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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

MMHS Seclusion and Physical Restraint Reduction Policy

Policy [√] Procedure [ ] Protocol [ ] Guideline [ ]

Location: Mayo Mental Health Service

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Title of PPPG Development Group:	MMHS Multidisciplinary Review and Oversight Committee for Restrictive Practices
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Version		Revision History
3	Inserted	Front Cover Updated 5.4.4. A DASA is completed on persons, as appropriate, in the High Dependency Unit (HDU) in AMHU every 24 hours, in order to assess and manage risk of aggression in the next 24 hours. An elevated score on DASA

	Inserted	signifies that staff engagement is necessary, and a short-term risk management plan needs to be developed 5.4.5 A DASA can be completed on a person in the AMHU main ward and other approved centres in MMHS as deemed necessary by staff.

1.0 Purpose

1.1 The purpose of this Policy is to:

1.1.1. Clearly document how MMHS aims to reduce or, where possible eliminate, the use of seclusion and physical restraint within its approved centres;

1.1.2. Address leadership, the use of data to inform practice, specific reduction tools in use, development of the workforce, and the use of post incident reviews to inform practice;

1.1.3. Clearly document how the approved centre will provide positive behaviour support as a means of reducing or, where possible eliminating, the use of seclusion and physical restraint within the approved centre.

1.2 Scope

1.2.1 This policy applies to all staff working in Approved Centres in MMHS

- Adult Mental Health Unit
- An Coillin
- Teach Aisling
- St Annes

1.2.2 It is the policy of MMHS that mechanical restraint is not used in the service

1.3 Objective

To provide direction to staff in MMHS on the process for the reduction and where possible, elimination of Seclusion & Physical Restraint.

1.4 Outcome

Mayo Mental Health Services is committed to the reduction and where possible elimination of episodes of seclusion and restraint within its service.

1.5 PPPG Development Group

MMHS Multidisciplinary Review and Oversight Committee for Restrictive Practices

1.6 PPPG Governance Group

MMHS Area Management Team approve this policy.

1.7 Supporting Evidence

1.7.1 Mental Health Act (2001) Amendments (2015 & 2018)

1.7.2 Rules Governing the Use of Seclusion (MHC, 2022)

1.7.3 Code of Practice on the Use of Physical Restraint (MHC, 2022)

1.7.4 The uses of restrictive practices in approved centres activities report (MHC, 2020).

1.7.5 Seclusion and Physical Restraint Reduction Strategy: Consultation Report. (MHC, 2014)

1.7.6 Evidence review to inform the review of the code of practice on the use of physical restraint and the rules governing seclusion and mechanical means of bodily restraint in inpatient Mental Health Services (RCSI faculty of Nursing & Midwifery, 2022)

1.8 Glossary of Terms and Definitions

Approved Centre: A "centre" means a hospital or other inpatient facility for the care and treatment of persons suffering from mental illness or mental disorder. An "approved centre" is a centre that is registered pursuant to the Mental Health Act 2001-2018. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Mental Health Act 2001-2018.
Clinical Governance: A system for improving the standard of clinical practice including clinical audit, education and training, research and development, risk management, clinical effectiveness and openness.
De-escalation: The use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression.
Dignity: The right of an individual to privacy, bodily integrity and autonomy, and to be treated with respect as a person in their own right.
Person: All references to 'person' in this document should be taken to mean a voluntary or involuntary patient or resident, as defined in the 2001 Act.
Physical Restraint: Is defined by the Mental Health Commission (2022) as "the use of physical force (by one or more persons) for the purpose of preventing the free movement of a person's body when the person poses an immediate threat of serious harm to self or others".
Policy: Written statement that clearly indicates the position of the organisation on a given subject.
Positive behaviour support: involves assessments that look beyond the behaviour of a person and seek to understand the causes or triggers of the behaviours. These causes may be social, environmental, cognitive, or emotional. The approach is one of behaviour change as opposed to behaviour management.

Rights Based Approach: Integrating human rights norms and principles in the design, implementation, monitoring and evaluation of policies and programmes. The principles of equality and freedom from discrimination are central.
Seclusion: Is defined by the Mental Health commission (2022) as "the placing or leaving of a person in any room, at any time, day or night, such that the person is prevented from leaving the room by any means."
Trauma Informed Approach: Trauma-informed care is an approach which acknowledges that many people who experience mental health difficulties may have experienced some form of trauma in their life. A trauma informed approach seeks to resist traumatising or re-traumatising persons using mental health services and staff.
Unsafe Behaviour: When a person acts in such a way that they may injure themselves or others

2.0 DEVELOPMENT OF POLICY

2.1 Summary of the evidence from the literature. (Source: RCSI faculty of Nursing & Midwifery, 2022)

Over 30 years ago, the United Nations (1991) established the desired underlying principle to rely on the least restrictive or intrusive treatment appropriate to the persons health needs. Further refined by the United Nations convention on the rights of persons with disabilities in 2006 (United Nations, 2006), these principles have informed the legal provisions and regulation of seclusion and restraint internationally. In particular, seclusion, physical and chemical restraint are considered to be at odds with contemporary evidence-informed approaches to Mental Health Care which should be based on a recovery orientated ethos and principles of ensuring human rights (WHO, 2019). However, there has been an escalating concern about restrictive practices in the broader sense in psychiatry for the past 22 years (Muir-Cochrane, Oster and Grimmer, 2020). These include but are not limited to physical restraint, mechanical restraint, chemical restraint, seclusion, time out, open area seclusion or environmental restraint, close observations, locked doors, night-time clothing. The evidence is clear that restrictive practices can cause deleterious physical and psychological consequences (Chieze, Hurst et al. 2019) for those subjected to them. There have been numerous reports and incidents supporting the need to reduce or eliminate these practices internationally. In response, many governments and health services globally have acknowledged the issues associated with restrictive practices and have instigated national policies and guidance to reduce or eliminate them in Mental Health Services. The most recent impetus for the reduction of restrictive practices occurred in the UK in 2018, when the UK Government passed the Mental Health Units (Use of Force) Act (2018). This Act, known as Seni's Law, legislated for mandatory reporting and reduction in restrictive practices and was brought into effect following a serious incident review into the death of Olaseni Lewis. Mr Lewis died as a result of excessive and disproportionate restraint by police in the presence of staff in a seclusion room at the Bethlem and Maudsley Hospital in 2010. It is clear that practices which were once considered standard in

the management of challenging behaviours and in best interests of the patient, have entered a new paradigm of risk and safety management as opposed to therapeutic intervention. This presents a challenge to regulators, service providers, professionals and service users alike. There are instances where restrictive practices are considered necessary for the safe management of high-risk patients and where apparent reductions in the level of restriction over time can indicate progress in the rehabilitative sense (Kennedy et al, 2020). There are also instances where it is considered necessary to maintain safety in the day-to-day environment of inpatient mental health care which involve different forms of restrictive practices (Wilson et al, 2017). The international and evidentiary developments combined with these normative practices, have created an ethical quagmire for staff working in these environments. Evidence over the past two decades or so, has highlighted the complexities associated with the precursors of behaviours and events which may lead to restrictive practices. In inpatient care restrictive practices are known to be preceded by internal (patient), external (environmental) and interpersonal (relationships) factors (Duxbury, 2002; Duxbury and Whittington, 2005). Evidence-based approaches such as Safewards (Bowers, 2014) are reorienting day to day practice to avoid conflict and containment and maximise therapeutic engagement between staff and patients. At an organisational level seclusion and restraint reduction imperatives and evidence-based approaches are now established as essential in the governance of mental health services, including in the Irish context (MHC, 2014). What is important here is the recognition that the issues associated with restrictive practices are complex, involve all levels of the healthcare organisation and as such all levels of the healthcare organisation must address the issue. In its role as regulator of Irish Mental Health Services, the Mental Health Commission (MHC) of Ireland is empowered to develop regulatory and/or practice guidelines on these critical issues. To date within the Irish context the MHC has provided regulatory and practice guidance on the use of seclusion and mechanical means of bodily restraint (MHC 2009) and physical restraint (2009). Following extensive consultation with experts and stakeholders, a strategy for the reduction of seclusion and restraint in Irish Mental Health Services was published in 2014 (MHC, 2014). This strategy had a strong evidence base and provided services with a suite of actions designed to support reduction in the use of seclusion and restraint. However, despite this, seclusion and restraint remains a feature of Irish Mental Health Care and there has been little difference in reporting trends over time. In fact, the MHC reports on activity on the use of seclusion and restraint in approved centres show that physical restraint has increased in the intervening period.

2.2 **Detail resources necessary to implement the Policy**

The provision of appropriate training to staff in MMHS

3.0 GOVERNANCE AND APPROVAL

3.1 Outline formal governance arrangements

MMHS Area Management Team approved this Policy

4.0 COMMUNICATION AND DISSEMINATION

4.1 This Policy will be implemented through management structures in MMHS.

4.2 This Policy can be accessed electronically on MMHS Policy Portal

5.0 IMPLEMENTATION

5.1 Roles & Responsibilities

5.1.1 The Registered Proprietor has overall accountability for the Mayo Mental health Service Reduction Policy and must appoint a named senior manager responsible for the approved centres reduction in physical restraint and seclusion.

5.1.2 The Registered Proprietor has overall accountability for the use of physical restraint and seclusion within Mayo Mental Health Service.

5.1.3 MMHS Multidisciplinary Review and Oversight Committee for Restrictive Practices are responsible for the over sight of physical restraint and seclusion used within Mayo Mental Health Services Approved Centres.

5.1. 4 MMHS Multidisciplinary Review and Oversight Committee for Restrictive Practices are accountable to the Registered Proprietor.

5.1.5 It is the role and responsibility of the MMHS Multidisciplinary Review and Oversight Committee for Restrictive Practices to meet quarterly and must

- determine if there was compliance with the code of practice on the use of physical restraint and rules governing use of seclusion in approved centres in MMHS.
- determine if there was compliance with Mayo Mental Health Service policies and procedures relating to physical restraint and seclusion;
- Identify and document any areas for improvement;
- identify the actions, the persons responsible, and the timeframes for completion of any actions;
- provide assurance to the Registered Proprietor Nominee that each use of physical restraint and seclusion was in accordance with the Mental Health Commission's Code of Practices and Rules.
- produce a report following each meeting. This report should be made available to staff who participate, or may participate, in physical restraint and seclusion, to promote on-going learning and awareness. This report should also be available to the Mental Health Commission upon request.

5.1.6 It is the role and responsibility of the MMHS Multidisciplinary Review and Oversight Committee for Restrictive Practices to oversee the implementation of this Physical Restraint and Seclusion Reduction Policy for Mayo Mental health Services.

5.1.7 It is the responsibility of all Heads of Discipline to ensure that staff under their remit sign electronically that they have read and understand this policy.

5.1.8 It is responsibility of all staff working within Mayo Mental Health Services to adhere to this policy

5.2 Leadership

5.2.1 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. Proactive and persistent leadership has been highlighted in many systematic reviews to be pivotal in achieving reductions in seclusion and restraint use (Mental Health Commission 2014).Key actions include:

- Include seclusion and restraint reduction as an explicit goal within the mission, vision and philosophy of care statements of MMHS.
- Engage staff at all levels in relation to this policy and provide opportunities for staff at all levels to participate in the ongoing developments in relation to seclusion and restraint reduction.
- Implement an organisational culture which embodies a collaborative and recovery oriented approach and an atmosphere of mutual engagement and respect.
- Monitor progress on actions identified in the reducing restrictive practices strategy.
- Ensure all episodes of seclusion and restraints are reviewed by members of the multidisciplinary team.

5.3 The use of data to inform practice

5.3.1 Approved Centre databases are a prerequisite for systems to monitor their seclusion and restraint practice and reduction efforts in line with other national efforts. Without such a database the service would be unable to establish with any certainty whether services are reducing the use of seclusion and physical restraint (MHC, 2014).

5.3.2 MMHS Multidisciplinary Review and Oversight Committee for Restrictive Practices will review the databases for seclusion and restraint for each approved centre and produce an annual report on the use of physical restraint and seclusion used within 6 months of the end of calendar year. The report should include:

- aggregate data that should not identify any individuals;

- a statement about the effectiveness of the Mayo Mental Health Service approved centre's actions to eliminate, where possible, and reduce physical restraint and seclusion;
- a statement about the approved centre's compliance with the code of practice on the use of physical restraint and rules governing use of seclusion;
- a statement about the compliance with the approved centre's own reduction policy
- The total number of persons that the approved centre can accommodate at any one time.
- The total number of persons that were admitted during the reporting period.
- The total number of persons who were physically restrained during the reporting period.
- The total number of episodes of physical restraint.
- The shortest episode of physical restraint.
- The longest episode of physical restraint.
- The total number of persons who were secluded during the reporting period.
- The total number of episodes of seclusion.
- The shortest episode of seclusion.
- The longest episode of seclusion.

5.3.3 The Registered Proprietors nominee will sign the report and publish it on the appropriate website.

5.3.4 Data should be utilised to inform staff education and training to improve practice

5.3.5 MMHS Multidisciplinary Review and Oversight Committee for Restrictive Practices will review and consider what additional information/variables may be required to inform the ongoing review of restrictive practices

5.3.6 Data will be available to staff and multidisciplinary teams so that they can measure the effects of their efforts to reduce the use of seclusion and restraint.

5.4 Specific Reduction Tools/Interventions in Use (including Trauma Informed Care and Positive Behavioural Support approaches)

5.4.1 MMHS have systems in place to monitor risk, and approaches to support de-esclation, these are reviewed as necessary to ensure the service develops additional supports and approaches in line with recommended practices.

5.4.2 All staff working in approved centres to complete online training on DASA IV (Dynamic Appraisal of Situation Aggression – Inpatient

Version). The DASA tool consists of seven items, scored on a daily basis and it allows nursing staff to rate patients in terms of support that may be required. Patients who score high on the DASA IV scale will require increased input over the next twenty-four hours to reduce potential for serious incidents of violence.

5.4.3 A DASA is completed on persons, as appropriate, in the High Dependency Unit (HDU) in AMHU every 24 hours, in order to assess and manage risk of aggression in the next 24 hours. An elevated score on DASA signifies that staff engagement is necessary, and a short-term risk management plan needs to be developed

5.4.4 A DASA can be completed on a person in the AMHU main ward and other approved centres in MMHS as deemed necessary by staff.

5.4.5 Based on an understanding of the person and their mental health needs during their time in an approved centre, ways of supporting the person can be included as part of their overall plan of care, the following proactive strategies maybe utilised

- Use of de-escalation Techniques.
- Use of low arousal approaches
- Consistency in approach ensuring that interventions are implemented in the same manner by each staff member.
- Listening to service users and their family, actively seeking involvement in care planning.
- Offering an opportunity for choice e.g. how service user spends their time, their food choices.
- Encouragement of Autonomy – creating opportunities for choice, learning and recovery planning.
- Using appropriate communication strategies i.e. matching communication to the persons communication ability e.g. using a communication passport, interpreter services, visual aids.
- Providing opportunity for positive social interactions including staff, other residents, family, and community contacts.
- Apply learning from Previous Risk assessments.
- Applying learning from debriefing, service user feedback, audit findings and what can be done differently.

5.4.6 Developing Trauma Informed Care and Positive Behavioural Support approaches within MMHS.

5.4.6.1 Trauma- Informed Care (TIC) is an approach to care and service provision based on an awareness of the high prevalence of trauma in the lives of people accessing mental health services, the impact of traumatic experiences, and the potential for trauma or re-traumatization to occur in the context of care (Isobel et al., 2021; Muskett, 2013). Trauma-Informed Care is founded on the principles of safety,

trustworthiness, choice, collaboration and empowerment (Menschner & Maul, 2016; Muskett, 2013)

- ***Empowerment***: Using individuals' strengths to empower them in the development of their treatment
- ***Choice***: Informing service users regarding treatment options so they can choose the options they prefer
- ***Collaboration***: Maximizing collaboration among health care staff, service users, and their families in organizational and treatment planning
- ***Safety***: Developing health care settings and activities that ensure service users' physical and emotional safety
- ***Trustworthiness***: Creating clear expectations with service users about what proposed treatments entail, who will provide services, and how care will be provide

5.4.6.2 Positive Behaviour Support (PBS) involves assessments that looks beyond the behaviour of a person and seek to understand the meaning, function, and causes of the behaviours of concern. These causes may be social, environmental, cognitive, or emotional.

5.4.6.3 MMHS will continue to review the ways in which trauma informed and positive behaviour support practices can be developed within our service.

5.4.6.4 Each Approved Centre in MMHS has a restrictive practice reduction plan which is regularly reviewed and updated.

5.5 Workforce Development and Staff Training

5.5.1 Data analysis will be utilised to inform staff education and training to improve practice

5.5.2 Staff involved in seclusion and physical restraint must attend Therapeutic Management of Violence and Aggression (TMVA) mandatory training provided by appropriately trained trainers in MMHS. Within the training staff learn de-escalation skills, alternatives to physical restraint and seclusion and the monitoring of the safety of the person during and after the physical restraint. The training will also include an introduction to trauma-informed care, cultural competence, human rights, including the legal principles of restrictive interventions and positive behaviour support

5.6 Post Incident Reviews

The Multidisciplinary debrief and multidisciplinary review post each episode of restraint and seclusion provides learning and support opportunities for all involved, which aim to effectively use learning from occurrences to prevent future episodes of seclusion or restraint.

6.0 MONITORING, AUDIT AND EVALUATION

The implementation of this Policy will be monitored and continuously improved as required

7.0 REVISION/UPDATE

This policy will be reviewed in one year or sooner if necessary. The review will be completed by all relevant stakeholders.

8.0 REFERENCES

Isobel, S., Wilson, A., Gill, C., Schelling, K., & Howe, D. (2021) What would a trauma-informed mental health service look like?' Perspectives of people who access services. International Journal of Mental Health Nursing,3, 495-505

Mental Health Commission (2014) Seclusion and Restraint Reduction Strategy
Mental Health Commission (2022) Rules Governing the Use of Seclusion.

Mental Health Commission (2022) Code of Practice on the Use of Physical Restraint

Mental Health Act (2001) Amendments (2015 & 2018)

Menschner, C., & Maul, A. (2016). Key Ingredients for Successful Trauma-Informed Care. Implementation Center for Health Care Strategies, IN

Muskett, C (2013). Trauma-informed care in inpatient mental health settings: A review of the literature. International Journal of Mental Health Nursing,23, 51-59

RCSI Faculty of Nursing & Midwifery (2022) Evidence review to inform the review of the code of practice on the use of physical restraint and the rules governing seclusion and mechanical means of bodily restraint in inpatient Mental Health Services

Appendix 1

Membership of the MMHS Multidisciplinary Review and Oversight Committee for Restrictive Practices involved in developing this Policy

Please list all members of the development group (and title) involved in the development of the document.

Executive Clinical Director *Dr Anne Cullen*	Psychologist *Dr Patrick McHugh*	Business Manager *Aidan Sweeney*	Occupational Therapist *Clem McLoughlin*
Area Lead for Service User Engagement *Maria McGoldrick*	Nurse Practice Dev Co-ordinator *Catherine Cunniffe*	Social Worker *Eimear Scahill*	ADON *Rajeev Ramasawmy*
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No conflict of interest was identified.