Submission to the NSW Government

Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities

Australian College of Mental Health Nurses
Mental Health Seclusion Review  
c/o Mental Health Branch  
NSW Ministry of Health  
North Sydney NSW 2059

The Australian College of Mental Health Nurses (ACMHN) welcomes the opportunity to provide a submission to the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities.

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1. Our Organisation

The Australian College of Mental Health Nurses (ACMHN) is the peak professional organisation representing mental health nurses in Australia. A primary objective of the ACMHN is to enhance the mental health of the community through the pursuit of efforts to improve service and care delivery to those affected by mental illness and disorder. The ACMHN also sets standards of practice for the profession and promotes best practice in mental health nursing.

As the peak professional organisation for mental health nurses in Australia, ACMHN has been involved in a range of activities focusing on achieving reduction and ultimate elimination of seclusion and restraint, including:

- Conducted a project commissioned by the National Mental Health Commission as part of the National Seclusion and Restraint Project (outcomes to be finalised)
- Development of the Seclusion and Restraint Position Statement and Background Paper
- Signing the National Mental Health Commission Seclusion and Restraint Declaration
- Published articles on seclusion and restraint

2. Introduction

The ACMHN acknowledges the Terms of Reference (TOR) for the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities. This submission will focus on a number of key issues that are relevant to the TOR:

- Nurses’ perceptions of seclusion and restraint and the barriers and enablers to reducing seclusion and restraint
- Current approaches to seclusion and restraint
- Limitations of the current NSW Health Policy on Aggression, Seclusion and Restraint in Mental Health Facilities
- The qualifications, skills and experience of the nursing workforce in providing evidence-based, high quality mental health care to consumers

3. Feedback from ACMHN members

The ACMHN sought input from its members in NSW in relation to the Inquiry Terms of Reference. Responders affirmed a commitment to reducing seclusion and restraint and working towards ultimate elimination, but consistently identified common barriers to achieving this in practice. The most common theme referred to a lack of education and training in mental health for nurses being employed in mental health settings. Members also referred to the challenges of responding to individuals who are drug affected (e.g. due to methamphetamine use); or of frequently having to respond in situations where the organisational and physical environment prevents less restrictive alternatives from being readily available, particularly because there is often little opportunity for proactive engagement.

The following provides a brief snapshot of feedback received from ACMHN members in NSW:
Observation

The ACMHN member feedback focused predominantly on the use of seclusion and restraint and the organisational and environmental factors that may impact on practice, rather than making specific comment about clinical observation. The ACMHN submission therefore focuses on seclusion and restraint, however the College wishes to briefly comment on the issue of observation. The College welcomes the recently released NSW guidance document on observation and engagement and suggests this continue to be developed, with a particular focus on supporting services and staff to increase positive and proactive engagement.

Observation in the context of mental health nursing is an important tool for maintaining safety and carries with it a number of challenges in the current therapeutic environment. Challenges associated with observation are in some ways similar to those identified for seclusion and restraint, in that they may involve:

- Resource constraints (staffing and skill mix not well matched to patient need)
- Significant fluidity in patients’ mental state, not just from day to day, but from one moment to the next (feedback from MHNs suggests this is increasingly more challenging with increased number of patients under the influence of methamphetamines). This may mean that a risk assessment (and its associated observation level) recorded earlier in a nurse’s shift may no longer be accurate throughout the duration of a shift.

Many of the current behaviours and clinical practice issues we are now seeing (especially in acute mental health units) is a direct result of lack of education.”
- “One prominent factor regularly reported by staff working in the area is the inverse proportional factors in staff experience and patient volatility.”
- “In times of stress or when high on drugs, the individual becomes very strong, generally incoherent and a danger to themselves and others.”
- “A pressing issue in this whole debate is undergraduate nurse education. Nurses who work in mental health are no longer specialist trained.”
- “Confidence and knowledge in using pharmaceutical sedation is used less (sic), however there is no increase in the physical staffing numbers or ratios nor an increase in the training and ongoing education of front line staff to skill up and model desirable de-escalation and psychological support, skills training.”
- “In the case of Lismore, it can be associated with limitations to accessibility to suitably qualified and experienced staff and possibly embedded poor practice. This is possibly not a one off.”
- “I had one student advise me that he wanted to work in MH because he was male and strong.”
- “More mandated mental health subjects in an undergraduate nursing degree is a good start. If it isn’t mandated heads of schools won’t do it. Our mental health nurses have gone from having 3 year or 18 month specialist training to – in some cases – none.”
Poor physical environment (combined with inadequate resources) that poses challenges for conducting scheduled observations on multiple service users and on service units which are often exceeding capacity. (Victorian Department of Health, 2013).

The National Institute for Health and Care Excellence (NICE) has observation guidance available on its website (NICE, 2015). Importantly, this guidance emphasises the importance of having a policy on positive engagement. Feedback from ACMHN members indicates that mental health nurses feel they are not supported in their workplace to positively engage with service users outside of the tasks that involve scheduled observations, administering medication etc for each patient. As per the approach to reducing seclusion and restraint, the ACMHN wishes to note the importance of adopting strategies that provide nurses with the resources, skills, leadership, physical and policy environment to conduct observation that is reflective of the individual person’s dynamic needs, and provide greater opportunities for positive and proactive engagement.

4. Nurses’ perceptions towards seclusion and restraint

Successful reduction and ultimate elimination of seclusion and restraint not only requires education and awareness of the evidence surrounding the effectiveness and harms of the practices, but also the evidence-based best practice alternatives and the systemic changes involved in ensuring those alternatives are readily available to frontline staff.

Extensive evidence exists about the harms associated with seclusion and restraint (Muir-Cochrane et al., 2014) and on consumer’s perceptions about its’ use, which are predominantly negative, contradicting any belief that it has any value as a therapeutic intervention (Brophy et al., 2016a; Brophy et al., 2016b; Van Der Merwe, 2013; Light et al., 2012; Kontio et al., 2012). Seclusion has been independently attributed to increased duration of admission (up to 25 days), even when other factors such as symptom severity at the time of admission were controlled for (McLaughlin et al, 2016).

Contrary to this evidence:

- The majority of mental health professionals support the continued use of some form of restraint for the management of violence and aggression (Kinner et al, 2016; Happell & Harrow, 2010).
- Nurses express a range of views about seclusion and restraint: from unease and avoidance, to acceptance and the notion that the use of the intervention is necessary because there are no alternatives other than to contain, to the view that the intervention is therapeutic (Perkins et al. 2012; Goethals et al. 2011; Maguire et al., 2012, Happell and Koehn, 2011c; Happell and Koehn, 2010).

This discrepancy between staff views relating to seclusion and restraint and the available evidence, suggests it is not just raising awareness and the content of the message that is important. Broadly, priority must also be given to what is happening at an organisational level to support the workforce, so it is possible for staff to not only hear the message about seclusion and restraint reduction, but more importantly, to believe reduction and ultimate elimination is achievable in their workplace without compromising safety. A key challenge identified in the literature points to reduction approaches in many psychiatric units tending to focus on de-escalation techniques, which by definition, place nursing staff in a situation where an individual’s behaviour has already begun to pose a problem and requires an immediate response (Tomagová et al., 2016; Johnson, 2010).
Preliminary findings from the ACMHN Seclusion and Restraint Project

The College has recently conducted a project funded by the National Mental Health Commission to explore mental health nurses’ perceptions of and attitudes towards seclusion/restraint use, as well as investigating nurse perceptions regarding factors that may impact upon the reduction and ultimate elimination of seclusion and restraint (ACMHN, 2017). It is hoped that this project will provide important information on the factors and perceptions of mental health nurses that influence their decisions to use seclusion and restraint and their level of confidence in reducing those practices.

Stage one of the project involved an online survey, while the second stage of the project involved conducting focus groups with nurses to further explore issues influencing seclusion and restraint use and elimination. The final Project report (ACMHN, 2017) was been submitted to the National Mental Health Commission in August 2017.

Excerpts of the evidence included in the literature review for this project has been incorporated into this submission and the submission was also prepared in consultation with the Project’s Research lead, Prof. Eimear Muir-Cochrane, who is the Professor of Nursing and Midwifery at Flinders University and an internationally recognised expert on seclusion and restraint in mental health settings.

ACMHN position

The Australian College of Mental Health Nurses (ACMHN) Seclusion and Restraint Position Statement (2016) states that ‘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’.

The NMHC Position Statement on seclusion and restraint in mental health notes that research into the prevention and safe management of behavioural escalation is essential, and should consider all ages and include people with lived experience of these difficulties, their families and carers. This should add to the body of evidence supporting the need to change, reduce and eliminate seclusion and restraint practices.

The American Psychiatric Nurses Association (APNA) note in their position statement The Use of Seclusion and Restraint that they support ongoing efforts to reduce and ultimately eliminate seclusion and restraint, but call for research supporting evidence-based practice for preventing and managing behavioural emergencies.

5. Legislation

It is the position of the ACMHN that regulation or legislation in relation to seclusion and restraint needs to:

a. ensure the rights of the individual consumer are paramount, particularly protecting a population whose circumstances make them highly vulnerable
b. ensure the rights of staff, other consumers and other persons, to safety and protection from violence and aggression in health care settings
c. ensure frontline staff such as nurses are not placed in a position where their safety or the safety of others is compromised due to regulatory requirements (or due to fear of prosecution) which make it difficult or impossible to respond in an emergency situation

d. ensure the health care culture remains one that promotes reporting and monitoring of the use of restrictive practice, without fear of legal reprise (which may increase risk under-reporting, fear and uncertainty among the workforce)

e. support ongoing seclusion and restraint reduction and ultimate elimination as an organisational responsibility

Perceived conflicts with Work Health Safety (WHS) legislation

As suggested by the evidence cited in the section on policy approaches, a perception still exists among a minority that any efforts to reduce seclusion and restraint will compromise and contradict Work Health Safety legislation. However, in a discussion about the use of restraint and containment in the disability sector, Chan (2015) argues that reduction approaches which include strategies to reduce the underlying need to use seclusion and restraint (i.e. by aiming to reduce the incidence of violence and aggression) more closely align with the principles of work health and safety. It is the position of the ACMHN that improvements to Work Health and Safety can be achieved through the effective implementation of evidence-based strategies that recognise opportunities for reducing the incidence of violence and aggression and improving milieu in mental health service settings.

6. Policy

Current approaches to reducing seclusion and restraint

A key issue with current approaches is that they have a central focus on de-escalation, which by definition begins from the point at which a situation has already begun to escalate out of control. As depicted in the diagram over the page, 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 support the adoption of evidence-based practices that seek as much as possible to prevent behavioural escalation from occurring in the first place (Johnson, 2010). Such a shift requires leadership and support from government and organisations to transition their service model and achieve the necessary buy-in from frontline staff to ensure successful implementation.
Difficulty achieving and sustaining reduction and elimination of seclusion and restraint has prompted a rethink about the factors influencing use of seclusion and restraint and what strategies could be implemented to address those factors.

It is not simply a case of staff knowing how to apply alternatives, but whether they are supported within their work environment so that those alternatives are readily available, staff are trained in evidence based practices and feel confident and supported to implement them (Muir-Cochrane, et al. 2014).

Features of current evidence-based approaches to reducing seclusion and restraint emphasise:

- staff development; improving organisational culture; organisational and team leadership, making adjustments to the physical environment; and the involvement of consumers, family members and support persons (Melbourne Social Equity Institute, 2014) greater direction and leadership at the jurisdictional and organisational levels, so that systemic and organisational barriers to reducing seclusion and restraint can be addressed.
- 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, therefore avoiding or significantly reducing the need to implement de-escalation strategies (Johnson, 2010)
- the adoption and upskilling of the workforce in current evidence based clinical practices, such as trauma-informed care (Mental Health Coordinating Council, 2013).
- a need for further research to examine evidence-based practices on the prevention and safe management of behavioural emergencies and alternatives to seclusion and restraint
**NSW Health Policy on Aggression, Seclusion and Restraint in Mental Health Facilities**

As is still common amongst many existing policies and approaches to seclusion and restraint in Australian mental health services, the current NSW Health Policy on *Aggression, Seclusion and Restraint in Mental Health Facilities in NSW* focuses predominantly on de-escalation and what to do if seclusion or restraint is required. Just two pages of the entire main body of the document focus on ‘preventing’ and ‘minimising’ ‘disturbed behaviour’. The remainder of the document describes the policy, practice and processes which must be followed when needing to use seclusion and restraint. As discussed earlier, the mental health system must align itself with current evidence which supports moving away from a de-escalation-focused approach (which assumes behavioural escalation has already occurred) and toward an approach in which the primary focus is to reduce the prevalence of violence and aggression in mental health services. The policy should also reflect the numerous opportunities to involve consumers in reduction approaches, whether that be through care planning, debriefing, review committees or implementation working groups.

The NSW policy also states that “clinical and non-clinical staff working in mental health facilities in NSW will undertake all possible measures to prevent and minimise disturbed or aggressive behaviour and reduce the use of restrictive practices such as seclusion and restraint”. The policy states that all staff and management must comply, yet does not acknowledge the evidence-based factors needed to facilitate and sustain compliance, that are not directly in the control of individual nursing staff.

The ACMHN wishes to emphasise that in the vast majority of circumstances, the primary issue is not that the workforce is not complying with such a directive, but that the ‘possible measures’ referred to in the policy are often unavailable and staff are generally not being adequately supported or provided with the tools or the organisational environment to implement less restrictive alternatives. ‘Non-compliance’ with a policy to reduce and ultimately eliminate seclusion and restraint may in fact be more reflective of systemic issues, such as increasing use of underqualified staff, poor leadership and organisational culture and/or physical environment, and staffing levels and skill mix that are not well matched to patient acuity.

**ACMHN Recommendation:** The ACMHN recommends that the NSW Policy on Seclusion and Restraint be updated to include greater emphasis on evidence-based strategies that may precede de-escalation techniques.

**Contextual differences between service settings**

Policy and practices can be very specific to the service setting, the consumer characteristics and the level of expertise readily available within the service.

In the acute mental health setting:

- the use of seclusion and restraint is a clinical decision that *should* be made by trained staff. That is, mental health nurses who have postgraduate qualifications and training in mental health. (However this is increasingly not the case in reality, as indicated by the ACMHN member feedback).
- while seclusion and restraint can be enacted by a mental health nurse during an emergency, immediate authorisation and ongoing assessment by a medical practitioner(s) is required
- episodes of seclusion and restraint are regulated by policy and procedure and include limits on time, regimented monitoring and review, and care of the person
- episodes of seclusion and restraint are reported and reviewed by the broader clinical team (mental health nurses, treating psychiatrist, allied health) and monitored by service managers and administrators)
• additional monitoring and reporting processes exist, which vary due to jurisdiction, the legal status of the person (e.g. official visitors, person detained under the mental health act, voluntary patient, guardianship order etc.).

While there may be times where violence may be predictable (or risk of violence may be increased), for example:
• based on an individual’s personal history of aggression and violence
• where the person is known to the mental health staff
• where the person is intoxicated and threatening violence
• where the person is arriving with police
• where the person’s family or friends are indicating that they have been violent, aggressive, or threatening violence or aggression, or where there is a history of same
• where the person is acutely unwell and extremely paranoid

There will be other situations where violence and aggression is not so readily predictable and restraint or seclusion may be required as an emergency.

In a community mental health setting:
• violence and aggression towards mental health staff would likely trigger involvement of police and/or ambulance staff and would indicate the need for a more acute mental health service setting.

Factors influencing nurses’ use of seclusion and restraint
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. However, a range of factors for why seclusion and restraint is used in mental health services have been identified, including factors such as the physical and social environment, staff training and preparation, organisational priorities, resources and communication have a strong influence on the ability to reduce seclusion and restraint (Riahi, Thomson and Duxbury, 2016). Shepley et al. (2017) found that mental health nurses and other clinical staff expressed that the ‘fishbowl’ nursing stations and lack of private rooms for consumers were not conducive to best practice or to promoting a positive culture on the unit.

Research has demonstrated that most seclusions occur in the first few days of admission, with more males than females, with younger people who are experiencing psychosis and when the consumer and staff are not known to each other (Oster et al., 2016, Muir-Cochrane et al., 2014; Beghi et al., 2013). In addition, trauma (Mental Health Coordinating Council, 2013), dual diagnoses; amphetamine induced acute behavioural disturbance (McKenna et al, 2017) and forensic history (Maguire et al., 2012), have also been identified as consumer characteristics associated with seclusion and restraint.
Substantial evidence both in Australia (Oster et al., 2016) and internationally (Knutzen et al., 2014), suggests that it is a minority of consumers in a mental health facility who account for the majority of seclusion or restraint occurrences. Such findings fall somewhat outside the aim of teaching staff to know how to use alternatives, but are still very useful for focusing reduction interventions.

Risk assessment is part of every mental health assessment and as such, it may be possible to identify consumers who are more at risk of being involved in episodes of seclusion and or restraint. However, it is important that there is provision in any legislation or regulation around the management of emergency situations by mental health staff, including doctors and nurses.

**Seclusion and restraint in the context of acute mental health services**

Nurses, doctors and support staff all have a role in ensuring the safety of consumers and others on a mental health unit. As such, they also have a role with regard to the authorisation of and use or cessation of seclusion and restraint. In mental health settings, seclusion and restraint are clinical interventions – however, this is not to say that they are, or that they are considered to be, ‘therapeutic’ clinical interventions.

Nurses, doctors and support staff are required to utilise the least restrictive intervention at all times. However, there are times where seclusion or restraint may be the least restrictive option, for example:

- where a consumer is being treated under the mental health act and is required to receive medication, but is refusing, and where every attempt has been made to encourage the individual to accept medication voluntarily
- in an emergency situation, where one consumer assaults or threatens to assault another consumer, staff or others; or where one consumer is damaging property which places the safety of themselves or of another person (staff, consumer, carer, visitor) at risk

In the event of an emergency, a doctor, unit manager or shift manager may, or may not be present on the unit at that time. The nursing staff who are present on the unit at that time will be required to act in the best interest of the safety of all concerned. The duress alarm will be pressed and a decision will need to be made to ensure safety of all concerned. This may mean that staff clear the area and wait for support staff to arrive, or it may mean that the individual is immediately restrained and secluded by the nursing staff present.

Again, the role of all staff will be to ensure the safety of the individual, and the adherence to policies and procedures and reporting requirements around seclusion or restraint. This always involves contacting the medical officer in charge/on duty, the nurse in charge and the shift manager.

Post seclusion, there should be some documentation of discussion with consumers to debrief and discuss how this could be handled differently if the situation were to arise again. While this isn’t always an option, there are scenarios where consumers and carers can offer suggestions regarding when and whether less restrictive alternatives aimed at preventing behavioral escalation from occurring may have been available at an earlier point. Consumers and carers should have the opportunity to provide input into safety plans that aim to identify possible triggers and signs that there is a risk of behavioural escalation, as well as individualised strategies for prevention and alleviation of distress.

7. Reporting

When used proactively, data has been shown to provide nursing staff with the information needed to reflect on incidents involving seclusion and restraint use and to identify opportunities for continuous improvement (Gaskin et al, 2007).
Mental health services collect information about the use of seclusion and restraint already, such as through the seclusion review committees and the reporting of serious incidents (e.g. for physical restraint). This occurs at an individual level by the organisation, as well as at a service and systemic level through the Mental Health Seclusion and Restraint National Best Endeavours Dataset Specification (AIHW, 2016). The dataset has been implemented by the Australian Health Ministers Advisory Council’s (AHMAC) Safety and Quality Partnership Standing Committee (SQPSC), and state and territory agencies. For the mental health sector, it will be a case of creating an online mechanism for feeding that information into a state-wide database which enables automated and manual reporting at the individual, organisational, sector and State level. The capacity for each organisation to auto-generate reports at the individual and organisational level would be an important tool for organisations to maintain progress and inform continuous improvement to reduce use.

"Strategies that may enhance the already significant guidelines to seclusion and restraint might include:
- Mandatory debriefing and documentation of same re patients who have been secluded;
- Daily (service) reporting of seclusion/restraint incidences - this would identify to all clinicians restraint/seclusions within the sector."

– ACMHN member

A key objective in reducing the occurrence of aggression and violence in mental health settings is to maximise opportunities for proactive engagement between front line staff and consumers (Hamrin et al., 2009). Any regulatory requirements, including reporting and other documentation, should be streamlined so that it facilitates an increase in available staff time with regard to proactively engaging with consumers.

Data collected should be predominantly used to educate, support and enhance practice. A punitive response to information collection about use (via reporting or through another source) should only be applied where it is evident that an individual or organisation has acted in a way that is negligent (for example, a service has demonstrated breaches in policy or practice around seclusion and restraint which it has not acted to address).

**ACMHN Recommendation:** The ACMHN recommends that any efforts to improve reporting and data collection are considered in the context of providing greater opportunities for nursing staff to proactively engage with consumers.

**ACMHN Recommendation:** The ACMHN recommends that data should be reviewed by a seclusion and restraint review committee which includes consumers and carers, with a view to using the data to explore opportunities where improvements can be made.

**8. Clinical governance and oversight**

As discussed earlier, the discrepancy between nurses’ views relating to seclusion and restraint and the available evidence, suggests it is not just raising awareness, training and the content of the message that is important.
At an individual level, nurses are obligated to deliver the best care for their patients. However, as the evidence suggests, organisational (e.g. leadership, staff mix, physical environment) and systemic (e.g. mandated education/training in mental health, funding to support adequate staffing levels and skill mix) factors can substantially help or hinder nurses as they strive to meet their obligations as individual health professionals.

“I can speak up now and not worry about losing my job.”
— ACMHN member

For this to be achievable, individual services must also be supported by government and government policy to make the necessary changes at the systemic level.

Good clinical governance, supported by government, must give priority to what is happening at a systemic, organisational and management level to support the mental health nursing workforce. This is critical for staff to be able to see that it is possible to reduce seclusion and restraint in their workplace, without compromising safety. A culture needs to be fostered at an individual service level that encourages and rewards good practice and provides education, clinical supervision\(^1\) and peer or managerial support (e.g. identifying positive role models within the team).

**ACMHN Recommendation:** The ACMHN recommends that NSW Health focus their activities on supporting mental health services to achieve a greater reduction in seclusion and restraint by:

- Streamlining mandatory documentation and reporting arrangements to facilitate increased proactive engagement between mental health nurses and consumers
- Providing funding that supports the recruitment of a skilled and competent workforce and carefully managing the recruitment of nursing assistants and enrolled nurses across NSW mental health services so that the skill mix is appropriate to the level of acuity within the service
- Securing mandated, evidence based mental health education in undergraduate nursing degrees and developing a program to increase clinical placements across the diverse range of public, private, acute, community and primary mental health settings.

\(^1\) See the ACMHN Clinical Supervision Position Statement: [http://www.acmhn.org/career-resources/clinical-supervision](http://www.acmhn.org/career-resources/clinical-supervision) [Accessed 19 July 2017]

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**Practice standards**

ACMHN members generally shared a strong view that there is a shift toward staffing levels in mental health services that are inappropriately matched to the high level of acuity and increasing recruitment and rostering of staff without qualifications and training in mental health and evidence based therapeutic interventions.

The reasons for this are multi-faceted. Firstly, there is no consistent, mandated approach to the qualifications, skills and experience of nurses being recruited into mental health settings. Crucially however, mental health nursing has been identified as experiencing existing and predicted future workforce shortages, greater than any other segment of the nursing workforce, which is indicative of a service provision crisis (Australia’s Future Health Workforce – Nurses Overview Report August 2014).
ACMHN member feedback

“Currently, where I work there is a plethora of junior staff including, RNs, AINs and ENs who lack the ability to identify increasing agitation, deterioration in mental state, or imminent aggression. This has contributed to a recent increase in aggression within the unit.”

“There is a need to review behaviour and understand why it occurs. What sits behind the established practice? There is a link to lack of knowledge, limitations to staffing, support, education, etc”

“Staff are fearful, staff do not have the theoretical understanding nor the clinical skills. How can they – they don’t get exposed to much mental health content in their u/grad degree.”

“In an ideal world there would be a return to the intensive training of mental health nurses (as supernumerary).”

“Students go straight in to mental health with their BN (with no mental health training at all). Most don’t then do post grad studies in mental health (they should have to). You can’t work in Midwifery without being a midwife yet people with lived experience of mental illness are expected to accept less??”

“….in some BN programmes they get no mental health subjects at all. This lack of education and awareness is starting to have serious impacts on consumers who require care.”

Nursing and Midwifery Code of Conduct and ACMHN Standards for Mental Health Nursing

As health professionals registered with AHPRA through the Nursing and Midwifery Board, mental health nurses are required to comply with the Nursing and Midwifery Code of Conduct and professional standards1. However, these are general standards applicable to all registered nurses, regardless of the area of nursing in which they are employed.

The ACMHN Standards for Mental Health Nursing2 provide a practical guide to measure how mental health care is provided. They focus on the performance of mental health nurses across a range of clinical environments and include professional, knowledge skills and attributes. They specify the minimum level of performance required for a registered nurse practising in any mental health setting. These standards of practice are what should be at a minimum used to determine performance and to develop professional development programs across mental health settings, as well as individual professional development. Too often professional standards are not used effectively and the guiding standards reflect broader organisational standards, rather than standards specific to the profession and to practice.

The ACMHN Scope of Practice further articulates what mental health nurses do and can be used by individuals and services to consider the range or scope of practice one could expect from mental health nurses.

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**Credentialing**

Methods of recognising nurses with the qualifications, skills, expertise and experience to deliver high quality mental health care vary greatly across the mental health sector. This is supported by feedback from ACMHN members, many of whom report working alongside nurses with very little or no qualifications, training or experience in mental health.

Credentialing is a core component of clinical/ professional governance or self-regulation, where members of a profession set standards for practice and establish a minimum requirement for entry, continuing professional development, endorsement and recognition. The Mental Health Nurse Credential recognises the qualifications, skills, expertise and experience of nurses who are practicing as specialist mental health nurses. It demonstrates to employers, professional colleagues, consumers and carers that an individual nurse has achieved the professional standard for practice in mental health nursing.

> “There are decreasing numbers of nurses who have specialist training in MH.”
> - ACMHN member

> “Fundamentally, decisions surrounding the implementation of seclusion & restraint should be facilitated by specialist MH nursing staff who have a minimum Grad Cert PG training or credentialed & have attended the mandatory training required for seclusion & restraint.”
> - ACMHN member

**Supporting trauma-informed practice**

People accessing health care bring with them a personal history and there may be elements of this history that can be a source of trauma. These individuals are particularly vulnerable to experiencing disparities in health care and health outcomes and are at risk of being re-traumatised by their experiences when accessing health care (Reeves, 2015). The Australian health system generally does not adequately take account of the impact of trauma on mental health and health outcomes and this is evidenced by the lack of awareness and focus on trauma and trauma informed care in health policy, practice and services (Mental Health Coordinating Council, 2013).

A recent review of trauma-informed care for mental health nurses working in acute inpatient settings identified an urgent need for training and clinical supervision to support the mental health nursing workforce to adopt trauma-informed approaches in their everyday practice (Wilson, Hutchinson and Hurley, 2017). Training in trauma informed care is available via MHPOD (2012) and the Blue Knot Foundation has developed a resource to support the implementation of trauma informed care, titled *Practice Guidelines for the Treatment of Complex Trauma & Trauma Informed Care and Service Delivery* (Kezelman and Stavropoulos, 2012).

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Continuing Professional Development (CPD)

The ACMHN provides continuous professional development (CPD) and has developed a number of elearning modules available to members and non-members which can be accessed through the ACMHN CPD portal. Providers and organisations can also apply for ACMHN endorsement of professional events, educational activities or products (e.g. online training and resources) via the College website.

The ACMHN also wishes to note that training, education and the upskilling of the broader health workforce in mental health is necessary, but that the degree of success of such endeavours is also to a degree dependent on the extent to which the broader policy environment and service system supports implementation by individual health professionals on the ground.

“We need definitely 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 example, 1:1 nursing, sitting with the patient in a quite area that is non-threatening and so on”

9. System capacity building

Chemical restraint

While this review focuses on seclusion and physical restraint, the ACMHN would like to see a focus on reviewing chemical restraint across the NSW mental health system. Consumer groups have identified the reduction of chemical restraint as an issue needing to be addressed as part of the broader approach to reducing seclusion and restraint (Kinner et al, 2016).

For the purposes of this submission, the ACMHN is using the definition referred to in the report prepared by the Melbourne Social Equity Institute for the National Mental Health Commission (pg 29, 2014); that is, ‘medication given primarily to control a person’s behaviour, not to treat a mental illness or physical condition’. Unfortunately, this area carries a high degree of ambiguity currently as most jurisdictions do not refer to chemical restraint in their legislation and there is significant variation on what is interpreted as being chemical restraint, versus what is considered ‘treatment’ of a mental illness.

There is growing concern that medication (in the form of a sedative on a PRN basis for example), may be being used as a substitute for other forms of restraint (such as physical restraint and seclusion) across the mental health system (Hu, 2017 - Honours Thesis). While the ACMHN understands the complexity in conducting such work, it is of great importance that in order to provide the best care to people experiencing mental illness, consumers are provided with the greatest opportunity to get the most benefit out of their treatment. It is the view of the ACMHN that this is less achievable if the structure of the current mental health system indirectly supports the use of sedation in lieu of developing the organisational, staffing and environmental factors needed to provide person-centred care aimed at addressing the underlying cause of aggressive and violent behaviour.
ACMHN Recommendation: That NSW Health collect data on and review the use of chemical restraint across mental health settings in NSW, with a view informing decisions regarding the possible need to update relevant policy and legislation and provide the workforce with the guidance and tools needed to apply less restrictive alternatives.

Utilising the consumer perspective to strengthen reduction approaches

The consumer perspective is crucial in responding to conflict and reducing the need for seclusion and restraint in mental health settings (Brophy et al, 2016). Consumers have identified the need for a greater emphasis on building skills amongst the workforce to apply therapeutic interventions aimed at alleviating distress prior to behavioural escalation; in addition to developing a service environment that provides the opportunities for this to occur (Brophy et al, 2016).

The role of NSW Health

As the National Mental Health Commission is heavily involved in this space already, the role of the NSW Ministry of Health should be to work with the NMHC and provide leadership in the implementation of identified strategies to reduced and ultimately eliminate seclusion and restraint in mental health settings in NSW. NSW Health has ultimate responsibility for ensuring resources and policy facilitate the recruitment and retention of a mental health nursing workforce that is appropriately qualified and skilled to deliver high quality, evidence-based mental health care. Likewise, driving practice improvement and supporting the mental health nursing workforce to engage more with consumers will require a commitment from NSW Health to address the barriers identified in the literature that prevent this from happening.

The ACMHN suggests that NSW Health may wish to refer to the significant Australian research and reports relating to the mental health sector in this space that have already been published as it works to implement improvements in care across the sector. This should include publications and research undertaken, or commissioned, by the National Mental Health Commission and publications by frequently cited Australian authors, particularly authors that focus on seclusion and restraint in the context of mental health nursing, since this workforce represents the predominant workforce making decisions to use seclusion or restraint in the mental health sector.

ACMHN Recommendation: The ACMHN recommends that the NSW Government work with the National Mental Health Commission and the ACMHN to provide leadership in the implementation of identified strategies to reduce and ultimately eliminate seclusion and restraint.

10. Conclusion

Consumers deserve a trauma-informed mental health service delivered by trained mental health professionals with postgraduate qualifications. Mental health nurses are the largest group providing care to people experiencing mental illness and are central to the provision of care within the least restrictive environment.

Yet there is good evidence to suggest that generally nurses do not feel supported as a workforce to achieve reduction in their service and face multiple significant barriers to effectively implementing a seclusion and restraint reduction approach. Governments and services must increase their focus on how to provide the mental health nursing workforce with the necessary skills, physical environment and organisational and service structures to fulfil such an aim.
Organisational initiatives are needed which facilitate the adoption of evidence-based practices that seek to prevent behavioural escalation from occurring in the first place, as well as ensuring that staff are equipped with knowledge and skill across a full range of evidence-based therapeutic practices to minimise aggression and violence in the workplace.

The ACMHN encourages the Review Committee to contact the National Mental Health Commission to obtain further detail on the outcomes of the recent project conducted by the College on ‘Supporting mental health nurses towards cultural and clinical change: Facilitating ongoing reduction in the use of seclusion and restraint in mental health settings in Australia’ (ACMHN, 2017). If the Review Committee require any further information regarding, the Project, comments made in this submission, or would like to discuss the College’s workforce development activities, please contact the ACMHN.

### 11. References


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