Title	Restrictive Practice Reduction Policy	Reference Number	C.O.P/Rule
Owner	Laura Scully D.O.N/A	Version	V 1
Author	Restrictive Practice Oversight Committee	Effective From	02/04/23
Approved By (LEAD)	Dr Christina Mc Grady (Clinical Director)	Review Date	02/04/26
Approval Date	02/04/23	Page	Page 1 of 12

Title: **Policy - Restrictive Practice Reduction**

Scope: DNC-MHS

Reviewed By: Restrictive Practice Committee - 2023, Mental Health Service Management Team – 2023.

Owner: Laura Scully D.O.N/A

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Date: 19th May 2023.

Approved by (LEAD): Dr Christina Mc Grady (Clinical Director)

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Date: 19th May 2023.

Document Control	
Master Copy or Controlled Copy	

Document History			
Changes to this document in different versions must be detailed below. Rationale for any changes should also be given			
Version Number / Name of Document	**Type of Change – i.e. Legislative / Claim / Complaint / Incident Review / Best Practice**	**Date**	**Details of Change**
V01 – 2023	Original Doc	January 2023	Original Doc

1.0 Statement

Within the context of acute mental health care, a Restrictive Practice Reduction Policy (RPRP) should be central to the strategic management of the Approved Centre and embedded as an integral part of the way all staff work on a day to day basis. This will ensure there is an overarching framework of responsibility at every level.

Dublin North City Mental Health Service (DNC-MHS) (RPRP) has been informed by the work of the Mental Health Commissions 'Seclusion and Restraint Reduction Strategy 2014'. DNCMHS recognises the inherit rights of a person to personal dignity and freedom in accordance with national and international human rights legislation. Seclusion, Physical Restraint and Mechanical Restraint are only permitted in rare and exceptional circumstances.

This policy addresses the compliance requirements of the Mental Health Commission (MHC) that every approved centre must have a Restrictive Practice Reduction Policy (2023).

Related policies / documents:

A) Revised Rules governing the use of Seclusion and Mechanical Means of Bodily Restraint (2022)

B) Addendum to the Rules Governing the use of Seclusion and Mechanical Means of Bodily Restraint (2011)

C) Mental Health Act (2001) – Section 69(2)

D) Judgement Support Framework (2020)

E) Mental Health Commission – Seclusion and Restraint Reduction Strategy (December 2014)

F) Associated policies include policy on:

Physical Restraint

Seclusion

Staffing

Premises

Mechanical Restraint

Additional Risk Management

Clinical Risk Assessment and Management

Incident Reporting

2.0 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.

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.

Debriefing: A person-centred structured process involving the person who was restrained and/or secluded and member of their Multi-disciplinary Team (MDT), which offers an opportunity to:

- Talk about the feelings, reactions and circumstances surrounding a person's experience of restraint and/or seclusion from their perspective
- Discuss alternative de-escalation strategies that could be used to avoid the use of restrictive interventions
- Discuss the person's preferences in the event where a restrictive intervention is needed in the future

De-escalation: The use of techniques (including verbal and non-verbal communication skills aimed at defusing anger and averting aggression.

Person Centred: Person centred focuses on the needs of the person, ensuring that the persons, preference, needs and values guide clinical decisions or support and providing care that is respectful and responsive to them.

Physical Restraint: The use of physical force (by one or more persons) for the purpose of preventing the free movement of a person's body where he or she poses an immediate threat of serious harm to self or others.

Positive Behaviour Support: Involves assessments that look beyond the behaviour of a person and seek to understand the caused or triggers of the behaviour.

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.

Restrictive intervention :Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patients movement, liberty and or/freedom to act independently in order to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is taken

Restrictive Practice Reduction Programme: Multi-component action plans, which aim to reduce the use of restrictive interventions

Seclusion: " 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."

(Revised Rules governing the use of Seclusion and Mechanical Means of Bodily Restraint, 2022).

Trauma Informed Care: 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 reset traumatising or re-traumatising persons using mental health services or staff.

Person: In keeping with the language of a recovery orientated approach the term person refers to patients, residents and persons admitted to the approved centre.

"For the purpose of Section 69 of the mental Health Act 2001 a "patient" refers to a person to whom an admission or renewal order relates" ",... and a voluntary patient as defined by the 2001 Act".

(Revised Rules governing the use of Seclusion and Mechanical Means of Bodily Restraint, 2022)

3.0 Responsibilities

3.1 This policy applies to all staff working in DNC-MHS

3.2 This policy applies to all persons availing of DNC-MHS

4.0 Leadership

4.1 Leadership as noted by the Mental Health Commission (MHC, 2014) denotes "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 fundamental in achieving reductions in seclusion and restraint use (MHC, 2014).

4.2 Dublin North City Mental Health Service (DNC-MHS) is committed to minimising the use of seclusion and all forms of restraint within the service and is leading this through the local Oversight Compliance and Operations Committees within each approved centre.

4.3 The content of this policy, agreed actions and subsequent updates will be effectively communicated by the senior management team and members of the oversight/compliance committee, to those working in their respective areas / DNC-MHS Approved Centres.

4.4 The Oversight Compliance and Operations committee will communicate to the senior management team through the nominated lead, the recommendation to reflect the commitment to the reduction of restrictive practice within the mission, vision and philosophy of care statements of the approved centres of DNC-MHS.

4.5 DNC-MHS is committed to developing pathways which allow for person's/their designated representatives/family members to express their views and opinions on restrictive practices and their reduction.

4.6 DNC-MHS is committed to creating processes that facilitate staff in providing feedback, comments, ideas, recommendations and concerns to the restrictive practice working group.

4.7 DNC-MHS is committed to networking with other mental health services nationally and to the provision of training and education on this policy so as to facilitate best practice.

5.0 Engagement

5.1 A holistic person-centred approach will be used to meet the person's needs that are unique and individualised to them and their situation.

5.2 All staff should demonstrate a positive attitude and work from a trauma-informed care perspective while developing a trust-based relationship when communicating with others.

5.3 Upon admission and orientation to the Approved Centre, clear expectations routines and rules are explained.

5.4 Individual Care Plan(s) should reflect, record and outline the care and treatment planning of any restrictive practice measures.

5.5 De-escalation strategies that identify a person's coping mechanisms should be collaboratively established.

5.6 Any written information provided should use plain language, be inclusive and culturally sensitive.

5.7 Ensure that staff interaction with people is through daily positive engagement such as providing/involvement of recovery-orientated therapeutic programmes, a positive behaviour support approach that may include the use of positive behaviour support plans, ward/unit community meetings, engagement in individual treatment goals and 1:1 de-escalation interventions where applicable.

5.8 Debriefing of the person must be carried out if a restrictive intervention takes place (Please see debriefing section) below.

5.9 People with lived experience, should be recruited as advocates to promote the development of Restrictive Practice reduction within the service and have access to the Irish Advocacy Network/Peer Advocacy in Mental Health.

5.10 In the unforeseen circumstance that a person is admitted to an approved centre under the age of 18 years, they must be provided with information regarding the Youth Action Project (YAP).

6.0 Debriefing

6.1 The Person - Restrictive Practice Review and Re-Integration to the Ward

6.1.1 Following a period of seclusion and/or restraint the person should be supported in the process of re-integration to normal ward/unit activities. A member(s) of the treating team should facilitate this process.

6.1.2 The person who was restrained and/or moved to seclusion must be sensitively debriefed after each episode of seclusion and/or physical/mechanical restraint. The debrief should be conducted by someone not directly involved in the occurrence (where possible).

6.1.3 The debrief must take place as soon as it practicable (within 2 working days), but in all instances should be at a time that the person can fully engage in the process; their capacity and mental functioning

should be considered. The person's preference for the timing of, and who should conduct the review should be considered.

6.1.4 The person who was restrained and/or secluded will be encouraged and facilitated to have a nominated support person accompany them to the debrief session.

6.1.5 The clinical rationale for the use of seclusion and/or restraint should be explored with the person and their experience of it where possible.

This discussion should include where possible the following:

6.1.5.1 Does the person understand why they were secluded and/or restrained?

6.1.5.2 What factors lead up to the seclusion and/or restraint episode in the person's opinion?

6.1.5.3 An explanation of the decision-making by staff which considered the intervention(s) necessary, and the opportunity for the person involved to respond.

6.1.5.4 How does the person who was restrained and/or secluded feel about the necessity, reasonableness and appropriateness of the use of seclusion and/or restraint?

6.1.5.5 How does the person feel now, after the event?

6.1.5.6 How can the need for any further episodes of seclusion and/or restraint be avoided in the future?

6.1.5.7 If the episode has had a negative impact on the therapeutic relationship between the person and staff, how best can it be resolved?

6.1.5.8 The outcome of the discussion should be documented in their individual care and treatment plans. The views of the person who was restrained and/or secluded about the episode should be documented in their clinical notes.

6.1.6 Within 5 working days or at the earliest opportunity after seclusion has ended, a Multidisciplinary Team review of the episode of Restrictive Practice must occur in order to process aspects of the experience and learn from it. The review should assess the following:

6.1.6.1 Triggers/antecedent events and early warning signs for the behaviour that resulted in restraint and/or seclusion being initiated.

6.1.6.2 Least restrictive or alternative intervention(s) attempted.

6.1.6.3 Missed opportunities for earlier intervention.

6.1.6.4 Identification of alternative de-escalation strategies.

6.1.6.5 De-escalation preferences of the person and safety planning measures identified.

6.1.6.6 Assessment of factors in the physical environment that may have contributed to the episode of restrictive practice.

6.1.6.7 Actions to eliminate or reduce future restrictive practices for the person e.g. the development of a positive behaviour support plan.

6.1.7 Every attempt is made to identify what factors contributed to the behaviour which resulted in seclusion, what knowledge was unknown or missed, how to reduce the risk of it re-occurring in the future, and impact on the therapeutic relationship between the person and staff.

6.2 Other Persons on the ward/unit

6.2.1 Post-incident debrief is available to both staff and other people. Psychological support should be facilitated for all other persons on the ward/unit who were not involved in the incident but may have been negatively affected.

6.3 Staff

6.3.1 Following a period of restraint and/or seclusion, staff members should be supported to process the events before, during and after the episode with a senior member of staff.

6.3.2 Any member of staff who requests support post an episode of restraint and/or seclusion should be advised of, and if appropriate referred to, organisational support mechanisms in place, such as - the Employee Assistance Programme. Local debrief and support is available through line management.

6.3.3 Staff are supported to critically appraise their actions and feelings regarding an episode of seclusion and/or restraint. Establishing what worked well should be reviewed, as well as, what did not work well and what alternatives might be tried in the future.

6.4 The Organisation

6.4.1 The organisation will support the debriefing of each person and staff following an episode of Restrictive Practice

6.4.2 The organisation will arrange and support appropriate training in trauma-informed care to staff working in the Approved Centre who may be involved in Restrictive Practice.

6.4.3 Episodes of restraint and/or seclusion are reviewed to identify measures which might prevent re-occurrence.

6.4.4 Quaterly organisational reviews should occur to identify preventive and/or quality improvements.

6.4.5 The organisation will support environmental changes identified as contributing to restraint and/or seclusion where possible.

7.0 Data

7.1 The incidents of violence, harassment and aggression are managed using the approved centre's Additional Risk Management Policy, Clinical Risk Assessment and Management Policy and Incident and Management Reporting and Management Policy, which is in line with the HSE Incident Management Framework 2020. The incidents are reviewed and the learning from the incidents are shared across the service and actions are taken to prevent the re-occurrence of similar incidents. The approved centre will ensure that the use of restrictive interventions are reduced to the lowest level possible.

7.2 The multi-disciplinary Oversight Compliance and Operations committee will meet quarterly to analyse in detail every episode of restrictive practice. The Restrictive Practice Lead for the approved centre together with the Mental Health Act Administrator will produce a report which is made available to the staff in the approved centre to promote continuous learning and awareness. This report should be made available to the Mental Health Commission upon request.

7.3 The Mental Health Act Administrator will maintain a database for physical/mechanical restraint and seclusion episodes and this data is used to compile an overall annual report. This annual report signed by the Registered Proprietor of the approved centre is made publicly available on the Registered Proprietor's website within six months of the end of the calendar year.

8.0 Environment

8.1 Therapeutic Environment

8.1.1 DMC-MHS has established a therapeutic engagement committee whose primary function is to review and improve the therapeutic environment in the approved centre.

8.1.2 The environment should take in account each person's needs that includes safety, privacy, dignity, gender, cultural-sensitivity, sufficient physical space, social and spiritual expression and sensory needs.

8.1.3 The environment should promote a recovery oriented approach that embodies an atmosphere of listening, attentiveness and respect.

8.1.4 The therapeutic environment should include staff, persons and designated contacts input and experiences, working collaboratively in the design and development of treatment programmes.

8.1.5 The therapeutic environment should provide programmes that offer occupational, social, sensory integration, creative expression and recreational activities, which provide structure, routine and predictability on a daily basis.

8.1.6 The therapeutic environment should provide facilities for people that may have mobility, orientation, visual or hearing impairment or other special needs.

8.1.7 The environment should have information provided in plain English and provide interpretation services as required.

8.2 Physical Environment:

Recent literature recognises the importance of the physical environment in supporting the reduction of restrictive practices and facilitating better outcomes in mental health settings.
DNC-MHS is committed to optimising the physical environment conductive to reducing restrictive practice. To reduce the association between de-escalation and seclusion, there is access to separate rooms that are designated for 'time out' or space(s) that can assist people if they require the practice of 'self-calming' or sensory integration.

9.0 Regulation

9.1 DNCMHS are committed to ensuring there is full compliance with all requirements of the Mental Health Commission (MHC) revised Codes of Practice and Rules (2022). As per the MHC regulations and recommendations there is an identified lead for restrictive practice reduction in the approved centre.

9.2 The approved centre has reviewed and updated its policies on the use of Seclusion, Physical Restraint and Mechanical Restraint incorporating recovery focused, trauma informed practices including the procedural changes outlined in the Rules and Codes of Practice effective from January 1st 2023.

9.3 Greater emphasis has been placed on therapeutic interventions, the therapeutic environment, co-production of individualised care planning, de-escalation and debriefing.

9.4 The Oversight Compliance and Operations Committee is tasked with monitoring all episodes of restrictive practices and meet on a quarterly basis. Where appropriate areas for improvement are identified and documented by means of an action plan.

9.5 There is regular audits on episodes of restrictive practice and data is collated to inform practice.

9.6 Workforce development has been prioritised to include a review of the existing training programmes and the edition of new training programmes such as trauma informed care.

10.0 Staffing

10.1 The Quality Framework for Mental Health Services in Ireland stresses that the skills, expertise and morale of staff are key factors in the delivery of a quality mental health service. Staff are pivotal to achieving the successful implementation of this policy and there must be multi-disciplinary collaboration in the development and implementation of service specific initiatives and plans.

10.2 Staff should be supported emotionally and psychologically through appropriate structures and processes that do not unintentionally re-traumatise or re-trigger.

10.3 Front line staff are an essential part of all decision-making and safety planning processes and are central to the co-production of care planning with those who use our service.

11.0 Education

11.1 Appropriate training, reflection and supervision is essential for ensuring staff are continually equipped with the necessary skills. Helping develop the workforce in trauma-informed practice is a priority of the service. The importance of ensuring staff are equipped with good de-escalation skills is a key priority for induction and on-going continuous professional development.

11.2 All staff within DNC-MHS involved with Restrictive Practice should be familiar with this policy, the rules, associated policies and documents as detailed in the introduction of this policy.

11.3 It is the responsibility of the DNCMHS management team to ensure that this policy, procedures, training and associated processes and implementation regarding restrictive practices are implemented throughout the DNCMHS. The mandatory nature of this policy, rules and training will be conveyed to all staff.

11.4 Each Head of Discipline is required to ensure that all staff within their respective remit are trained in restrictive practice reduction strategies.

11.6 Mandatory training includes TMVA (Therapeutic Management Violence and Aggression) or CPI Safety Intervention Training formerly known as MAPA as appropriate

11.7 There will be a greater emphasis on staff receiving training in prevention approaches which may include: -

- 11.7.1 Trauma Informed Care
- 11.7.2 Cultural Competence
- 11.7.3 Human Rights Training including the legal principles of restrictive practice
- 11.7.4 Positive behaviour support including the identification of causes or triggers of the person's behaviours, including - social, environment, cognitive, emotional or somatic
- 11.7.5 All relevant HSEland modules including:
  - 11.7.5.1 Module 1: Changes to the Rules and Code of Practice on Restrictive Practices
  - 11.7.5.2 Module 2: Changes to the Rules on Seclusion
  - 11.7.5.3 Module 3: Changes to the Code of Practice on Physical Restraint
  - 11.7.5.4 Module 4: Changes to the Rules on Mechanical Restraint

12.0 Document Control

12.1 Where copies of policies and procedures are required, these shall be treated as controlled documents and stored centrally in hard copy folders where they are accessible for all staff.

13.0 Communication

13.1 It is the responsibility of the heads of each discipline to ensure their staff are aware of the Restrictive Practice Reduction policy / procedures, understand the documentation, and have signed the policy to demonstrate this.

13.2 The Heads of Discipline shall maintain a record of this communication with staff.

14.0 Document Availability

14.1 This policy and procedure shall be made available to all relevant staff via the Controlled Policy and Procedure Document Folder.

14.2 A controlled copy of this policy and appendices shall be made available in hard format on each ward/unit of the Approved Centre. This copy will be in a central location for ease of access.

15.0 Audit and Evaluation

15.1 This policy shall be reviewed at a minimum every three years or as required

15.2 Seclusion and Physical Restraint audits shall be conducted by the frontline staff of DNCMHS and reviewed at the Oversight Compliance and Operation Committee to ensure that compliance is maintained with the policies, procedures and processes.

15.3 An annual report on reduction strategies within the Approved Centre is completed and opportunities for improvement of the practice and any future learning are disseminated. This requirement is the responsibility of the DNCMHS management team. This annual report will be forwarded and made available for the Mental Health Commission.

16.0 References

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Gaskin, C.J., Elsom, S.J. and Happell, B. (2007) Interventions for reducing the use of seclusion in psychiatric facilities Review of the literature. British Journal of Psychiatry. 191. 298-303.

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