57% increase in restrictive practices for mentally ill in 10 years

Mental Health Commission report reveals worrying trends in seclusion and restraint

A new report by the Mental Health Commission has revealed a 57% increase in episodes of restrictive practices on patients in Ireland's in-patient mental health facilities over the past 10 years.

The report documents the use of seclusion, mechanical restraint and physical restraint in all approved centres for the care and treatment of those suffering from mental illness during the years 2017 and 2018. However, it also draws comparisons with figures reported by the Commission in 2008 - the year the mental health regulator first commenced reporting on restrictive practices across approved units.

The Commission reported 4,765 combined episodes of physical restraint and seclusion in 2008. In contrast, it has reported that there were 7,420 episodes of restrictive practices reported to the Commission in 2017, and 7,464 in 2018. The 2018 figure equates to a 57% increase in the total reported for 2008.

In terms of intervention types, the report revealed an 18% increase in episodes of physical restraint over a 12-month period, with 5,665 episodes recorded in 2018 compared to 4,773 in 2017. Physical restraint was used in 85% of centres in 2018, as opposed to 81% in 2017, while 1,207 people were physically restrained in 2018, 82 more people than in 2017.

There were 1,799 episodes of seclusion in 2018, compared to 1,392 in 2017, a 29% increase year-on-year. The report also noted that seclusion was used in 42% of centres in 2018, and that there were 317 episodes in 2018 where a person was secluded for more than 24 hours, and 81 episodes where a person was secluded for over 72 hours, both totals representing a marked increase from 2017.

In contrast, the use of mechanical restraint was low in 2017 and 2018. Only one approved centre - the Central Mental Hospital - reported the use of mechanical restraint, with all episodes involving the use of handcuffs.

"This report provides information on the use of restrictive practices, the services using them, the people affected, and the quality and safety of the interventions," said Director of Standards and Quality Assurance at the Mental Health Commission, Rosemary Smyth.

"The Commission has an oversight role to ensure that restrictive interventions are only used where strictly necessary, and that any interventions are undertaken safely, and in line with specified rules and codes of practice. Any intervention which is used and which compromises a person's liberty should be the safest and least restrictive option necessary to manage the immediate situation. It must be proportionate to the assessed risk, and employed for the shortest possible duration.

"The Commission continues to strongly advocate for the use of de-escalation measures over restrictive practices. For these measures to be successful, it is essential that staff are appropriately trained in de-escalation and in clinical risk management. In 2017, the Commission set mandatory training for all healthcare professionals in approved centres in the prevention, de-escalation and management of violence and aggression."

The Chief Executive of the Mental Health Commission, John Farrelly, said that while the report clearly demonstrated an open culture of reporting, it also evidenced a lack of oversight and

governance in the use of restrictive practices by the Health Service Executive (HSE) over a 10-year period.

"It's very heartening that the people working in our mental health services are both forthcoming and honest when it comes to reporting instances of restrictive practices. We want that to continue, and services and their staff should be complemented for their courage and candour in this respect.

"However, we also have to acknowledge that we have a cultural issue when it comes to the use of restrictive practices in this country that we need to tackle without delay. When one considers that there is no evidence of a therapeutic benefit associated with the use of restrictive practices, and limited evidence of restrictive practices reducing behaviours of violence and aggression, it is disappointing to note that episodes of restrictive practices in this country have increased by 57% in just 10 years. The legal basis for restrictive practices must always be interrogated if we are to vindicate the human rights of persons accessing services. Every such person has a right to dignity, bodily integrity, privacy and autonomy.

"Earlier this year, the Mental Health Commission took the decision to prosecute the HSE following reports by our inspectors of conditions at The Department of Psychiatry at St Luke's Hospital, Kilkenny that referenced reports of hair and hardened food and other dirt on the floor of the unit's seclusion room, along with fluid stains on the room's walls and windows by the Commission's inspections.

"The conditions in St Luke's demonstrated a clear disrespect for mental health patients and while we have not found evidence of similar conditions in any other seclusion room since then, the fact that seclusion is still being used in 42% of approved centres today is a worrying statistic and one that we would like to see drop significantly.

"Similarly, while it is very welcome that services no longer use bodily garments – more commonly known as strait jackets – we have been calling for legislation to ensure the laws governing the physical restraint of individuals is fit for purpose. The Commission intends to put forward recommendations in this regard as part of our current review of the Heads of Bill to amend and update the Mental Health Act 2001," added Mr Farrelly.

The Mental Health Commission has written to the HSE seeking a clear strategy and implementation plan that will contribute towards a significant reduction in episodes of restrictive practices across the country's mental health services. This plan should also set out how the HSE plans to increase compliance with the regulation on de-escalation training.

'The Use of Restrictive Practices in Approved Centres – Seclusion, Mechanical Restraint and Physical Restraint: Activities Report 2017 and 2018' can be accessed at www.mhcirl.ie.

Notes to editor

The Mental Health Commission:

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.

Approved Centres:

A centre is “a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder” (from Mental Health Act 2001). To operate an in-patient mental health service in Ireland, the service must be registered as an ‘approved centre’ with the Mental Health Commission. Each centre must re-register for approval every three years. Upon registration, the service must comply with regulations made under the 2001 Act. Failure to comply with regulations may result in enforcement action including: corrective and preventative action plans, an immediate action notice, a regulatory compliance meeting, registration conditions, removal from the register (closure), and prosecution.

Approved centres are also required to return non-identifiable aggregate data on the use of seclusion, mechanical restraint, and physical restraint on an annual basis.

Restrictive Practices

This includes the use of mechanical means of bodily restraint, physical restraint and seclusion.

Seclusion

Seclusion is defined 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”.

Mechanical Restraint

Mechanical restraint is defined as “the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient’s body”.

Physical Restraint

Physical restraint is defined 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”.