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 acknowledged this point of view in their recently updated position statement *Minimising the use of seclusion and restraint in people with mental illness* (RANZCP 2016), balancing the negative aspects of seclusion and restraint against the need for interventions under certain circumstances. 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."

Reducing and, where possible, 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 (SQPSC) and Mental Health Information Strategy Standing Committees (MHISSC). The SQPSC's National Mental Health Seclusion and Restraint ('Beacon') project implemented best practice initiatives in 11 services, demonstrating substantial reductions in the use of seclusion and restraint. Eleven national forums have subsequently been held, the most recent in May 2017, to share results and support broader change efforts to shift restrictive practice out of mental health units entirely.

Since 2008–09, the Safety and Quality Partnership Standing Committee (SQPSC), operating under the auspices of the Council of Australian Government's Health Council, has successfully negotiated the ongoing collection and publication by the AIHW of national seclusion events occurring in Australian specialised mental health acute public hospital services. Data on the use of mechanical and physical restraint was included in the collection in 2013–14 and was reported for the first time in May 2017. 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. The national data demonstrates a substantial reduction in the use of seclusion within specialised acute public hospital mental health services over the last five years. While still too early to show a trend, it is anticipated that a similar reduction in restraint will be seen over time.

Key points

- Almost half (48.2%) of all mental health-related hospital admissions with specialised psychiatric care involved patients with an involuntary mental health legal status, compared with 19.4% of residential mental health care episodes and 13.5% of community mental health care contacts in 2015–16.
- Nationally, seclusion rates have fallen from 10.6 events per 1,000 bed days in 2011–12 to 8.1 in 2015–16.
- The average duration per seclusion event was 5.3 hours in 2015–16.
- Nationally, there were 9.2 *Physical restraint* events per 1,000 bed days and 1.7 *Mechanical restraint* events per 1,000 bed days in 2015–16.

References

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

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

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

Senate Community Affairs References Committee (2016). <http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/IndefiniteDetention45> Viewed July 2017.

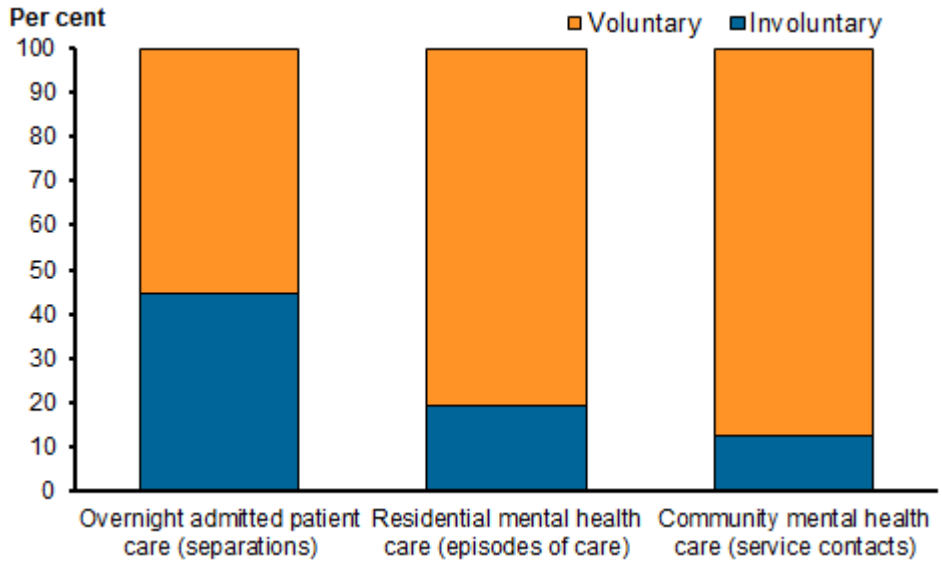
Involuntary mental health care

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 territories 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, 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 was in admitted units, where nearly half (48.2%) of all public hospital overnight mental health-related separations with specialised psychiatric care were involuntary at some stage during their separation. Note that patients may not remain involuntary for the full period of their admission to hospital, however the separation is coded as involuntary if the patient has received involuntary treatment at any time during the admission. Around 1 in 5 residential mental health care episodes (19.4%) and community mental health care service contacts (13.5%) were involuntary in 2015–16 (Figure RP.1).

Figure RP.1: Mental health care, by setting and mental health legal status (per cent), 2015–16



Sources: National Hospital Morbidity Database, National Residential Mental Health Care Database, National Community Mental Health Care Database.

Source data: Restrictive practices Table RP.1 (503KB 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 is or is not 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.

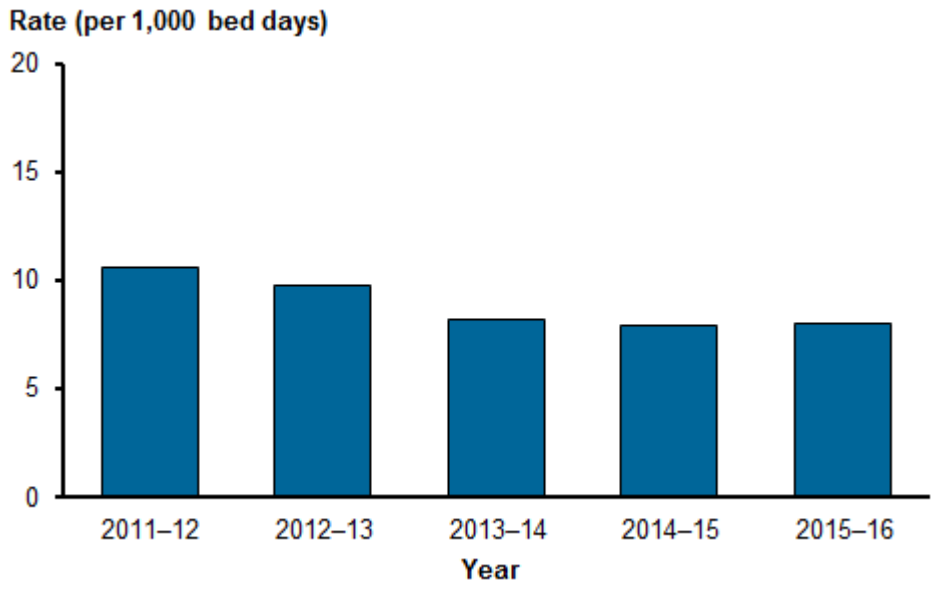
While seclusion can be used to provide safety and containment at a time when this is considered necessary to protect patients, staff and others, it can also be a source of distress not only for the patient but for support persons, representatives, other patients, staff and visitors. Wherever possible,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

Seclusion and restraint may be used across the range of mental health services; however, the focus of the 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

Nationally, there were 8.1 seclusion events per 1,000 bed days in 2015–16; a decrease from 10.6 in 2011–12 (Figure RP.2). This represents an average annual reduction of 6.7% over the 5-year period though there has been a slight increase in the rate from 2014-15.

Figure RP.2: Rate of seclusion events, public sector acute mental health hospital services, 2011–12 to 2015–16



Source: National Seclusion and Restraint Database

Source data: Restrictive practices Table RP.2 (503KB XLS).

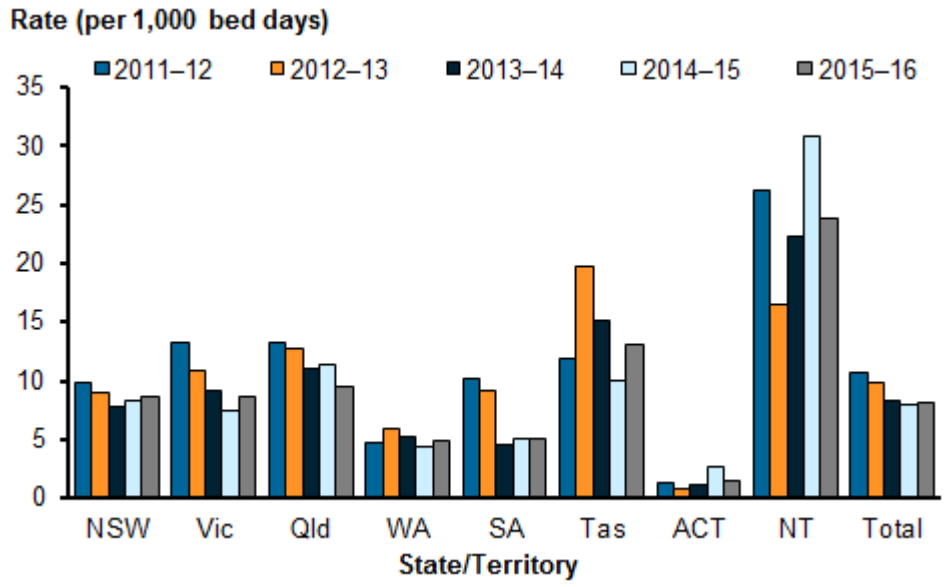
States and territories

Over time

In 2015–16, the Northern Territory had the highest rate of seclusion, with 23.9 seclusion events per 1,000 bed days, and the Australian Capital Territory had the lowest (1.6). Seclusion rates have fallen for 5 of the 8 states and territories between 2011–12 and 2015–16 (Figure RP.3).

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. For further data quality information see the data source section.

Figure RP.3: Rate of seclusion events, public sector acute mental health hospital services, states and territories, 2011–12 to 2015–16



Notes: The increase in the state-wide Tasmanian seclusion rate for 2012–13 and 2013–14 data is due to a small number of clients having an above average number of seclusion events. Due to increased use of community-based treatment, Victoria has fewer beds per capita than other jurisdictions resulting in higher acuity thresholds for admissions. As such, it may be useful to view the rate of seclusion events in a broader population context (rates per capita). Similarly, 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. Also, high rates of seclusion for a few individuals have a disproportional effect on the rate of seclusion reported.

Source: National Seclusion and Restraint Database

Source data: Restrictive practices Table RP.2 (503KB XLS)

Frequency and duration

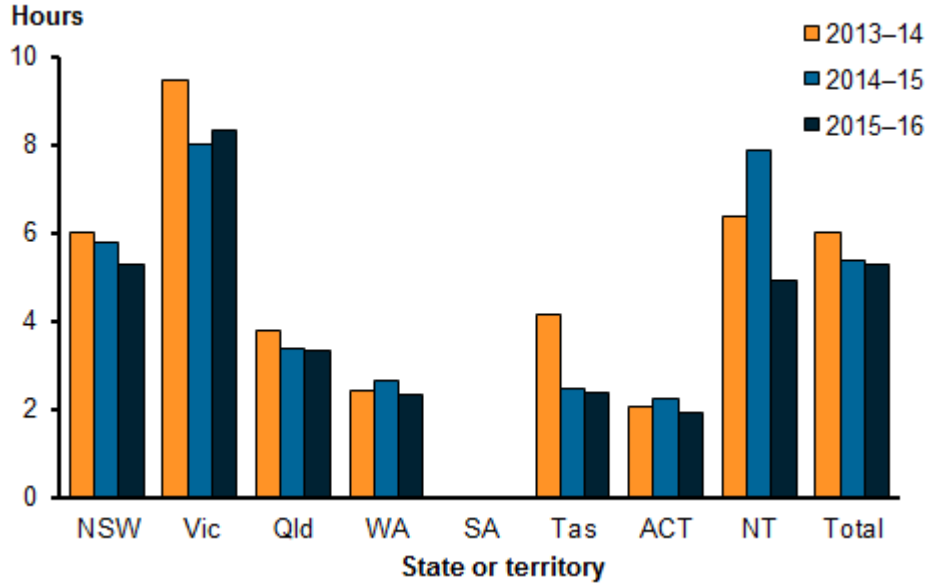
Frequency and duration of seclusion events were collected for the first time in 2013–14.

One in 20 (5.0%) episodes of care provided by Australian public sector specialised acute hospital services involved a seclusion event in 2015–16, a slight decrease from 2013–14 (5.4%). The Northern Territory had the highest proportion of episodes with a seclusion event (10.8%), while South Australia had the lowest (2.7%). The average number of seclusion events for patients who were secluded was 2.0 events per admitted care episode in 2015–16 which is largely unchanged compared to 2013–14 (2.1). The Australian Capital Territory was unable to provide the number of admitted patient care episodes and as such is excluded from the national proportion of seclusion events per episode.

The average duration of a seclusion event excluding *Forensic* services was 5.3 hours in 2015–16, 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. Data for South Australia is also excluded from the national average duration due to its use of a 4 hour block recording methodology.

Victoria reported the longest average seclusion duration with an average of 8.3 hours per seclusion event. The Australian Capital Territory had the shortest, of 1.9 hours (Figure RP.4).

Figure RP.4: Average number of hours in seclusion per seclusion event, public sector acute mental health hospital services (excluding Forensic events), states and territories, 2013–14 to 2015–16



Note: Due to longer duration times in Forensic settings, these events have been excluded from this analysis. 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. Due to increased use of community-based treatment, Victoria has fewer beds per capita than other jurisdictions resulting in higher acuity thresholds for admissions. Higher acuity on admission may be reflected in an inflated average duration for seclusion events compared to other jurisdictions.

Source: National Seclusion and Restraint Database

Source data: Restrictive practices Table RP.2. (503KB XLS)

Target population

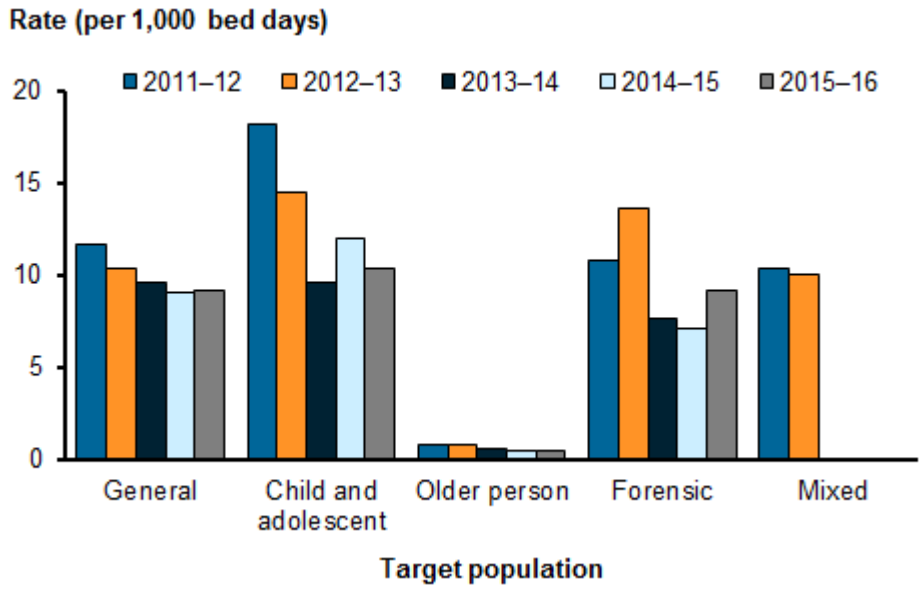
Seclusion data can also be presented by the target population of the acute specialised mental health hospital service where the seclusion event occurred. Around three quarters (78.7%) of in-scope care (total number of bed days) was provided in *General* services (data not presented). *Older person* services accounted for 13.5% followed by *Forensic* (4.2%) and *Child and adolescent* (3.6%) services.

However, data should be interpreted with caution as this methodology uses the target population of the service unit, that is, the age group that the service is intended to serve, not the age of each individual patient. Also, 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.

Over time

The highest rate of seclusion was for *Child and adolescent* services with 10.3 seclusion events per 1,000 bed days, followed by *General* services (9.2), *Forensic* services (9.2) and *Older person* services (0.5). Although a reduction in seclusion rates for the 5 years to 2015–16 was observed for all target population categories, some variability is apparent from year to year (Figure RP.5).

Figure RP.5: Rate of seclusion events, public sector acute mental health hospital services, by target population, 2011–12 to 2015–16



Note: Queensland and the Northern Territory do not report any acute Forensic services, however forensic patients can and do access acute care through General units.

Source: National Seclusion and Restraint Database

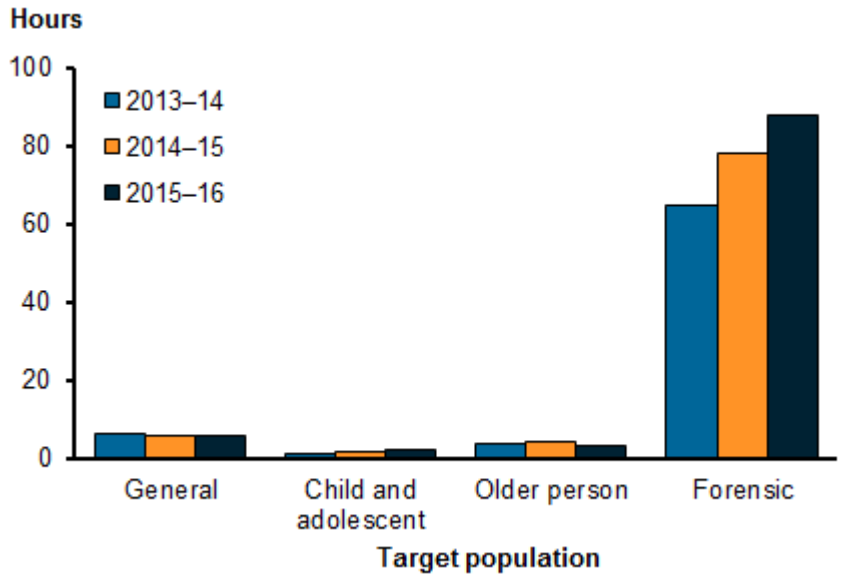
Source data: Restrictive practices Table RP.3 (503KB XLS)

Frequency and duration

Forensic services reported the highest proportion of episodes of care involving seclusion events, with 22.2% of all mental health-related episodes involving seclusion in 2015–16. This was followed by *General* (5.1%), *Child and adolescent* (3.9%), and *Older person* (0.8%) services, with all rates relatively stable from 2013–14 to 2015–16.

Forensic services had the highest frequency of seclusion, with 3.0 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; 87.9 hours per seclusion event, which is much greater than all other target population categories (1.9 to 5.5 hours). This may also be partly due to the way seclusion is recorded in *Forensic* services. *General* services reported an average time of 5.5 hours per seclusion event, followed by *Older person* (2.9 hours) and *Child and adolescent* (1.9 hours) services. The average time of the seclusion event decreased for *General* services and Older person services, and increased for *Child and adolescent* services and *Forensic* services between 2013–14 and 2015–16 (Figure RP.6).

Figure RP.6: Average number of hours in seclusion per seclusion event, public sector acute mental health hospital services, by target population, 2013–14 to 2015–16



Note: Data for South Australia is excluded from the national average duration due to its use of a 4 hour block recording methodology. Queensland and the Northern Territory do not report any acute Forensic services, however forensic patients can and do access acute care through General units.

Source: National Seclusion and Restraint Database

Source data: Restrictive practices Table RP.3 (503KB XLS)

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 2015–16, hospitals located in *Major Cities* had a seclusion rate of 7.9 events per 1,000 bed days. This rate was higher than that for *Inner Regional* facilities (7.7), and lower than that for *Outer Regional* and *Remote* area facilities combined (11.2). The proportion of mental health-related admitted care episodes with a seclusion event was similar across facilities in all areas (around 5%).

On average, seclusion events in facilities in *Inner Regional* areas were longer in duration (6.4 hours) than those in *Major Cities* (5.1) and *Outer Regional* and *Remote* areas (4.9).

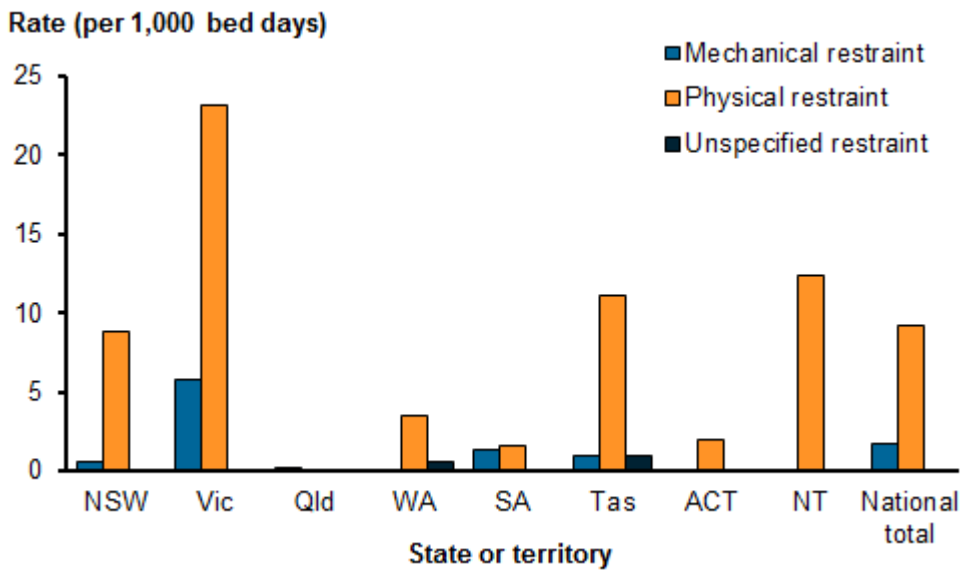
Restraint

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 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, was a very small component in 2015–16. Data improvement initiatives are expected to remove the need for an unspecified restraint category from 2016–17 onwards.

States and territories have different policy and legislative requirements regarding restraint and have therefore had different processes and systems for collecting data, different definitions of restraint and differences in the types of restraint which are reported. As such caution is needed in interpreting this data and comparing results. See the Data source section for further information.

Nationally, there were 9.2 physical restraint events per 1,000 beds days; mechanical restraint was less common (1.7 events per 1,000 bed days) (Figure RP.7). *Mechanical restraint* was not reported by the Northern Territory, and data on *Physical restraint* was not reported by Queensland. Of the states reporting data, Victoria had the highest rate of *Mechanical* and *Physical restraint* events (5.8 and 23.2 events per 1,000 bed days, respectively). This is likely to be the result of higher acuity admission thresholds due to lower per capita bed numbers inflating the results on a per bed day basis.

Figure RP.7: Rate of restraint events, public sector acute mental health hospital services, states and territories, 2015–16



Note: Victoria has fewer beds per capita than other jurisdictions resulting in higher acuity thresholds for admissions. Higher acuity on admission is likely to be reflected in an apparent higher rate of restraint per bed day compared with reporting on a population basis.

Source: National Seclusion and Restraint Database

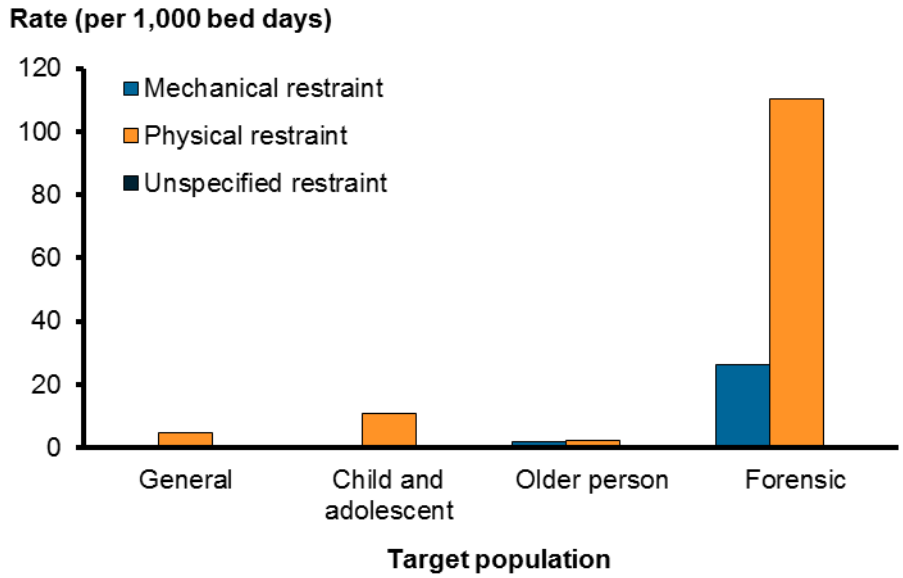
Source data: Restrictive practices Table RP.5 (503KB XLS).

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 2015–16, the use of restraint (both *Physical* and *Mechanical*)

was more common in *Forensic* services than other service types (Figure RP.8). The *Physical restraint* rate for *Forensic* services (110.2 events per 1,000 beds days) was over 10 times the rate for *Child and adolescent* services (10.9) and 20 times the rate for *General* services (5.0). The rate of *Mechanical* restraint was also highest in *Forensic* services.

Figure RP.8: Rate of restraint events, public sector acute mental health hospital services, by target population, 2015–16



Source: National Seclusion and Restraint Database

Source data: Restrictive practices Table RP.6 (503KB 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 2013–14 and the Admitted patient care NMDS 2014–15.

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. See the Residential mental health care NMDS 2014–15: National Residential Mental Health Care Database, 2015; 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 2014-15: National Community Care Database, 2015 Quality Statement. Previous years' data quality statements are also accessible in METeOR.

Seclusion 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 2015–16 seclusion data was over 95% based on acute beds admitted units reported to the Mental Health Establishments National Minimum Data Set in 2014–15.

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

Restraint data quality information

The Safety and Quality Partnership Standing Committee (SQPSC) authored a discussion paper on the development of the Restraint data collection (SQPSC 2017). Variations in state and territory legislation and reporting requirements may result in differences in the reporting of restraint events, as presented in the key concepts section. Further, changes in legislative and reporting requirements mean that data quality can be compromised as new data systems take time to become embedded in routine practice. Data reported by states and territories therefore may vary in terms of the reporting of restraint events and data quality. Comparisons should be made with caution.

New South Wales

Several services were considered as being out of scope for reporting restraint data, including a number of *Forensic* services in operation in NSW. Data scope is consistent with scope of services reported in other NSW local publications.

Victoria

Victoria reports the total number of "bodily restraint" events in their Chief Psychiatrist's Annual Report and Mental Health Annual Report series, alongside other additional contextual information and specific commentary on the use of restraint. The approach removes duplicate events where *Physical* and *Mechanical restraint* were used at the same time during a single event. Victorian data should not be added to generate a total result for the state.

Queensland

The Mental Health Act 2016 came into effect in March 2017. For the 2015–16 collection, *Physical restraint* events were not recorded. Data for *Physical restraint* events is expected for the 2017–18 reporting period.

Western Australia

Investment in data collection methodologies resulted in improvements to data quality for 2015–16. Despite these investments, a small component of restraint data was reported as unspecified restraint type. Data improvements are anticipated to remove the need for the unspecified category from 2016–17 onwards.

Tasmania

Data collection systems in Tasmania were undergoing change during the 2015–16 collection period. It is anticipate that the 2016–17 collection will be able to separately identify all restraint events as either *Mechanical* or *Physical restraint*.

References

AIHW 2016. Admitted patient care: Australian hospital statistics 2014–15: Health services series no. 68. Cat. no. HSE 172. Canberra: AIHW.

NCCC (National Casemix and Classification Centre) 2012. The international statistical classification of diseases and related health problems, 10th revision, Australian modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS), 8th edn. Wollongong: University of Wollongong.

Key Concepts Restrictive practices

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. See the data source section for information 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 provides 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.