Restrictive practices

Background

People with mental illness and their carers advocate that restrictive practices (involuntary treatment, seclusion and restraint) do not benefit the patient and that these interventions either always or often infringe on human rights and compromise the therapeutic relationship between the patient and the clinician (Melbourne Social Equity Institute 2014).
The Royal Australian and New Zealand College of Psychiatrists acknowledge this point of view in their position statement *Minimising the use of seclusion and restraint in people with mental illness* (RANZCP 2016), which advocates that seclusion should only be used as a safety measure of last resort where all other interventions have been considered. The Australian National Mental Health Commission's (NMHC) *Position statement on seclusion and restraint in mental health* (NMHC 2015) calls for leadership across a range of priorities including "national monitoring and reporting on seclusion and restraint across jurisdictions and services."

Working towards eliminating the use of seclusion is a policy priority in Australian mental health care and has been supported by changes to legislation, policy and clinical practice. Reduction efforts have been supported by the Australian Health Ministers' Advisory Council, through its key mental health committees, the Safety and Quality Partnership Standing Committee (SQPSC) and Mental Health Information Strategy Standing Committees (Allan et al. 2017, SQPSC 2017). Twelve national forums on restrictive practices have been held, the most recent in November 2018, to share results and support broader change efforts to shift seclusion and restraint out of mental health units entirely.

Data on the use of seclusion, mechanical and physical restraint by hospital was reported for the first time in December 2018. Public reporting enables services to review their individual results against state/territory, national rates and like services, thereby supporting service reform and quality improvement agendas.

Data downloads

XLS Restrictive practices tables 2017-18

PDF Restrictive practices section 2017-18

Data coverage includes the time period 2008–09 to 2017–18. Data in the Involuntary mental health care section was last updated in October 2019.

Key points

45.8% of overnight mental health-related hospital separations with specialised psychiatric care were for people with an involuntary legal status in 2017–18.

6.9 seclusion events per 1,000 bed days were reported for acute specialised mental health hospital services in 2017–18, down from 13.9 in 2009–10.

5.1 hours was the average seclusion duration in 2017–18.

10.3 physical restraint events per 1,000 bed days and **0.5 mechanical restraint events** per 1,000 bed days were reported in 2017–18.

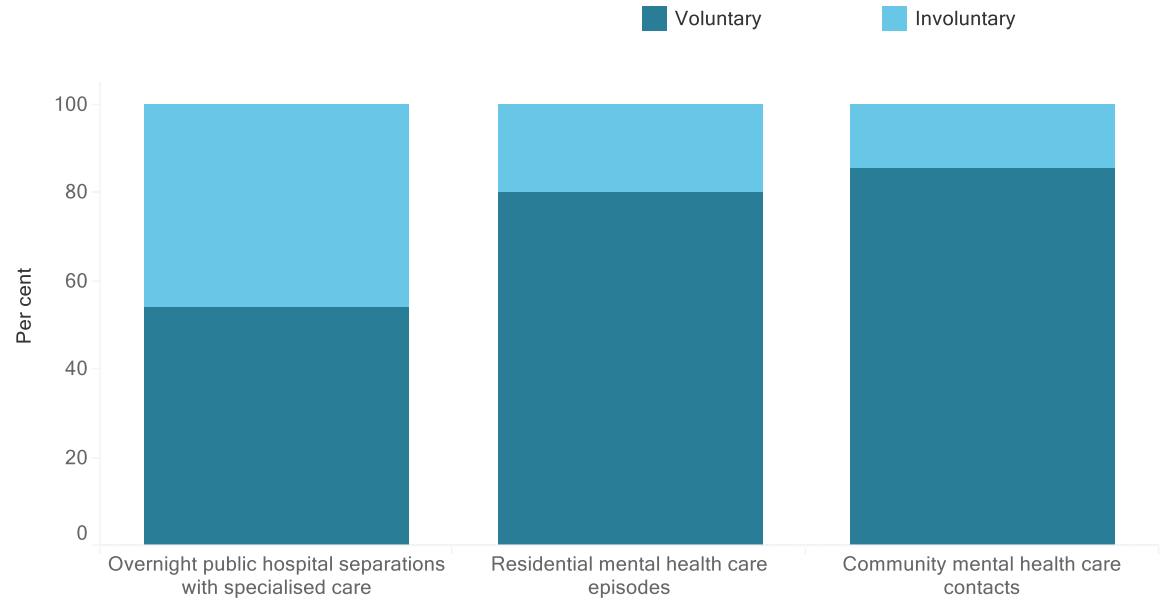
Involuntary mental health care

States and territories have individual legislation on the treatment of people with mental illness; all have provisions relating to the treatment of people in an involuntary capacity. This means that, under some specific circumstances, treatment for mental illness, including medication and therapeutic interventions, can be provided under a treatment order without the individual's consent, either in hospital, residential care or in the community.

Each state and territory's mental health act and associated regulations provide the legislative cover that safeguards the rights and governs the treatment of patients with mental illness receiving care. Legislation varies between state and territories but all contain provisions for the assessment, admission and treatment of patients on an involuntary basis, which, in this report, is defined as 'persons who are detained in hospital or compulsorily treated in the community under mental health legislation for the purpose of assessment or provision of appropriate treatment or care'.

By setting, the highest proportion of involuntary treatment in specialised mental health units for 2017–18 was in admitted units, where nearly half (45.8%) of public hospital overnight mental health-related separations with specialised psychiatric care were involuntary at some stage during the separation. Note that a separation is coded as involuntary if the patient has received involuntary treatment at any time during the admission; however, not all patients remain involuntary for the full period of their admission to hospital. Around 1 in 5 residential mental health care episodes (20.0%) and 1 in 7 community mental health care service contacts (14.5%) were also involuntary in 2017–18 (Figure RP.1).

Figure RP.1: Mental health care, by setting and mental health legal status (per cent), 2017–18



Sources: National Hospital Morbidity Database, National Residential Mental Health Care Database, National Community Mental Health Care Database; Table RP.1.

www.aihw.gov.au/mhsa

Source data: Restrictive practices tables 2017-18 (514KB XLS)

Seclusion

Seclusion is defined as the confinement of a patient at any time of the day or night alone in a room or area from which free exit is prevented. The purpose, duration, structure of the area and awareness of the patient are not relevant in determining what constitutes seclusion.

Seclusion also applies if the patient agrees to or requests confinement and cannot leave of their own accord. However, if voluntary isolation or 'quiet time' alone is requested and the patient is free to leave at any time then this social isolation or 'time out' is not considered seclusion.

While seclusion can be used to provide safety and containment at times when this is considered necessary to protect patients, staff and others, it can also be a source of distress; not only for the patient but for support persons, representatives, other patients, staff and visitors. Wherever possible, alternative, less restrictive ways of managing a patient's behaviour should be used, and hence the use of seclusion minimised.

Seclusion and restraint may be used across the range of mental health services; however, the focus of the national data collections to date has been limited to the acute specialised mental

health hospital service setting, since this service setting has been the focus of many of the associated quality improvement initiatives.

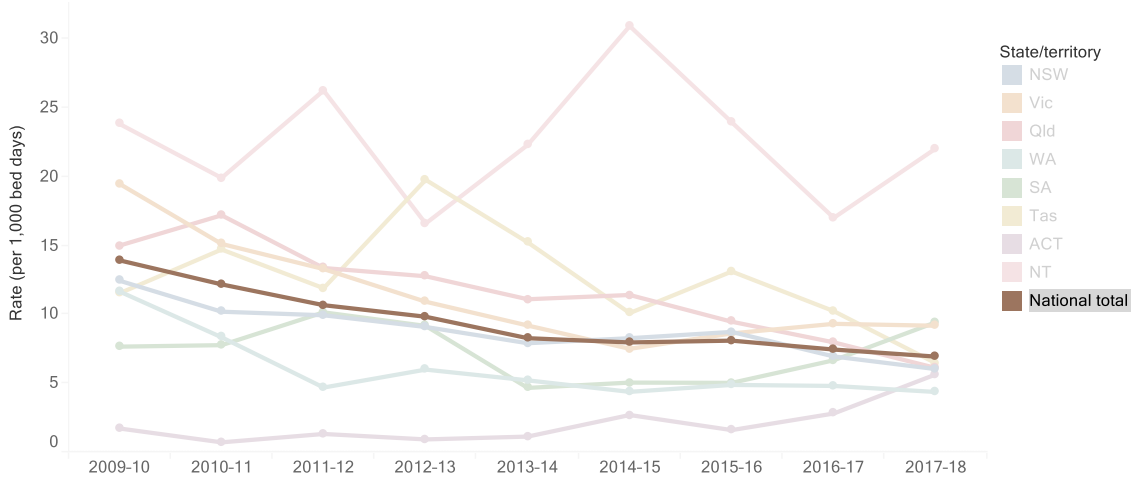
Overview

In 2017–18, there were 11,315 seclusion events nationally in public sector acute mental health hospital services, which represents 6.9 seclusion events per 1,000 bed days; a decrease from 11,937 seclusion events, or 7.4 seclusion events per 1,000 bed days in 2016–17. This continues the downward trend observed since 2009–10 (the first year of full national data collection – a rate of 13.9 seclusion events). Over the period from 2013–14 to 2017–18 there has been an average annual reduction in the rate of national seclusion events of 4.3%.

States and territories

In 2017–18, the Northern Territory had the highest rate of seclusion in public sector acute mental health hospital services, with 22.0 seclusion events per 1,000 bed days, compared with Western Australia, which had the lowest (4.3). Seclusion rates have fallen for more than half of the states and territories between 2016–17 and 2017–18 (Figure RP.2). While the seclusion rate for the Australian Capital Territory has been consistently lower than the other states and territories, an above average number of seclusion events for a small number of clients resulted in the seclusion rate doubling in 2017–18. However, data for smaller jurisdictions should be interpreted with caution as small changes in the number of seclusion events can have a marked impact on their overall seclusion rate. Further data quality information can be found in the data source section.

Figure RP.2: Rate of seclusion events, public sector acute mental health hospital services, states and territories, 2009-10 to 2017-18



Source: National Seclusion and Restraint database; Table RP.3

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Source data: Restrictive practices tables 2017-18 (514KB XLS)

Notes: The increases in the state-wide Tasmanian seclusion rate for 2012–13 and 2013–14 data, and for the ACT in 2017–18 are due to a small number of clients having an above average number of seclusion events. Victoria's service delivery model produces a higher threshold for acute admission and the seclusion and restraint metrics may be inflated compared to other jurisdictions. Due to the low ratio of beds per person in the NT compared with other jurisdictions, the apparent rate of seclusion is inflated when reporting seclusion per bed day compared with reporting on a population basis. In addition, high rates of seclusion for a few individuals have a disproportional effect on the rate of seclusion reported.

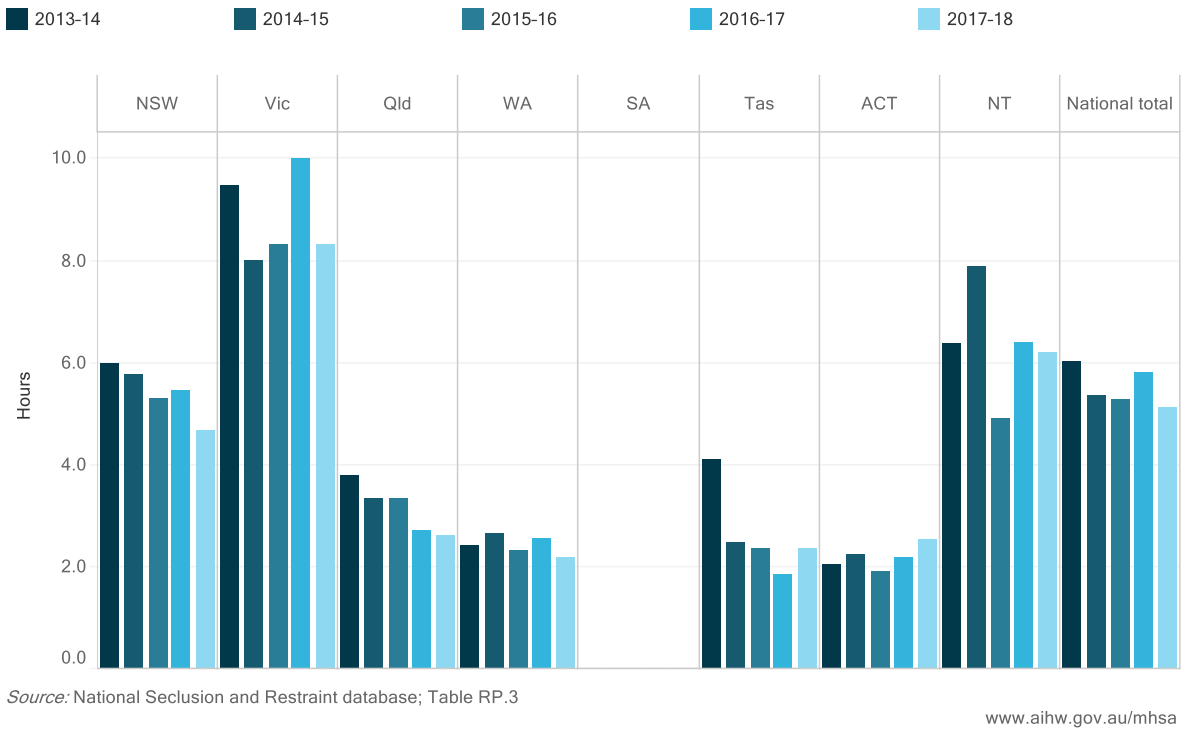
Frequency and duration

Frequency and duration of seclusion events were collected for the first time in 2013–14. The Australian Capital Territory was unable to provide the number of admitted patient care episodes and, as such, the national results for the frequency of seclusion during episodes of care is limited to those states and territories that can supply data. Duration data for South Australia is also excluded from the national average duration due to issues with the data recording methodology used in South Australia.

About one in 26 (3.8%) episodes of care provided by in scope Australian public sector specialised acute hospital services involved a seclusion event in 2017–18, a decrease from 2013–14 (5.4%). The Northern Territory had the highest proportion of episodes with a seclusion event (16.3%), while Queensland had the lowest (2.4%). Nationally, there were on average 2.1 seclusion events per episode of care with seclusion, which has remained relatively stable since 2013–14 (2.1).

The average duration of a seclusion event, excluding *Forensic* services, was 5.1 hours in 2017–18, down from 6.0 hours in 2013–14. *Forensic* services provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment. *Forensic* service data has been excluded as forensic seclusion events are typically of longer duration, and substantially skew the overall duration average. Victoria reported the longest average seclusion duration of 8.3 hours per seclusion event in 2017–18, compared with Western Australia (2.2 hours) which had the shortest (Figure RP.3).

Figure RP.3: Average number of hours in seclusion per seclusion event, public sector acute mental health hospital services (excluding Forensic services), states and territories, 2013-14 to 2017-18



Source data: Restrictive practices tables 2017-18 (514KB XLS)

Note:

- South Australia report seclusion duration in 4 hour blocks which precludes average seclusion duration calculations.
- Queensland and the Northern Territory do not report any acute *Forensic* services, however, forensic patients can and do access acute care through *General* units.
- The Australian Capital Territory now provides *Forensic* mental health acute inpatient services as of 2016–17 with the establishment of an acute inpatient service (i.e. Dhulwa Mental Health Unit).
- Victoria's service delivery model produces a higher threshold for acute admission and the seclusion and restraint metrics may be inflated compared to other jurisdictions. Higher acuity on admission may be reflected in an inflated average duration for seclusion events compared to other jurisdictions.

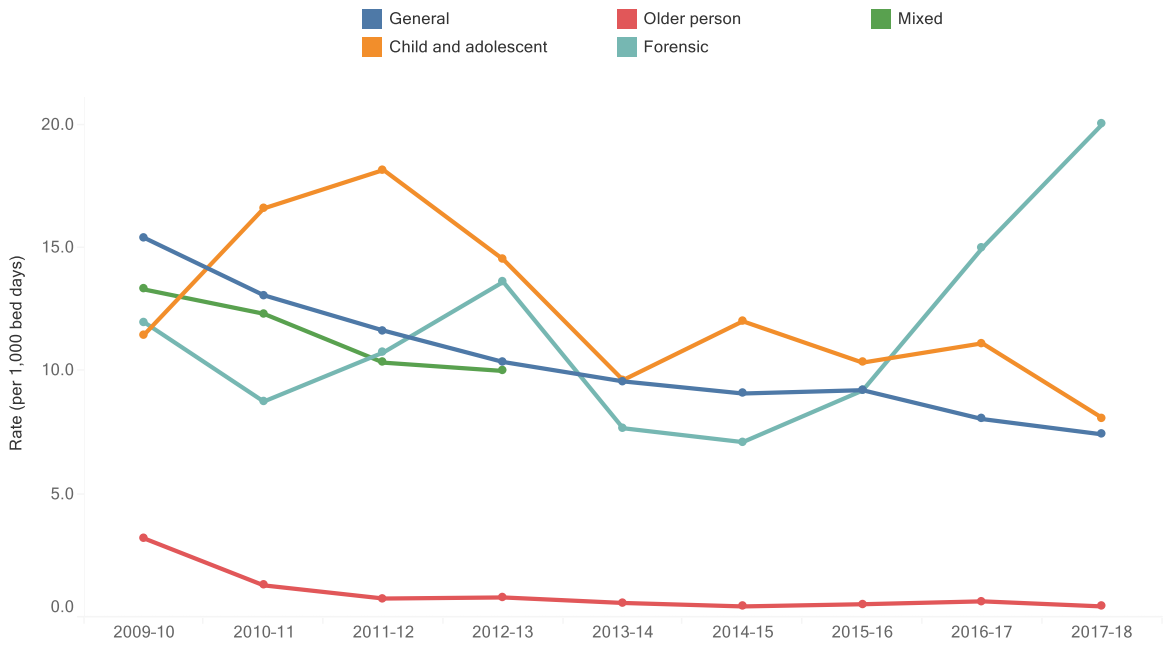
Target population

Seclusion data can also be presented by the target population of the acute specialised mental health hospital service where the seclusion event occurred. Around three-quarters (78.0%) of in-scope care (total number of bed days) was provided in *General* services (unpublished data). *Older person* services accounted for 14.5% followed by *Forensic* (3.8%) and *Child and adolescent* (3.7%) services.

The highest rate of seclusion was for *Forensic* services with 20.0 seclusion events per 1,000 bed days, followed by *Child and adolescent* services (8.1), *General* services (7.4) and *Older person* services (0.4). The increase in seclusion events in the *Forensic* target population from 15.0 events in 2016–17 to 20.0 events in 2017–18 is largely attributable to a small number of units in New South Wales, South Australia and Victoria and likely represents improved reporting practices. Although an overall reduction in seclusion rates was observed for most target population categories since 2009–10, some variability is apparent from year to year (Figure RP.4).

Note: Data presented is the target population of the service unit; that is, the age group that the service is intended to serve, not the age of individual patients. In 2013–14, improvements were made to the reporting of target population categories. The *Mixed* category was removed as an option for reporting. Data for the *Mixed* category was most commonly a mix of *General*, *Child and adolescent* and/or *Older person* services. Time series data by target population should therefore be approached with caution. Seclusion metrics for a small number of *Youth* hospital beds reported by Victoria, Queensland, Western Australia, and the Northern Territory are also included in the *General* category.

Figure RP.4: Rate of seclusion events, public sector acute mental health hospital services, by target population, 2009-10 to 2017-18



Source: National Seclusion and Restraint database; Table RP.4

www.aihw.gov.au/mhsa

Source data: Restrictive practices tables 2017-18 (514KB XLS)

Frequency and duration

Forensic services had the highest proportion of episodes of care involving seclusion events, with 25.5% of all mental health-related episodes involving at least one seclusion event in 2017–18. This was followed by *General* (3.9%), *Child and adolescent* (2.9%), and *Older person* (0.8%) services, with all rates relatively stable from 2013–14 to 2017–18.

Forensic services also had the highest frequency of seclusion, with 6.1 seclusion events per episode when seclusion was used at least once during an episode of care. Seclusion events that occurred in *Forensic* services also had the longest average duration: 57.0 hours per seclusion event, which is much greater than all other target population categories. This may be due to difficulties in applying the seclusion definition to the forensic context. *General* services reported an average time of 5.3 hours per seclusion event, followed by *Older person* (5.2 hours) and *Child and adolescent* (1.3 hours) services. The average time of a seclusion event decreased for *General* and *Forensic* services, increased for *Older person* services, and stayed the same for *Child and adolescent* services between 2013–14 and 2017–18.

Remoteness

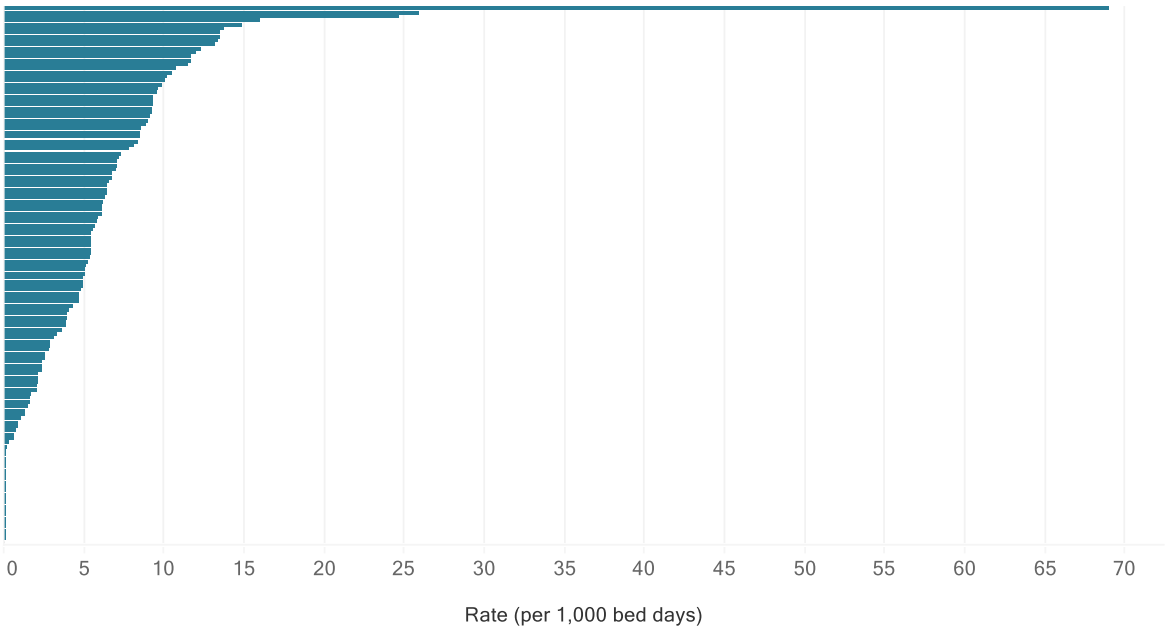
Due to the small number of hospitals located in *Outer Regional* and *Remote* areas, for the purpose of remoteness analysis these categories have been combined. There were no hospitals in the seclusion dataset located in *Very Remote* areas.

In 2017–18, hospitals located in *Major Cities* had a seclusion rate of 6.9 events per 1,000 bed days. This rate was higher than that for *Inner Regional* facilities (6.2), and lower than that for *Outer Regional* and *Remote* area facilities combined (9.8). The proportion of mental health-related admitted care episodes with a seclusion event was lower in facilities located in *Major cities* (3.7%), than those in *Inner regional* areas (3.9%) and *Outer regional* and *Remote* areas (5.1%). However, seclusion events in facilities in *Major Cities* were on average longer in duration (5.3 hours) than those in *Inner Regional* areas (4.3 hours) and *Outer Regional* and *Remote* areas (5.2 hours).

Hospital level data

Figure RP.5 shows the variation in the seclusion rate across Australia in 2017–18. Note that data includes public sector acute mental health hospital services only and excludes forensic units. The variability in seclusion rates between hospitals may be due to a range of factors, such as the hospital's service delivery model, the number of acute mental health service units in the hospital, the patient casemix, and the target population of the service units.

Figure RP.5: Rate of seclusion, public sector acute mental health hospital services, hospital level, 2017–18



Source: National Seclusion and Restraint database; Table RP.8

www.aihw.gov.au/mhsa

Source data: Restrictive practices tables 2017-18 (514KB XLS)

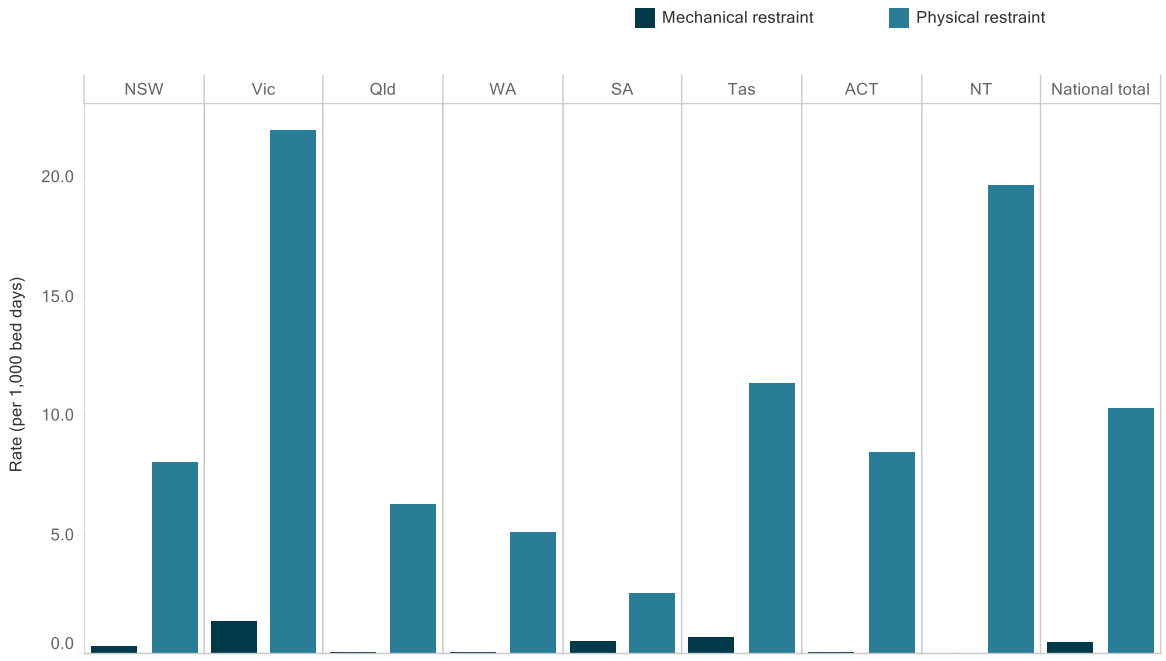
Restraint

Restraint is defined as the restriction of an individual's freedom of movement by physical or mechanical means. Data for two forms of restraint are specified by the Mental health Seclusion and Restraint National Best Endeavours Data Set (SECREST NBEDS): *Mechanical restraint* (for example, using devices such as belts, or straps); and, *Physical restraint* (for example, the application by health care staff of hands-on immobilisation techniques). Unspecified restraint, that is, the type of restraint is unknown, has been removed from 2016–17 onwards. Data on *Physical restraint* is available for Queensland for the first time for 2017–18.

States and territories have different policy and legislative requirements regarding restraint practices and have therefore had different processes and systems in place for collecting data, and differences in the types of restraint which are reported. In addition, the reporting of restraint data is still a novel exercise, with the first release of data occurring in May 2017. It is expected that data quality will improve over time as information systems are refined and definitions are better understood by the sector. As such, caution should be exercised when interpreting this data and comparing results between states and territories and over time. The data source section has further information about data quality.

In 2017–18, there were 16,917 *Physical restraint* events nationally, which represents 10.3 *Physical restraint* events per 1,000 bed days; while *Mechanical restraint* was less common (796 events, representing 0.5 events per 1,000 bed days) (Figure RP.6). Victoria had the highest rate of *Physical restraint* events (22.0 events per 1,000 bed days) and *Mechanical restraint* events (1.4 events per 1,000 bed days). This may be the result of Victoria's service delivery model producing a higher threshold for acute admission and inflating restraint metrics compared to other jurisdictions.

Figure RP.6: Rate of restraint events, public sector acute mental health hospital services, states and territories, 2017-18



Source: National Seclusion and Restraint database; Table RP.6

www.aihw.gov.au/mhsa

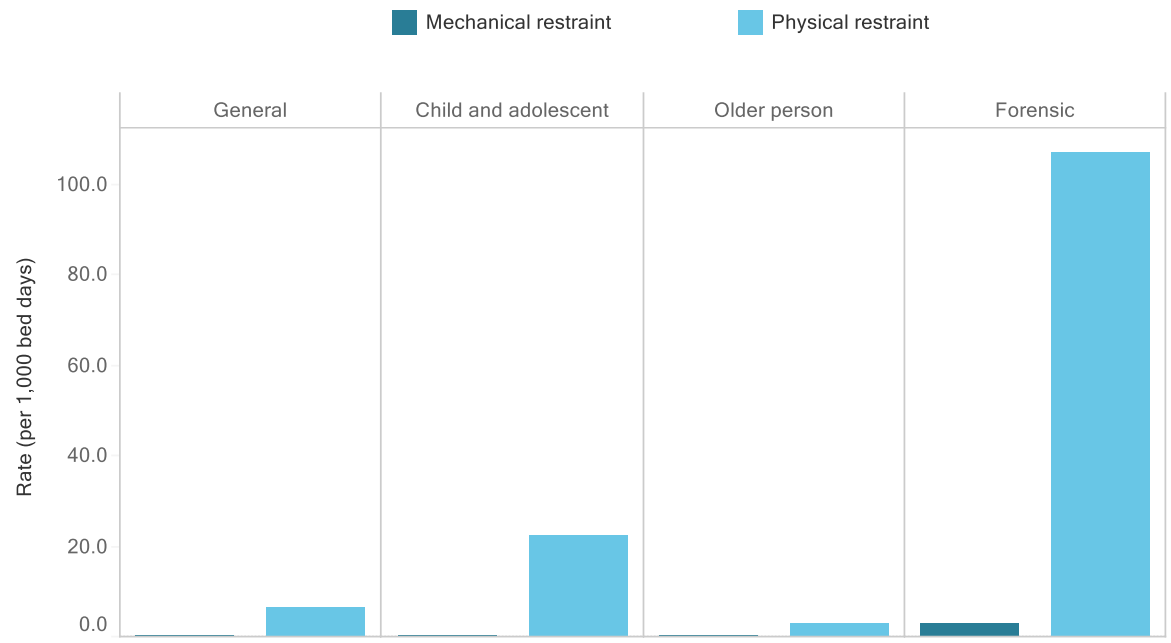
Source data: Restrictive practices tables 2017-18 (514KB XLS)

Notes: Victoria's service delivery model produces a higher threshold for acute admission and the seclusion and restraint metrics may be inflated compared to other jurisdictions. Victoria uses a specific methodology to derive the total number of restraint events. Queensland's Mental Health Act 2016 came into effect in March 2017. For the 2017–18 collection, *Physical restraint* events were recorded for the first time. However, as a new collection, caution is required when interpreting comparisons over time as these may be reflecting differences in business processes for recording data rather than a true variation in the use of physical restraint.

Target population

Restraint data can also be presented by the target population of the acute specialised mental health hospital service where the restraint event occurred. In 2017–18, the *Physical restraint* rate for *Forensic* services (107.2 events per 1,000 bed days) was over 4 times the rate for *Child and adolescent* services (22.5) and over 17 times the rate for *General* services (6.3). The rate of *Mechanical* restraint was also highest in *Forensic* services (Figure RP.7). From 2015–16 to 2017–18, the use of restraint (both *Physical* and *Mechanical*) was more common in *Forensic* services than other service types.

Figure RP.7: Rate of restraint events, public sector acute mental health hospital services, by target population, 2017-18



Source: National Seclusion and Restraint database; Table RP.7

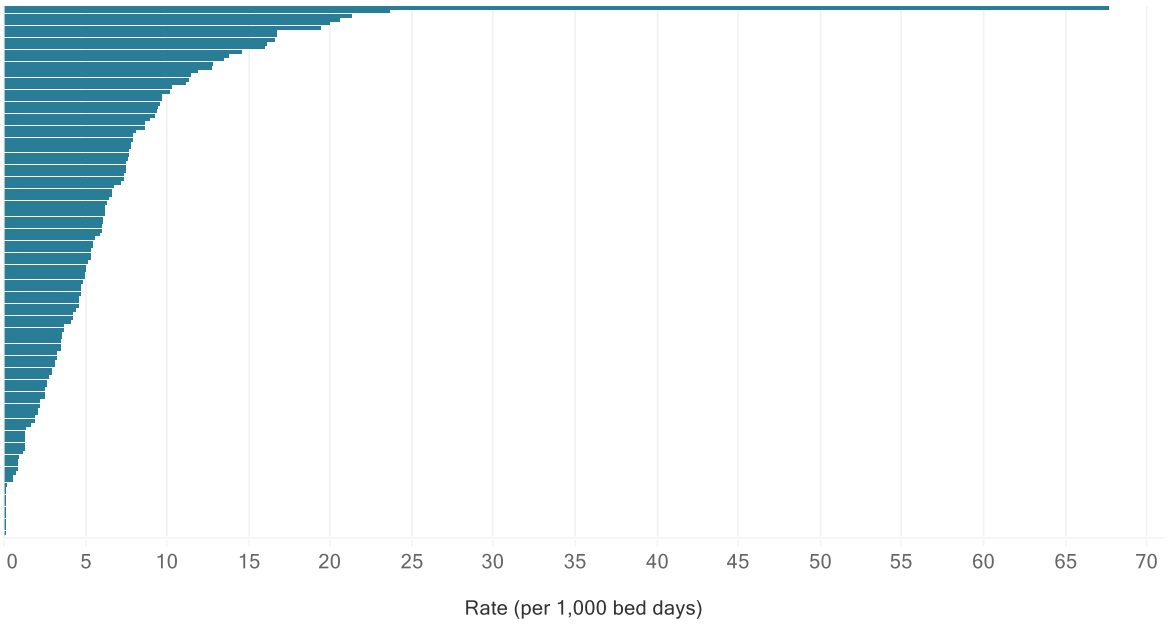
www.aihw.gov.au/mhsa

Source data: Restrictive practices tables 2017-18 (514KB XLS)

Hospital level

Figure RP.8 shows the variation in the physical restraint rate and Figure RP.9 shows variation in the mechanical restraint rate across Australia in 2017–18. Note that data includes public sector acute mental health hospital services only and excludes forensic units. The variability in restraint events between hospitals may be due to a range of factors, such as the hospital's service delivery model, the number of acute mental health service units in the hospital, the patient case mix, and the target population of the service units.

Figure RP.8: Rate of physical restraint events, public sector acute mental health hospital services, hospital level, 2017-18

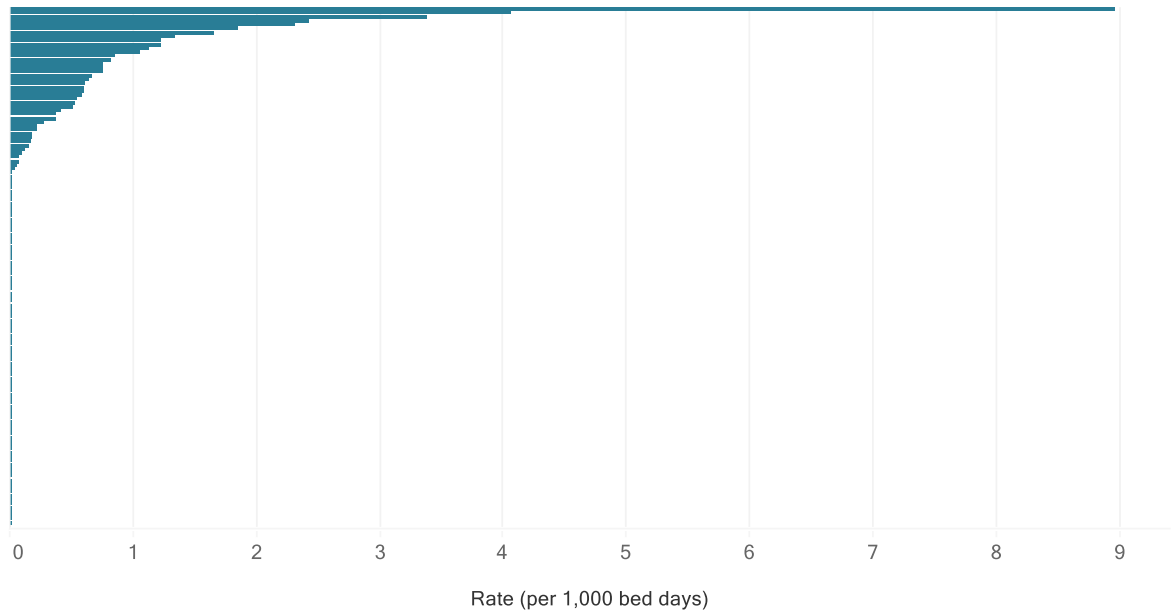


Source: National Seclusion and Restraint database; Table RP.8

www.aihw.gov.au/mhsa

Source data: Restrictive practices tables 2017-18 (514KB XLS)

Figure RP.9: Rate of mechanical restraint events, public sector acute mental health hospital services, hospital level, 2017-18



Source: National Seclusion and Restraint database; Table RP.8

www.aihw.gov.au/mhsa

Source data: Restrictive practices tables 2017-18 (514KB XLS)

Data source

Involuntary care quality information

National Hospital Morbidity Database

The National Hospital Morbidity Database (NHMD) is a compilation of episode-level records from admitted patient morbidity data collections in Australian hospitals. It includes demographic, administrative and length of stay data for each hospital separation. Clinical information such as diagnoses, procedures undergone and external causes of injury and poisoning are also recorded. For further details on the scope and quality of data in the NHMD, refer to the Data quality statement: National Hospital Morbidity Database 2014–15 and the Admitted patient care NMDS 2017–18.

National Residential Mental Health Care Database

Quality Statements for National Minimum Data Sets (NMDSs) are published annually on the Metadata Online Registry (METeOR). Statements provide information on the institutional environment, timeliness, accessibility, interpretability, relevance, accuracy and coherence. Refer to the Residential mental health care NMDS 2017–18: National Residential Mental Health Care Database, 2018; Quality Statement.

National Community Mental Health Care Database

Data Quality Statements for National Minimum Data Sets (NMDSs) are published annually on the Metadata Online Registry (METeOR). Statements provide information on the institutional environment, timelines, accessibility, interpretability, relevance, accuracy and coherence. See the Community mental health care NMDS 2017–18: National Community Care Database, 2018 Quality Statement. Previous years' data quality statements are also accessible in METeOR.

Seclusion and restraint data quality information

Variations in state and territory legislation may result in exceptions to the definition of a seclusion event as presented in the key concepts section. Data reported by jurisdictions may therefore vary and jurisdictional comparisons should be made with caution. The estimated acute bed coverage for 2017–18 seclusion and restraint data was complete coverage based on acute beds admitted units reported to the Mental Health Establishments National Minimum Data Set in 2016–17.

State and territory specific information is included in the accompanying Data quality statement.

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Melbourne Social Equity Institute 2014. Seclusion and Restraint Project: Overview. Melbourne: University of Melbourne.

NMHC (National Mental Health Commission) 2015. Position Statement on seclusion and restraint in mental health. Sydney: NMHC.

RANZCP (Royal Australian and New Zealand College of Psychiatrists) 2016. Position Statement 61: Minimising the use of seclusion and restraint in people with mental illness, Melbourne: RANZCP.

SQPSC (Safety and Quality Partnership Standing Committee) 2017. Use of restraint in Australian specialised mental health hospital services: Discussion paper on the development of a national data collection.

Restrictive practices - Key Concepts

Key Concept	Description
Mental health legal status	**Mental health legal status** is defined as whether a person is treated on an involuntary basis under the relevant state or territory mental health legislation, at any time during an episode of admitted patient care, an episode of residential care or treatment of a patient/client by a community based service during a reporting period (METeOR ID 534063).
Restraint	**Restraint** is defined as the restriction of an individual's freedom of movement by physical or mechanical means. **Mechanical restraint** The application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict his or her movement. This is to prevent the person from harming himself/herself or endangering others or to ensure the provision

	of essential medical treatment. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture except where the devices are used solely for the purpose of restraining a person's freedom of movement. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint. **Physical restraint** The application by health care staff of 'hands-on' immobilisation or the physical restriction of a person to prevent the person from harming himself/herself or endangering others or to ensure the provision of essential medical treatment.
Seclusion	**Seclusion** is defined as the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. Key elements include that: 1. The consumer is alone. 2. The seclusion applies at any time of the day or night. 3. Duration is not relevant in determining what is or is not seclusion. 4. The consumer cannot leave of their own accord. The intended purpose of the confinement is not relevant in determining what is or is not seclusion. Seclusion applies even if the consumer agrees or requests the confinement. The awareness of the consumer that they are confined alone and denied exit is not relevant in determining what is or is not seclusion. The structure and dimensions of the area to which the consumer is confined is not relevant in determining what is or is not seclusion. The area may be an open area, for example, a courtyard. Seclusion does not include confinement of consumers to High Dependency sections of gazetted mental health units, unless it meets the definition. More information can be found in the data source section about jurisdictional consistency with this definition.
Target population	Some specialised mental health services data are categorised using 5 **target population** groups (see METeOR identifier 445778): • Child and adolescent services focus on those aged under

18 years.

- Older person services focus on those aged 65 years and over.
- Forensic health services provide services primarily for people whose health condition has led them to commit, or be suspected of, a criminal offence or make it likely that they will reoffend without adequate treatment or containment.
- General services provide services to the adult population, aged 18 to 64, however, these services may also provide assistance to children, adolescents or older people.
- Youth services target children and young people generally aged 16-24 years.

Note that, in some states, specialised mental health beds for aged persons are jointly funded by the Australian and state and territory governments. However, not all states or territories report such jointly funded beds through the National Mental Health Establishments Database.