Use of restraint in Australian specialised mental health hospital services:

Discussion paper on the development of a national data collection
Use of restraint in Australian specialised mental health hospital services: Progress report on the development of a national data collection.

A report produced for the Australian Health Ministers Advisory Council’s (AHMAC) Mental Health Drug and Alcohol Principal Committee (MHDAPC) by the Safety and Quality Partnership Standing Committee (SQPSC).

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Background

Seclusion and restraint are forms of restrictive interventions used in Australian mental health care settings. People with mental illness and their carers advocate that restrictive practices 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 use of restraint in particular can lead to serious harm and even death (Rakhmatullina et al. 2013).

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 statement recognises that while best-practice care reduces, and where possible eliminates, the use of seclusion and restraint, that there are certain circumstances where their use is supported; as a safety measure to protect the patient, staff and/or others when all other interventions have been exhausted. Further, restrictive practices “should be used within approved protocols by properly trained professional staff in an appropriate environment for safe management of the consumer” and must not be used as a form of punishment.

Internationally, the issue of patient rights versus safety of the patient and others has been addressed in a similar way to the RANZCP approach, that is, all attempts should be made to eliminate restrictive practices, but that seclusion and restraint remain intervention options available to clinicians as a last resort (Department of Health UK 2014, Emanuel et al. 2013, Canadian Psychiatric Association 2010, Commonwealth of Pennsylvania 2006).

The Australian National Mental Health Commission’s (NMHC) Position statement on seclusion and restraint in mental health (NMHC 2015) echoes the premise of the commitment made by Australian governments in 2005 to the National safety priorities in mental health: A national plan for reducing harm, which aims to reduce and where possible eliminate the use of seclusion and restraint (NMHWG 2005). The research supporting the Commission’s position statement explores the complex issues around the use of seclusion and restraint, in particular the balance between patient’s rights and the safety of patients and others (Melbourne Social Equity Institute 2014). In order to better understand the use of restrictive practices in Australia, the NMHC position statement calls for leadership across a range of priorities including “national monitoring and reporting on seclusion and restraint across jurisdictions and services.”

Since 2008–09, the Safety and Quality Partnership Standing Committee (SPQSC), operating under the auspices of the Council of Australian Government’s Health Council, has successfully negotiated ongoing collection and publication of national seclusion events occurring in Australian specialised mental health acute public hospital services (AIHW 2015). 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. SPQSC has been pursuing a similar data collection on the use of restraint; however, the task has proven to be more complex to date than the seclusion data collection experience.
**Legislative, Policy and Guideline environment**

The use of restraint in Australian mental health service settings is governed by individual state and territory legislation, service provision policies, regulations and guidelines resulting in disparate practice and data systems. These differences between the states and territories presents unique challenges in developing a comparable national restraint data collection. Table 1 outlines some of the known differences between state and territory in terms of their approach to the use of restraint in mental health services.

**Table 1: Restraint, by state and territory**

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>WA</th>
<th>SA</th>
<th>Tas</th>
<th>ACT</th>
<th>NT</th>
</tr>
</thead>
<tbody>
<tr>
<td>State/territory legislation governs the use of mechanical restraint</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>State/territory legislation governs the use of physical restraint</td>
<td>✗</td>
<td>✓</td>
<td>✓*</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>State/territory level standards and/or guidelines exist for the use of restraint for use in mental health settings</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Data for mechanical restraint routinely collected centrally and publicly reported</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Data for physical restraint routinely collected centrally and publicly reported</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>Adverse events associated with the use of restraint are routinely collected centrally (may not be reported)</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

* The Queensland Mental Health Act 2016, not implemented at the time of writing, includes governance of physical restraint.

The Australian Law Reform Commission made specific mention of the legislative and regulatory differences in their discussion paper *Equality, Capacity and Disability in Commonwealth Laws*, which called for a national approach to the regulation of restrictive practices (ALRC 2014). The NMHC position paper also explored the potential benefits of nationally uniform regulations and guidelines for the use of seclusion and restraint (NMHC 2015). While uniformity would be desirable, in the absence of legislative coherence a range of service level reforms, aimed at eliminating the use of restraint in mental health settings, have been enacted by Australian governments since the 2005 commitment:

i. *National Seclusion and Restraint Reduction Forums*, of which there have been ten, the most recent in 2015 entitled “From here to there: Shaping the path to harm free care”.

ii. A national framework for recovery-oriented mental health services: guide for practitioners and providers (AHMAC 2013) includes the concept of ‘Recovery, self-determination and safety’ stating that “Mental health practice and service delivery consistent with recovery principles require an emphasis on maximising choice and self-determination. It also requires a reduced reliance on coercion, seclusion and restraint.”

iii. *National standards for mental health services 2010* (Department of Health 2010) include a range of standards aimed at promoting the rights of individuals and the elimination of seclusion and restraint. For example, standard 1.9 “The mental health service (MHS) upholds the right of the consumer to be treated in the least restrictive environment to the extent that it does not impose serious risk to the consumer or others.”, and standard 2.2 “The MHS reduces and where possible eliminates the use of restraint and seclusion within all MHS settings.”.
Foundations for establishing a national restraint data collection

Building on the success of the national seclusion data collection activities, the SQPSC has been pursuing the development of a national restraint data collection, which has required detailed consideration and negotiation of a range of technical data related issues. SQPSC’s progress to date with this initiative is detailed in this report.

Definition of restraint

A specially constituted Restraint Working Group (RWG) of the SQPSC developed national definitions of Restraint, Mechanical restraint and Physical restraint (Table 2). These definitions have subsequently been endorsed by the Mental Health, Drug and Alcohol Principal Committee and are included in the National Health Data Dictionary, the foundation for collecting nationally comparable Australian health data.

<table>
<thead>
<tr>
<th>Table 2: Nationally agreed definition of Restraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restraint</td>
</tr>
<tr>
<td>Mechanical restraint</td>
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<tr>
<td>Physical restraint</td>
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</tbody>
</table>

Source: Restraint glossary item, National Health Data Dictionary (METeOR ID 558140)

Identification of a reliable data source

SQPSC investigations established that states and territories vary in their capacity to report data against the agreed definitions. Variance is mostly due to jurisdictional differences in the collection and reporting of data about restraint events rather than fundamental issues applying the definitions to local mental health service settings. Collection of data via routine administrative National Minimum Data Sets was determined to be a prohibitively lengthy option, due to coding and counting unit incongruities. Further, uncertainty regarding the ability of restraint events to be adequately coded from patient file notes was considered to be a substantial risk to data quality and completeness.

SQPSC established that states and territories had implemented alternate mechanisms to collect data on restraint events, using a mix of electronic and manual paper-based methods. Data on restraint events was found to be reported to the offices of state and territory Chief Psychiatrists (or equivalent) in accordance with state and territory legislative requirements that stipulate reporting of restraint events or local data collection agreements. The Chief Psychiatrists’ restraint data holdings were therefore identified as the most viable, timely, ongoing data sources for national reporting.
**SQPSC restraint data request**

To date SQPSC has undertaken two restraint data collection exercises, based on the agreed national definitions, using data sourced from the offices of the Chief Psychiatrists (or equivalent), subject to the following data collection rules:

- Restraint data was limited to specialised mental health public hospital acute service units.
  - Short stay mental health units were in scope, e.g. Psychiatric Emergency Care Centres.
  - Wards or units other than specialised mental health services, such as Emergency Departments, were out of scope.
  - Specialised mental health acute forensic hospital services were in scope regardless which department managed the service, for example, health versus correctional services department.

- Data was requested at the hospital level, disaggregated by the target population of the services provided by the hospital, that is, the population group primarily targeted by a specialised mental health service (child and adolescent, forensic, general or older person services; see METeOR ID 493010 for the definition).

- Data could be provided either as separate counts for mechanical and physical restraint or as a total ‘unspecified’ restraint count.

The data requests were managed by the offices of the Chief Psychiatrists, as the legal data custodians of the identified data source. It is important to note that SQPSC is conducting a separate data development activity on the use of injectable medications to rapidly calm individuals and/or relieve symptoms during specialised mental hospital care. These pharmaceutical intervention events were excluded from the restraint data collection activity, despite sometimes referred to as a form of restraint.

**State and territory restraint data**

**2013–14 data collection**

The first SQPSC restraint data collation exercise using 2013–14 data yielded a mixed result. At the time, several states and territories were reviewing, or had recently implemented, new mental health legislation and policies, some of which included changes to restraint reporting requirements. Therefore, with a number of restraint data collections undergoing modifications or in their infancy, overall data quality was assessed as being inadequate for public reporting.

**Issues with data governance**

The data collection activity exposed that the governance of restraint data collections differs between the states and territories. That is, while all Chief Psychiatrists have unfettered access to data collected in order to discharge their legislative obligations (see Table 1), the data custodianship of a jurisdictional collection does not always necessarily reside with the Chief Psychiatrist. This adds an additional level of complexity to both the day to day management of these collections and data refinement and development activities.
2014–15 data collection

The second data request for 2014–15 restraint data was judged to be more successful, providing the basis to inform both the volume of overall restraint use within each state/territory and to demonstrate progress towards a nationally comparable restraint data collection.

Nationally, 12,644 restraint events were recorded in specialised mental health acute public hospital services in 2014–15, across the range of service target population categories.

State and territory profiles presented below are sourced from the SQPSC 2014–15 restraint data collection exercise. The profiles include commentary on the progress of each state and territory towards establishing a robust, routine restraint data source, on the local use of data and future data development commitments. Known differences between data sourced from the SQPSC data exercise and other publicly available data are noted where applicable.

Important note: Comparisons between states and territories are not considered valid at this time and should not be made due to ongoing investigations into known variation in reporting requirements between states and territories. In agreeing to publish these data, states and territories recognise further work is required before a nationally comparable data set can be achieved.

### New South Wales

<table>
<thead>
<tr>
<th></th>
<th>Restraint events (per 1,000 bed days) 2014–15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical restraint</td>
<td>8.3</td>
</tr>
<tr>
<td>Mechanical restraint</td>
<td>0.1</td>
</tr>
</tbody>
</table>

New South Wales has a multi-level policy and monitoring system that governs restrictive practice use. At the time of writing, the revised *Reducing Restrictive Interventions in Mental Health* policy is anticipated to be published in the near future.

**Local data use:**

Comparative data at a unit level is reported quarterly. Restrictive practices data is routinely a focus in NSW’s Clinical Benchmarking Program. The data and potential strategies for reduction are discussed at local site visits with clinicians and members of their leadership team.

**Future data development directions:**

Nil
Victoria collects and publicly reports more detailed information than was requested for the SQPSC activity. Available data includes patient demographics such as gender and age, body position during restraint, duration of restraint, reason for restraint and number of restraint events in the same hospital admission. See the Chief Psychiatrist’s Annual Report 2014–15 for further information which also provides detailed commentary on the Victorian results. Note that data may differ to the above due to ongoing data validation processes.

**Local data use:**
Restraint data is used at local and state level as part of quality performance initiatives.

**Future data development directions:**
2014–15 was the first period that data was recorded according to the 2014 Act, which included for the first time the mandatory reporting of physical restraint.

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Queensland does not collect data on physical restraint events; however, under the new Mental Health Act 2016, these events will be recorded. Queensland collects and publicly reports more detailed mechanical restraint data than was requested for the SQPSC activity. See the Queensland Director of Mental Health 2014–15 report for additional information. Note that data differs substantially to the above due to the scope specified for this report, that is, specialised mental health acute public hospital services.

**Local data use:**
The Mental Health Alcohol and Other Drugs Statewide Clinical Network has an important role supporting services. For example, in June 2015, the Network hosted a Least Restrictive Practices Roundtable attended by key staff from acute adult mental health hospital services across Queensland. The Roundtable promoted shared learnings from evidence-based programs that support a reduction in the use of restrictive practices such as seclusion and restraint.

**Future data development directions:**
In April 2016, Queensland implemented functionality within the clinical information system to enable the collection of mechanical restraint data. Complete data from this source will be available from the 2016–17 reporting year.

The Queensland Mental Health Act 2016 was passed in March 2016 and requires the recording of physical restraint events. Work is underway to determine the circumstances in which recording is required and modifications will be made to the clinical information system to allow for the collection of physical restraint data. Complete data from this source should be available from the 2017–18 reporting year.
Not all specialised mental health hospital services in Western Australia (WA) are authorised to use restraint. Mechanical restraint is rarely used in authorised WA mental health services, with no events reported during 2014–15. When restraint is used to escort a patient to seclusion, the restraint event is not reported separately to the seclusion event.

Local data use:
The Mental Health Act 2014 (MHA14), implemented on 30 November 2015, saw new reporting instruments established by the Mental Health Commission and approved by the Chief Psychiatrist. The MHA14 requires the Chief Psychiatrist to publish an Annual Report to be tabled in Parliament for the period 30 November 2015 to 30 June 2016. The Chief Psychiatrist encourages authorised mental health services to openly publish seclusion and restraint data publically within their services allowing for opportunities to ensure focus is on providing the least restrictive care to patients.

Future data development directions:
The WA Mental Health Act 2014 comprised a raft of changes, including provisions around the use of seclusion and restraint. These changes involve both the circumstances under which restraint can be used and the reporting requirements. The Act requires authorised mental health services to report the details of every seclusion and restraint event directly to the Chief Psychiatrist. In addition, authorised mental health services keep their own register of seclusion and restraint. The Office of the Chief Psychiatrist has implemented a process to validate the accuracy of the data reported to the Chief Psychiatrist against the data collected by the authorised mental health services for their internal Registers. The Chief Psychiatrist WA remains committed to working collaboratively with the Mental Health Unit, Department of Health and the Mental Health Commission to update mental health information systems as resources permit.

South Australia collects and publicly reports more detailed restraint data than was requested for the SQPSC activity. While data is available for the number of restraint events, duration and reason for event data are reported in combination with seclusion. See the Annual Report of the Chief Psychiatrist of South Australia 2014–15 for additional information and commentary. Note that data differs substantially to the above due to the scope specified for this report, that is, specialised mental health acute public hospital services.

Local data use:
Data is reported and discussed at state-wide monthly Strategic Mental Health Quality Improvement Committee and bi-monthly Trauma Informed Practice Working Group meetings, chair by the Chief Psychiatrist.

Future data development directions:
South Australian reviewed the reporting of restraint in the Safety Learning System in July 2013 which substantially improved the collection of restraint data. Work is ongoing to further collate more detailed clinical data to the collection.
Tasmania

Tasmania restraint data is available for ‘unspecified events’ only, that is, the data source does not distinguish between mechanical and physical restraint events for the 2014–15 period.

Tasmania publicly reports a range of restraint data including the broad area in which the event occurred and overall average restraint duration and reason for restraint. See the ‘Statutory roles’ section of the Chief Psychiatrist Annual Report 2014–15 for further information.

Local data use:
Tasmania has established a Statewide Restrictive Intervention Panel to review all incidents of restrictive practice. These reviews will identify both structural and case-specific problems and will enable discussion and implementation of suitable remedies aimed at keeping these practices to a minimum.

Future data development directions:
The Tasmanian data collection methodologies have undergone substantial development over the last couple of years. Work is ongoing to improve data quality for the ‘type’ of restraint. It is anticipated that the 2015–16 data will be of sufficient quality to report mechanical and physical restraint events separately.

Australian Capital Territory

No restraint events were reported to the restraint data collection for mental health services in the ACT during 2014–15.

The use of mechanical restraint is a rare occurrence in the ACT. While the use of physical restraint was recorded in ACT data systems for 2014–15, the data were not in a format that was readily available to supply to the national collection. With the implementation of the Mental Health Act 2015 on 1 March 2016, the Canberra Hospital and Health Service has capacity to supply data for national reporting from 2015–16 onwards.

Local data use:
Once data becomes routinely available, it will further inform the nature of any restraint and action needed to reduce/eliminate restraint.

Future data development directions:
The Canberra Hospital and Health Service is working towards a Restraint Register, covering all health services. (Note: at present, this register is already in place in mental health services.) Existing processes under the Mental Health Act 2015 are under review inclusive of all aspects of the Act since its implementation.
Although there are provisions governing use of mechanical restraint in the Act, mechanical restraint is not used in Northern Territory services.

Local data use: Not applicable.

Future data development directions: Nil
National restraint data collection measurement and comparability issues

Despite the improvement between the 2013–14 and 2014–15 data collection exercises, a range of issues impact on the ability to compare results between states and territories and to monitor restraint activity in Australian specialised acute mental health hospital services over time.

1. Data quality issues

States and territories are responsible for the quality of their data collections which may be affected by such issues as:

- compliance with jurisdictional reporting requirements, mostly commonly in relation to under reporting;
- the impact of the collection system type, for example, manual paper based versus electronic records;
- the impact of transitions to new data collection systems, especially when these have occurred during a reporting period.

2. Data comparability issues

The national definition of restraint is the foundation for a routine national collection; however, comparability is affected by local interpretations of the definition and the range of exclusions based on individual state and territory legislation. There are differences in state and territory legislation that explicitly exclude some physical interactions between staff and patients that might be considered to meet the national definition of restraint. For example, support or assistance to a patient in their daily living activities (holding onto a patient to/from a bed) may or may not be explicitly excluded as a form of physical restraint. Further, the interaction between mental health legislation and other state and territory laws may also impact on the reporting of restraint events. For example, restraint by state and territory police officers permitted under state laws is likely excluded; however, variation may be possible in reporting restraint events under these circumstances both within and between states and territories.

3. Data does not cover all places where restraint may occur.

The SQPSC data collection exercise was specifically limited to specialised public acute mental health hospital services. This approach does not address the use of restraint on people with a mental illness as they transition through other parts of the health system. For example, data was not collected from state and territory emergency departments, which are often the presenting location for patients in their most unstable, acute phase of mental illness. A recent study found that while the restraint rate in four emergency departments was relatively low at approximately 0.04% of all presentations, over 90% of all patients restrained had a mental illness and were subsequently compulsorily hospitalised (Gerace et al. 2014). SQPSC is mindful of this limitation; however, the ability to collect, collate and report data on restraint events for mental health patients in non-mental health service areas is limited. Further investigation of methods to collect and report restraint events for mental health patients beyond specialised mental health services acute public hospital services is ongoing.
4. Reporting data for patients who transition within a hospital

The limitation of the scope of this national initiative to specialised acute mental health hospital services does not address the situation when a patient transitions from one ward/unit to another within a hospital. For example, a patient may enter the hospital via the emergency department and may be restrained, either before or during the emergency treatment. The restraint may continue until the patient is transferred to the specialised mental health ward/unit. Whether to include such events in the total restraint events count is contentious. Judgments about the ability of mental health policies, programs and training to reduce the rate of restraint would be influenced by actions of those operating beyond the scope of targeted service improvement strategies. From the patient’s perspective, these boundary issues are largely irrelevant. SQPSC is cognisant of the need to explore the use of restraint beyond the confines of specialised mental health services to ensure safe and effective care is provided to individuals experiencing a mental health crisis during any encounter with any hospital service in Australia. From a data comparability and longer term monitoring perspective, it is likely that the inclusion/exclusion of such events is not consistent both within and between states and territories and over time, and this will impact on the utility of the data collection to monitor the progress of national service improvement initiatives.

Way forward

SQPSC is committed to developing a routine, national restraint data collection to provide a comprehensive view of the use of restraint in Australian specialised mental health services, in order to support service level reforms aimed at reducing, and where possible eliminating, the use of restraint in mental health services. However, the data quality and comparability issues discussed in this paper indicate that further work is required to develop a robust, valid national data collection. The data collated in the two restraint data exercises demonstrate that progress is being made and that there is an ongoing commitment to establishing a national data collection by all states and territories. SQPSC is intent on developing meaningful national level indicators based on a valid, robust data collection that will enable the monitoring of the progress of national and state and territory system level reforms.
References

Australian Health Ministers’ Advisory Council (AHMAC) 2013. *A national framework for recovery-oriented mental health services: policy and theory.* Canberra: AHMAC.


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.