Restrictive practices such as seclusion and restraint are undesirable and should only be used as a last resort, according to the Mental Health Commission

The Commission calls for a reduction in the use of restrictive practices. Such practices were used in 79% of in-patient mental health services and there were 5,000 episodes reported in 2016

Embargoed until 01:01 (Dublin) 19th October 2018. There is no therapeutic benefit to restrictive practices and an increasing focus is needed on the use of preventive approaches and de-escalation for managing behaviour, according to the Mental Health Commission (MHC), which published a report on the use of restrictive practices in approved centres in 2016 today.

Commenting on the publication Rosemary Smyth, Interim Chief Executive, Mental Health Commission said, “Intervention that compromises a person’s liberty is very serious and should only ever be used as a last resort. We know that there is no evidence of a therapeutic benefit associated with the use of restrictive practices and there is also limited evidence of restrictive practices reducing behaviours of violence and aggression. The Commission is not in favour of such practices and encourages other measures to de-escalate situations.”

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. If used, it 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.

In 2016, there was a total of 5,000 episodes of seclusion and physical restraint recorded nationally which involved 1,291 residents of approved centres. Physical restraint was the most frequently used restrictive intervention. It was used in the majority of approved centres and accounted for almost 70% of all interventions. Seclusion accounted for almost 30% of restrictive interventions.

In 2014, the Commission published a Seclusion and Restraint Reduction Strategy (MHC, 2014) for the purposes of achieving significant reductions in the use of seclusion and physical restraint while also ensuring resident and staff safety.

Most approved centres do not have access to a psychiatric intensive care unit and in a situation where de-escalation techniques are not effective, can be left with last resort options of seclusion, physical restraint or rapid tranquilisation. A Vision for Change, the government policy on mental health services, recommended 30 intensive care beds per 1,000,000 population: based on the current population this would amount to 140 beds. The Commission is aware of only 42 beds nationally.

“The Commission strongly advocates for the use of de-escalation measures over restrictive practices. For these 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 to be trained in the prevention and management of violence and aggression. We are hopeful that increased training levels will contribute to the reduction of restrictive practices and we will continue to monitor the situation closely.”

Summary of findings

- Restrictive practices, including physical restraint and/or seclusion, were used in the majority (79%) of in-patient mental health services (approved centres) in 2016.
- In total there were 5,000 episodes of restrictive practices reported to the Mental Health Commission in 2016.
- When the Commission started reporting on restrictive practices in 2008, there were 4,765 episodes of physical restraint and seclusion.
- In December 2014, the Commission published a Seclusion and Restraint Reduction Strategy setting out a framework for the reduction of restrictive practices in approved centres.

Seclusion

- Seclusion was used in 42% of approved centres in 2016, this compares to 39% in 2015.
- There were 1,475 episodes of seclusion in 2016, this was a decrease from 1,485 in 2015.
- 636 people were secluded in 2016.
- The HSE Community Healthcare Organisation (CHO) with the highest rate of episodes of seclusion per population was CHO 5: South Tipperary, Carlow, Kilkenny, Waterford, and Wexford.
- The CHO with the lowest rate of episodes of seclusion per population was CHO 1: Cavan, Donegal, Leitrim, Monaghan and Sligo.
- More male residents than female residents were secluded (64%).
- The majority of residents secluded were under 40 years old (62%).
- There were 213 episodes where a person was locked in seclusion for over 24 hours.
- There were 43 episodes where a person was locked in seclusion for over 72 hours.
- There was considerable variation between approved centres in the average duration of seclusion.

Physical Restraint

- Physical restraint was used in 79% of approved centres in 2016, this compares to 75% of approved centres in 2015.
- There were 3,525 episodes of physical restraint in 2016, this was an increase from 3,267 in 2015.
- 1,155 people were physically restrained in 2016.
- The CHO with the highest rate of episodes of physical restraint per population was CHO 3: Clare, Limerick, North Tipperary/East Limerick.
- The CHO with the lowest rate of episodes of physical restraint per population was CHO 8: Laois/Offaly, Longford/Westmeath, Louth/Meath.
- More male residents than female residents were physically restrained (54%).
- Over 90% of episodes of physical restraint lasted less than 15 minutes.
- The highest proportion of episodes of physical restraint were initiated between 10am and 11am.
- 1 in 4 people restrained were aged between 18 and 29.
Notes to the Editor:

Physical restraint is defined in the Code of Practice on the Use of Physical Restraint in Approved Centres 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” (MHC, 2009b).

Seclusion is defined in the Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint 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” (MHC, 2009a).

Mechanical means of bodily restraint is defined in the Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint as “the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient’s body” (MHC, 2009a). 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” (MHC, 2009a).

Mechanical restraint to prevent immediate threat to self or others is rarely used.

About 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.

To operate an in-patient mental health service in Ireland, the service must be registered as an ‘approved centre’ with the Mental Health Commission. Upon registration the service must comply with regulations made under the Mental Health Act 2001. 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.