



Mental Health Commission

Consultation on Draft Seclusion and Physical Restraint Reduction Strategy

June 2012

Please return feedback by post or email (preferably typed) by **12th September 2012**. If you would like us to send you a hard copy of this guide, please contact us.

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The Closing date for Feedback is 12th September 2012

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Date of your comments (DD/MM/YYYY) <div style="font-size: 1.2em; font-weight: bold; text-align: center;">29 / 08 /2012</div>									
<p>Is this response a joint response or from an individual?</p> <p>Individual <input type="checkbox"/></p> <p>Joint <input checked="" type="checkbox"/> XX</p> <p>If this is a joint response by a group please specify the number of respondents this submission is made on behalf of</p> <p style="text-align: center;">26 member organisations of the coalition</p> <p>The category of professionals or individuals it represents (e.g. 2 x Consultant Psychiatrists, 1 x Psychologist, 1 x Service User):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">22</td> <td>Voluntary organisations providing community services, supports, housing and information</td> </tr> <tr> <td style="text-align: center;">2</td> <td>Professional associations (the College of Psychiatry Ireland and the Irish Assn for Counselling and Psychotherapy) (The College of Psychiatry is an associate member)</td> </tr> <tr> <td style="text-align: center;">1</td> <td>Provider of tertiary mental health services (St. Patrick's University Hospital) (also an associate member)</td> </tr> <tr> <td style="text-align: center;">1</td> <td>Provider of inpatient advocacy services (Irish Advocacy Network)</td> </tr> </table>	22	Voluntary organisations providing community services, supports, housing and information	2	Professional associations (the College of Psychiatry Ireland and the Irish Assn for Counselling and Psychotherapy) (The College of Psychiatry is an associate member)	1	Provider of tertiary mental health services (St. Patrick's University Hospital) (also an associate member)	1	Provider of inpatient advocacy services (Irish Advocacy Network)	<p>Please specify the mental health service area, where relevant, that you are principally working in:</p> <p>Child and Adolescent <input type="checkbox"/></p> <p>General Adult <input type="checkbox"/></p> <p>Forensic <input type="checkbox"/></p> <p>Later Life <input type="checkbox"/></p> <p>Intellectual Disability <input type="checkbox"/></p> <p>Research <input type="checkbox"/></p> <p>Other, please specify below <input type="checkbox"/></p> <div style="border: 1px solid black; padding: 10px; margin-top: 10px; text-align: center;"> <p>Not applicable. Mental Health Reform advocates for all categories of mental health services.</p> </div>
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Section 1 -Introduction

The Mental Health Commission is commencing a consultation exercise on its Draft Seclusion and Physical Restraint Reduction Strategy. The draft strategy includes 18 actions which are presented in this consultation document.

A number of developments encouraged the Commission to work on such a strategy. In particular:

- We already play a lead role in the regulation of seclusion and restraint and encourage services to try and reduce the use of these interventions;
- We have published annual reports on the use of seclusion and restraint in 2008, 2009 and 2010 and we monitor data collected on the use of these interventions on an ongoing basis;
- Concerns have emerged internationally over the safety and effectiveness of restrictive interventions and of their impact on patients; and
- Seclusion and restraint reduction initiatives have taken place successfully in other countries.

The actions included in the draft strategy were informed by international good practice initiatives. A copy of the knowledge review which informed the draft strategy is available for download from the Commission website – www.mhcirl.ie

The knowledge review summarises the findings of a number of literature reviews in the area of seclusion and restraint reduction. It highlights nine intervention categories which the evidence shows have been effective in achieving reductions in other jurisdictions. They include areas such as leadership, training and education and patient/family/advocate involvement. These are consistent with many of the themes in *A Vision for Change* (Department of Health and Children, 2006) and the *Quality Framework for Mental Health Services in Ireland* (MHC, 2007).

Researchers and policy makers have advocated seclusion and restraint reduction strategies which are composed of multiple interventions linked to the above areas.

We considered the literature findings in an Irish context before choosing which actions to include in a draft seclusion and physical restraint reduction strategy for Ireland. Eighteen actions have been included along with organisations and/or individuals that we suggest should be responsible for the implementation of each action. Further information is provided in Section 2 of this consultation document.

In developing the draft strategy, we have been especially mindful of the current fiscal climate and the Moratorium on Recruitment and Promotion in the Public Services. For instance,

evidence based interventions such as increased staff-to-patient ratios are not possible due to the moratorium.

We have also included actions which complement existing policy and guidance in the area of seclusion and physical restraint. The strategy includes three actions which provide further guidance on the implementation of existing rules/provisions of 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* in the areas of training (Action 10), debriefing (Action 17) and review procedures (Action 18).

It should be acknowledged that some actions may have resource implications for services, such as organising peer-to-peer networking between services (Action 2) and the implementation of policies and procedures associated with guidance on training, debriefing and review procedures.

The draft strategy was approved by the Commission at the end of 2011 with a commitment to undertake a wider consultation before implementation.

We have decided to carry out a written consultation and are seeking your views on the draft strategy and the actions that you would prioritise for implementation. The Commission will also link in with service user groups to ascertain their views through additional methods.

Our goal is to produce a strategy that is both collaborative and evidence-informed and which enables a measurable reduction in the use of seclusion and restraint in approved centres to be achieved.

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

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

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

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

Section 2 -Draft Strategy Action Points

The 18 actions are set out below. These should be read in conjunction with the Seclusion and Physical Restraint Reduction Knowledge Review.

Take a look at them and then consider the questions in the next section.

1. The MHC should request regular updates on the implementation of those aspects of the HSE Strategy for Managing Work-Related Aggression and Violence within the Irish Health Service, *Linking Service and Safety* (HSE, Dec 2008) that relate to seclusion and physical restraint.
Action: MHC
Intervention Category: Policy and regulation changes

2. Peer-to-peer networking should be organised between mental health services with a particular emphasis on creating links between services that report relatively high overall uses of seclusion and physical restraint and services that report relatively low overall uses of seclusion and physical restraint.
Action: HSE & independent mental health service providers
Intervention Category: Leadership

3. Responsibility should be allocated to HSE senior managers for the implementation of this strategy in all publicly funded mental health services. Responsibility should be allocated for the implementation of this strategy to senior managers within each approved sector in the independent sector that uses seclusion and/or physical restraint.
Action: HSE & independent mental health service providers
Intervention Category: Leadership

4. (a) A seclusion and physical restraint reduction plan should be developed for each approved centre that uses seclusion and/or physical restraint. It should:
 - Include a mission statement;
 - Clearly articulate the approved centre's philosophy about seclusion and restraint reduction and the expectations that this places on staff;
 - Identify the role of the Clinical Director and senior management in directing the overall plan;
 - Describe the roles and responsibilities of all staff and indicates how they will be accountable for their responsibilities;
 - Commit senior management to creating a collaborative non-punitive environment to facilitate the reduction of seclusion and restraint in the approved centre;
 - Indicate how the approved centre intends to make use of data on seclusion and physical restraint to assist in reducing the use of both interventions;

- Indicate how staff training and education will assist in realising the goal of seclusion and restraint reduction;
- Support clinical audit;
- Be developed in consultation with staff, service users and advocates; and
- Be reviewed on an annual basis.

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

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

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

Action: Clinical Directors and Registered Proprietors

Intervention Category: Leadership

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

Action: MHC & HSE

Intervention Category: Staffing

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

Action: Clinical Directors and Registered Proprietors

Intervention Category: Staffing

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

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

Intervention Category: Staffing

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

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

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

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

Action: Clinical Directors and Registered Proprietors

Intervention Category: Training and Education

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

Action: Clinical Directors and Registered Proprietors

Intervention Category: Patient/Family/Advocate Involvement

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

Action: IAN, NSUE, MHC & HSE

Intervention Category: Patient/Family/Advocate Involvement

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

Action: MHC, HSE & independent service providers

Intervention Category: Using data to monitor seclusion and restraint episodes

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

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

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

Action: Clinical Directors and Registered Proprietors

Intervention Category: Using data to monitor seclusion and restraint episodes

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

Action: MHC with assistance from HSE and independent services

Intervention Category: Using data to monitor seclusion and restraint episodes

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

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

Intervention Category: Using data to monitor seclusion and restraint episodes

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

“A debriefing should take place with a resident after an episode of seclusion or physical restraint. A resident’s advocate, carer or family member should be granted the opportunity to participate in the debriefing with the resident, or, on his or her behalf, if the resident declines to do so and

where he or she consents to the participation of others. A debriefing should include a discussion of the events leading up to the episode of seclusion or physical restraint and address how the use of seclusion or physical restraint can be avoided in the future. The outcome of the debriefing should be documented in the resident's individual care and treatment plan. Approved centres should develop policies and procedures on debriefing that conform to this guidance".

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

Action: Clinical Directors and Registered Proprietors

Intervention Category: Review Procedures/Debriefing

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

Section 3 - Consultation Questions

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

Mental Health Reform welcomes the Mental Health Commission's initiative to develop a Seclusion & Physical Restraint Reduction Strategy. MHR has previously advocated that the Mental Health Act should be amended to require a programme to minimize and where possible phase out the use of seclusion and restraint in all inpatient services. The use of restraint is a restriction on a person's freedom of movement and, depending on the circumstances, may be a serious infringement of his/her rights to bodily integrity and dignity and, at an extreme, may constitute inhuman and degrading treatment. Mental Health Reform considers that as a first principle, force should not be viewed as a method for engaging service users in treatment. Force is not the way to support recovery. There is evidence that mental health services can achieve a dramatic reduction in the use of restraint where a dedicated zero-restraint programme is put in place.¹ The rate of physical restraint has steadily increased since 2008 when the Commission published its first full-year report on the issue. So too, the number of approved centres using physical restraint has not decreased during that time. Mental Health Reform believes it is vital that the Commission drives the reduction of seclusion and restraint in Irish mental health services as part of its statutory function to "promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres."

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

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. In particular, actions numbered 1, 3, 4, 7, 12, 13, 14 and 16 should be undertaken immediately. For the most part these concern actions that the Mental Health Commission can undertake directly, such as improved data collection, or that can be undertaken by mental health services as part of planning activities and are therefore largely cost neutral.

Action number 7 is urgent in order to ensure that seclusion and restraint is not occurring unnecessarily due to low staffing levels, however Mental Health Reform recommends that the action be amended. It is not clear that current staffing levels are adequate to prevent unnecessary seclusion and restraint. This action therefore requires that the Mental Health Commission establish safe staffing levels for various inpatient settings. Therefore Mental Health Reform recommends that the action be amended to include that the Mental Health Commission set staffing levels for various types of inpatient settings below which episodes of seclusion or restraint are more likely to occur. It should be possible for the Commission to analyse the staffing levels of the 55% of units that do not use seclusion, for example, as compared with those that do use it and in this way develop appropriate indicators.

In principle, actions numbered 10, 11, 17 and 18 should already be happening since these refer to compliance with rules and codes of practice already set by the Mental Health Commission. These actions should be distinguished in the strategy as pre-requisite actions and the strategy should specify how the Commission will ensure that compliance with its rules and codes of practice is increased, e.g. by the imposition of conditions for non-compliance.

¹ L Ashcraft and W Anthony (2008) 'Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services' *Psychiatric Services* 59:10:1198-1202.

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

Action 2 on peer-to-peer networking is a key initiative in order to drive change. Ensuring that services with higher levels of seclusion and restraint are put into contact with those who use none could help to foster better practice across services. Peer-to-peer networking would make sense as a medium-term objective that will require some planning and consultation with stakeholders in order to be developed.

Actions numbered 5 and 6 logically follow after the development of a seclusion and restraint reduction plan and therefore should be considered medium-term.

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

Action number 15 to develop electronic versions of the Register and Clinical Practice form are not likely to be feasible in the short term and so while planning for this could begin immediately, it is more likely to be achieved in the long-term.

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

Mental Health Reform considered that Action 8 to examine the feasibility of establishing psychiatric emergency response teams would not be appropriate in an Irish context. Such teams are suitable for large psychiatric hospitals where it might be feasible to have a dedicated team for such a specific purpose, however, in the context of the small-scale inpatient facilities that are the norm in Ireland it is difficult to see how having a dedicated emergency response team could ever be feasible. Mental Health Reform would also be concerned that such an approach could inadvertently de-skill other staff in inpatient units from being able to work appropriately with individuals in such a way as to obviate the need for seclusion and restraint. For these reasons, we recommend that this action is not pursued.

Mental Health Reform is concerned that Action 9 to ensure that staff are not working continuously with acutely unwell patients could undermine the development of team-working within community teams by disrupting the complement of staff on a regular basis. For this reason we recommend that this action is not pursued.

6. Please explain your responses to the above items:

See above.

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

Under its statutory remit to promote high standards and good practice in mental health services, the Mental Health Commission has a leadership role to play in reducing the use of seclusion and restraint in mental health services in Ireland. This leadership role should be set out more clearly in the Seclusion and Physical Restraint Reduction Strategy by including a vision statement or overall aim within the introduction to the strategy. **The strategy would benefit from a strong introductory vision statement that sets out the goal of the strategy as eliminating seclusion and restraint and the expectation by the Commission that mental health services will work towards this goal.** Such a vision statement would help to develop a shared understanding among all mental health professionals of the standard of service expected.

The Commission also must take the lead in monitoring the strategy and enforcing its own rules and codes of practice. The rate of physical restraint has steadily increased since 2008 when the Commission published its first full-year report on the issue. So too, the number of approved centres using physical restraint has not decreased during that time. At a time of increased pressure on resources, it is more important than ever that the Commission highlights any increase in the use of seclusion and/or restraint if it occurs and how this may relate to reduced resources. **The strategy should also spell out how the Commission will pursue fulfillment of the actions, including highlighting to units with high rates of seclusion and/or restraint how they compare to those who are not using seclusion and/or restraint, the use of conditions to ensure compliance with relevant rules and codes of practice, identifying and highlighting exemplars of good practice as well as regular reporting of progress on the strategy in the Commission's Annual Reports.**

The issue of seclusion and restraint needs to be considered within a wider context of an absence of a coherent management and accountability structure for the public mental health services in Ireland. It is difficult to see how significant progress can be made in the public mental health services in the absence of a clear management structure overseeing the mental health services. The strategy identifies the need to allocate responsibility for implementation to senior HSE managers, however it is not clear who these senior managers are; Clinical Directors do not have overall managerial responsibility and accountability for delivery of quality mental health services nor do any other staff have overall control. The anticipated new Director for Mental Health will provide a single point of accountability at the most senior level, but unless this is then distributed through clear lines of accountability through to catchment area level, there will still be a gap in the management structure. This wider context should be acknowledged in the introduction to the strategy and **the Commission should acknowledge the need for a wider management structure within the public mental health services that can drive an overall culture change that in turn will lead to a reduction in the use of seclusion and restraint.**

The strategy omits certain actions evidenced in international good practice such as increasing staff-to-patient ratios due to the current economic climate. While it is expected that such a move will not be undertaken in the short-term, Mental Health Reform believes that **it is important to include such an action in the**

strategy in principle so that the strategy accurately reflects international good practice evidence. The action to increase staff-to-patient ratios will require considerable planning to determine appropriate levels and therefore planning on the part of the Mental Health Commission in consultation with the HSE should be included in the short-term actions. Achievement of appropriate staffing levels should then be a medium to long-term goal.

Finally, given that the strategy has been drafted during a time of economic constraint, it should include a **relatively short time-limit for this strategy, on the order of three years, with a commitment to reviewing the strategy at the end of three years** in order to add actions that were not feasible during the first strategy.

References

For a full list of references, please consult the Seclusion and Physical Restraint Knowledge Review which should be read in conjunction with this consultation document.

Thank you for taking the time to take part in this consultation.

Please return feedback by post or email by **12th September 2012.**

Please return to:

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