



SECLUSION AND RESTRAINT REDUCTION STRATEGY

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1. INTRODUCTION

The Mental Health Commission is committed to the reduction of both the frequency and duration of seclusion and restraint episodes in approved centres¹ and to the complete elimination of the use of mechanical restraint² which based on current actions and efforts is a realistic and achievable goal.

The Commission acknowledges that achieving the reduction in seclusion and restraint will require a process of change. However the change required fits comfortably with the prevailing efforts to develop a culture of collaboration and recovery within services. This strategy presents a framework through which a sustainable programme of Seclusion and Restraint Reduction can be achieved and a structure through which service providers can demonstrate their efforts to accomplish this goal.

The goals of providing approved centres with a strategy include:

- Raising awareness of seclusion and restraint;
- Providing an opportunity for services to review current practices and encourage exploration of alternative approaches;
- Fostering a trauma informed culture respectful of human rights, collaboration, and recovery;
- Creating a therapeutic mental health service environment; and
- Providing organisations with a list of evidence-based actions that have been demonstrated to assist in efforts to reduce the use of seclusion and restraint.

¹ An approved centre is an in-patient mental health service registered by the Mental Health Commission.

² Use of mechanical restraint in circumstances of immediate threat of serious harm to self and others as defined in MHC Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint

1.2 BACKGROUND

Despite proponents of 'moral treatment'^[1] over the past 200 years advocating the elimination of coercive practices the issue has remained controversial^[2] and the widespread use of coercive measures has continued within mental health care on the proposition that such measures are necessary to preserve the safety of all concerned^[3].

Notwithstanding the safety imperative, coercive measures are often imposed against the individual's will, restrict their freedom and are generally disliked both by service users and staff^[3,4]. The debate surrounding the use of coercive measures has been intensified by the compelling evidence suggesting the potential risks of serious physical and psychological injuries being associated with these interventions.

In the US the issue gained public attention following the Pulitzer Prize-winning series by investigative journalists from a Connecticut newspaper which reported multiple fatalities associated with the use of restraints^[5]. The report prompted a investigation by the US General Accounting Office which confirmed the potential for serious physical injuries including fatalities^[6]. Far from being unique to the US, research studies and investigative reports have since reported similar fatalities within the psychiatric services of other jurisdictions^[7]. In addition to the serious physical risks to service users, there is also a growing recognition of the potential for serious injury to personnel involved in these interventions^[8,9].

Apart from the inherent physical risks, significant psychological distress has also been associated with involvement in, or witnessing of, these measures^[3]. Service users have reported feelings of anger, abandonment, depression, despondency and re-enactment of previous traumas^[10,11,12,13]. Personnel similarly have reported feelings of intense fear, stress, ambivalence, guilt and disappointment that situations were not resolved in a more benign fashion^[3, 13,14,15].

In addition to the physical and psychological risks, there is a very substantial financial cost incurred in the use of coercive interventions. Based on the analysis of unit costs from a sample of 15 units drawn from 136 adult acute inpatient psychiatric services, researchers in the UK estimated an annual cost of £72.5 million for managing all conflicts and £106 million for employing all containments within English psychiatric services^[16]. Furthermore the use of coercive measures creates the potential for corrupted cultures of care^[17], diminishes the care experience, and damages the relationship between service recipient and provider^[17,18,19].

Understandably personnel who find themselves in the precarious position of having to balance respect for service user autonomy with the imperative to manage risk can experience troubling ethical conflicts^[2,19]. Whereas clinicians typically resolve such dilemmas through the judicious employment of evidence-based best practice in the best interests of the individual, in the case of coercive interventions making such professional judgements is seriously hampered by the limited empirical evidence and lack of consensus as to the risks, benefits and effectiveness of available alternatives^[2,3,4,19].

Three successive Cochrane reviews over a period of twelve years sought to evaluate the relative effectiveness of seclusion and restraint within mental health settings and to estimate the effectiveness of alternative strategies to prevent seclusion and restraint. On all three occasions the reviews revealed that the evidence base was seriously lacking with the exception of noting some adverse effects associated with the use of coercive measures^[20,21,22]. The reviews concluded that the continued use of seclusion or restraint was questionable in the absence of well-designed studies to support practice. Subject experts have concurred with the proposition of very limited empirical evidence supporting practice and point out the significant ethical and methodological challenges involved in conducting research related to coercive interventions^[4, 19].

In the absence of robust empirical evidence clinicians must rely upon best practice. Similar to the deficit of empirical evidence however, there is a virtual absence of consensus as to what constitutes best practice in the use of coercive interventions in general, and restraints and seclusion in particular. Establishing best practice is further impeded by the absence of a unified definition of coercive interventions, agreement as to the purpose of their use, and very significant variance in the rates of use between and within services.

While there is considerable variance in definitions, interventions can be broadly categorised as 'Enforced medication' 'Seclusion' 'Physical restraint' and 'Mechanical restraint'^[23]. The division between these is incomplete, as more than one intervention is commonly involved (e.g. seclusion may require the initial use of physical restraint).

The risks and benefits of these interventions is contested with one commentary based on a review of the literature identifying that two opposing lines of thought. Proponents support the use of these interventions as therapeutic with the caveats that these should be part of a broader therapeutic approach which is focused on prevention, that the least restrictive measure is used for the shortest possible duration, and that the service user is closely monitored and supported. Interventions should never be employed punitively, be limited to occurrences of disruptive and/or dangerous behaviours which do not respond to less restrictive interventions, and that the use of all coercive measures should be subject to transparent recording and internal and external review in order to avoid abuse^[24].

Opponents conversely question whether these interventions have any therapeutic value and/or effectiveness, highlighting service users perceptions of interventions as aversive to an extent which eliminates any potential therapeutic effect, and coercive to the extent that they damage the therapeutic working alliance. Opponents also highlight the physical risks, in addition to the potentially serious psychological distress especially for those with histories of trauma^[24].

This considerable divide of opinion is reflected in professional practice. One US reviewer for instance in 1994 concluded that it would be 'nearly impossible' to operate a mental health programme without access to some form of seclusion, physical or mechanical restraint^[25]. However a later review by California state in 2002 reframed the use of seclusion and restraint within mental health services as a 'failure' and 'not a treatment'^[26] and there is evidence that this understanding has filtered into US treatment facilities^[27]. Beyond whether interventions should be used, there is wide variance of opinion as to the safety, effectiveness and acceptability of specific interventions used within mental health settings^[25].

Opinion is equally divided on the use of medication with one US state-funded review reporting that experts disagreed on the use of enforced medication use in mental health, with some perceiving it to be 'chemical restraint' while others proposed that medications used to treat specific psychiatric illnesses should be considered treatment measures rather than a restraint^[29]. This division is also apparent in research with one UK report highlighting that some studies made no distinction between the use of consensual PRN [give as needed] medication and coerced intramuscular injection, despite the very obvious differences in these from the perspective of the service user^[30].

The paucity of research and absence of professional consensus is reflected in clinical practice with a variance in the use of interventions which is difficult to explain. One survey of 225 psychiatric hospitals across all US states reported large deviations in the rates of seclusion and restraint used between states^[31], while a survey of 125 psychiatric settings within a single state, (New York), reported that seclusion and restraint rates 'varied dramatically' among settings and were difficult to explain by differences in the patient populations alone^[32]. A later US paper based on a review of twenty years of literature suggested that the use of restraint and seclusion may be as reflective of the treatment programme as it is of the clients^[33].

Apart from inter and intra state differences there are also significant differences between service settings with one survey of 25 US child and adolescent units reporting a six fold rate of seclusion and restraint use compared to adult services in the same state^[34], a finding that was disturbing in the context of a later study which reported 45 restraint related fatalities between 1993 and 2003 in US child and adolescent psychiatric facilities^[35].

The disparity of opinion within the US reflects a broader divergence of opinion between US and Europe psychiatric services, with American services more likely to regard seclusion and restraint as being necessary, and being more likely to use mechanical restraints than equivalent European services^[1].

However within European services there is also a very considerable variation both in the type of coercive measures used and the frequency of their use. One review based on literature from twelve countries found huge differences between European countries in the frequency of coercive interventions, the types of interventions used and the duration of their use. Rates of use by percentage of admissions ranged for 3.3% to 35%, the duration of interventions ranged from nine minutes to 1182 hours, and the number of interventions per 100,000 populations ranged from 0 to 580^[36]. A later study by the same researcher presented three clinical vignettes to members of the European Violence in Psychiatry Research group. Analysis from the 16 countries which responded revealed a lack of clinical uniformity with 'net beds' used in two countries, 'involuntary medication intravenous' used in five countries, and 'physical restraint' used in eight countries. The interventions used with greatest uniformity were 'mechanical restraint' used in nine countries, 'involuntary medication intramuscular' used in 14 countries and 'close observation/1:1 nursing' used in 15 countries^[37]. In addition to the huge diversity in the frequency of use, the study authors commented on the difficulty reconciling that interventions which were routinely used in one country were legally and/or ethically forbidden, or regarded as inhumane or unsafe in others^[37].

The limited evidence base and absence of professional consensus as to best practice in the use of coercive measures has hindered efforts by both practitioners and regulators to minimise their use. However there has been a welcome increase in research attention to the subject^[37] both in terms of the number of studies being undertaken and, of equal or more importance, a shift away from epidemiological measures of usage to studies producing findings with more clinical utility.

For example Whittington^[30] investigated the attitudes and preferences of 1361 service users and 1226 staff in three regional English acute care mental health services regarding different types of coercive measures. The three methods most approved by service users were 'intermittent observation', 'time out', and 'PRN medication' while the three methods most approved by staff were 'transfer to a psychiatric intensive care unit', 'PRN medication', and 'observation'. The study revealed approval differences within the two groups associated with gender, age, their experience of having used or having been subjected to coercive measures.

The approval ratings of service users varied significantly whether they had experienced being subjected to various interventions. Interestingly those who had been subjected to PRN medication and constant observation approved of these measures more strongly than service users who had not, while those who had been subjected to physical restraint and enforced IM medication disapproved of these measures more strongly than service users who had not. The study authors concluded that efforts should be made to minimise the use of physical restraint, locked-door seclusion, and coerced IM medication as these were the methods most disapproved of by service users.

Bowers et al^[3] investigated the feasibility of substituting the use of seclusion with what was described as a 'less coercive and more acceptable practice' of 'time out' with 522 patients on 84 units in 31 English hospitals. Seclusion was defined as being 'isolated in a locked room' while time out was defined as a service user being 'asked to stay in room or area for period of time, without the door being locked'. The 'time out' was usually spent in the service user's own bedroom, alone, and on a consensual basis. The study revealed that both interventions had been used in similar circumstances and both had brought disturbed behaviour to a close in half of the cases. Outcome measures from both interventions appeared to be equally good and the authors proposed that the evidence supported the proposition that the use of seclusion could be reduced safely, and in many cases substituted with less coercive and more acceptable measures.

Steinert et al^[19] conducted a randomised controlled trial comparing the traumatic impact of being subjected to either 'locked door seclusion' or 'mechanical restraint' with 102 German service users using the 'Coercion Experience Scale' (CES) as a standardised measure of their subjective distress. While initial findings suggested no differences between the groups, a follow up study one year later revealed significantly higher CES scores for those who had experienced 'mechanical restraint' compared to those who had experienced 'locked door seclusion'. The follow-up study also assessed for symptoms of posttraumatic stress disorder (PTSD) using the 'Impact of Event Scale-Revised' (IES-R). While there were no notable differences between the groups the IES-R scores for two service users who had experienced mechanical restraint and one who had experienced seclusion indicated probable PTSD. The authors concluded that 'seclusion' was the less traumatising of the two measures. A noteworthy observation, in the context of this strategy, was that while service users experienced a wide range of negative feelings during the intervention, that 'contact with staff' was reported to be the 'most helpful' in alleviating their distress.

Georgieva et al^[38] investigated the 'effectiveness' and 'subjective distress' experienced by 125 service users who had been subjected to four different types of coercive interventions in the acute ward of a Netherlands psychiatric hospital. The study used a prospective design to examine the relationships between the type of coercive intervention used and the effectiveness and subjective distress. Effectiveness was assessed by rating service user behaviour immediately after the intervention and at 24 hours post the event. Subjective distress was examined using the Coercion Experience Scale (CES) at the debriefing with the service user. Univariate statistics revealed no significant differences in the effectiveness of the different interventions. Statistical analysis revealed significant differences in the degree of subjective distress, with 'involuntary medication' being experienced as the 'least distressing overall', 'least humiliating', and resulted in least adverse physical effects and least sense of isolation. The findings revealed that any combination of coercive interventions, regardless of type, caused significantly more physical adverse effects and feelings of isolation than individual interventions. The authors concluded that the use of multiple interventions should require significant justification considering the associated distress and that, in the absence of advance directives from the service users or information on their individual preferences, involuntary medication may be more justifiable than either seclusion or mechanical restraint.

From the above studies it is evident that research into the area of coercive interventions extends beyond geographical boundaries, has increased in sophistication and is more clinically focussed. The purpose referencing these studies is not to propose specific interventions, nor to suggest an exhaustive review of the literature, but rather to set the context of developing this strategy against a backdrop of limited empirical evidence. Additionally there is a potential value in both the continued surveillance of the emerging literature, and engagement with clinicians and researchers from other jurisdictions.

The emerging research evidence has been paralleled by increasing professional attention to the issue. For example the World Psychiatric Association (APA), in acknowledging the neglect of the issue, hosted a Thematic Conference on Coercion in Psychiatry in 2007 which has been described as possibly the first international scientific event dedicated specifically to the issue^[39]. Notably one of the factors attributed to the success of the event was the degree of engagement and dialogue between the providers and recipients of treatment. Also 2011 witnessed the publication of the first authoritative text specifically devoted to the issue of 'Coercive Treatment in Psychiatry' which includes multiple perspectives and contributions from some of the leading clinicians and scholars globally in addition to having one of the five sections devoted to service users' perspectives^[40].

Interestingly, in the context of this strategy, the text considers coercion 'within the healing and ethical framework of therapeutic relationships and partnerships at all levels' and ultimately aspires to inform the international discussions and initiatives which aim to minimise coercion^[40].

One issue addressed in the text is the degree to which it is possible to define best practice standards for the use of coercive measures in psychiatry^[41]. While the authors acknowledge the incomplete state of empirical research and the lack of professional consensus as to what constitutes best practice, they also highlight the duty to pursue clinical excellence in the best interests of service users. They propose that three different approaches may be used to define a best practice standard, namely the 'viewpoints of personal virtue and wisdom', 'reliance on empirical evidence', and 'use of consensus'. All three however have limitations. While personal virtue and wisdom have inspired many of the humanitarian reforms in psychiatry, this approach lacks empirical validity and reliability. While empirical evidence is objective, at this time evidence is insufficient to provide answers to many challenges encountered in clinical practice. While consensus elicits multiple perspectives, it is highly dependent on the views of opinion leaders. In the context of existing evidence the authors propose that a carefully balanced combination of evidence and consensus can currently be considered as the best approach to achieve best practice standards^[41]. This significance of this commentary should not be lost in the context of preparing a strategy for seclusion and restraint reduction. The proposed best practice sits comfortably with the approach adopted in the formulation of this strategy which has balanced reliance on empirical evidence, limited as it is, with an extensive process of stakeholder engagement.

The developments described above are testimony to the current attention to the issue of coercive interventions within contemporary mental health practice. From both research and practice perspectives some common themes emerge, most notably the importance placed on relationships, emphasis on engagement with service users, the need to minimise the use of coercive measures, and to improve our knowledge and practice if and when such measures become necessary.

Understandably there have been considerable efforts to reduce the use of coercive interventions and some success has been achieved in this regard. A review undertaken in the UK of 36 post-1960 empirical studies of interventions to reduce mechanical restraint and seclusion among adult psychiatric inpatients identified diverse interventions which commonly included new or revised seclusion and restraint policies, staffing changes, staff training, case review procedures, or crisis management initiatives^[42].

While most studies reported reduced levels of mechanical restraint and/or seclusion, the authors concluded that the standard of evidence was poor and the research did not specify which reduction interventions were most, and least, successful^[42].

A review undertaken in the same year in Australia^[43] of 29 evaluation studies of single seclusion and/or restraint reduction programmes identified seven key themes of actions including (i) policy change/leadership; (ii) external review/debriefing; (iii) data use; (iv) training; (v) consumer/family involvement; (vi) increase in staff ratio/crisis response teams; and (vii) programme elements/changes. Outcomes indicated that programmes were successful in reducing the frequency and duration of seclusion and restraint use while maintaining a safe environment. Similar to the UK review above the author noted the need for systematic research to understand which elements of successful programmes were the most powerful in reducing incidents of seclusion and restraint.

Gaskin^[44] in a more recent review reported the success of initiatives to reduce the use of restrictive practices in mental health services. The range of interventions was similar to those previously mentioned with the notable additions of increased emphasis on engagement with service users, the clinical and environmental quality of the treatment programmes, and enlightened psychosocial treatment approaches which integrate both recovery and trauma informed principles. What did not change however was the authors conclusion that because services tended to implement several actions concurrently, determining which features are more important than others is impossible at this time. It should be noted that these three reviews were not mutually exclusive and their respective commentaries in some instances refer to the same original research.

Murphy and Bennington-Davis^[45] implemented a cultural-change strategy entitled the 'Engagement Model' to minimise the use of seclusion and restraint in a US mental health programme. The programme included a high acuity 24-bed inpatient unit, with two-thirds of all admissions on an involuntarily basis, and a seven to eight day length of stay, in addition to an outpatient service. The four year initiative reduced the use of seclusion from 365 episodes in year one to a single episode in the final two years, and hundreds of episodes of mechanical restraint in the first year to zero in the final three years. Notably this initiative, and a subsequent book, was jointly led by the Clinical Director and the Chief Executive.

Smith et al^[46] studied the use of seclusion and mechanical restraint in a large US state hospital system from 1990 to 2000, and the rate of staff injuries from assaults between 1998 and 2000. The rate and duration of seclusion and restraint were calculated from the database of recorded episodes which included the date, time, duration, and justification for each episode, in addition to the demographic and clinical characteristics of the service users involved.

Staff injuries from patient assaults were studied from reports of compensation claims. The usage and duration of seclusion decreased dramatically during the study period from 4.2 to 0.3 episodes per 1000 patient-days between 1990 and 2000, with the average duration decreasing 10.8 to 1.3 hours. Similarly the use of mechanical restraint decreased from 3.5 to 1.2 episodes per 1000 patient-days and the average duration decreased from 11.9 to 1.9 hours over the same period. Notably, no significant changes were seen in rates of staff injuries between 1998 and 2000^[46].

Borckardt^[47] studied the effect of a system-wide initiative to minimise the use of seclusion and restraint in a large US state-funded hospital. The large scale experimental study involved the review of 89,783 patient-days over a 3.5-year period. Similar to previous studies a statistically significant reduction of 82.3% ($p=.008$) in the rate of seclusion and restraint was observed over the course of the study.

Wale et al^[48] studied the effectiveness of a three year seclusion and restraint reduction initiative in the New York City health system, the largest municipal health system in the US, with facilities providing psychiatric emergency and inpatient services. In the final year of the study 1117 inpatient psychiatric beds with an average length of stay of 22.2 days generated over 19,000 discharges, while the emergency services provided 36,000 psychiatric visits. The frequency of restraint fell from 0.089 episodes per 1000 patient hours in year one to 0.078 in year two and 0.064 in year three. The frequency of restraint episodes decreased from 0.044 episodes per 1000 patient hours in year one to 0.026 in year two to 0.032 in year three. The total duration of mechanical restraint per 1000 patient hours decreased by 28%, and by 27% for seclusion episodes. The duration per episode of restraint decreased from a mean of 246.81 to 57.62 minutes, and episodes of seclusion from 88.78 to 50.50 minutes. All reductions in use and duration were statistically significant beyond $p>0.05$. Notably there was a dramatic decrease in patient injuries from 28 in year one, to eight in year two, to seven in year three. Staff injuries however remained unchanged from which the authors concluded, that despite fewer occurrences, there remained a minimal number of incidents which presented a risk to all involved.

Azeem et al^[49] studied the effectiveness of a seclusion and restraint reduction initiative in a US child and adolescent service which admitted 458 youth over the course of the three year study period. The use of seclusion and restraint reduced from 93 episodes involving 22 youths in the first six month period of study, to 31 episodes involving eleven youths in the final six month period. The authors noted their encouragement that the positive results of the initiative had been achieved relatively quickly and sustained over the longer term.

While the previous studies were conducted in the US, more recently similar studies have emerged within Europe. Noorthoorn^[50] compared two acute admission wards in the Netherlands over a 30 month period. Both units served a similar population and had a similar staffing complement. The 'experimental' ward implemented a programme of twelve actions to reduce seclusion and restraint while the 'control' ward continued with 'care as usual'. In the 29 months of the study the wards cumulatively had 2533 admissions of 1470 different service users with mean length of stay of 26 days. The findings revealed a significant difference between the 'experimental' and 'control' wards in the number of seclusion incidents. Notably, the difference which was observed in the first year became more powerful in years two and three. Two interesting findings were that service users admitted more than once, to either of the wards, had a higher probability of being secluded and that the duration of these seclusions did not differ between the wards. The authors concluded that, despite the indisputable success of the seclusion and restraint reduction initiative on the 'experimental' ward, the comparison demonstrated the combination of twelve interventions and could not differentiate the value of the individual components.

Putkonen^[51] conducted one of the very few randomised controlled trials into the reduction of seclusion and restraint over a one year period in a national secure psychiatric hospital in Finland. Of the 13 wards in the hospital four wards were randomly assigned as either 'intervention' or 'control' wards. Following the seclusion and restraint reduction initiative, the proportion of patient-days with seclusion, restraint, or room observation declined from 30% to 15% on the intervention wards compared to from 25% to 19% on the control wards. Seclusion-restraint duration decreased from 110 to 56 hours per 100 patient-days on the intervention wards but increased from 133 to 150 hours on control wards. Notably, the incidence of violence decreased on both intervention and control wards. Between-groups differences were significant for 'seclusion-restraint-observation' days ($p=.001$) and 'seclusion-restraint duration' ($p=.001$) but not for occurrences of violence ($p=.91$), from which the authors concluded that the reduction in seclusion and restraint had been achieved without any corresponding increase in occurrences of violence.

In summary the research evidence guiding the use of coercive measures is limited in establishing the safety and/or effectiveness of specific coercive measures, and lacking in comparative analysis of different measures. The huge variation between and within different countries in the choice, frequency, and duration of coercive measure used demonstrates a lack of professional consensus between professionals as to what constitutes best practice.

More encouragingly however there has been a recent shift in research toward studies with more clinical utility is encouraging from both regulatory and professional perspectives.

There is sufficient evidence to support the implementation of seclusion and restraint reduction initiatives with the caveat that, because many initiatives are cumulatively reported, the relative value of specific singular actions is difficult to establish. This is a significant limitation in the context of services who must prioritise actions within finite resources. Also reports of success must be considered with the presumption that unsuccessful efforts are unlikely to be published.

The importance of the current state of incomplete evidence and absence of professional consensus should not be lost in the context of preparing this seclusion and restraint reduction strategy with its aspirations to reflect evidence-based best practice. The suggestion that a carefully balanced combination of evidence and consensus can currently be considered as the best approach to achieving best practice standards^[41] is comforting considering the deliberate balance between evidence and engagement employed in the formulation of this strategy.

1.3 DEVELOPMENT OF THE STRATEGY

This strategy is the product of extensive stakeholder consultation and careful consideration of literature from both practice and research perspectives. The purpose of the extensive consultation was to ensure the development of a meaningful improvement effort that is truly reflective of the voices and concerns of all stakeholders, while the consideration of a broad range of literature was to ensure that the strategy reflects the contemporary knowledge base of evidenced-based best practice.

This intentional and balanced approach to both engagement and evidence was a deliberate effort to develop a strategy with a high probability of achieving an improved service experience for both the recipient and providers of mental health services.

Implementation of this strategy has the potential to provide an acceptable evidence-based best-practice response to this difficult area of practice, to a standard which parallels or exceeds comparable mental health services internationally.

The Commission initially undertook a review of literature related to seclusion and restraint reduction, from which a 'knowledge review' was developed that summarised current international evidence-based best practice^[52]. The knowledge review identified a number of key interventions which had been utilised in successful seclusion and restraint reduction initiatives internationally.

Implementation of initiatives with a demonstrated success elsewhere was considered from an Irish perspective and integrated into a draft Seclusion and Restraint Strategy^[53]. The draft strategy was then distributed widely for consultation seeking the views of stakeholders both on the strategy in general terms, and on the specifics of the key actions proposed. The consultation generated 52 submissions which were presented to the Commission^[53].

The feedback from the consultation process was in the main positive with enthusiasm for having a strategy in place. The feedback included some comments and concerns which are briefly outlined below.

- There was near unanimous support for the development and implementation of local Seclusion and Restraint Reduction plans as a matter of priority and similar enthusiasm for the immediate implementation of some proposed actions.
- Many respondents were less enthusiastic however about the viability of implementing other actions, particularly those related to data collection and analysis.

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- Many respondents highlighted the impact of the current economic crisis on staffing levels, and noted that achieving implementation of the strategy in its entirety would be a struggle under prevailing financial pressures.
 - A number of respondents considered the absence of any reference to the practice of involuntary medication or 'medication as restraint' as a serious omission.
 - A number of respondents considered the absence of any reference to the physical environment of services as a serious omission.
 - A number of respondents expressed concerns in regard to adopting a 'one-size fits all' approach, and were of the view that a more localised adaptation of the strategy would foster ownership by those tasked with its implementation. Local adaptation would also facilitate the development of service specific initiatives that are sensitive and responsive to the unique needs within diverse services. By way of example, services for older persons and those with intellectual disabilities would require very different service specific initiatives.

The issues identified through consultation were considered carefully by the Commission and a number of changes were subsequently made to the draft strategy including:

- Mechanical restraint was included as an intervention targeted for reduction.
- Involuntary medication was included as an intervention targeted for reduction.
- The physical environment was incorporated within a key intervention theme.
- Actions were aligned into eight key themes which incorporated most of the 18 actions identified in the original draft strategy.
- A number of additional actions were introduced with the acknowledgement that implementation will vary according to the nature of the service and the available evidence. This step supported the proposition that innovations can be more readily adopted and implemented if they are adapted to suit local needs.
- It was acknowledged that a phased implementation process is appropriate, based on the service specific priorities and feasibility.

The strategy was restructured into **eight key intervention** themes including;

1. LEADERSHIP
2. ENGAGEMENT
3. EDUCATION
4. DEBRIEFING
5. DATA
6. ENVIRONMENT
7. REGULATION
8. STAFFING.

While structuring the strategy into eight key themes with associated action sets is pragmatically useful, it is important to understand that while the key themes are distinct that they are also interdependent. Colton uses the example of an educational curriculum which enhances treatment programmes and staff performance as an example of how addressing a single theme can assist in achieving others^[54].

In its entirety the strategy relies greatly on the strength of the relations between service recipients and providers within a high quality recovery oriented working alliance.

Service providers, following a critical appraisal of the strategy, should prioritise attention to the interventions which can feasibly be implemented and produce the greatest return on effort.

Prioritisation should find a balance between the needs of local services, and the feasibility of implementation. In circumstances of limited resources, implementation of initial actions should be strategically aligned such that achievements can serve as a platform for the later implementation of more challenging tasks.

1.3 DEFINITION OF TERMS

Within the Irish context four forms of restrictive interventions are, or have been, used in approved centres. These include seclusion, physical restraint, mechanical restraint, and involuntary medication. For the purposes of this strategy these interventions are defined below:

SECLUSION:

refers to 'the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving' (MHC, 2009a).

MECHANICAL RESTRAINT:

refers to mechanical means of bodily restraint, as defined in the 2001 Act, involving 'the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient's body'" (MHC, 2009a).

PHYSICAL RESTRAINT:

refers to 'the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident's body' (MHC, 2009b).

INVOLUNTARY MEDICATION:

refers to the involuntary administration of intramuscular or intravenous medication against the individuals clear objection.

NOTE

The use of seclusion, physical restraint, and mechanical restraint, in approved centres is currently regulated by the Mental Health Commission through the statutory 'Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint'^[55] and the 'Code of Practice on the Use of Physical Restraint in Approved Centres'^[56] issued pursuant to the Mental Health Act, 2001^[57]. The Commission however, does not regulate the use of involuntary medication as the use of medication in general is governed through existing primary and secondary legislation.

The Commission recognises that other restrictive interventions, including features of patients' environment such as the routine locking of doors and/or buildings resulting in restrictions of free movement or personal privacy may also be experienced as restraint. Elements of this strategy may therefore also be used to target reductions in other forms of restraint although it is acknowledged that these are not the primary focus of this reduction strategy. It is important to ensure that efforts to secure reductions in the use of seclusion, physical restraint, mechanical restraint and involuntary medication should not involve the increase in the use of other restrictive interventions and/or other adverse events.

It should be noted that the general principles espoused in Mental Health Commission rules and codes are applicable to all forms of restrictive interventions. Therefore any intervention employed which may compromise a person's liberty should in all instances be the safest and least restrictive option of last resort necessary to manage the immediate situation, be proportionate to the assessed risk, and employed for the shortest possible duration.

2. THE STRATEGY

The Seclusion and Restraint Reduction strategy consists of eight inter-related intervention themes as outlined in Figure 1 below.



Figure 1: MHC Seclusion and Restraint Reduction Strategy

Attention to each theme is outlined below and accompanied with a set of associated actions. The strategy themes and associated actions should be considered as a framework to guide services in their selection of actions that are appropriate for their setting.

It is important to point out however that while individual actions should be service specific in order to be sensitive to the particular needs of service users, that attention to each theme is necessary in order to implement the strategy as a whole.

2.1 LEADERSHIP

Leadership refers to the support for, and the strong commitment to, seclusion and restraint reduction efforts among senior administrative and clinical staff within mental health services, and those in key persons within government, regulatory and other stakeholder organisations. Proactive and persistent leadership has been highlighted in many systematic reviews to be pivotal in achieving reductions in seclusion and restraint use^[42,43,44,54].

The seminal work of Okin examining the factors associated with restraint and seclusion reduction identified 'highly visible, consistent and effective organisational leadership.'^[54] as the most important ingredient of success^[58]. A US report published jointly by the APA/APNA suggested that restraint and seclusion reduction were inevitably tied to the organisations vision and mission with success dependent upon the priority and understanding of the clinical and administrative leadership^[59]. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has also noted the pivotal role of management in bringing about the change of culture necessary for seclusion and restraint reduction goals to succeed^[60].

Colton^[54] from his extensive work with organisations proposed that successful seclusion and restraint reduction initiatives were a function of a conscious decision on the part of both administrative and clinical leaders that seclusion and restraint reduction was a goal worthy of organisational resources and commitment. Colton proposed that where leadership believed that seclusion and restraint provided no therapeutic benefit, reduction initiatives were more likely to be successful, while conversely, where leadership believed that seclusion and restraint provided a therapeutic benefit or were at best a necessary evil, the organisation tended to struggle with the process.

Huckshorn's^[27] indepth study of seclusion and restraint reduction identified the crucial roles of leadership in managing the necessary change of values, beliefs, and practices and building a shared vision a seclusion and restraint minimised service. Success required that leadership proactively identified and resolved challenges encountered by staff during reduction initiatives and to ensure the issue was included in key performance improvement measures.

This irrefutable importance of leadership was evidenced in many submissions during the MHC consultation with one explicit comment from Shine that 'a commitment for change and leadership of that change is required before any actions can be implemented'. The critical leadership role of nurses was also frequently noted in submissions with the engagement of nursing identified as crucial to the successful implementation of the strategy.

KEY ACTIONS: LEADERSHIP

- **Assign responsibility for local implementation** of the strategy to the Clinical, Administrative and Nursing Directors as the commitment of all is critical.
- Establish an inclusive **Seclusion and Restraint Reduction working group** led by the Clinical director, involving staff members from core clinical disciplines, persons with lived experience, advocates, and others who may assist, to support the implementation of this strategy.
- All members of the working group should be **allocated the time and training necessary** to serve as champions to the seclusion and restraint reduction effort.
- Include seclusion and restraint reduction as an explicit goal **within the mission, vision and philosophy of care** statements of the service.
- Develop centre-wide and service specific **seclusion and restraint reduction plans** which include goals, objectives, persons responsible, actions and specified timelines.
- **Engage staff at all levels** in relation to the seclusion and restraint reduction strategy and **provide opportunities for staff at all levels to participate** in the development of the service specific seclusion and restraint reduction plan.
- **Formally mark the commencement** of implementation within each service in order to disseminate plans widely and continuously communicate plans and actions to foster engagement and support.
- The Clinical Directors and key working group members must **clearly disseminate agreed plans** to reduce seclusion and restraint throughout their respective areas of responsibility.
- **Allocate responsibilities to clinical governance** committees to ensure that seclusion and restraint reduction efforts are **incorporated into all relevant policies and procedures** (e.g. seclusion, restraint, and involuntary medications).
- **Implement an organisational culture** which embodies a collaborative and recovery oriented approach and an atmosphere of mutual engagement and respect.
- **Monitor progress on actions** specified in seclusion and restraint reduction plans and allocate responsibility to someone to evaluate progression of specified goals.
- Include the progress of the seclusion and restraint reduction plan as a **standing item on the agenda** of multidisciplinary team meetings.
- Develop a safe and **accessible process** for staff and others to **provide comments, ideas, recommendations, concerns**, to the Clinical Director or members of the seclusion and restraint working group regarding the reduction project.
- **Utilise networking between mental health services** to facilitate the sharing of best practice by including seclusion and restraint reduction on the agenda of regional and/or national forums.

2.2 ENGAGEMENT

The Mental Health Commission is explicit in our expressed commitment to work closely with providers and users of services and with family and carer groups in promoting the development of high quality services which are person-centred and recovery-oriented.

Apart from being closely aligned to the MHC vision of how mental health services should be provided, the core positioning of such proactive engagement will enhance the likelihood of success of initiatives which seek to reduce the use of seclusion and/or restraint. It has been demonstrated that engaging service users, families and advocates can be a powerful catalyst for change when implementing seclusion and restraint reduction initiatives^[61,62].

Many of the actions within the strategy rely on active engagement with service users, family members and advocates and direct participation in reduction initiatives, such as de-escalation approaches which are dependent on collaborative engagement, involvement in environmental improvements, and the development of service specific plans of seclusion and restraint reduction.

It is also important that mechanisms exist for service users and others to provide feedback on care and treatment planning, and on the services overall. Such measures facilitate the creation of service environments which proactively minimise conflictual engagements, thereby minimising circumstances which may lead to the use of seclusion and restraint.

The involvement of persons with lived experience of mental health services has been demonstrated to enhance efforts to reduce the use of seclusion and restraint. Working closely with staff, service users have a role in contributing to staff education regarding effective and sensitive engagement with service users and families^[61].

KEY ACTIONS: ENGAGEMENT:

- Emphasis on patient-centeredness and the importance of **service user and family involvement** in care and treatment planning are **explicit** in the philosophy of care.
- Communications with service users and families is **respectful of their needs** and situations.
- Family members (or others designated by the service user) are **informed of a significant change** in the service user's condition, their response to treatment, and/or occurrences involving the use of seclusion and/or restraint (subject to the consent of the service user).
- **Service users and service user representative** groups and advocates are **involved** in local initiatives to reduce use of seclusion and restraint including for example participation in working groups, development of service specific plans and involvement in debriefing (as appropriate).
- **Service users and service user representative** groups and advocates are **involved** in developing adjustments made to the ward environment, such as refurbishment, comfort rooms, intensive care units or others.
- Upon admission, **orient service users and their families** to the approved centre and the care and treatment programme.
- Inform **service users and their families** of seclusion and restraint policies including the circumstances in which these interventions may be used and the procedures for later review of occurrences.
- Implement a **structured risk assessment** with an evidence base in reducing use of seclusion and restraint.
- Ensure that **staff interaction with service users** is in compliance with the Rules and Code of practice related to service user monitoring during episodes of seclusion and/or restraint.
- Ensure that **training** in seclusion and restraint reduction **involves service users** and families both in development and delivery.
- Establish a **family and friend's group** or similar forum.
- Provide opportunities for service users, family members, and advocates groups **to provide feedback** into the development and review of programmes, policies and procedures.
- Make use of objective **service user satisfaction surveys** which are undertaken by persons external to the centre, to inform decision making.

2.3 EDUCATION

Many comments from the consultation process highlighted education and training as critical to the success of the strategy. Many submissions cited the importance of skills identified in the MHC knowledge review, including de-escalation techniques, debriefing and attitudes to the use of seclusion and restraint. The absence of a nationally standardised training response to the management of aggression and violence was frequently noted. Rather than being a uniquely Irish issue, the regulation and standardisation of training has been identified internationally as a concern especially in regard to training in the use of physical interventions^[28,63]. There is very limited research on physical interventions with many studies having been noted to be lacking in methodological quality and/or independence^[64].

Requirements that staff are provided with training and education are already addressed in existing Mental Health Commission standards with standards 7.1-7.4 of the Quality Framework^[65] addressing the areas of staff skills and expertise. The Commission is of the view that full compliance with existing standards will contribute significantly to the knowledge base required for successful seclusion and restraint reduction.

It is important that the distinction is understood between training in the management of aggression and violence and the training necessary for staff to effectively implement seclusion and restraint reduction. The former is focussed on the prevention, early recognition, de-escalation and reactive safety strategies specifically surrounding aggression and violence, whereas training in seclusion and restraint reduction involves a much broader focus incorporating all the key themes of this strategy. The provision of training in the management of aggression and violence alone has been equated with 'fire fighting' rather than 'fire prevention' which at best achieves only a partial response to the seclusion and restraint reduction and at worst creates the erroneous illusion that the issue has actually been addressed^[66].

Huckshorn's^[27] in-depth study identified the key factors associated with training as the inclusion of both leadership and direct-care staff, and that the training provided was perceived as credible. The involvement of leadership was identified as essential as their role includes continuous informal training and role modeling.

There is an opportunity for the engagement of service users in training provision as both recipients and providers have a shared interest in restraint reduction as the 'safest restraint for both groups is the one that never happens'^[63].

The Commission is conscious of the need to provide staff with the knowledge and skills necessary to align their practices with facilitating seclusion and restraint reduction and will develop an appropriate training curriculum which will be made available to services.

KEY ACTIONS FOR TRAINING AND EDUCATION THEME:

- The Mental Health Commission will develop a standardised **training curriculum** on seclusion and restraint reduction that addresses:
 - **Attitudes and misconceptions** related to seclusion and restraint;
 - **Trauma-informed Care**;
 - **Recovery-oriented Services**;
 - **Physical risks** associated with the use of seclusion and/or restraint;
 - **Psychological risks** associated with the use of seclusion and/or restraint;
 - Evidence based early recognition tools, structured **risk assessment, de-escalation** and **crisis management** protocols;
 - Utilisation of seclusion and restraint in a **risk minimised** manner;
 - Roles, purpose, and methodology of **debriefing**;
 - **Approved policies** on seclusion and restraint; and
 - The **philosophy of care** and treatment within approved centres.

- Services will implement a **seclusion and restraint reduction training** curriculum as developed by the MHC.
- **Require attendance** at training and consider classification of training as **mandatory** for all multidisciplinary staff working **within approved centres**.
- Require **new staff to attend training** during orientation and monitor congruence.
- Require **part time and locum staff** to attend training.
- Engage **service users and family members** in the development and delivery of training.
- Organise **refresher and updates** to assist staff maintain current knowledge.
- Include **learning** informed by **debriefings** and **data analysis** in future training.
- Combine **coaching and supervision with training** in order to ensure transfer of learning to practice.

2.4 DEBRIEFING

Debriefing following any adverse event, including the use of seclusion and/or restraint, provides potent learning and support opportunities for all involved. While there are many regulatory and professional mandates to conduct effective debriefing^[55,56] there remains some confusion as to its specific role purpose and function. Debriefing in the context of this strategy includes three distinct but associated processes all of which aim to effectively use learning from occurrences to prevent future episodes of seclusion or restraint.

TRIPARTITE OVERVIEW OF DEBRIEFING AND OCCURRENCE REVIEW			
	SERVICE USER	STAFF	ORGANISATION
PURPOSE	Process	Reflect	Learning
METHOD	Structured Debriefing	Structured review and supervision	Contextual review of occurrence
OUTPUT	Re-engagement with treatment team	Learning-informed enhanced practice	Prevention and/or remediation

FIGURE 2 DEBRIEFING AND OCCURRENCE REVIEW STRUCTURE

From McKenna ^[67]

Service User

As required by the MHC Rules and Code of Practice, service users should be debriefed following an episode of seclusion and/or restraint. Specifically, the service user must be afforded the opportunity to discuss the episode with members of the multi-disciplinary team involved in his or her care and treatment.

The debriefing should provide service users with the opportunity to focus on the events leading up to the seclusion or restraint episode, and clinicians with an opportunity to explain the rationale for their decision making. Cumulatively, these shared perspectives on the occurrence should focus on developing strategies through which occurrences might be prevented and/or less coercively managed in the future.

Critically the key function of the debriefing is to reconnect the service user and treatment team so that their collaborative working toward recovery can continue unhindered. This is especially important as episodes of seclusion and/or restraint inherently distort the power balance needed for collaborative working.

It is important to remember that providing debriefing with a service user who has been involved in an occurrence, which may have been experienced as traumatising, needs to be extremely sensitive in terms of its timing and those involved, as well as being sensitive to the service user's level of functioning. Those providing the debriefing might include a staff member or peer (appropriately trained for this role), or the key worker with whom the service user may be willing to explore their emotions and behaviour prior to the episode and explore strategies through which they can work through difficulties in the future without the need for external management of behaviour.

Staff

It is equally important that staff members have the opportunity to debrief following episodes of seclusion and/or restraint. While the opportunities for reflective learning is the core of staff debriefing, it also provides a safe and supportive environment in which staff have the opportunity to work through issues and/or feelings which may have emerged during an episode. It is important that the focus is on supportive enhancement of professional practice, and that staff are aware of the organisational support mechanisms in place should an issue be causing personal distress.

Clinical leadership is pivotal in creating the culture in which staff are encouraged to critically appraise their actions and feelings during the event in an open and honest manner using a 'root cause analysis' methodology. As espoused in the Linking Service and Safety³ strategy, the key is for the focus to remain on '*fact finding*' rather than '*fault finding*'^[18].

The Organisation

The third component of debriefing is the organisational review which may identify either preventive or remedial quality improvements. Occurrences are reviewed to identify measures which might prevent re-occurrence, or broader improvements which are necessary across the service.

There is potential for an organisational review committee, or the seclusion and restraint working group, to undertake reviews using a structured approach to analysis of occurrences. The contextual understanding of occurrences described in Linking Safety & Service as being a function of four considerations including the service user, the staff, the interaction, and the environment might provide a useful structure in this regard^[18].

³ 'Linking Service and Safety: together creating safer places of work' is the strategy for managing aggression and violence within the Irish health service.

KEY ACTIONS: DEBRIEFING

DEBRIEFING: SERVICE USER

- Service users must be sensitively debriefed after each episode of seclusion and/or restraint with due regard to their wishes as to who should conduct the debrief.
- Each debriefing should be used as an opportunity for reconnection between the service user and the treatment team.
- The debrief should take place as soon as is practicable, but in all instances should be at a time that the individual can fully engage in the process.
- The debrief should be conducted by someone not involved in the occurrence.
- Debriefing must have regard to the capacity and mental functioning of service user but should be attempted in all instances.
- An opportunity should be provided for an advocate to accompany the service user for the debriefing, or alone if the service user declines to do so, or where their level of functioning hinders involvement (subject to the consent of the service user).
- Debriefing should include a discussion of events including service user's emotions and behaviours leading up to the episode of seclusion and/or restraint.
- Debriefing should include an explanation of the decision-making by staff which considered the intervention necessary, and an opportunity should be afforded to the service user to respond.
- Each debriefing should explore how occurrences can be avoided in the future by identifying the triggers/antecedents events which contributed to the occurrence and identifying alternative de-escalation strategies to be used in future.
- The outcome of the service user's debriefing should be documented in his or her individual care and treatment plan.

KEY ACTIONS: DEBRIEFING

DEBRIEFING: STAFF

- Debriefing should serve as a **learning/support/supervision** opportunity for staff to process seclusion and restraint episodes and their associated feelings and actions. This forum should remain professionally focused with an appropriate referral arrangement for staff if indicated.
- Debriefing should consider the **'threshold of imminent danger'** in appraising the decision-making and type of intervention used. Senior clinical leaders need to consider that responses to conflict/perceived danger are influenced by personal and work-related experiences, and supervisory instructions.
- Debriefing should explore how staff, individually and collectively, **might avoid future occurrences** by identifying the trigger/antecedent events which contributed to the occurrence and identifying alternative de-escalation strategies to be used in future.
- Debriefing should review events leading up to seclusion or restraint, **what worked well, and less so**, and what alternatives might be tried in future.
- Debriefing should explore the most **effective timing and means of re-engagement** with service users for staff who were involved in the occurrence.
- Debriefing should be recorded including **follow-up plans** or actions decided upon.

DEBRIEFING: ORGANISATION

- Include **debriefing for service users and staff** and the **organisational review procedures** in policies on seclusion and restraint.
- Provide **appropriate training** for peers/advocates who participate in debriefing processes.
- Establish a **review committee** to **analyse** episodes of restrictive interventions in detail and recommend steps to prevent future events.
- **Conduct** a formal review of each episode of seclusion and/or restraint after the debriefing of the service user/advocate and staff member.
- The chair of review meetings should be someone who was not involved in initiating the episode of seclusion or restraint being reviewed.
- Individualised treatment plans should incorporate interventions that have been found to be effective in reducing the need for seclusion and restraint.
- The centre should have a clinical review process to provide consultation in the development of treatment interventions that reduce use of seclusion and restraint and/or for service users who are not responding to current treatment efforts.

2.5 DATA

A national database has been identified as a prerequisite for systems to monitor their seclusion and restraint practice and reduction efforts in line with other international efforts^[23]. Without such a database it is suggested that mental health systems will be unable to establish with any certainty whether services 'could or should' reduce the use of seclusion^[3].

A US state funded effort to measure chemical restraint identified three key challenges in developing a quality database, namely a 'readily available source of data from which valid and reliable information can be extracted', a 'clearly agreed definition of observable events' and a 'feasible system to support data collection'^[29].

Services are currently required to collect data on the use of seclusion, physical restraint and mechanical restraint use in accordance with the relevant Rules and Code of Practice^[55,56]. While compliance with current regulations has generated a reliable national database, it is important that the use of this data extends beyond the statutory measurement of seclusion and restraint use to serving as a quality measure of psychiatric care, with the proposition that such data is a proxy for harder to measure intangibles including leadership, effective treatment, patient and staff safety, staff training, patient and staff morale, and commitment to patients and their recovery^[33]. This shift is required for data to serve as a source of clinical and organisational learning supporting the reduction of seclusion and restraint.

It is important when implementing a seclusion and restraint strategy to monitor for possible substitution effects and for that reason it is necessary to extend data collection to include the use of involuntary medication where this is not routinely collected at present.

While improved collection and enhanced analysis of data may present a challenge for some services, what seems equally clear is that better use of data collection and analysis is an important component of the strategy. Monitoring the progress and achievement of the strategy's overall goals will rely on making full use of seclusion and restraint data. The need for, and effectiveness of, targeted quality improvement initiatives is also dependent on identifying service challenges which emerge from interrogating data.

While full implementation of this theme might not be feasible by all services in the shorter term, each service will implement actions to the greatest degree practicable following a critical appraisal of service specific priorities which are achievable within available resources.

All approved centres will at a minimum record both unit specific and centre-wide data including the:

- Number of **episodes of seclusion** used each month
- Number of **episodes of mechanical restraints** used each month
- Number of **episodes of physical restraint** used each month
- Number of **administrations of involuntary medication** used each month
- **Number of service users restrained** using mechanical equipment each month
- **Number of service users secluded** each month
- **Number of service users physically restrained** each month
- Number of service users **administered involuntary medication** each month.
- **Service user injury rates** during seclusion/restraint episodes each month
- **Staff injury rates** sustained during seclusion/restraint episodes each month
- **Staff injury rates** caused by service users during violent episodes each month
- Staff involved in occurrences
- Adverse events, both unit specific and centre-wide

On a once off basis each centre will establish a baseline measure of occurrences of each of the interventions described above during the previous year (as best as can be reasonably be retrieved). While this may involve both time and effort, it is important that each centre has a reliable baseline against which to benchmark future progress.

Alternative methods of collecting data, for example as part of audit functions, should be explored as soon as practicable, with a target of providing reliable data to senior clinical and administrative management at a minimum of once monthly.

KEY ACTIONS: DATA

- **Ensure compliance** with all MHC Rules and Codes of practice related to the recording of data on the use of seclusion, physical restraint and mechanical restraint.
- **Ensure data on the use of these interventions** is submitted to the Mental Health Commission monthly.
- Establish a mechanism for collecting data on use of **involuntary administration of medication by unit, centre and service user**.
- Establish a mechanism for collecting data on the **use of mechanical restraint by unit, centre and service user**.
- Conduct additional analysis using data collected on the use of seclusion and restraint which supports clinical audit (which are not required to be returned to the Commission) including:
 - Seclusion and restraint episodes by **unit, shift, day, time and duration**;
 - Seclusion and restraint episodes initiated by **different staff members**;
 - **Frequency and duration** of seclusion and restraint episodes by service user;
 - **Total number of service users secluded**, including demographics;
 - **Total seclusion hours** by unit and centre;
 - **Total number of seclusion episodes and duration** for each service user secluded;
 - **Information about both longer-term (months/years) and medium-term (weeks/months) trends in the use of seclusion and restraint**.
- Examine the feasibility of collecting additional data on seclusion and restraint to include:
 - **Use of alternative strategies** to replace seclusion and restraint;
 - **Themes and outcomes of debriefings**.
- Review seclusion and restraint data management procedures to identify scope for improvements including:
 - Procedures for **verifying the accuracy** of data;
 - Measures to monitor and **quantify seclusion and restraint** reduction;
 - Reviewing procedures that **identify 'outlier'** service users who may benefit from a specific targeted individualized strategies;
 - Identifying **issues of concern** which may respond to staff training and education;
 - Examining the feasibility of using quality improvement tools (such as cause and effect analysis and Pareto charts).
- Make **data routinely available** to staff and multidisciplinary teams so that they can measure the effects of their efforts to reduce the use of seclusion and restraint.
- **Benchmark data collected** in your service with that collected on seclusion and restraint in other approved centres where appropriate.
- Ensure that data from satisfaction surveys informs decision-making.

2.6 ENVIRONMENT

The inclusion of environment reflects the many comments in stakeholder feedback of the critical roles played by both the 'physical' and 'care' environments on the care experience of service users. There is evidence to support these comments with one UK review identifying 'ward centred' circumstances as one significant factor preceding conflict and containment rates on acute psychiatric units^[3,68]. Conversely there is compelling evidence of the effectiveness of enhancing the therapeutic value of the physical environments in reducing seclusion and restraint use^[44]. Some initiatives have focussed on unit aesthetics, including the use of warm colours, comfortable furniture, rugs and plants^[47]. Others have built comfort rooms, often with the use of multi-sensory facilities, while others have created such rooms by renovating seclusion rooms^[69,70]. Apart from evidence supporting the effectiveness of these measures many were relatively simple to implement^[44].

There is also recognition of the role that physical characteristics play in the creation of trauma informed environments which can facilitate the respectful engagement necessary for collaborative recovery oriented working^[44,47]. The quality of staff presence in the ward environment has been studied by rating the effectiveness of the availability of staff on the open areas of units to recognise and respond to service user distress at an early stage^[71] with the researchers proposing that staff presence fosters a culture of structure, calmness, negotiation and collaboration rather than control^[71]. One promising UK model incorporates environmental interventions as a strategy to manage conflict 'flashpoints' with proactive problem solving^[3].

In addition to the physical characteristics and engagement dimensions of the environment there is increasing attention to the care culture which prevails within units. An extensive US review described the culture as including the treatment philosophy which can lead to changes in service user behaviours which results in use of seclusion and/or restraints^[47].

A later Australian review identified the effectiveness of psychosocial models of care in efforts to reduce the use of restrictive interventions. These care models place emphasis on collaborative treatment planning, rehabilitation and empowerment with the psychological therapies available to assist service users identify their individual stress escalation and to develop calming strategies^[44].

KEY ACTIONS: ENVIRONMENT

CARE ENVIRONMENT:

- Promote an organisational culture that embodies a **collaborative and recovery oriented** approach and an atmosphere of listening, attentiveness and respect.
- Provide treatment plans based on expectations that are **reasonable and empower clients** to make effective choices that do not result in harm to self or others (mentally, emotionally and physically).
- Stakeholders including **staff, clients and families** are involved in the design and development of treatment programmes and treatment strategies.
- Provide programmes for service users which **promote recovery**, including creative expression, recreational activities, sensory integration, and education in the principles of recovery.
- Provide treatment programmes which are **evidence-based**, with the appreciation that recovery is not a linear process.
- Provide treatment programmes based on the assumption that cognitive, affective and behavioural changes are individual and which take into account the individual's **level of development and functioning**.
- Provide care plans that reflect **person-centred, holistic and recovery oriented** principles.
- Engagement uses "**Person-first Language**" acknowledging that language is a powerful means of communicating the perception of others and how they are valued.

PHYSICAL ENVIRONMENT:

- Ensure that décor is **warm with appropriate use of colour**, furnishings and plants.
- Ensure a clear and full view of ward space where service users interact with each other.
- Ensure that all signage including unit rules is written in **person-friendly** positive language.
- Ensure the environment furnishings **balance comfort with safety**.
- Ensure furnishings are in a **good state of repair**.
- Arrange furniture to facilitate **service user and staff interaction**.
- Use sound reducing materials, such as carpeting and ceiling tiles to **reduce noise** in living areas where appropriate.
- Ensure seclusion rooms balance needs for **safety with privacy** e.g. by minimising blind corners.
- Ensure seclusion rooms have appropriate and adequate **temperature controls** to promote a calming environment.
- Ensure seclusion rooms have **adjustable soft lighting** and consider soothing effects including clouds and blue sky.
- Ensure seclusion rooms **minimise isolation** and provide visual orientation, including natural lighting and **environmental cues** (for example being aware of the time).
- Examine the feasibility of removing seclusion rooms and replacing them with **comfort rooms for quiet time** to assist service users should they need to practice "self-calming", thereby reducing the association between de-escalation and seclusion rooms.

2.7 REGULATION

The introduction of new or amended rules and codes by the Mental Health Commission seeking seclusion or restraint reduction presents an opportunity for positive change. Policies, either through mandate and/or encouragement, can serve as an impetus for the development of innovative seclusion and restraint reduction initiatives at a local level.

Some reviewers have suggested that amendment to regulations and policies which tighten controls on the use of seclusion and restraint serve as levers for change^[61] while others cite examples of policy changes achieving such reductions^[72]. The evidence for this is equivocal however with other commentators proposing that while government policies are features of successful initiatives to reduce restrictive interventions, changes to legislation alone may be ineffective^[73].

The use of seclusion, physical restraint and mechanical restraint (though not involuntary medication) are currently regulated through the MHC 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^[55,56]. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has noted that 'in general, the Mental Health Commission's Rules Governing the Use of Seclusion & Mechanical Means of Restraint correspond closely to the CPT's standards as set out in its 16th General Report'^[74].

The requirement by the Mental Health Commission that all approved centres are in full compliance with the rules and codes governing the use of seclusion and restraint should assist services in their efforts to reduce the use of coercive interventions. These rules and codes of practice should guide the content of local policies on the use of interventions and require that approved centres demonstrate efforts to reduce the use of seclusion and restraint.

It is the position of the Mental Health Commission that seclusion and restraint reduction is an achievable outcome and subsequently organisations will be expected to demonstrate both the implementation and progress of this strategy.

Opportunities exist to align implementation efforts with other initiatives which address similar or related strategic obligations. By way of example there is a clear congruence between this strategy and the Linking Service and Safety strategy of the Health Service Executive, (specifically recommendation 19 and the associated recommendations 20-22) which require that services 'proactively aspire to provide services which are "seclusion and restraint minimised" at philosophical, organisational and operational levels' ^[18].

KEY ACTIONS: REGULATION

- Ensure **full compliance** with all requirements 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*.
- Each approved centre shall have a policy which explicitly addresses the:
 - Use of seclusion
 - Use of physical interventions
 - Use of mechanical restraint
 - Administration of involuntary of intramuscular or intravenous medication against the individual's clear objection.
- Each approved centre will ensure that all policies on the use of seclusion, physical restraint, and mechanical restraint are current, **fully compliant with the relevant MHC Rules and Codes of Practice**, and explicit as to the efforts in place to reduce the use of seclusion and restraint.
- Health services should continue implementation of the *Linking Service and Safety* strategy for Managing Work-Related Aggression and Violence (HSE, Dec 2008) and in particular those **elements that relate to seclusion and restraint minimisation** (Recommendations 19-22).
- A **nationally standardised training curriculum** that supports the reduction of seclusion and restraint is developed and made available to approved centers.

2.8. STAFFING

The Quality Framework for Mental Health Services in Ireland^[65], which outlines the existing standards for mental health services, stresses that the skills, expertise and morale of staff are key factors in the delivery of a quality mental health service. It is quite clear that staff are pivotal to achieving the successful implementation of both the spirit and letter of this strategy.

While most staff identify the use of restrictive measures as sometimes necessary, many experience significant emotional distress when involved in the deployment of such interventions including fear, guilt and a dissonance between their role as carer and the requirement to maintain the safety of all concerned^[3,13,14].

Understanding staff involvement in the use of coercive measures is complex. One UK study of ward staff in inpatient psychiatric settings revealed that negative staff morale increased, and positive staff morale decreased, the likelihood of conflict and containment events occurring^[68]. Another UK study of 'Attitudes to Containment' involving 1226 staff in English acute mental health services found greater acceptance of containment measures among staff who had been involved in their use^[30]. A later Australian study of 123 nurses revealed an association between therapeutic optimism and the justification rating for the use of seclusion. Participants with higher therapeutic optimism and lower emotional exhaustion were significantly less likely to support the use of seclusion^[75].

Despite the burdens associated with involvement in coercive measures, indications are that staff do their best to avoid coercive measures and their efforts are valued by service users. There is some evidence to support this with one UK study of aggression and violence toward nursing staff on five UK acute inpatient wards finding that the most frequently used measure by staff to manage occurrences was by engaging with the service user. Even when preventative measures fail, service users value staff support with one study of service user distress associated with seclusion and restraint finding that despite a wide range of negative emotions, 'contact with staff' was most helpful measure in alleviating their distress^[19].

The issue of staffing needs to be considered in the context of the prevailing economic difficulties and the Moratorium on Recruitment and Promotion in which it is unlikely that increasing staff-to-patient ratios is a realistic or achievable goal for most services in the shorter term. The actions chosen under the 'Staffing' theme subsequently emphasise changes in roles and function rather than ratios.

Notwithstanding the challenges to staffing ratios, it is also important not to underestimate the potential for risks to staff to be reduced, and the greater engagement in therapeutic activities which can be achieved through the reduced use of seclusion and restraint.

KEY ACTIONS: STAFFING

- Ensure **multi-disciplinary collaboration** in the local implementation of the seclusion and restraint reduction strategy and the development of service specific initiatives and plan.
- Ensure that the seclusion and restraint working group and senior clinical leaders are **allocated time and training** to champion the reduction of seclusion and restraint.
- Review staff scheduling/rostering to:
 - Explore opportunities to minimise prolonged working with acutely unwell service users;
 - Ensure that adequate staff are available at critical times, such as during transitions, at change of shift, in the evening, and at times of high acuity;
 - Consider the staff mix who implement interventions in terms of age, gender, training and education, experience, and ability to relate to service users.

3. IMPLEMENTATION

The actions outlined in this strategy have the potential to align the ideological aspirations of national mental health policy as a collaborative recovery oriented service with an evidence-based best practice response to seclusion and restraint reduction which at least equals or exceeds comparable mental health services internationally.

A core value of collaborative engagement has underpinned the development of this strategy by combining a comprehensive review of related literature with an extensive process of stakeholder consultation, and engaging the assistance of international subject experts.

While the task of implementation should not be underestimated, particularly in the prevailing financial climate, neither should services be reticent to undertake well evidenced actions which have achieved a significantly enhanced care experience for both the recipients and providers of care in other jurisdictions.

Services should be encouraged by the compelling evidence that many of these actions outlined in the strategy are relatively simple to implement, demonstrate effectiveness at an early point, and have resulted in sustainable improvements. Further encouragement is to be found in the evidence that the seclusion and restraint minimised services have resulted in safer care environments and have potentially considerable cost savings.

The actions outlined need to be implemented adopting a strategic, integrated, cohesive and balanced approach. While the evidence supporting the concurrent implementation of all actions is compelling, the evidence is less clear as to the value of implementing individual components. This confronts service leaders with a dilemma which will require that they implement the strategy to the optimal level achievable based on a critical appraisal of service specific priorities within available resources.

While the Mental Health Commission is conscious of the challenges confronting services, the expectation is that all services will demonstrate the implementation of the strategy to the greatest degree practicable in the shorter term and have a viable and time specific plan for complete implementation. Within a period of three years there should be tangible evidence that services have achieved a seclusion and restraint minimised service.

The Commission will as a priority develop a standardised educational programme which will:

- Address the core leadership objectives necessary to inform implementation of the strategy.
- Provide the opportunity to inform the implementation of key actions
- Support services in initiating their seclusion and restraint reduction effort.
- Provide the opportunity for meaningful engagement with service users, families and advocates.
- Provide the opportunity for engagement with staff at all levels.
- Assist services develop an overall implementation plan and inform specific initiatives such as risk assessment, debriefing and environmental enhancements.

This work will be undertaken as a priority with a targeted time frame of six months between the release of the strategy and first programme delivery.

In parallel to developing an effective educational programme the Commission will review current data collection related to seclusion and restraints with a view to amending the requirements as outlined in the strategy. This exercise will also provide the opportunity:

- To benchmark a baseline measure of the use and duration of interventions nationally against comparable health services internationally; and
- To benchmark a baseline measure of interventions used in the context of evidence-based best practice.

This review will be undertaken with a targeted time frame of nine months between the release of the strategy and the amendment of data requirements as outlined in the strategy, and eighteen months for completion of the comparative analysis of baseline data.

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