Australian Government
Australian Institute of Health and Welfare

Transforming acute mental health care

When Australia's clinical mental health teams looked to reform outdated and potentially harmful therapeutic practices, they turned to data for support.

Restrictive practices known as seclusion and restraint have been used in acute mental health settings for centuries to manage the behaviour of people suffering from psychiatric illnesses. But, more than a decade ago in Australia, concerns from patients, their families and their carers about the harm being caused by these practices sparked a widespread call for change.

In 21st century Australia it's widely considered that such practices can violate human rights, can do far more harm than good and should be avoided by using alternative clinical strategies. Last decade, clinicians began to initially reduce, then work towards the elimination of, restrictive practices. At the time, however, there was no national picture about how these restrictive practices were being used and to what extent. Each of the states and territories was doing things differently, making it difficult to benchmark and compare what was happening on a national scale. And so, working through the Australian Health Ministers' Advisory Council, the nation's 8 chief psychiatrists enlisted the assistance of the AIHW to develop a robust, national methodology to monitor the use of restrictive practices in mental health facilities.

In 2013 the Institute released the first national set of figures on seclusion as part of its Mental Health Services in Australia report. It has updated and expanded the data yearly ever since. The impact has been extraordinary—producing a powerful example of the influence of data to support and drive change. In the 7 years since the AIHW's reporting began on the use of seclusion, the incidence of the practice has halved, reflecting frontline changes in clinical care. While this fall cannot be solely attributed to the availability of data, the data played a role and without it we wouldn't know if seclusion was becoming more or less prevalent. National restraint data was also made public for the first time in 2017.

Dr Nathan Gibson, the Chief Psychiatrist of WA, says the data has acted like a 'powerful non-judgemental mirror' held up to clinicians and mental health facilities, allowing them to see how they are performing. 'This data has been a really explicit tool to actually say to people: "look how you're functioning compared with the next place,"' he explains. 'Work had already begun on strategies to reduce restrictive practice prior to the release of national comparative data, and a broad package of actions is essential. But the release of national figures was really important. Releasing these annual comparative figures publicly has been a key driver for the sustained decline of seclusion rates around Australia. It's the transparency of the data and the fact that it's high quality. People trust it because it comes from the AIHW.'

‘The delivery of this sort of data to people who are on the ground doing the work completely changes their engagement; it actually drives quality improvement,’ says Dr Leanne Beagley, Chief Executive Officer of Mental Health Australia. ‘The delivery of this data has underpinned one of those very neat cycles where there’s been a clinical problem for patients and clinical teams, it’s a concern in the community, and we’ve asked: what do we need to do to change practices including workforce development, and how do we monitor it in an ongoing way? We are now in the “monitoring it in an ongoing way” phase, and what’s exciting about that is being able to track and keep an eye on what everyone agrees was a problem.’

In a clinical sense, seclusion and restraint are terms that describe ways of managing mental health patients that ultimately remove their physical freedom. During seclusion a person is confined to a room and prevented from leaving it. Restraint can be an even more confronting form of restriction that involves physical force, mechanical devices or medication. By definition, it can range from a staff member simply putting their hands on a patient for a few minutes to prevent them from self-harming through to an extremely agitated and aggressive patient being held down by as many as 6 or 7 staff.

13.9
↓
7.3

Number of **seclusion events per 1000 bed days** in acute specialised mental health hospital services **dropped from 13.9** in 2009–10 **to 7.3** in 2018–19

The **average seclusion duration** in 2018–19 was **4.2 hours**

In 2018–19, the **Northern Territory** had the **highest rate of seclusion** in public sector acute mental health hospital services (**13.6 seclusion events** per 1000 bed days); **New South Wales had the lowest** (**6.0**).