the Australian College of Mental Health Nurses Inc.

Supporting Mental Health Professionals towards cultural and clinical change: Facilitating ongoing reduction in seclusion and restraint in mental health settings in Australia

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PROJECT SUMMARY

Definitions

For the purpose of this project the following definitions were used:

Seclusion- refers to deliberate confinement of the consumer alone in a room or area from which free exit is prevented.

Physical restraint- refers to hands-on immobilisation, holding the consumer or restriction of the consumer's freedom of movement by staff.

Mechanical restraint- refers to restricting a consumer's freedom of movement with devices such as jackets, belts, cuffs, and soft shackles.

Acknowledgements

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Australian Government

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EXECUTIVE SUMMARY

The terms 'violence' and 'aggression' refer to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained, or the intention is clear (NICE, 2015). There are many factors that impact on violence and aggression in mental health settings, from environment and ward milieu to the attitudes and behaviours of staff and consumers. Violence and aggression adversely affect the health and safety of consumers, staff and visitors. Restrictive practices such as seclusion and restraint can be used to manage risk of harm to consumers and others. However, seclusion and restraint can also be traumatic for staff and consumers and in some instances, may result in an escalation of the violent or aggressive behaviour the intervention was intending to address.

While mental health policy nationally is clearly directed towards reducing seclusion and restraint, on its own, this is not sufficient. Workplace culture and staff attitudes have been identified as key to further progressing the reduction and ultimate elimination of seclusion and restraint in mental health settings. While the attitudes and experiences of all staff that work within the mental health setting are important, because mental health nurses play a central role in the provision of mental health care in all mental health settings and are primarily involved with initiating/instigating and ceasing seclusion and restraint, a focus on their unique experience is vital.

The Australian College of Mental Health Nurses (ACMHN) was commissioned by the National Mental Health Commission to undertake a project to better understand the decision-making processes of mental health nurses regarding the use of seclusion and restraint, including:

- their perspectives, experiences and attitudes towards the use of seclusion and restraint;
- the barriers and enablers they experience in relation to the reduction and elimination of seclusion and restraint;
- the training they have received around de-escalation techniques and approaches;
- the commitment of the service and service leaders to recovery-oriented practice and a trauma informed approach;
- the processes required to support attitudinal and practice change; and,
- the cultural aspects that impact on their perspectives, experiences, attitudes and practice.

A first for Australia, this research has been an important piece of work in understanding the mental health nurses' experience around the use of seclusion and restraint in Australian mental health and emergency department (ED) settings. A literature review, online survey and nine focus groups were conducted to elucidate the experiences of mental health nurses in Australia as outlined above.

Key findings of each component of the project will be discussed further in this report, but include:

- Nurses reported being faced with threatening situations on their units and that they felt only somewhat safe in their workplaces. However, they were confident in their abilities to work with hostile or aggressive consumers and to enact seclusion and restraint when needed.
- Person centered and trauma informed care approaches were recognised by nurses as central to nursing care, but were overshadowed by the daily exigencies of every day care with acutely unwell consumers, including those with substance misuse disorder.

- The consumers and carers consulted reflected nurses' concerns around safety, skills mix, staffing, drug intoxication, environmental barriers and training and education.
- Careful consideration of the concerns that nurses have about safety and adequate preparation of staff to work in acute psychiatric inpatient units and in EDs (with mental health consumers) is vital, particularly to further efforts to reduce and ultimately eliminate seclusion and restraint

This report makes thirteen recommendations which align with the six core strategies of seclusion and restraint reduction (Huckshorne 2006) and address the following goals:

1. Mental health nurses need to feel safe at work
2. More effective and efficient data collection and use is required
3. Nurses have the required education, knowledge, skills and capabilities to reduce and eliminate seclusion and restraint
4. Alternatives to the use of seclusion and restraint are provided
5. Consumers are actively involved in strategies to reduce seclusion and restraint
6. Nurses are educated and trained in de-escalation and debriefing techniques.

Active, committed, high-profile leadership is essential in any process to reduce seclusion and restraint, and must be present at all phases (O'Hagan et al, 2008). This project demonstrates a further show of leadership by the National Mental Health Commission, through its funding of this project, and by the Australian College of Mental Health Nurses (ACMHN) as the national representative of the mental health nursing profession. The ACMHN is committed to seclusion and restraint reduction and ultimate elimination in mental health service settings in Australia and focused on supporting the mental health nursing workforce to achieve practice and cultural change, by exploring their thoughts, attitudes, experiences and vision for mental health service environments that are both physically and emotionally safe for consumers, staff and others.

The ACMHNs Position Statement on Seclusion and Restraint (2016) is available at Appendix 1.

LITERATURE REVIEW

All Australian governments have made a commitment to reducing and where possible eliminating seclusion and restraint in all service settings (Melbourne Social Equity Institute, 2014; National Mental Health Working Group, 2005). See Appendix 2: Timeline of Policy Activity around seclusion and restraint reduction, for further details. The National Mental Health Consumer and Carer Forum (NMHCCF) position is that seclusion and restraint are 'not evidence-based therapeutic interventions', that they are 'commonly associated with human rights abuses', that they 'cause short and long term emotional damage to consumers' and that they 'demonstrate a failure in care and treatment when they are used' (NMHCCF 2009, p7).

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) includes a number of articles that each have clear implications for avoiding restrictive practices, including Article 12 (Equal Justice before the Law), Article 15 (Freedom from Torture or Cruel, Inhuman or Degrading Treatment or Punishment), Article 16 (Freedom from Exploitation, Violence and Abuse), Article 17 (Protecting the Integrity of the Person), Article 18 (Liberty of Movement and Nationality). The United Nations Committee on the Rights of Persons with Disabilities has stated that it is concerned that persons with disabilities, particularly those with intellectual impairment or psychosocial disability, are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraints and seclusion, in various environments, including schools, mental health facilities and hospitals' (JFA Purple Orange 2017 p.7)

Most models for reducing and where possible eliminating the use of seclusion and restraint now focus on the characteristics of people needing care, the physical and policy environment and organisational/team culture. This literature review aimed to explore the attitudes, perceptions and experiences of mental health nurses towards the reduction and ultimate elimination of seclusion and restraint, particularly as they relate to the barriers and enablers that have been commonly identified. Mental health nurses play a central role in the provision of mental health care in all mental health inpatient settings. As part of their role, nurses working in mental health settings make clinical judgements and form views about a range of related issues e.g. risk, violence, safety, the environment, the staff mix and consumer acuity, which will also likely influence their behaviour (e.g. see Downes et al 2016; McCann et al 2014; Goethals et al, 2012). Hamrin (p.223, 2009) concluded that future research was needed to explore the multiple levels of factors involved that impact on variability of staff-patient interactions and that 'a greater understanding of the staff's attitudes and interpersonal skills with patients is needed'.

Because mental health nurses represent the staff that are most likely to use seclusion and restraint, and are predominantly responsible for 'making the decision to enact seclusion and restraint in emergency situations' (NMHCCF, 2009 p2), they therefore also play a crucial role in reducing, and ultimately ending, the use of seclusion and restraint in Australian mental health services (ACMHN 2016). In addition, the review identified successful interventions that have resulted in reducing seclusion and restraint, both nationally and internationally.

Key findings from the literature review include:

- Initiatives to reduce or eliminate seclusion and restraint have been implemented world-wide using, for example, six core categories to reduce seclusion and restraint (US) and Safewards, a multi-interventional model to reduce conflict and containment in in-patient psychiatric wards. Their efficacy is dependent on organisational factors including staff education and preparation, resources and organisational priorities.
- Consumers have negative views about seclusion and restraint.
- Nurses have mixed views about seclusion and restraint, from avoidance and distress to acknowledgement that they feel they have no other alternatives to employ in aggressive and violent situations.
- Nurses use seclusion and restraint to gain control and maintain safety on the unit and can feel pressured to use containment methods.
- Factors such as the physical environment and milieu of the care setting, staff training and preparation, organisational priorities, resources and communication have a strong influence on attempts to reduce seclusion and restraint.
- Challenges to implementing a restraint-free environment include insufficient resources (staff ratios, inadequate physical environment and equipment); concerns about safety and duty of care; inadequate skills/practice development opportunities for staff and limited to no education for families about alternatives; conflicts between staff approaches, specific approaches for individual consumers and policies; lack of understanding and empathy with consumer, and communication difficulties.
- Nurses see seclusion and restraint as a necessary safety intervention and a last resort management tool, and they do not believe containment methods can be eliminated under current conditions.
- Research has identified a number of consumer characteristics that increase their likelihood of being secluded or restrained, and are useful to target in reduction interventions.
- Organisational policies and workplace culture can encourage the use of seclusion and restraint.
- Exposure to seclusion and restraint can increase tolerance to its use.
- There is a need for a cultural shift in reduction approaches from an aim focused primarily on de-escalation, to an approach in which the main priority is to prevent behavioural escalation from occurring in the first place.

ONLINE NATIONAL SURVEY

Findings from the literature review informed a national survey of mental health and other nurses regarding their knowledge and perceptions regarding barriers and enablers to eliminating seclusion and restraint use in inpatient settings and emergency departments (EDs) in Australia.

The survey explored nurses' perceptions of and attitudes towards seclusion/restraint use, as well as investigating nurse perceptions regarding factors that may impact upon elimination of these practices including consumer (acuity, presenting condition), staff (attitudes) and unit (culture) factors.

The ACMHN entered into an agreement with Flinders University, under the leadership of Professor Eimear Muir-Cochrane, to undertake the survey and evaluate the results, as well as to analyse the findings for the third project deliverable, the focus groups.

Research Objectives

The research objectives were to:

1. Examine nurses' perceptions regarding the use of seclusion and restraint in inpatient psychiatric/mental health settings and Emergency Departments (ED) in Australia.
2. Examine nurses' perceptions and attitudes regarding whether seclusion and restraint can be eliminated, and perceived barriers and enablers to reducing and eliminating seclusion and restraint use in inpatient psychiatric/mental health settings and EDs in Australia.
3. Examine factors (e.g., unit culture, staff collaboration) associated with nurse perceptions and attitudes regarding whether seclusion and restraint can be reduced or eliminated.

Survey Development

The online anonymous quantitative survey was developed by the research team at Flinders University. Questions in the survey were from either previously-designed measures of attitudes to seclusion/restraint and working practices with psychiatric/mental health consumers (see Table 1 below); or based on the Flinders University team's work in the area and the Literature Review, which was provided to the researchers by the ACMHN Project Team. Participants were also asked demographic questions at the end of the survey.

Table 1: Questions were drawn from the following measures based on appropriateness and reported validity/reliability.

1	Attitudes to Containment Methods Questionnaire	Bowers et al.,	2004	Measure examines nurses' attitudes regarding seclusion/ restraint use such as perceived efficacy, safety, and acceptability. This measure measures aspects separately for seclusion, physical restraint, and mechanical restraint.
2	Staff Attitude to Coercion Scale	Husum et al.,	2008	Measures nurses' perceptions regarding seclusion and restraint use, including the extent to which these practices prevent dangerous situations, are necessary, and can be reduced.

3	Seclusion and Restraint Experience Questionnaire	Korkeila et al.,	2016	Measures nurses' experiences of seclusion/restraint use in their workplaces, including perceptions regarding overuse, alternatives to minimise use, and reasons for use.
4	Mental Health Professionals Stress Scale	Cushway et al.,	1996	Measures sources of pressure in health care professions, such as too many tasks to complete and lack of adequate staffing. We have also written items to include with MHPSS items that are likely to be positive factors in deceasing stress, such as positive ward culture, trust/confidence in colleagues, and being able to build rapport with patients.
5	Confidence in managing inpatient aggression questionnaire	Martin & Daf-fern	2006	Measures nurses' perceptions of safety in their workplace and confidence in unit policies regarding managing aggression. This measure is included since seclusion/ restraint is often employed with patients who are behaving in an aggressive way.
6	Working Environment Scale	Røss berg et al.,	2004	Measures aspects of the nurses' work environment, including opportunities to develop confidence in skills and ability to use of knowledge and experience, as well as factors such as perceptions of number of tasks that need to be completed and support from other staff.
7	Nursing Work Index-Revised	Australian) (University of Wollongong,	2009	Measures health professionals' perceptions of presence or absence of particular aspects in their workplace; for example, support services, good working relationships, continuity of care, and good communication.

The Research Team undertook an ethics approval process through Flinders University Ethics Review Committee to conduct the work. A copy of the survey questions is available by contacting the ACMHN (enquiries@acmhn.org).

The survey was disseminated/promoted over five weeks in April-May 2017. Participants were asked to complete the online anonymous survey comprising of questions related to the research topic. The survey took approximately 25 minutes to complete. Over 630 responses were collected with complete data from 533 respondents. Data were removed if respondents indicated they worked outside of Australia or solely in a service that was not an inpatient unit or emergency department (e.g., only in community mental health). This resulted in a final sample of 512 respondents. Data were then coded for subsequent statistical analysis.

The final sample of 512 nurses (71.9% female, mean age = 47.73 years) worked predominantly in adult acute inpatient units (50.20%) or EDs (21.48%). Nearly 90% of respondents were registered nurses, and approximately 70% had a mental health qualification. All states and territories were represented, with respondents working across metropolitan areas, rural, and remote zones.

Survey Findings

Specific findings of the survey were:

- Most nurses had been involved at some point in their career in the use of physical restraint (96.48%) and seclusion (95.31%), with less involved in mechanical restraint (63.48%).
- Nurses worked in units where physical restraint (92.58%) and seclusion (82.42%) were used, with nurses working less frequently in units where mechanical restraint was used (38.09%). Nearly 30% (28.13%) of nurses indicated all three methods were used on their units; and 19 nurses reported none of the methods were used.
- Seclusion, physical restraint, and mechanical restraint were seen as necessary methods to maintain safety, although they were viewed as a last resort; nurses were also aware of potential harms to the therapeutic relationship and consumer autonomy stemming from the use of these methods.
- Seclusion and physical restraint were seen as more acceptable and effective than mechanical restraint, although nurses did not hold strongly favourable views of any of the methods.
- Nurses tended to disagree that containment methods could be eliminated from their units, though mechanical restraint elimination was seen as more of possibility than seclusion and physical restraint.
- The most-commonly perceived barriers to seclusion and restraint elimination were: inadequate staffing levels; lack of staff experience, training and skills in using alternative methods; consumers being drug-affected and violent; acuity of consumers condition; and inappropriateness of the treating environment (e.g., lack of space, high stimulation).
- The most-commonly reported enablers to seclusion and restraint elimination were: strong clinical leadership; trained and experienced staff; adequate staffing levels; and staff-consumer rapport and good therapeutic relationships.
- Nurses did not believe that seclusion and restraint were overused in their units or that alternative measures were not employed as often as possible. However, they did report differences in staff attitudes regarding containment measures and individual staff members' willingness to use seclusion and restraint on their units.
- Nurses believed that seclusion and restraint were most likely to be used for consumer aggression and violence, damage to property, and when consumers were intoxicated (drug or alcohol-affected). Verbal aggression was seen as unlikely to lead to seclusion or restraint use.
- Perceptions of lack of adequate staffing and good staff role models, poor management and supervision, inappropriate physical environment, and overcrowding were seen to increase the likelihood of seclusion and restraint use.
- Rapport and empathy, knowing consumers, and a trauma-informed approach to care were seen to decrease the likelihood of seclusion and restraint use.
- Nurses reported being faced with threatening situations on their units and that they felt only somewhat safe in their workplaces. However, they were confident in their abilities to work with hostile or aggressive consumers and to enact seclusion and restraint when needed.
- Nurses felt they were able to utilise their clinical skills in their units, were trained to prevent seclusion and restraint where possible, and received support in consumer treatment from clinically-competent colleagues.
- Nurses reported limited consistency in staff caring for the same consumers from day to day, which they believed was problematic for developing a therapeutic relationship.

Examination of the relationships between attitudes towards seclusion and restraint use and workplace experiences found:

- Nurses who held stronger beliefs that seclusion and restraint were needed practices in mental health care had more favourable impressions of seclusion and physical restraint; were less concerned with their units' use of containment measures; were younger and more likely to be male; and had lower perceptions of their ability to maintain safety on the unit.
- Nurses who held greater concerns regarding seclusion and restraint use on their specific units were more concerned regarding the potential harm to consumers from these methods; perceived less need for seclusion and restraint use in mental health care; had less favourable impressions of seclusion; reported more team conflict, less team collaboration, and had less positive perceptions of management; and were more likely to be male.
- Nurses who worked in EDs compared to those working in acute adult inpatient units perceived greater need for mechanical restraint; reported experiencing greater team collaboration; and tended to hold stronger beliefs that seclusion and restraint use were needed.

Implications of Survey Findings

Findings highlight the importance to seclusion and restraint reduction and elimination efforts of:

- strong clinical leadership
- sufficient staff numbers and resources
- training, education, and appropriate resources for the use of alternative methods to seclusion and restraint that maintain staff and consumer safety
- consideration of the appropriateness of the physical environment for consumer treatment
- staff attitudes towards the use of seclusion and restraint with a focus on trauma-informed, empathic care
- team collaboration and cohesion

FOCUS GROUPS

The ACMHN was required to conduct a series of six face to face focus groups with mental health nurses, with at least one in a regional/remote location. The purpose of the focus groups was to further explore the experiences of mental health nurses, using questions developed by the Flinders University research team and Steering Committee and a Facilitation Guide developed by the Project Team.

Nine focus groups were coordinated by the ACMHN Events team and conducted in Sydney, Darwin, Canberra, Melbourne, Newcastle, Toowoomba, Perth and two via teleconference. A total of 44 mental health nurses participated in the focus groups. Senior mental health nurses who were also experienced group facilitators conducted the sessions. Facilitators were provided with a Facilitator Guide, which outlined the questions and the purpose of the session, and attended a briefing session conducted by a member of the Steering Committee to ensure facilitator consistency. All sessions were audio recorded, transcribed by a transcription company, and then analysed by the Flinders University Research Team. All respondents completed a participant consent form.

Findings from Focus Groups

Findings from the focus group discussions demonstrate significant barriers to the elimination of restraint and seclusion, although there was general support for reduction of all containment measures.

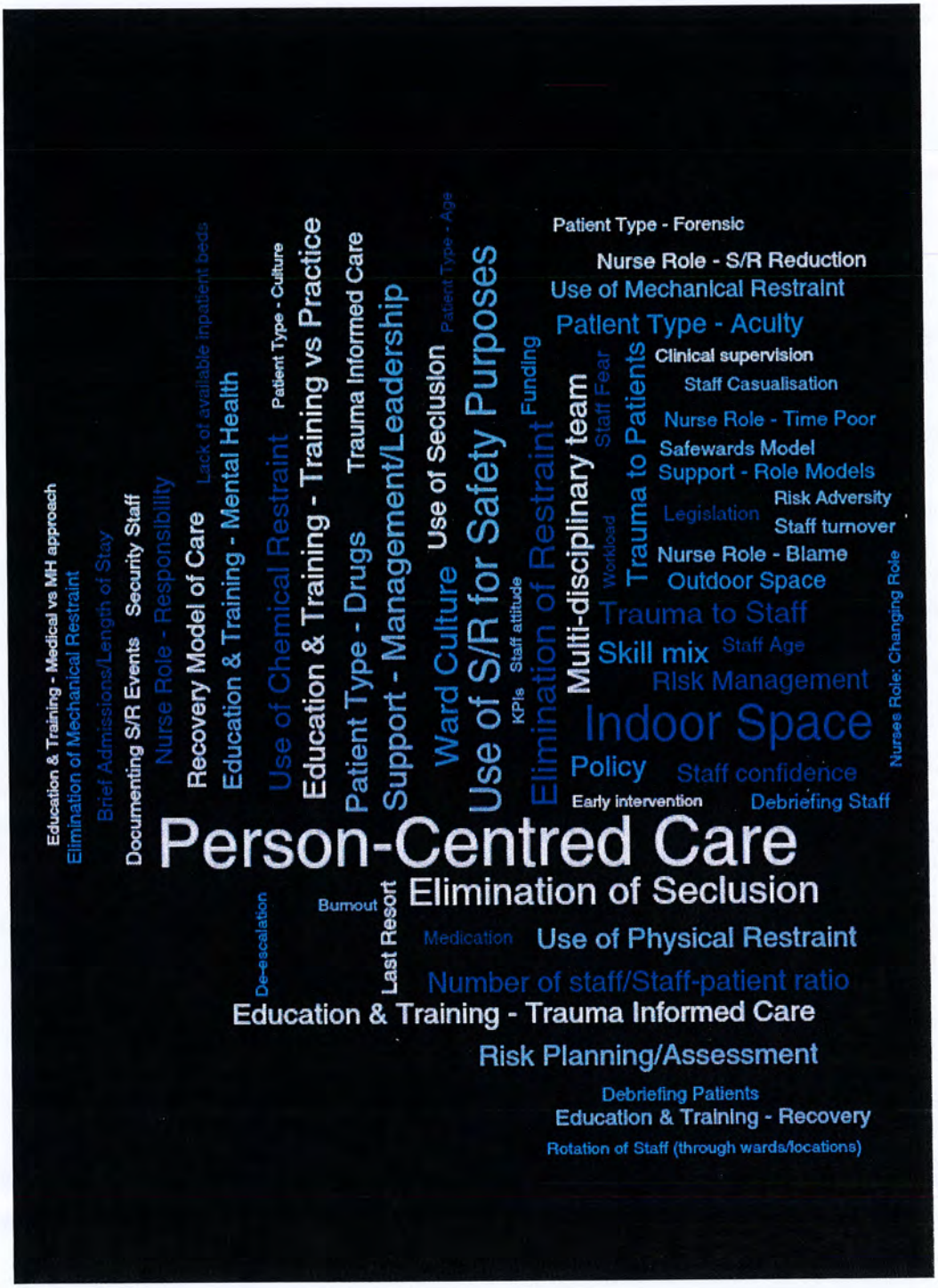
Findings are summarised below:

- Nurses saw seclusion and restraint as 'their business', used to maintain safety as a last resort, and traumatic for both nurses and consumers.
- Nurses described high levels of staff turnover, inadequate skill mix (particularly on weekends), casualisation of nursing staff positions, and an ageing workforce as factors working against seclusion and restraint reduction initiatives.
- The changing role of the nurse, with nurses being time poor, having high workloads and an emphasis on the administration of medication, affected nurses' ability to reduce/eliminate seclusion and restraint, and limited their ability to practice person centered and individually designed care.
- Nurses felt blamed and self-blamed about the use of restrictive measures.
- Physical restraint, seclusion and medication were frequently used together in aggressive and violent situations.
- Nurses perceived that high consumer acuity and consumers presenting with substance misuse-related issues (crystalline methamphetamine, in particular) contributed to the use of seclusion and restraint.
- Poorly designed psychiatric units, lack of beds, short length of stay, 'shunting' of consumers from EDs to psychiatric units were all perceived as barriers to a restraint-free environment.
- Education and training were significant enablers to reducing seclusion and restraint as was a person centered ward culture.
- Debriefing for consumers and staff was seen as a significant enabler in efforts to reduce seclusion and restraint whereas poor and incomplete documentation about restraint events was a barrier to restraint reduction.
- The presence of security staff increased perceptions of safety as well as increasing the likelihood of seclusion and restraint being used.

The ACMHN received a number of emails from individuals who were unable to attend a focus group but who wanted to express an opinion. Please see Appendix 3 for two comments that provide an insight into the experience of one nurse, and demonstrate the complexity of the situation from the nurse's perspective.

The word cloud at Figure 1 below includes a summary of the key themes to emerge from the data (note, size connotes number of responses).

Figure 1: Summary of Key Themes (note, size connotes number of responses)



Consumer and carer seminar

The ACMHN held a seminar to present the findings and implications of the project to interested consumers and carers on 16th August 2017- with opportunity to attend in Canberra (at Mental Health Australia) or via teleconference.

The seminar was promoted to consumers and carers by the National Mental Health Consumer and Carer Forum through their networks, Mental Health Australia's social media (Facebook / Twitter) and CEO Update, and via ACMHN Facebook/Twitter. Seven participants (4 face to face, 3 via teleconference) joined the meeting. Participants were provided with executive summaries of the survey focus group findings as pre-reading.

ACMHN CEO Kim Ryan introduced the project and research lead Professor Eimear Muir-Cochrane provided an overview of the research findings. See Attachment 4 for a copy of the presentation Professor Muir-Cochrane spoke to at the meeting.

A summary of general comments and feedback from participants is provided below:

- Participants acknowledged that in some ways the experiences of mental health nurses were similar to the experiences of consumers and carers in regard to potential for psychological and physical harm.
- There were strong concerns around people presenting to mental health services under the influence of methamphetamine (ICE) and the impact that those presentations have on the experience and perceptions of clinicians towards people with mental illness.
- There were concerns expressed that people who are drug affected, whether admitted to mental health services and/or detained under the mental health act, but who do not experience a mental illness (other than as a symptom of acute intoxication), increase the stigma attached to people with mental illness; for example, through reports in the media.
- There was support for the suggestion that people with drug-induced psychosis should be cared for in a drug and alcohol focused settings, not mental health settings. Entry points for drug affected people and mental health consumers should be different to each other.
- There was acknowledgment that many of the environmental constraints, such as entry points to the service, or the interior design of mental health units, were not conducive to seclusion and restraint reduction, a comment;

  > *The design of MH units with glass walls where the staff live on one side and the patients live on the other. That gets between people working with people. Where seclusion and restraint happen less often, it's because there's less 1:1 contact of nurses doing what nurses do well.*

- Participants acknowledged the complexities associated with the issue of seclusion and restraint, including, from personal experience, fear of being exposed to aggression or violence from other consumers, and fear of being contained themselves to protect them from someone who was behaving aggressively (e.g. being locked in their bedroom while someone who was aggressive was pacing up and down the hallway). Participants demonstrated a strong sense of not wanting to be secluded or restrained. It was also acknowledged that when other consumers were being aggressive or violent, they could see that at times it was about the priority of maintaining safety for all, one comment was;

There is a safety issue too, if my son is in the unit and he could be harmed by the person who is impossible to approach; you cannot reason with somebody; this is where this issue of what is the least dangerous situation, is it to hold the person down and give them an injection that knocks them out for a few hours, is that not the best outcome for the person themselves and other patients?

- Participants empathised with the difficulties staff experience when trying to move patients around to make way for consumers of high acuity, or those who are drug affected.
- There were concerns that reasonable expressions of frustration were at times responded to punitively by medical staff and nurses through the use of seclusion and/or restraint. Under staffing was seen to increase the likelihood of this occurring, a comment;

  I do believe sedation and restraint are at times done punitively not because there's a 'nursing or medical reason' to do it, not just because of under staffing.

- Participants noted the lack of options available to consumers (and mental health nurses) caused by mental health services being insufficiently staffed, which created problems that would lead to an increase in seclusion and restraint, a comment;

  Another thing is lack of options – we've made this new unit state of the art, but the options aren't being utilised. For example, there's not enough staff to supervise the gym or the table tennis room. What are the resources? What are the options?

- Participants identified skill mix as a very important component of seclusion and restraint reduction, comments were;

  It's not just about sufficient staff numbers, because it's not just about more nurses, it has to do with who is there, what their capabilities are, what their capacities are. I would endorse better staffing, not just more numbers (which is also an issue). It's the same in a surgical ward where if ¾ staff are agency nurses with a scatter of skills it makes a big difference to the outcomes for the ward than the better trained, regular nurses who know the patients. It's also about peer workers and advocates.

  On any shift you (need to) have the right mixture of skills and levels.

- There was support for the increased use of a peer workforce, comments were;

  Politics of consumer movement has been about this is what works best for us, I know what works best for me; Seclusion and Restraint is the opposite of that. We need to put more early planning into improving that.

  Peer workers and advocates on hand could provide those 45 minutes of support; some nurses try and connect with family members and support. Cup of tea with love. We are trying to reach your son, is there anyone else you'd like me to contact because you're getting really loud? Please explain to me what you need, and I will get it for you. We want to help people to help us.

- Education and training were seen as the cornerstones to reducing episodes of seclusion and restraint.
- Clinical supervision was identified as an important factor in supporting seclusion and restraint reduction and changing the culture and attitudes towards these practices, one comment was

  Example from NSW – for the Project Air project, they have put in and is being rolled out for BPD and dissociation, trauma etc. Nurses, consumers and carers that came up with model that provided

better clinical supervision for the staff and they've got a Gold Card so that those who are fitting in whatever category they identify with/frequent users – Gold Card entry clinic, so that the staff who deal with them are more consistent with the way they are dealt with. This system has reduced S&R and dramatically changed the attitudes. You can have all the training in the world, it doesn't change the system. They'll say all the right words that they are recovery oriented, but they aren't - that doesn't actually influence how they feel. Consistent debrief and supervision.

Participants were invited to identify the top issues that they would highlight as being important for moving forward with reduction and elimination of seclusion and restraint. Participants identified;

1. Addressing problems with staffing, skill mix and capability as a high priority.
2. Better training and education around trauma informed care, as well as building the knowledge and capacity required to de-escalate and intervene early where a person is distressed. It was acknowledging that increasing staff knowledge may assist in changing staff attitudes and workplace culture.

CONCLUSION AND RECOMMENDATIONS

The ACMHN appreciates the support of the National Mental Health Commission in undertaking the *Supporting mental health professionals towards cultural and clinical change: Facilitating ongoing reduction in seclusion and restraint in mental health settings in Australia* project.

A first for Australia, this research has been an important piece of work in understanding the mental health nurses' experience around the use of seclusion and restraint in Australian mental health and emergency department settings. Mental health nurses are front line workers and key decision makers around use and cessation of seclusion and restraint. Acknowledging this important role and understanding nurses' experiences is an important step in being able to further support cultural and clinical change, with the view to ongoing reduction and elimination of seclusion and restraint use in Australia.

Research results identified that person centered and trauma informed care approaches were recognised by nurses as central to nursing care, but were overshadowed by the daily exigencies of every day care with acutely unwell consumers. The first principle of trauma informed care is safety. If nurses do not feel safe in inpatient settings, seclusion and restraint reduction strategies are unlikely to be entirely successful. Careful consideration of the concerns that nurses have about safety and adequate preparation of staff to work in acute mental health/psychiatric inpatient units and in EDs (with mental health consumers) is necessary.

The working environment and the nature of symptomatology and behaviour by presenting consumers described in the findings present a clear illustration of what is currently occurring on acute mental health/psychiatric inpatient units. Acuity of consumers and the presence of people with substance misuse disorders made seclusion and restraint reduction problematic. Training and education was a core factor of which nurses were concerned, together with the poor quality of the built environment, and a need for a strong multi-disciplinary approach to aggression management on the units.

Consultation with consumer and carer participants regarding the project findings reflected the nurse participants' concerns around safety, skills mix, staffing, drug intoxication, environmental barriers and training and education.

The following recommendations respond to the findings of the survey, the focus groups and the consumer and carer consultation. Recommendations align with the six core strategies of seclusion and restraint reduction (Huckshorne 2006).

STRATEGY ONE: Leadership Towards Organisational Change

Goal: Mental health nurses need to feel safe at work.

Recommendation #1: That the National Mental Health Commission (NMHC) disseminates the findings of this report broadly across multi-disciplinary forums, to ensure that all healthcare professional groups develop an understanding of the mental health nurse experience. When this occurs, true collaboration is more likely to occur.

Recommendation #2: That the NMHC convenes an Implementation Group to address the issues and concerns raised in this research.

Recommendation #3: That the implementation group be multi-disciplinary, to ensure staff from different disciplines involved in consumer care work together to examine ways to reduce the use of restrictive practices. It is important for the multi-disciplinary team to understand the mental health nurse perspective, and that the barriers and enablers to seclusion and restraint reduction and elimination from their perspectives are understood.

STRATEGY TWO: Using data to inform practice

Goal: More effective and efficient data collection and usage.

Recommendation #4: Clinicians are provided opportunities to influence what data is being collected and have access to the data to analyse its implication strategies for reduction and elimination of seclusion and restraint practices.

STRATEGY THREE: Workforce development

Goal: The nurses have the required education, knowledge, skills and capabilities to reduce and elimination seclusion and restraint.

Recommendation #5: All nurses working in mental health settings need to be undertaking or have acquired formal post graduate mental health qualifications.

Recommendation #6: That every workplace identifies a Clinical Nurse Consultant (CNC) who is trained in trauma informed care and who acts as a champion for both trauma-informed care and seclusion and restraint reduction and elimination. This CNC could provide in-service training to staff on de-escalation techniques and engage in discussions with staff to identify how to address barriers and provide clinical leadership. A multi-disciplinary panel including consumer and carer representatives should be established to review all episodes of seclusion or restraint. The review will consider whether seclusion was appropriately used, what could have been done differently and, based on the review, provide a written report.

Recommendation #7: That the National Nursing and Midwifery Education Advisory Network (NNMEAN) support an increase in mental health theoretical and clinical content in Bachelor of Nursing degrees.

Recommendation #8: That regular clinical supervision be made available to all mental health nurses.

Recommendation #9: That mentoring and support around mental health be available to all nurses working in emergency departments.

Recommendation #10: That concerns around the ageing workforce in mental health nursing be addressed as a priority concern regarding staffing and safety in acute inpatient mental health services.

STRATEGY FOUR: Use of seclusion/restraint reduction tools

Goal: Provide alternatives to the use of seclusion and restraint.

Recommendation #11: Nursing staff need access to alternatives to seclusion and restraint. Resources need to be provided, and barriers to access resources need to be addressed. This needs to occur in every mental health service. This may also need to consider the physical environment of units.

STRATEGY FIVE: Consumer roles in inpatient settings

Goal: Consumers are actively involved in strategies to reduce seclusion and restraint.

Recommendation #12: That consumer and carer representatives are included on all review panels.

STRATEGY SIX: Debriefing techniques

Goal: Nursing staff are educated and trained in de-escalation and debriefing techniques.

Recommendation #13: Nurses in emergency departments need training around de-escalation and trauma informed care. This needs to be regularly reinforced in all services nationally.

In summary, clinicians, consumers, carers and industry stakeholders are now tasked with how to use these new understandings in a collaborative quest to reduce restrictive measures, with the aim of ultimate elimination and maintaining quality care in a safe environment. Investment needs to be made in staffing, the environment and education, with strong management/leadership, and support to embed person-centred and trauma informed care into a nationwide least restrictive practice initiative.

Knox et al (2012) offer a final useful comment to consider regarding seclusion and restraint reduction initiatives. These authors contend that psychiatric emergency services and acute inpatient psychiatric units are focused on the treatment of very acutely unwell patients often presenting with substance misuse as well as mental health problems. For those reasons, it may not be possible to entirely eliminate seclusion and restraint. However, reduction programs can reduce utilisation rates significantly.

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APPENDIX ONE: Timeline of policy activity around seclusion and restraint reduction

2005

In 2005, Australian Health Ministers endorsed the *National safety priorities in mental health: a national plan for reducing harm*, which identified four priority areas including reducing use of, and where possible eliminating, restraint and seclusion.

2008

A 2008 report *Best practice in the reduction and elimination of seclusion and restraint* by Te Pou in New Zealand[1] noted that researchers have been able to consistently report best practices based on successful seclusion and restraint minimisation efforts. These reflect USA literature and include:

- A national direction supporting seclusion and restraint reduction and elimination.
- Active, committed and high profile organisational leadership and oversight, and an organisational culture that demonstrates recovery oriented approaches.
- Workforce development encompassing recruitment, education, supervision and staff involvement initiatives.

Other methods also include:

- Service user development and participation,
- Milieu (i.e. setting and environment) management and use of practical tools, such as engagement in meaningful activities, an atmosphere of listening and respect, de-escalation and sensory modulation, and
- Effective debriefing and collection and use of information.

2009

The National Mental Health Consumer & Care Forum (2009), highlighted six key strategies to end seclusion and restraint:

1. Better Accountability – a measure to monitor the rate of involuntary seclusion and restraint in Australia and be established under national plans.
2. Implementation of evidence based approaches to ending seclusion and restraint.
3. Adherence to standards and public reporting – regular monitoring of the application of relevant standards.
4. Support for mental health professionals towards cultural and clinical practice change.
5. Better Care Planning – consumers have individual and holistic assessments and are involved in the development of their own care plans.
6. Review Relevant Mental Health Legislation- assess the compatibility of each jurisdiction's mental health legislation and policy to ensure consistency with international law protecting the rights of people with disabilities.[2]

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1 O'Hagan, M, Divis, M, and Long, J (2008), Best practice in the reduction and elimination of seclusion and restraint; Seclusion: time for change. Auckland: Te Pou Te Whakaaro Nui: the National Centre of Mental Health Research, Information and Workforce Development.

2 National Mental Health Consumer and Carer Forum (2009), Ending Seclusion and Restraint in Australian Mental Health Services. NMHCCCF.

2013

In 2013, the National Mental Health Commission (NMHC) undertook a project *Reducing Seclusion and Restraint* to look at best practice in reducing and ultimately eliminating the seclusion and restraint of people with mental health issues and to help identify good practice approaches.

A number of focus groups were held as part of this project. Participants were recruited via an invitation to participate through contacts in each State and Territory, with a maximum of ten participants for each focus group. In each location, one of the focus groups consisted of carers, families and support persons who have experienced a family member or person close to them being secluded or restrained. The other focus group consisted of adults with lived experience of mental health service provision that has included seclusion and/or restraint.

The questions posed to the focus groups were designed to be consistent across the groups. Participants were asked about preferred methods and strategies for reducing or eliminating seclusion and/or restraint, how they would define seclusion and restraint and what constituted 'poor' practice. (Reduction of Seclusion and Restraint Project Report 2014).

A resulting NMHC position statement states:

> *The Commission...promotes the need for shared ownership from people, services and industry to work together to achieve the reality of the reduction and ultimate elimination of seclusion and restraint in mental health services.*

In the NMHCCF position statement, together with the NMHC project and in other national and international literature (see Research summary below), the importance of ward/organizational culture and attitudes of staff are key factors influencing the use, reduction and ultimate elimination of seclusion and restraint. This project will therefore particularly focus on cultural (attitudinal and clinical) change as an important driver to support the continued reduction of seclusion and restraint in Australian mental health services.

Reduction of seclusion and restraint has been demonstrated to be possible. The main barriers to reducing seclusion and restraint include:

- Lack of identified good practice/agreed clinical standards;
- Insufficient quality improvement activity and clinical review;
- Inappropriate use of interventions and variation in practice;
- Varying levels in staff knowledge or skills for preventing use and identifying alternative interventions, and appropriately triage mental health presentations;
- Limited availability of staff training and knowledge on early warning signs of agitation and interventions to prevent using seclusion and restraint;
- Limited access to staff education and training; and
- Limited availability of resources and poor facilities.[3]

3 The Royal Australian and New Zealand College of Psychiatrists (2010) Position Statement 61, Minimising the use of seclusion and restraint in people with mental illness, June 2010.

The available literature and position statements from other relevant mental health organisations consistently identify particular factors or strategies to reduce seclusion and restraint, which include:

- National direction and oversight
- Cultural change and organisational leadership
- Physical changes to the environment
- Using data and research to inform practice
- Supporting the workforce, including training and care planning
- Involving consumer, family and carers
- Reviewing relevant legislation[4 5 6 7]

The NHMC position paper on seclusion and restraint discusses the USA National Association of State Mental Health Program Directors (NASMHPD) training curriculum, which has been used in sites around the world including New Zealand. The training curriculum describes six core strategies to reduce the use of seclusion and restraint:

- 'Leadership towards organisational change' – outlining a philosophy of care that targets reductions in seclusion and restraint
- 'Consumer roles in inpatient settings' – having an inclusive approach that involves consumers, carers and other advocates in reduction initiatives
- 'Using data to inform practice' – using data to review, analyse and monitor patterns
- 'Workforce' – developing procedures, practices and education that promotes recovery and seeks to understand the underlying cause/s of the violent and aggressive behaviour
- 'Use of seclusion and restraint reduction tools' – assessments and other resources to develop individual aggression prevention approaches
- 'Debriefing techniques' – analysing why seclusion and restraint events occurred and evaluating the impacts on individuals with lived experience, families and carers and service providers.[8]

4 American Psychiatric Nurses Association (2014), Position Statement: The Use of Seclusion and Restraint, Original 200, Revised 2007, Revised 2014.
5 National Mental Health Commission (2015), A case for change: Position Paper on seclusion, restraint and restrictive practices in mental health services. NMHC, Australian Government, Canberra.
6 National Mental Health Consumer and Carer Forum (2009), Ending Seclusion and Restraint in Australian Mental Health Services. NMHCCCF
7 The Royal Australian and New Zealand College of Psychiatrists (2010), Position Statement 61, Minimising the use of seclusion and restraint in people with mental illness, June 2010.
8 National Mental Health Commission (2015), A case for change: Position Paper on seclusion, restraint and restrictive practices in mental health services. NMHC, Australian Government, Canberra.

The NMHC's recommendation in their position paper on seclusion and restraint outline a course of action to reduce and ultimately eliminate seclusion and restraint:

- Educate mental health practitioners about multi-intervention strategies.
- Agree to uniform definitions, targets and reporting frameworks.
- Ensure seclusion and restraint practices and interventions are evaluated.
- Adopt a national approach to the regulation of seclusion and restraint.[9]

9 Ibid

APPENDIX TWO: ACMHN Position Statement on Seclusion & Restraint (2016)

It is the position of the Australian College of Mental Health Nurses (ACMHN) that:

- In order to succeed in reducing/eliminating seclusion and restraint, the prevailing attitude must be (or become) one that considers an incident of seclusion or restraint as a 'failure in care'
- The use of seclusion and restraint...in all mental health services settings is a harmful practice that is traumatic for consumers, their families as well as staff, which should be reduced and ultimately ended.
- Restrictive practices are never 'therapeutic', should ultimately be considered a 'treatment failure', and only implemented as a last resort. They should never be used for the purposes of punishment, discipline, negative inducement, coercion or staff convenience, or where less restrictive practices are accessible and achievable.
- 'Last resort' means that all other less restrictive therapeutic interventions have been tried and failed, and there is imminent danger to self/others and safety needs to be maintained.
- The following principles guide action on seclusion and restraint:

  1. The least restrictive intervention possible must be used during the crisis

  2. In the event where seclusion and/or restraint become necessary, safe and approved techniques must be used at all times, and these must only be implemented by competent, trained mental health nurses or staff.

  3. Consumers have the right to be treated with dignity and respect, in a culturally appropriate manner and have their choices respected. Staff must act to maintain the person's dignity and emotional wellbeing at all times.

  4. The person's physical needs must be met – for example, access to food and drink, access to a bathroom.

  5. All legal requirements must be met (e.g. relating to duration of the intervention) as well as monitoring, assessment and review, including medical assessment and physical observations.

  6. The person needs to understand under what circumstances the restrictive practices will be discontinued, and these practices need to be discontinued at the earliest possible time. After such occurrences a review should be undertaken with the consumer, carers and/or family and staff involved, to diminish the harmful and traumatising effects that seclusion can have.

- Efforts to reduce and eliminate seclusion and restraint must be led by government at the national, state and territory level in Australia to achieve agreement on: o definitions on seclusion and restraint; o consistency in legislation; o targets and reporting frameworks for consistent data; and o a national approach to the regulation of seclusion and restraint. This will enable consistent monitoring of seclusion and restraint and assist in researching evidence-base prevention and management of behavioural emergencies and alternatives to seclusion and restraint.
- There must be research into examining evidence-based practices on the prevention and safe management of behavioural emergencies and alternatives to seclusion and restraint.
- Mental health services must provide safe and supportive environments for consumers receiving care and mental health nurses and all staff providing care. Consumers, carers and families must be collaboratively involved in developing policies and processes on dealing with behavioural emergencies.
- The culture of an organisation has a significant impact on the processes used and there must be shared ownership among leaders to create a work environment that supports ending seclusion and restraint to enable this to be realised.

- Mental health nurses must be supported by mental health service administrators and nursing leaders, through access to and provision of:

    o appropriate training in de-escalation techniques and critical incident management

    o opportunities to implement alternatives to seclusion and restraint

    o implementation of changes to the physical environment wherever possible, to provide a calming milieu and access to quiet, safe spaces for consumers who are distressed

    o policies, procedures and adequate staffing levels to prevent and manage behavioural emergencies and implement alternatives to seclusion and restraint

- Mental health nurses play a central in the provision of mental health care in all settings, and therefore have a crucial role in reducing, and ultimately ending, the use of seclusion and restraint. This requires nurses to take leadership in changing the organisational culture of mental health service settings, and demonstrate a commitment to implement recovery oriented approaches and alterative techniques to seclusion and restraint practices.

- The ACMHN supports the NMHC Seclusion and Restraint Declaration and the principles it articulates.

APPENDIX 3: ONE NURSES' STORY

The following comments were emailed to the ACMHN by an individual who was unable to attend a focus group but wanted to express an opinion. We had a number of members who responded in this way. The following comments outline the complex nature of the mental health nurse experience and reflects a common experience of respondents to the survey and focus group- that of exposure to violence in the workplace and the concern around safety for all:

COMMENT 1: "Firstly thank you for giving me the opportunity to have a say. Secondly, I would just like to apologise for my long winded response. I have never put pen to paper like this before and I only write as I talk. I am no academic, but I am honest and I am passionate about my job and the people I care for and work with. I love my job as much now as I did when I first started. So here goes-

I have work in mental health now for near 41 years. I trained in a Hospital when it was basically custodial care and we were still using straitjackets. I have seen many changes over the years particularly with medications which has obviously been for the better. I have been around for the changes with the Richmond report, the Burdekin report, the changes to the Mental Health Act, the training of nurses from Hospitals to University, basically I have seen the lot. I have worked in 3 area Mental Health Services. I have watched nurses come and go, doctors come and go, Directors come and go, and so on.

I have seen over the years many uses of seclusion. Many in my 41 years I have to admit were unwarranted and in some units at times very over used. These days and more recently over the past 5-10 years I have seen it used less and less which is a good thing. I am a very strong advocate for the patient and will not support any use of seclusion unless it is absolutely warranted. I believe if we are doing a good job we will see in 99% of cases the potential for aggression/violence, and we should have the skills to be able to de-escalate or use least restrictive interventions to prevent the use of seclusion.

However, I believe, there will always need to be the use for that 1% where even if it is identified early enough, the intervention that we have used is not enough at the time.

For example- A 6' 5" young fit male patient ripped the metal hinge off the back off his bedroom door, and started smashing the wall and the unit up threatening to take the heads off other patients and staff if anyone came near him. Security attended and were going to attempt to take him down. My decision was no – as someone would have got hurt as he was still swinging the mental bar at us. Police were called to assist, and had to use the police dog to enable them to disarm him. The man was carried to seclusion by Police and security, and given rapid sedation. He needed to be transferred to a higher security area for everyone's safety. This male patient took weeks to recover, but no-one got hurt. It is the rare occasions like this that I believe seclusion is needed. These times are rare, but not to have a safe place to put people when they are like this is going to place staff and patients at a higher risk then they already are.

We definitely need to be looking at ongoing education at learning how to de-escalate earlier rather than later. We need to be looking at education further for using other least restrictive interventions, for e.g. 1:1 nursing, sitting with the patient in a quite area that is non-threatening and so on, but to eliminate seclusion completely in my view is going to be potentially a dangerous move.

These are my personal views and again thanks for the opportunity to be able to put these forward."

COMMENT 2: "We are getting a new unit in approx. 2 years, but it still will not address how we can avoid seclusion for the very aggressive patient. In the past 8 years or so I believe that there have been 3 serious and dangerous incidents where we have had to use seclusion...on one occasion a male affected by drugs picked up a very heavy exercise bike and smashed it through the nurses station window. We had 3 females on duty and 1 HSA. You can only imagine the fear. They retreated and a duress was instigated but also due to the aggressive patient the Police were called and he was initially placed in seclusion and rapid sedation used. He was sedated and transferred to a higher secure unit. The other was more recently- a patient from London that no one knew...we had no history except from his mother, who said "he wants to kill people when unwell, he is very dangerous". He became unwell when holidaying with his mum and wanted to kill her. She was fearful and he was bought in by Police. He was pacing and stating he was going to kill someone. We attempted to de-escalate and security were on hand. I was able to give him IMI sedation after oral did not work. He was in his bedroom and security were just in general conversation with him while we were waiting for sedation to have effect when he lunged at a security officer and attempted to choke him. He was restrained by the other security officers and Dr said to place him in seclusion which I believe was the right decision in this case as other patients were being exposed to this and he was still very aggressive threatening still to kill us. While in seclusion he did not settle and almost broke the seclusion door to which security had to lean up against while we waited for Police to arrive to assist. He was unable to be de-escalated by Police and eventually they had to do a take down with assistance from Security. He was also transferred when safe to a higher secure unit. I am sorry this is long winded but these examples are ones that I believe needed to be place in seclusion, for everyone's safety. There have been times though when other staff have used it inappropriately and we have discussed this, and hence our use of seclusion has been reduce dramatically and hopefully will continue to do so."