Australian Nursing & Midwifery Federation
VICTORIAN BRANCH

535 Elizabeth Street
Melbourne Victoria 3000

Box 12600
A'Beckett Street PO
Melbourne Victoria 8006

anmfvic.asn.au
t 03 9275 9333
f 03 9275 9344
e records@anmfvic.asn.au

ABN 80 571 091 192
RTOID: 22609

ANMF (Vic Branch) Submission to Department of Health

Strategy towards elimination of seclusion and restraint

July 2023

ANMF (Vic Branch) welcomes this opportunity to provide a more detailed submission in response to the Engage Victoria paper on the elimination strategy. ANMF has engaged widely with members from various areas of nursing and midwifery including mental health, emergency departments, ICU and medical/surgical areas. As per the elimination paper, the strategy will consider the use of restrictive interventions in settings regulated by Victorian Mental Health legislation, which includes general wards of public hospitals, Emergency Departments (Eds), Intensive Care Units (ICUs) forensic settings and transportation.

At the outset, our members universally agree with the Royal Commission's vision to eliminate seclusion and restraint. Many reflected that nurses and midwives are a caring profession and at our core, seek to do no harm to those in our care. This support for the vision of the strategy was coupled with an honest reflection that sometimes members are forced to make the best clinical decision under extremely difficult circumstances. This submission will address this tension and provide recommendations for alternatives that must form part of the potential actions.

Similarly, on paper the draft vision and draft principles were not contested or opposed but in essence the 'how' statement appears challenging for our members to realise. And importantly, that lived experience being the 'why' must include the lived experience of those who currently are required (as a last resort) to administer restrictive interventions. This was strongly felt from the many members who provided feedback- that the use of restrictive interventions is never the first line of treatment, and that alternatives are considered prior to any restrictive interventions being implemented.

Below we will describe the three main themes identified by members through their feedback to the paper.

1. **Occupational Health and Safety (OHS) concerns for the workforce.**

The main theme expressed by members was safety implications for the nursing/midwifery workforce that were not adequately reflected or described in the paper. Whilst 'safety for all' is recognised and welcomed as a core principle of the strategy, members did not feel there was genuine consideration of the OHS risks that the elimination strategy could pose to the workforce without substantive reform before 2031.

- *'Without the option of restraints to manage patients, I worry about the safety of staff and other patients in Emergency Departments'* While the service system remains unprepared, restraint, chemical or otherwise, will remain a required last resort mechanism to safeguard staff and consumers. A strategic, multi-faceted approach with a clear pathway to elimination is essential.
- Members expressed that they are '*distressed by the total absence of OHS perspective for staff and others in the elimination strategy'*. Others reiterated their ultimate concern that '*we need to know our workplace is safe'*. These comments suggest that whilst 'safety for all' is proposed as a draft pillar, members felt a level of scepticism that safety for those who work in the system was being balanced against the safety of consumers.

- Physical settings are a barrier to the 'how' draft statement in the paper. Often mental health units are not environments that are calming or spacious. Similarly, busy Emergency Departments (EDs) or Intensive Care Units (ICUs) with constant alarms, codes, visitors and a constant flurry of activity can be overwhelming places for psychologically distressed consumers. Our members working in mental health units/ED/ICU and medical wards outlined that the design, layout and overall environment in such clinical areas presents a barrier for staff to safely treat, care and support agitated or aggressive consumers.
- Furthermore, in these high demand clinical areas in particular, workers must be particularly alert for risks to other patients/consumers receiving treatment. Members mentioned how other consumers are frightened when there are loud, agitated consumers on the ward. They also identified length of stay in ED as a precursor to agitation and restrictive interventions being required.
- The discussion paper identifies 'data and accountability' as a one of the draft pillars of the strategy and yet aside from acute in patient unit seclusion/restraint data, nil else has been presented nor has qualitative research on the workforce perspective of seclusion and restraint been presented. This further highlights the lack of a balanced approach to all perspectives and views, despite 'workforce' forming one of the draft pillars of the strategy.

ANMF recommendations:

1. Expedite progress in legislating minimum nurse staffing profiles in mental health. Legally enforceable safe staffing levels (similar to general nursing and midwifery) will support recruitment and retention of mental health nurses which is urgently needed. Chronic understaffing must be addressed. Where there are adequate mental health nurses rostered, they can spend time with consumers to engage therapeutically, form relationships and rapport, and develop care plans for recovery. This time to provide quality and compassionate care would mean that consumers will feel more supported and heard which subsequently leads to an overall reduction in agitation, aggressive behaviours and restrictive interventions [1]
2. Implement consistent principles of safe workplace design that consider systems of work, elimination of risks and hazards for both staff and consumers wherever possible and create calming and therapeutic environments that support recovery. This should be undertaken in an OHS framework which has at its core consultation with staff, and principles of safety by design, as well as review and implementation of previous designs to identify learnings and opportunities for improvement.
3. Workforce education and capability. This must include standardised training in early identification of risk (both clinical and OHS) and de-escalation. This should also include increased access to mentoring and supervision programs in acute mental health wards. When restrictive interventions do need to be used as a last resort it must be implemented with empathy, explanation, and support and for the shortest possible

[1] *This was evidenced in a 2018 study by Wilson, Rae and Kar Ray, Mental health inpatients and staff members suggestions for reducing physical restraint: a qualitative study where they explored mental health consumers and staff member suggestions for reducing physical restraint. The results indicated that improving communication and relationships between staff and patients, recruiting more staff and freeing up time to spend with consumers can change the culture and reduce restrictive interventions*

duration and with a thoughtful debrief following the incident- which can ensure the detrimental effects for consumers are minimised. This should be incorporated in the incident reporting and investigation processes to ensure that reviews are undertaken from a clinical and OHS perspective, learnings and opportunities for improvement identified (both at an individual consumer care plan level, and a system of work level) and are implemented in a timely manner.

4. Targeted and bespoke education and support for other clinical areas like ED/ICU and medical/surgical wards. Members from these areas reflect a completely different culture and in some cases, approach to seclusion and restraint. This difference needs to be factored into the 'leadership and culture' pillar and when considering potential actions of the strategy.
5. Robust policy, procedures and guidelines around substance withdrawal must be in place, updated and regular training provided as we know that substance misuse and dependency contributes to increased occupational violence and aggression in healthcare. ANMF welcome the 'cohort specific responses' pillar which includes those consumers with co-occurring mental health and alcohol and other drug issues.
6. Embed OHS and risk management principles, including legislation, regulations, and compliance codes, in the management systems and models of care of healthcare settings that implement elimination of restrictive intervention. This will assist in ensuring that staff and management are given the necessary facilities, resources, education, training and awareness of their rights, obligations and future surrounding OHS regulatory framework.

2. No alternatives available:

Many members reflected that there is not currently, nor has there been proposed, any alternatives to restrictive interventions in various scenarios. Examples include:

a) When encountering agitated, aggressive, or violent consumers

b) When nursing/midwifery care needs to be provided to delirious or substance withdrawing consumers. Many members told us there has been an increase in substance affected consumers. These consumers require medical treatment care and support but can be very behaviourally disturbed.

c) When the safety of other consumers is at risk. An ED member explained a common scenario where they are caring for a frail, palliative patient or a young child, whilst simultaneously caring for a substance affected, loud, large male who may be threatening staff and others in the ED and behaviour is escalating. This member posed the question, 'What would we do instead…? 'What proposals are going to be in place to manage these patients without restraint?'

ANMF recommendations:

1. That the strategy incorporates evidence based best practice alternatives to restrictive interventions to keep nurses/midwives (and all healthcare workers) consumers and families safe. An example may be Mental Health Hospital in the Home model which we

know is attractive to consumers (and families/supporters) but are also innovative and positive models (when implemented with appropriate staffing levels, skill mix and resources) that are attractive to nurses and other workers. By treating and supporting more consumers at home (where they are most comfortable) in a well-resourced HITH program you are reducing the potential trigger or risk of restrictive interventions even being contemplated.

2. Decreasing consumer boredom can lead to reduced use of restrictive interventions. We have heard from members that the introduction of pet therapy, music, and art therapy, having access to gym and yoga decreases boredom. Including in the strategy such research or data on these positive factors would be beneficial.
3. Prioritising workforce wellbeing. If you have a strong, supported, well-resourced workforce, where burnout and compassion fatigue doesn't exist, it will lead to a decrease in restrictive interventions. This includes dedicated time for workers to attend clinical supervision and reflective practice.

3. No discernible workforce voice in the strategy:

Members felt the tone of the strategy left them out of the discussions, they mentioned they 'felt ignored and disappointed'.

a) One member commented that the '*feelings consumers have when restrained, - despair, shame, terror, and rage, - can also describe how a nurse feels when they have been assaulted by consumers. There has been a shift from rights and responsibilities of both staff and consumers to staff have responsibilities and consumers have rights.'*

b) Many members stated, '*we firmly believe in this strategy*', '*restraint is never the first line of treatment and is not taken lightly*', '*we always consider the patients best interests*' '*restraint is always the last resort*'. But they feel that these views are not captured in the discussion paper.

c) Many members reiterated that they come to work to care for their patients/clients/consumers but acknowledged without investments the vision may be hard to achieve.

ANMF recommendations:

1. Nurses make up the bulk of the healthcare workforce, yet their perspective, voice, suggestions, and contributions have not been clearly heard or reflected in this discussion paper. ANMF urges the Department to take stock of the sentiments expressed by ANMF members upon reading this paper- there is a great deal of work to do in ensuring the workforce is part of system transformation. A genuine co design model with the workforce and lived experience would lead to a more coordinated and balanced approach to the elimination strategy.
2. Include and incorporate retention of nurses and other healthcare workers in a reformed mental health system. Many members reported the impact of occupational violence and aggression on retention for example;

‘*I’ve known nurses to leave the system because it is too under resourced and dangerous’*

‘if we can’t restrain and we have no alternative, I for one will be looking for a new career after 26 years.’

After reviewing the many contributions from nurse/midwife members, the general tone is one of scepticism, disappointment and feeling devalued. Members feel the strategy must be re-balanced to ensure their safety concerns are heard and addressed. It is evident that failing to do this work, will dampen and threaten the success of the strategy in meeting it’s vision.

ANMF remain resolutely committed to working with our members and the Department to see the vision of the Royal Commission into Victoria’s Mental Health System with respect to seclusion and restraint realised whilst genuinely working towards a reformed system that is ‘safe for all’.