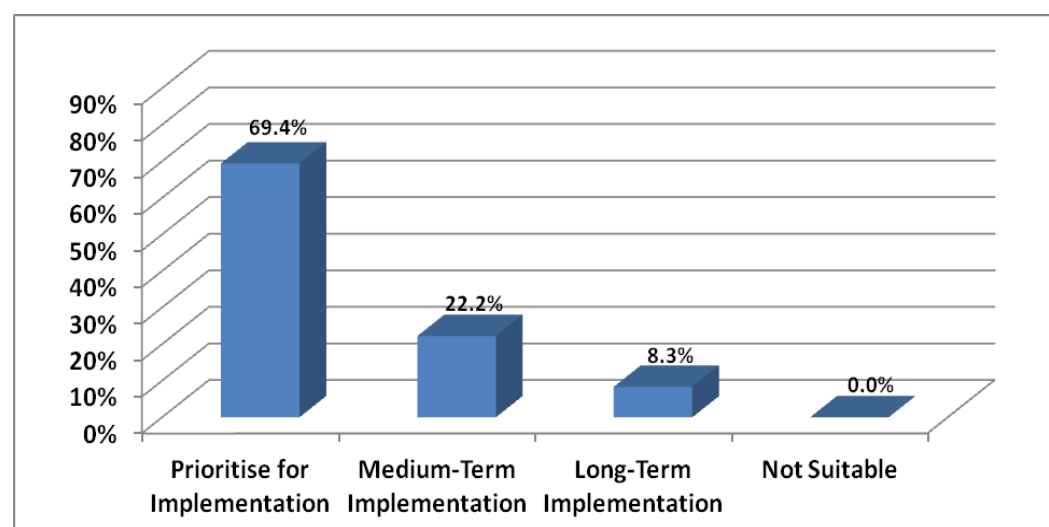
Comments on Action 18 – *Additional Guidance on Review Procedures*

Support for Action
Similar reasons for supporting the inclusion of this action as a priority were cited as were noted in relation to the action on debriefing. Putting in place adequate review procedures was frequently described as a valuable reflective and learning experience.

The National Federation of Voluntary Bodies drew the Commission's attention to Rights Review Committees (RRC) which have been established by a number of their member organisations. Such committees make a useful distinction between therapeutic interventions and rights restrictions.

Suggested Amendments to Action
Among the suggested changes to the action which were proposed were that:
- The chair of a review meeting should be independent and sufficiently empowered to challenge culture and practice, not just within teams, but also within the approved centre and wider psychiatry; and
- The process of restraint and seclusion, reviews and feedback can be quite emotive and a 'no blame' culture can lead to improved outcomes.

2.3 Findings for Consultation Question 7: Other Comments or Suggestions

The consultation document's final question asked participants:

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

Responses to this question were quite varied and covered a range of issues related to the strategy and to the issue of seclusion and restraint in general. We group the comments under a number of appropriate headings. These include comments relating to:
- Omissions from the draft strategy;
- The scope of the draft strategy;
- Implementation of the strategy;
- Perspectives on the use of Seclusion and Restraint;
- The Knowledge Review;
- Seclusion and Restraint Use among specific populations;
- Contextual Developments;
- Suggested Amendments to Commission Rules and a Code of Practice; and
- Issues that were outside the scope of the consultation.

Omissions

The role of the **physical environment** in promoting relaxation and recovery and therefore to a reduced need to use seclusion and restraint was regularly highlighted. Among the relevant characteristics of approved centres that were noted were:

- The amount of space and light available in the centre;
- The presence of high observation facilities;
- The presence of an adjoining open space such as a garden; and
- Soft furnishings.

Enhancing the environmental design of approved centre (reduced stressors such as crowding, noise etc.) may significantly reduce the need to use seclusion or physical restraint (perhaps the Commission could investigate whether this would be useful and produce standards so that as Approved Centers are replaced and updated more therapeutic, patient centered environments could be constructed) – [**Association of Occupational Therapists of Ireland Special Interest Group in Mental Health**].

One respondent considered it especially important to comment on the poor physical state of many approved centres.

The administration of medication was a recurring theme in several submissions. This included the use of medication for rapid tranquilisation or what was described by some respondents as chemical restraint. The knowledge review that accompanied the draft strategy acknowledged the evidence that the choice of anti-psychotic medication can influence rates of seclusion and restraint. The Commission considered, however, that it was inappropriate to include an action in the draft strategy related to the use of medication as a restraint in order to achieve reductions in the use of other restrictive interventions.

There was, nevertheless, a request for clarity from a number of respondents as to the status of medication in the strategy. The Psychiatric Nurses Association (PNA) considered that "*the reluctance by the Commission to address the use of medication as part of this strategy not as a means of restraint but sometimes necessary in the treatment of mental illness and distress and therefore must be referred to as a component in this strategy*". Others felt that the appropriate use of medication and in some cases, rapid tranquilisation, reduces the need for seclusion and restraint and the strategy needs to acknowledge this.

Medication is an integral part of the management of acutely unwell patients. It is integral to the treatment of mental illness which may underlie disturbed behaviour. The review was limited in relation to this and needs further consideration, and for its outcomes to be factored into the whole thrust of the document on restraint and seclusion – [**St Vincent's Hospital, Fairview**].

In contrast, other respondents were concerned at the prevalence of the use of medication to restrain patients. Service users reported negative side effects that had been experienced as a result of being administered such medication. Concern was expressed that some services

would achieve reductions in the use of seclusion and physical restraint once the strategy commenced by simply administering more medication to patients.

A number of respondents called for clear guidelines or a code of practice to regulate the use of psychotropic medication that is administered to restrain patients. There was also a call for an independent audit of mental health services to assess their use of medication for this purpose.

Other restrictive interventions which can be experienced as restraint and which were not addressed in the strategy were also highlighted. Two respondents felt that the strategy may benefit from viewing restraint in a similar manner as the government initiative, *Towards a Restraint Free Environment in Nursing Homes (2011)*. Its definition of restraint included physical, mechanical, chemical and environmental restraint. Common forms of restrictive practices that other respondents wished to acknowledge were:
- The practice of locking doors;
- Buildings that do not allow much movement or personal privacy; and
- Restrictions on access to personal belongings;

"The National Federation propose that all forms of restraint need to be defined and included comprising chemical, mechanical, environmental and physical restraint accompanied by a strict code of practice monitoring their use with clear guidance on consent.[2] We also propose that the living situation of the person may be a key factor in the existence of challenging behaviour and a sign of the person's distress" – **[National Federation of Voluntary Bodies].**

Increased staff-to-patient ratios were recognised as an effective means to reduce the use of restrictive interventions in the literature. We decided, however, that including an action relating to increased staff-to-patient ratios was unrealistic because of the staff shortages in so many services. Some respondents, nevertheless, felt that as it was an evidence informed initiative, it could not be ignored even if it required more resources than some of the other actions. One respondent noted that it was a much more appropriate action than staffing related actions that were included in the draft strategy, such as those related to staff rotation and the development of Psychiatric Emergency Response Teams (PERTs). Mental Health Reform considered that an action related to increased ratios should be included in the strategy in principle and that planning work related to its medium and long-term implementation could commence in the short-term.

Some additional omissions noted by respondents were the following:
- The strategy should address the **harshness of the practice of seclusion and restraint**;
- The strategy needed to more explicitly set out that its goal was also to achieve **decrease in the duration of seclusion and restraint**;
- The reduction strategy should expand its scope from focusing on seclusion and physical restraint to **also include mechanical restraint** and to clearly outline that it aims to completely eradicate the use of mechanical restraint;

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[2] DOHC (October 2011) TOWARDS A RESTRAINT FREE ENVIRONMENT IN NURSING HOMES - A POLICY DOCUMENT

- The strategy needs to more clearly establish that it is about a **shift in practices and a change in culture** and not just about reducing numbers and ticking boxes.

Scope of Strategy

The draft strategy aims to reduce the use of seclusion and physical restraint within approved centres in Ireland. This reflects the scope of the Commission Rules and Code of Practice that govern the use of seclusion and physical restraint. These are interventions that may be used on all residents of approved centres, including children and adolescents.

Suggestions were made that the scope of the strategy should extend to other locations. These included high support units such as Ballydowd Special Care Unit which provides secure residential accommodation for children with serious emotional and behavioural difficulties who are detained under a High Court Order for their safety and welfare. It was also suggested that it would be helpful if the strategy applied to penal institution such as St. Patrick's Institution where a number of the children detained there have a dual diagnosis of behavioural and mental health problems.

Frustrations were also expressed that restrictive practices are used in other locations that are not currently subject to statutory inspection. This includes in particular services providing care and treatment to service users with intellectual disabilities in non-approved centre settings. One respondent suggested that the Commission should ask the Inspector of Mental Health Services to carry out an audit of the prevalence of the use of seclusion and physical restraint outside approved centres and make recommendations as to how this should be monitored.

Implementation of Strategy

Respondents frequently addressed how the strategy might be implemented beyond the consideration of the issue in the different draft actions. Challenges to the successful implementation of the strategy were frequently highlighted. There was a widespread concern that the current **shortage of financial and staffing resources** may result in the strategy not being accepted or implemented.

"*There is no comment on funding but the introduction of ICT, audits, staff training, etc. all have resource implications. Many services are firefighting due to staff retirements and lack of resources at present so it is difficult to see how a quality initiative such as this, though very important, can be completed*" – [**SIPTU Health Division**].

On the other hand, some respondents noted that many of the strategy's actions were not resource intensive.

There was broad agreement that all actions when finalised should have an agreed **timeframe for implementation**. Different perspectives were offered, however, on what was an appropriate timeframe for implementation of the complete strategy. One respondent

considered that a relatively short time frame of around three years should apply because the strategy has been developed during a time of economic constraint. It was then recommended that a review should take place at the end of this timeframe in order to examine actions that were not feasible during the initial period of the strategy. It was still considered essential to prioritise all feasible actions immediately.

The protection of individuals from unnecessary seclusion and restraint is not something that should be delayed. The prohibitions against torture, inhuman and degrading treatment are absolute rights under international human rights law and all feasible actions to prevent the risk of these rights being violated should be undertaken as a matter of priority – [**Mental Health Reform**].

One respondent identified research from Australia which suggested that any seclusion and restraint reduction strategy would require long-term support for a period of at least three to five years.

Some submissions commented on the **role of the Mental Health Commission in implementing the strategy**. It was suggested that the Commission needed to take on more of a leadership role and indicate how it would follow through to ensure delivery of the different actions. One respondent felt that the Commission could also play a leading role in reducing the use of seclusion and restraint by insisting on the provision of resources to provide training for example and recommending capital expenditures to improve the conditions within approved centres. Another submission felt that the Commission's leadership role needed to be set out more clearly within the Seclusion and Physical Restraint Reduction Strategy through a strong vision statement.

Other comments addressing the strategy's implementation stated that:
- Consideration should be given to including the final strategy or key elements of the strategy in the relevant Rules and Code; and
- The strategy should be implemented through a recognised change model.

Perspectives on the Use of Seclusion and Restraint

A variety of perspectives on the use of seclusion and restraint were put forward by different respondents. Although the vast majority of consultation participants supported the implementation of a reduction strategy, a number of respondents considered that it needed to be fully appreciated that seclusion and restraint were sometimes needed. Other comments which were made were:
- The safety of staff and other patients also needs to be considered;
- Seclusion and restraint are perceived by many service users as punishment;
- Seclusion and restraint can be considered therapeutic approaches; and
- The reduction strategy needed to recognise that seclusion and restraint are quite separate approaches to the management of challenging behaviour.

The Association of Occupational Therapists of Ireland also shared with us their *Best Practice Guidance for Occupational Therapists: Restrictive Practices and People with Intellectual Disabilities".* This provides individual therapists with the information and resources they need to make decisions where they are asked to intervene in restrictive practices.

Knowledge Review

There was a broad welcome and praise for the knowledge review which accompanied the draft strategy. Some respondents, nevertheless, felt that the literature's focus on research carried out in child and adult in-patient facilities limited its relevance to some approved centres. A submission from a Mental Health Service for Older People considered that as the differing needs of older people had not been adequately considered in informing the strategy, a further review of the literature should be carried out to inform evidence based on this group. A similar suggestion was made by other respondents in respect of literature related to reduction initiatives and people with intellectual disabilities.

Other points noted were that:
- The review did not distinguish adequately between the very different populations of children and adults;
- The knowledge review did not include any literature from the UK; and
- We should be careful interpreting the findings of the knowledge review across jurisdictions and service types.

Seclusion and Restraint Use among Specific Populations

Some respondents focussed particular attention on the issues concerning particular sub-groups on whom seclusion and restraint are used. These included children and adolescents, people with intellectual disabilities, older people and persons using forensic mental health services. In general, respondents considered that specialist approaches were needed for specific populations and that a one-size fits all strategy would not work.

Contextual Developments

A variety of contextual developments were highlighted by consultation participants as important to consider. These included:
- The absence of a coherent management and accountability structure for the public mental health services, including a Director for Mental Health, which is needed to drive the culture change implicit in a reduction strategy; and
- The slow pace of implementation of *A Vision for Change*.

The failure to implement key recommendation of *A Vision for Change* was a source of frustration for many respondents who directly linked inadequate service provision with the high levels of seclusion and restraint in use in some services. This lead in particular to the

inappropriate placement of some patients in approved centres. Some approved centres wish to transfer patients with challenging behaviours to other facilities for instance but cannot because there is no access to a regional secure unit.

The inappropriate placement of many service users with mental illness and intellectual disability in approved centres was also noted. Respondents felt that the implementation of A *Vision for Change*'s recommendations in respect of mental health of intellectual disability teams and the development of intensive care rehabilitation units needed to be immediately prioritised.

Mental Health Commission Rules and Code of Practice Governing the Use of Seclusion and Physical Restraint

Suggested changes were also made by respondents regarding 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*. Such amendments would be best considered in the context of a review of any of these documents.

Outside Scope

Several suggestions were received which were beyond the scope of this strategy although related to the issues of seclusion and restraint. Most of these proposals related to matters that could only be changed through amendments to the primary legislation, i.e. the Mental Health Act 2001. They included proposals:

- To designate the *Code of Practice on the Use of Physical Restraint in Approved Centres* as Rules;
- To enhance the protection of rights of individuals regarding restraint and seclusion within the context of the current review of the Mental health Act 2001;
- To make it easier to transfer a patient to the Central Mental Hospital;
- To specify that restraint may only be used for the administration of treatment in exceptional circumstances; and
- To require consideration of whether the status of a voluntary patient should be changed to involuntary before they are secluded or restrained.

The Commission would also like to acknowledge a number of helpful suggestions that were received regarding the **format of the final strategy**.

3. Discussion and Next Steps

This consultation exercise has revealed a huge amount of support for the Commission's proposal to implement a seclusion and restraint reduction strategy. The Commission is encouraged by these views and by the large amount of interest in the area that was apparent in the submissions made. We would like to acknowledge that a lot of existing work is already talking place in the area. Many respondents took the time to provide details to us on good practice initiatives that are already in place in services. Others made commitments in relation to implementing reduction initiatives which is especially welcome.

It is clear from quantitative analysis that there is considerable support for immediately implementing certain actions as part of the strategy. More than 90% of respondents consider that a seclusion and restraint reduction plan should be prioritised for implementation for example. Significant support for the speedy implementation of many of our other proposed actions was also evidenced. These included proposals related to guidance on training and guidance on debriefing and assigning responsibility for implementation of the strategy.

Quantitative data analysis also pointed to those actions which respondents are less enthusiastic about implementing. Here, concerns emerged in particular over the proposal to examine the feasibility of removing seclusion rooms from approved centres and actions related to staffing and the use of data to monitor seclusion and restraint.

In addition to quantitative findings, it is also essential to consider the explanatory comments that were fed back to us. These have provided us with a fuller understanding of participant views on areas under consideration. For example, although just one fifth of respondents indicated that they did not consider the action related to the development of psychiatric emergency response teams was suitable to implement, the detailed commentary on this action came almost exclusively from those opposed to this action. An analysis of these comments revealed that those who were opposed to this action had significant concerns.

It is clear to us that there are many challenges associated with putting this strategy in place. As well as cross cutting issues such as a shortage of staffing and financial resources, there are also challenges specific to the implementation of certain actions.

Consultation findings and suggestions made will now be considered in detail by the Commission. We will shortly outline our proposals in relation to the seclusion and physical restraint reduction strategy that we intend to implement in 2013.

4. Appendix - List of Consultation Respondents

1. Acute Psychiatric Unit, Tallaght, Dublin West/South West Mental Health Services
2. Amnesty International Ireland
3. An Bord Altranais
4. Association of Occupational Therapists of Ireland (AOTI) Special Interest Group in Mental Health
5. Barnardos
6. Mr Michael Bambrick, Director of Nursing, West Cork Mental Health Services, Bantry General Hospital, Bantry, Co. Cork.
7. Ms Margaret Brennan, Specialist Mental Health, HSE Dublin North-East
8. Carlow/Kilkenny/South Tipperary Mental Health Services
9. Central Mental Hospital
10. Children in Hospital Ireland
11. Daughter of Charity Intellectual Disability Service
12. Mr Martin Denny, CNM3, South Lee Mental Health Unit, Cork University Hospital
13. Donegal Mental Health Services Nursing
14. Executive Clinical Directors, College of Psychiatry of Ireland
15. Faculty of General Adult Psychiatry, College of Psychiatry of Ireland
16. Galway Mental Health Services Consultant Psychiatrists
17. HSE Mental Health Act Training Group
18. Irish Advocacy Network (IAN) Ltd.
19. Irish Institute of Mental Health Nurses
20. Ms Lisa Kiernan, CNM1, St Patrick's University Hospital
21. Kildare/West Wicklow Mental Health Services
22. Mr Graham Malone, CNM1 & PMAV Instructor, Unit One, St Brigid's Hospital Complex, Ardee, Co. Louth.
23. Mr Liam Marley, CNM2 & PMAV Instructor, Kerry Mental Health Services
24. Dr. Mia Mc Laughlin, Consultant Psychiatrist, St. Luke's Hospital , Kilkenny
25. Mr Patrick Murphy, Staff Nurse & PMAV Instructor, HSE South.
26. North Dublin Mental Health Services
27. Nurse Education Policy Development Committee, Louth/Meath Mental Health Services
28. Member of the Public
29. Mental Health Nursing Forum, School of Nursing & Midwifery, Trinity College Dublin
30. Mental Health Reform

31. Mental Health Services for Older People, Louth/Meath Mental Health Services
32. Mid West Mental Health Services (Clare, Limerick and North Tipperary)
33. Multidisciplinary Restrictive Practice Reduction Group, St Josephs Intellectual Disability Service
34. National Federation of Voluntary Bodies
35. National Service Users Executive (NSUE)
36. Project Joint Governance Committee, Linking Service and Safety
37. Psychiatric Nurses Association (PNA)
38. Psychiatric Nurses Association (PNA) members in the National Forensic Service
39. School of Nursing, Midwifery & Health Systems, University College Dublin
40. Service User 1
41. Service User 2
42. Service User 3
43. Shine
44. SIPTU Health Division
45. South Tipperary Mental Health Services Consultant Psychiatrists
46. St Brendan's Hospital Multidisciplinary Team
47. St John of God Hospital Ltd
48. St John of God Community Services Ltd
49. St Patrick's University Hospital, St Edmundsbury Hospital, Willow Grove Adolescent Unit
50. St Vincent's Hospital, Fairview
51. Dr. Dermot Walsh, Consultant Psychiatrist, Former Inspector of Mental Hospitals
52. West and East Galway Mental Health Services in conjunction with the Mental Health Research Cluster, National University of Ireland, Galway.