

The use of seclusion, mechanical restraint and physical restraint in the country's mental health services is down by almost 12% in 2011

Mental Health Commission publishes report on the use of Seclusion & Restraint in 2011 and announces that it will introduce a seclusion and restraint reduction strategy in 2013

Thursday 14th March 2013. The overall use of restrictive practice used in mental health facilities across the country has dropped by almost 12% during 2011, according to a report published today by the Mental Health Commission (MHC). To build on this positive momentum the MHC will introduce a seclusion and restraint strategy this year which will set out actions for implementation by mental health services across the country, which should contribute to reducing these numbers further.

Commenting on the publication of the report, Mr John Saunders, Chairman of the Mental Health Commission said, "It is our view that the use of seclusion and restraint are not standard interventions but emergency measures which should be used in rare and exceptional circumstances and only in the best interests of the patient when the patient poses an immediate threat of serious harm to self or others."

"Our aim is to encourage approved centres to focus on preventative measures that eliminate or minimise the use of restrictive interventions. To that end the Commission has during 2012 completed a consultation exercise on a seclusion and physical restraint reduction strategy. That strategy will be published during 2013 and it will be implemented nationwide."

The use of seclusion and restraint varies widely between approved centres and this is in line with findings from other countries. Factors such as admission practices, ward design, staffing can all contribute to variation in use of seclusion and restraint.

The MHC's report, published today, details the use of three restrictive practices during 2011 – seclusion, mechanical restraint and physical restraint.

Seclusion

In the four year period from 2008 to 2011, the use of seclusion has steadily declined. Seclusion accounted for 35.5% of all restrictive interventions reported to the Commission in 2011. Less than half, 41.7%, of approved centres (32/68) indicated that they used seclusion in 2011 and the remainder (36) reported that they did not use seclusion.

In total, 1,683 seclusion episodes were reported in 2011 which when compared to 2010 show a decrease of 688 in the number of seclusion episodes recorded.

Duration of seclusion varied between approved centres ranging from less than 30 minutes to more than 72 hours. As we have seen in previous years, in 2011, over 40% of seclusion lasted for four hours or less and at least three quarters of all seclusion episodes did not extend beyond eight hours.

Although there has been a year-on-year decrease in the number of episodes of seclusion between 2008 and 2011, there has been an increase in the percentage of episodes that lasted longer than eight hours. In 2008, 11.5% of episodes lasted longer than eight hours whereas in 2011 24.8% lasted longer than eight hours.

For the fourth year, St Joseph's Intellectual Disability Services at St Ita's Hospital recorded the highest number of episodes of seclusion, the majority of which (99.7%) lasted less than eight hours. They reported 369 episodes of seclusion in 2011, a notable decrease on use reported in 2010 when there were 711 recorded. The National Forensic Service – Central Mental Hospital reported the second highest number of seclusion episodes (175), with the majority (78.2%) lasting longer than eight hours. Two dedicated child and adolescent approved centres, the Adolescent In-patient Unit, St Vincent's Hospital and the Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital, reported that they used seclusion in 2011.

Mechanical restraint

No mechanical restraint to prevent immediate threat to self or others was reported in 2011. In 2010, there were only three approved centres that reported using this mechanical restraint and it accounted for a very small proportion (0.3%) of restrictive intervention episodes for that year.

Physical restraint

There has been a year-on-year increase in the use of physical restraint. In total, 3056, episodes of physical restraint, in 52 approved centres, were reported in 2011 which is an increase of 71 episodes compared to 2010. During 2011 physical restraint accounted for 64.5% of all restrictive interventions reported to the Commission.

St Joseph's Intellectual Disability Services in St Ita's Hospital recorded the highest number of physical restraint episodes of all approved centres in 2011. This intervention was used 366 times, which was considerably less than their use in 2010 when they reported 616 episodes. All dedicated child and adolescent approved centres (5) reported using physical restraint, usage was up from 100 episodes in 2010 to 214 episodes in 2011.

In 2011, 90.5% of physical restraint episodes lasted for 15 minutes or less, 7.9% of episodes lasted for between 16 and 30 minutes and 1.6% lasted for more than 30 minutes.

In 2011, all 32 approved centres that used seclusion also used physical restraint; 22 centres only used physical restraint and 16 centres did not use any restrictive practices at all.

ENDS

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NOTES TO EDITOR

The Mental Health Commission is an independent statutory body. The primary functions of the Mental Health Commission are to foster and promote high standards of care and good practice in the delivery of mental health services and to ensure that the interests of those involuntarily admitted are protected, pursuant to the Mental Health Act 2001.

The Commission has produced *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* and a *Code of Practice on the Use of Physical Restraint in Approved Centres*, which regulate the use of seclusion and restraint in approved centres.

Approved Centre a “centre” means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder. An ‘approved centre’ is a centre that is registered pursuant to the Mental Health Act 2001. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the 2001 Act.

Mechanical restraint is defined in the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (MHC, 2009) as “the use of devices or bodily garments for the purposes of preventing or limiting the free movement of a patient’s body”. Version 2 of the Rules specifies that “*The use of cot sides or bed rails to prevent a patient from falling or slipping from his or her bed does not constitute mechanical means of bodily restraint under these rules.*”

Physical restraint is defined in the *Code of Practice on the Use of Physical Restraint in Approved Centres* (MHC, 2009) as “*the use of physical force (by one or more persons) for the purpose of preventing the free movement of a resident’s body when he or she poses an immediate threat of serious harm to self or others.*”

Restrictive interventions/restrictive practices for the purposes of this report include the use of mechanical restraint, physical restraint and seclusion.

Seclusion is defined in the *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (MHC, 2009) as “*the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving.*”