Restrictive practices in mental health care

+/- On this page

Key points

- **Almost 1 in 5 (19.9%)** residential mental health care episodes were for people with an involuntary mental health legal status during 2019–20.
- **Around 1 in 7 (14.7%)** community mental health care contacts were for people with an involuntary mental health legal status during 2019–20.
- **45.6% of hospitalisations** and **55.6% of patient days** in admitted hospital acute units were for people with an involuntary mental health legal status during 2019–20.
- **7.3 seclusion events** per 1,000 bed days were reported for acute specialised mental health hospital services during 2020–21, down from 13.9 during 2009–10.
- **5.2 hours** was the **average seclusion duration** during 2020–21.
- **11.6 physical restraint events** per 1,000 bed days and **0.7 mechanical restraint events** per 1,000 bed days were reported during 2020–21.

+/-Summary

In Australia, all states and territories collect data regarding the use of restrictive practices in public acute mental health services. Data include the provision of mental health treatment to

persons on an involuntary basis, and the use of seclusion and/or restraint, under state and territory mental health legislation.

Nationally in 2019–20 mental health care was provided to people on an involuntary basis during:

- 1 in 5 residential mental health care episodes (19.9%)
- 1 in 7 community mental health care service contacts (14.7%)
- almost 3 in 5 (55.6%) patient days in inpatient Acute units, and
- 1 in 2 (49.7%) patient days in inpatient Non-acute units.

People in acute hospital care in Australia were secluded 12,371 times during 2020–21 for 5.2 hours on average (excluding *Forensic* services). This represents 7.3 events per 1,000 bed days. The national seclusion rate has nearly halved over the last decade.

Nationally, during 2020–21 there were 19,690 physical restraint events and 1,108 mechanical restraint events, representing 11.6 and 0.7 events per 1,000 bed days respectively. Over the last five years (since data coverage began), the national physical restraint rate has not changed much, while mechanical restraint has more than halved.

Data on involuntary treatment in both community and residential mental health care setings have been available for almost two decades. The use of seclusion and restraint in acute admitted mental health care settings (first reported in 2016) and involuntary treatment in acute and non-acute admitted mental health care settings (first reported in 2019) are more recent data intiatives.

The collection and improvement of data on the use of restrictive practices in Australian mental health care is an ongoing initiative. Annual reporting continues through cooperative efforts in the mental health data sector under national priority endeavours, particularly through coordinated work with state/territory mental health authorities.

Spotlight data

Seclusion is the confinement of a person alone in a room or area where they are prevented from free exit.

National seclusion rate nearly halved from 2009-10 to 2020-21

This is real change in how services use seclusion and how patients are treated during hospitalisation

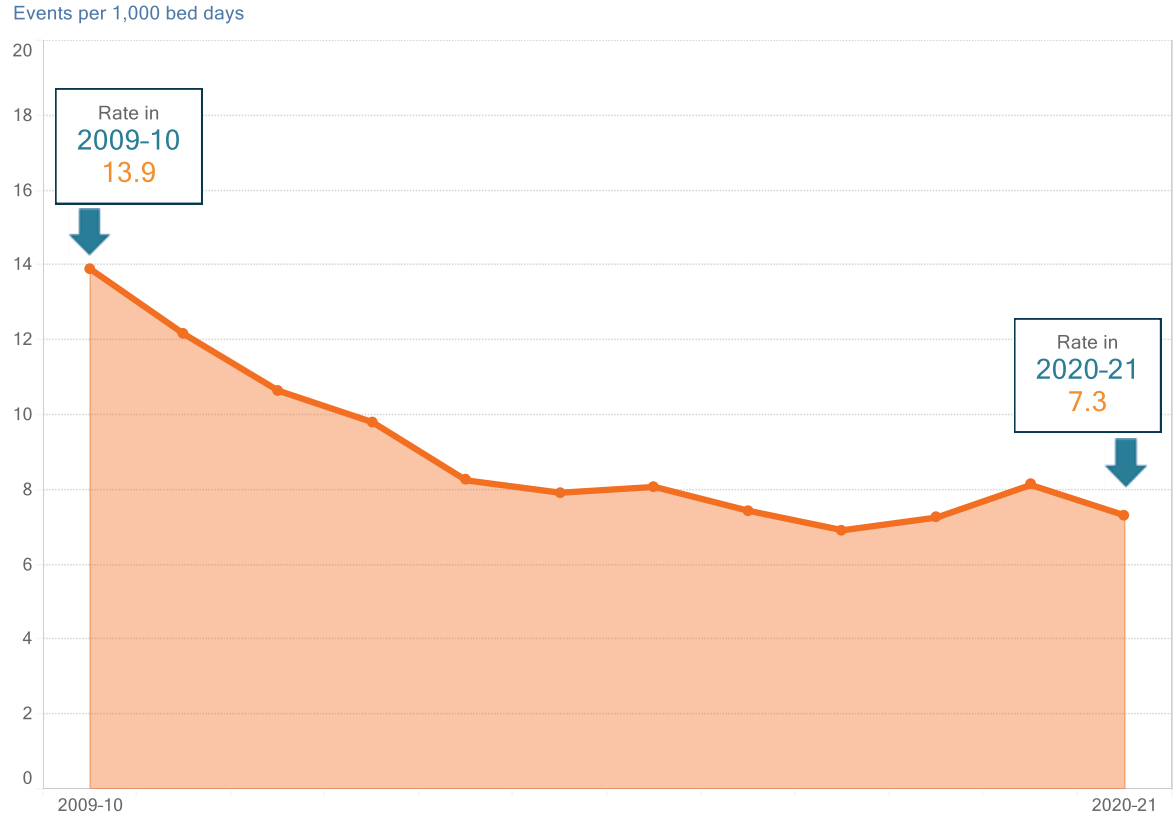

Figure RP Spotlight: Rate of seclusion in Australia, public sector acute mental health hospital services, 2009-10 to 2020-21.
http://www.aihw.gov.au/mhsa

Source: National Seclusion and Restraint Database, Table RP.5.

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Involuntary treatment in hospital care and rates of seclusion and restraint are national indicators under the Key Performance Indicators for Australian Public Mental Health Services.

Data downloads

XLS Restrictive practices tables 2020–21

PDF Restrictive practices section 2020–21

Link - Data source and key concepts related to this section

Data coverage is 2019–20 for involuntary care, 2008−09 to 2020–21 for seclusion, and 2015–16 to 2020–21 for restraint. This section was last updated in May 2022.

You may also be interested in:

- Consumer outcomes in mental health care
- Consumer perspectives in mental health care
- Specialised mental health care facilities

Introduction

Restrictive practices in care settings include any practices and interventions that restrict a person's rights, including their freedom to move (Australian Government 2014; SQPSC 2016).

State and territory mental health-related legislation specifies the conditions under which restrictive practices may be used. These include the assessment, admission and treatment of people in health services on an involuntary basis in some circumstances, and the use of seclusion (when a person is confined alone in a room or area where free exit is prevented) and restraint (when a person's freedom of movement is restricted by physical or mechanical means). Minimising the use of seclusion and restraint in mental health services is a key focus across multiple sectors—including consumers, carers, governments and services.

This section reports the latest available national data on the treatment of people on an involuntary basis in Australian public community mental health care services, residential mental health services, and acute and psychiatric hospitals. This section also reports data on the use of seclusion and restraint in Australian mental health acute hospital services.

Involuntary mental health care

All states and territories have legislation on the treatment of people with mental illness. These include provisions relating to the treatment of people on an involuntary basis, which means that under some specific circumstances, a treatment order can be applied to provide mental health treatment—including medication and therapeutic interventions—without the person's consent being given.

A person's mental health legal status indicates if their treatment was on an involuntary basis.

More about involuntary treatment

Each state and territory's mental health legislation and associated regulations provide the legal frameworks that safeguard the rights and govern the treatment of people with mental illness. Legislation varies between states and territories but all contain provisions for the assessment, admission and treatment of people on an involuntary basis. Approval is required

under mental health legislation in order to detain people in hospital for compulsory mental health care or to provide compulsory treatment in the community.

Involuntary care in this report refers to people who were compulsorily detained in hospital and/or treated in community services under mental health legislation for the purpose of assessment or provision of appropriate treatment or care.

In Australia, people can receive mental health treatment on an involuntary basis in community care, residential care, and/or admitted care settings.

Nationally, during 2019–20 around 1 in 7 community mental health care service contacts (14.7%) and 1 in 5 residential mental health care episodes (19.9%) were involuntary (Figure RP.1).

In community mental health services, care is recorded as involuntary if the person is receiving care on an involuntary basis at the time of contact. For residential services care is recorded as involuntary if the person received involuntary treatment at any time during their period of mental health care—the person may not have been given treatment involuntarily for the entire period of care.

Nationally, during 2019–20 around half of patient days in Acute admitted patient units (55.6%) and Non-acute admitted patient units (49.7%) were involuntary. This represents the proportion of time spent in hospital care under which people received involuntary treatment. People aged 35–39 years and 40–44 years had the highest proportion in Non-acute units, while people aged 25–29, 30–34 and 40–44 years had the highest proportion in Acute units

Figure RP.1: Mental health care with involuntary mental health status, by states and territories and setting, 2019–20

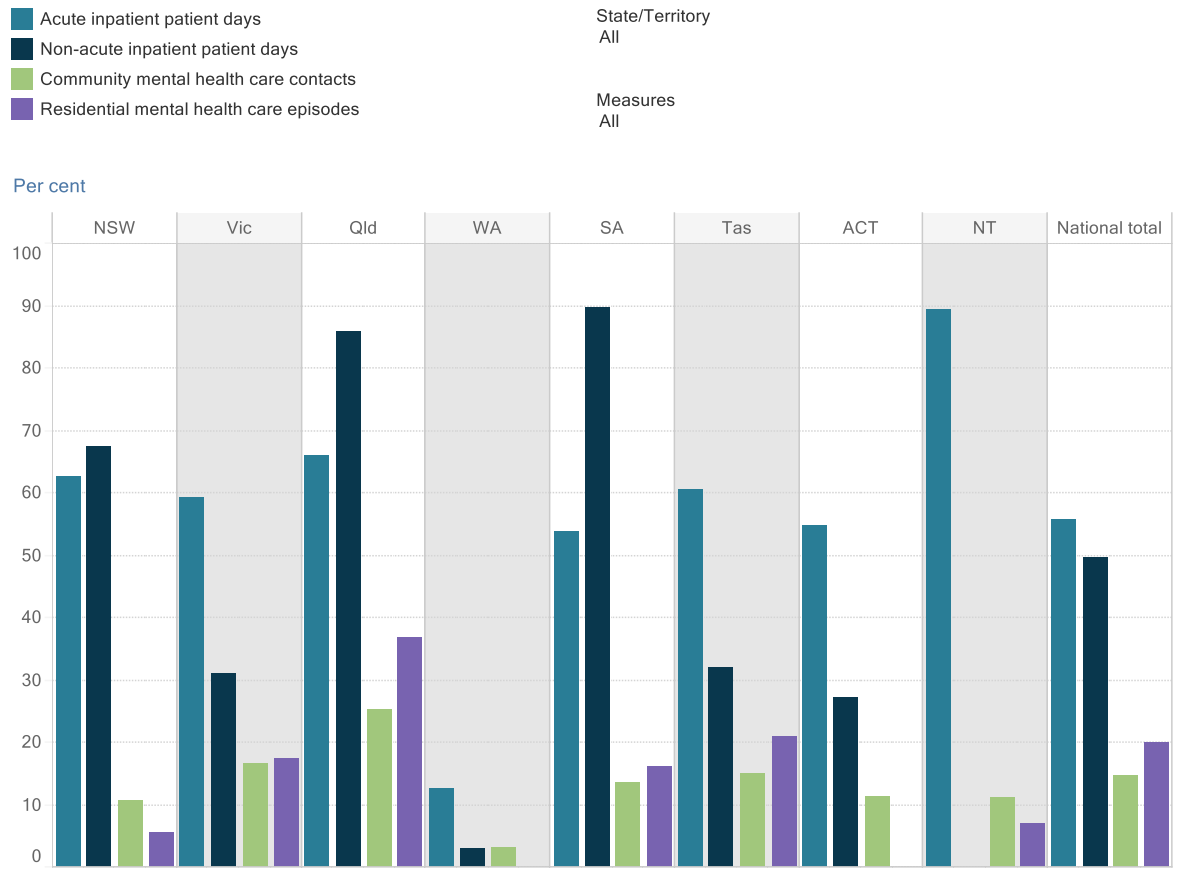

Figure RP.1 Mental health care with involuntary mental health status, by state/territory and service setting, 2019-20

http://www.aihw.gov.au/mhsa

Note: Direct comparison between settings is not possible due to different counting units and criteria. More information is in the data source section.

Sources: National Residential Mental Health Care Database, National Community Mental Health Care Database, State and territory governments; Tables RP.2 and RP.3.

Involuntary care in admitted settings can also be reported for hospitalisations. During 2019–20, almost half (45.6%) of hospitalisations in Acute units and almost 1 in 3 (30.9%) hospitalisations in Non-acute (Other) units nationally were involuntary (Table RP.3). Like residential care, a hospitalisation is coded as involuntary if the person received involuntary treatment at any time during the care period—patients may not be given involuntary treatment for their entire hospitalisation.

Involuntary treatment in hospital care is included in the Key Performance Indicators for Australian Public Mental Health Services. These indicators contribute to measuring the performance and progress of mental health services in Australia. The indicators are also

reported on Mental health services in Australia. Refer to the data source section for more information.

Seclusion and restraint in mental health care

Seclusion is the confinement of a person at any time alone in a room or area from which free exit is prevented. The purpose, duration, structure of the area and awareness of the person are not considered in determining what constitutes seclusion.

Seclusion also applies if the person agrees to or requests confinement of their own accord. However, if voluntary isolation or time alone is requested and the person is free to leave at any time then this is not considered seclusion.

Restraint is the restriction of a person's freedom of movement by physical or mechanical means. Physical restraint is the use of hands-on immobilisation techniques by health staff. Mechanical restraint is the application of devices on a person's body to restrict their movement (for example, belts or straps).

Use of seclusion and restraint practices

Each state and territory's Mental Health Act and associated regulations provide the legislative frameworks that safeguard the rights and govern the treatment of people with mental illness. Legislation varies between states and territories but all include criteria for when and where seclusion and restraint may be used.

Some people with mental illness and their carers advocate that restrictive practices do not benefit the consumer and that these interventions infringe on human rights and compromise the therapeutic relationship between the consumer and the clinician (Melbourne Social Equity Institute 2014).

Seclusion and/or restraint in health services can be used to provide safety and containment at times when this is considered necessary to protect consumers, health service staff and others. However, use of seclusion and/or restraint can also be distressing for the consumer, support people, representatives, other patients, staff and visitors. Wherever possible, alternative ways of managing a consumer's behaviour should be used to minimise the use of these restrictive practices.

The Royal Australian and New Zealand College of Psychiatrists acknowledges this point of view in its position statement *Minimising and, where possible, eliminating the use of seclusion and restraint in people with mental illness* (RANZCP 2021), which states that seclusion and restraint should only be used "…as a safety measure of last resort where all other interventions…" were considered.

Number of seclusion and restraint events

People receiving mental health care in hospitals were secluded 12,371 times nationally during 2020–21. On average, a seclusion event lasted for 5.2 hours (excluding *Forensic* services) (Figure RP.2).

Patients were restrained 19,690 times by physical means and 1,108 times by mechanical means nationally during 2020–21 (Figure RP.2.1).

Figure RP.2: Number and duration of seclusion events (2013–14 to 2020–21), average duration and number of restraint events (2015–16 to 2020–21)

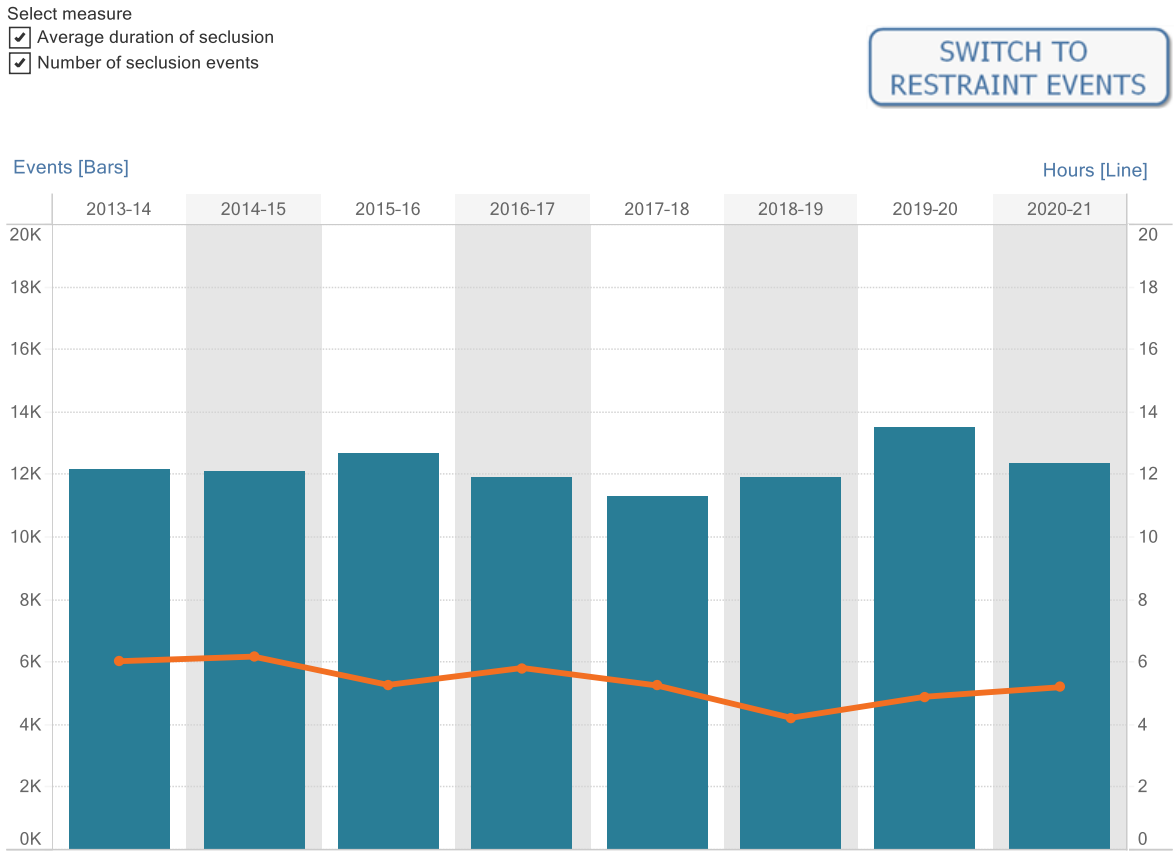

Figure RP.2: Number of seclusion events and average duration of seclusion, public sector acute mental health hospital services, national, 2013-14 to 2020-21

http://www.aihw.gov.au/mhsa

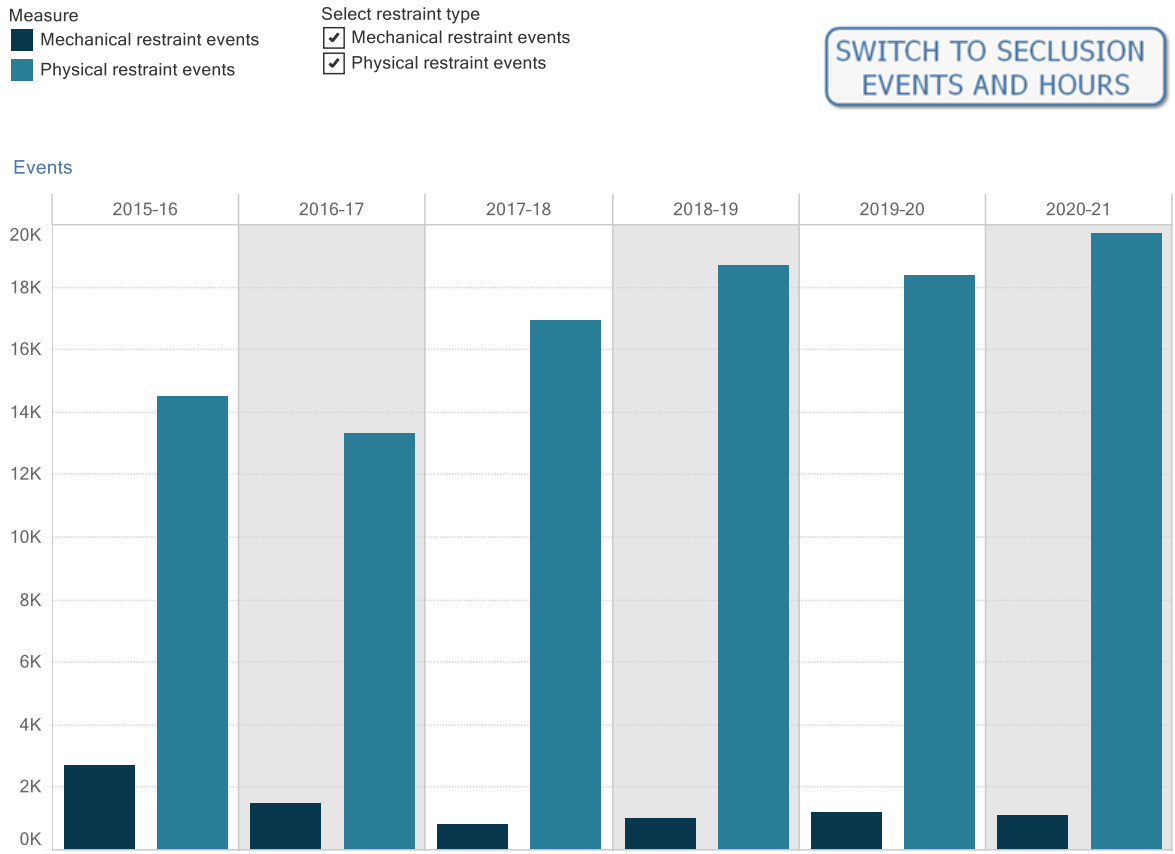

Figure RP.2.1: Number of mechanical and physical restraint events, public sector acute mental health hospital services, national, 2015-16 to 2020-21

http://www.aihw.gov.au/mhsa

Notes: Average duration of seclusion does not include South Australia prior to 2018–19.

Queensland did not collect information on physical restraint events prior to 2017–18.

Source: National Seclusion and Restraint Database, Tables RP.5 and RP.8

Rates of seclusion and restraint over time

During 2020–21 there were 7.3 seclusion events per 1,000 bed days. This is a decrease from a rate of 8.1 the previous year, and from 15.6 during 2008–09 when data coverage begins for most jurisdictions (Figure RP.3). There is an overall downward trend in seclusion rate observed from 2009–10, which marks the first year of data collection for all 8 jurisdictions (a rate of 13.9). Over the last 5 years (2016–17 to 2020–21) there has been an average annual decrease in the national seclusion rate of -0.4%.

Nationally, during 2020–21 there were 11.6 physical restraint events and 0.7 mechanical restraint events per 1,000 bed days (Figure RP.3.1).

The rate of physical restraint has remained between 10.1 and 11.6 in the period since 2015–16 when data coverage begins. The rate of physical restraint has increased from 10.3 in 2017–18, which marks the 1st year of collection for all eight jurisdictions.

The rate of mechanical restraint was 1.7 during 2015–16 when data coverage begins. Over the last 5 years (2016–17 to 2020–21) the average annual change in the mechanical restraint rate is -8.2%.

In keeping with the national priority to minimise the use of seclusion and restraint, rates are included in the Key Performance Indicators for Australian Public Mental Health Services national set (CHC 2017; National Mental Health Working Group 2005 as cited in NMHPSC 2013). These indicators contribute to measuring the performance and progress of mental health services in Australia. The indicators are also reported on Mental health services in Australia. Refer to the data source section for more information.

Rates of seclusion and restraint by states and territories

Figure RP.3: Rates of seclusion (2008–09 to 2020–21) and restraint events (2015–16 to 2020–21), by states and territories

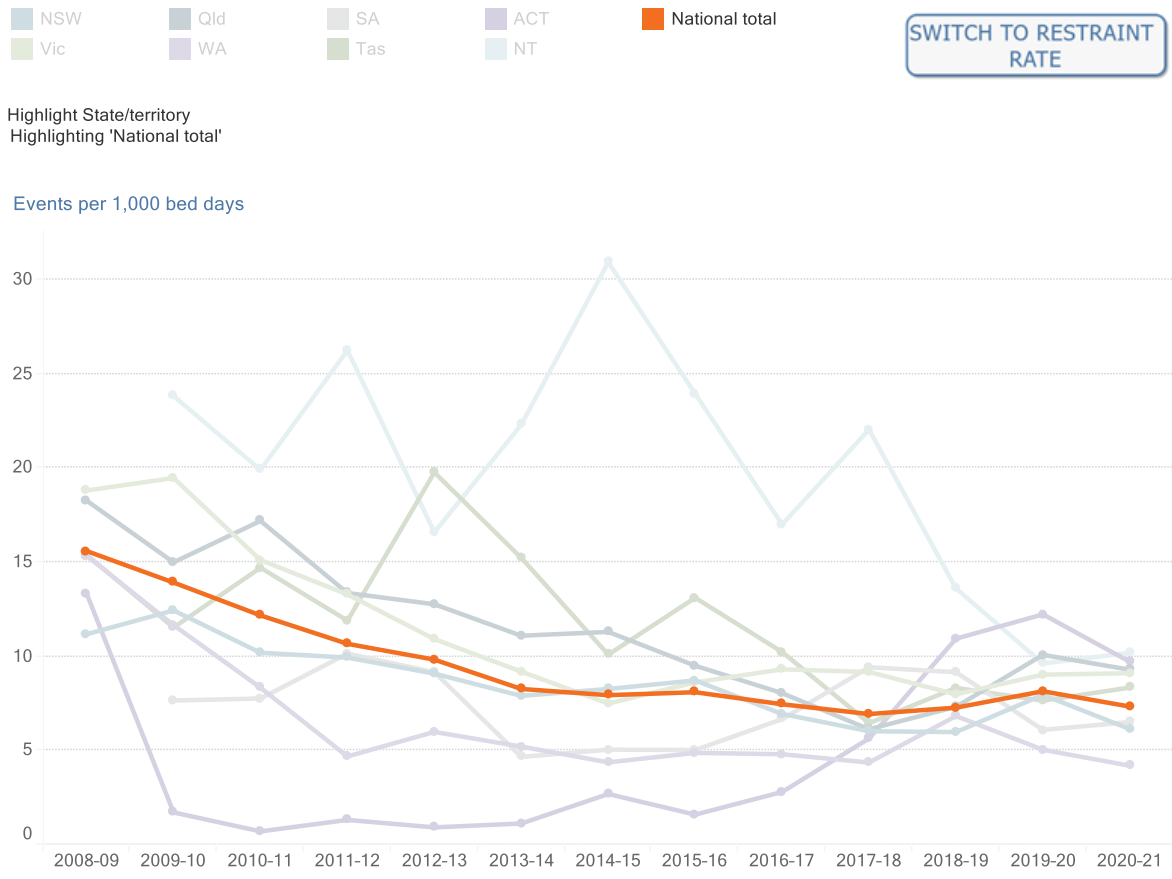

Figure RP.3: Rate of seclusion, public sector acute mental health hospital services, states and territories, 2008-09 to 2020-21
http://www.aihw.gov.au/mhsa

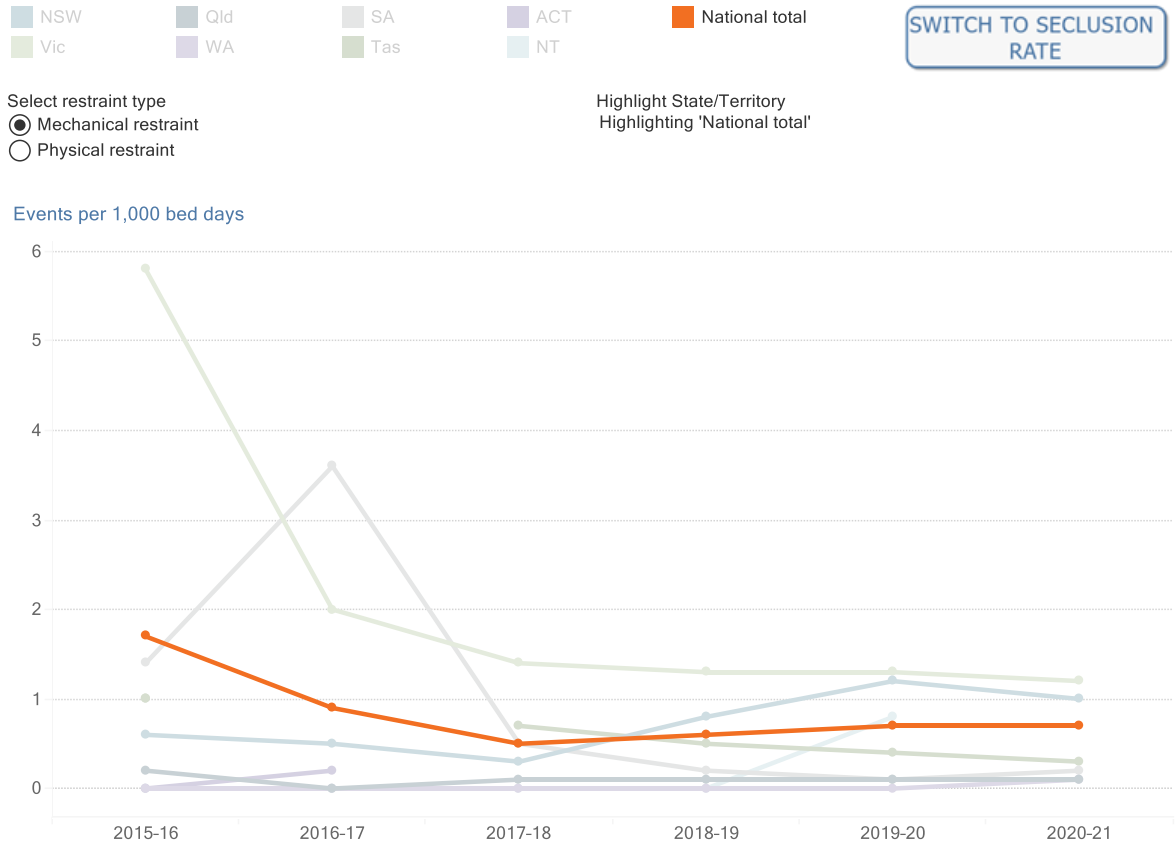

Figure RP.3.1: Rates of mechanical and physical restraint, public sector acute mental health hospital services, states and territories, 2015-16 to 2020-21

http://www.aihw.gov.au/mhsa

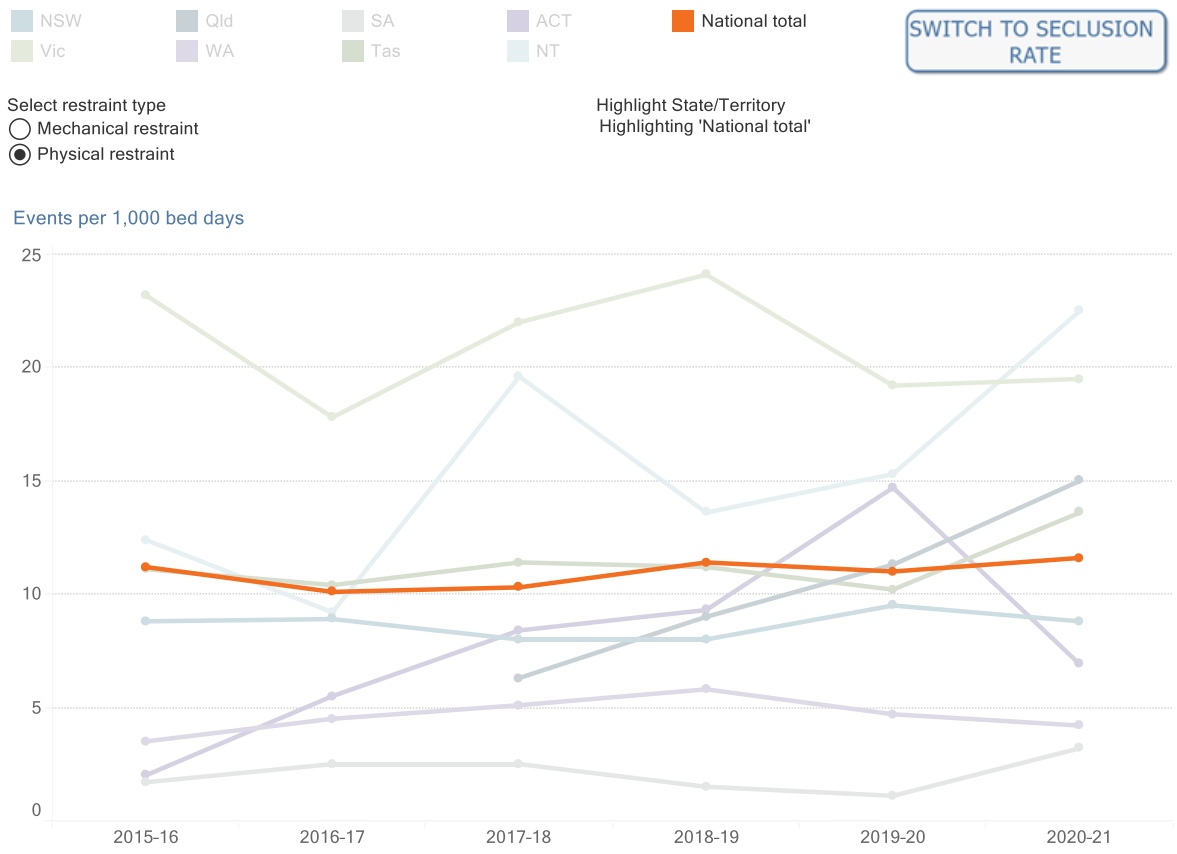

Figure RP.3.1: Rates of mechanical and physical restraint, public sector acute mental health hospital services, states and territories, 2015-16 to 2020-21

http://www.aihw.gov.au/mhsa

Notes: Rates are not calculated where numerators are less than 5 or denominators are less than 100 due to the potential for unreliable statistics.

Queensland did not collect information on physical restraint events prior to 2017–18. Comparisons between jurisdictions, between years, and for smaller jurisdictions should be undertaken with caution. More information is in the data source section.

Source: National Seclusion and Restraint Database, Tables RP.5 and RP.8

Read about seclusion and restraint by states and territories

Seclusion rates decreased for all jurisdictions in 2020–21 from the first year of data coverage (2008–09 or 2009–10) (Figure RP.3). Over this period, seclusion rates have more than halved for Victoria, Western Australia and the Northern Territory.

While the seclusion rate during 2020–21 increased from the previous year (2019–20) for Tasmania, Northern Territory, South Australia and Victoria, these rates are still lower than in 2008–09 or 2009–10. The seclusion rate during 2020–21 decreased from the previous year for the remaining jurisdictions.

Physical restraint rates decreased for Victoria during 2020–21 from the first year of data coverage (2015–16; 2017–18 for Queensland) while all other jurisdictions showed increases or

little change (Figure RP.3.1). The physical restraint rate during 2020–21 increased from the previous year for Victoria, Queensland, South Australia, Tasmania and the Northern Territory, and decreased for New South Wales, Western Australia and the Australian Capital Territory.

Mechanical restraint rates in 2020–21 are 1.2 per 1,000 bed days or lower. These rates have decreased or show little change from the first year of data coverage (2015–16), while the rate in New South Wales increased from 0.6 to 1.0.

Data for smaller jurisdictions should be interpreted with caution as small changes in the number of seclusion or restraint events can have a marked impact on their overall rate. Further data quality information is in the data source section.

Seclusion and restraint by target population

Seclusion and restraint data can also be presented by the target population of the service where the event occurred.

For seclusion data during 2020–21 around three-quarters (77.6%) of in-scope care (total number of bed days) was provided by *General* services. *Older person* services accounted for 13.9% followed by *Forensic* (4.4%) and *Child and adolescent* (4.0%) services.

The highest rate of seclusion during 2020–21 was for *Forensic* services with 27.3 seclusion events per 1,000 bed days, followed by *Child and adolescent* services (9.5), *General* services (7.3) and *Older person* services (0.3). *Forensic* services show an increase in the rate of seclusion events between 2009–10 and 2020–21, whilst *General*, *Child and adolescent* and *Older person* services show reductions. However, year on year variability is seen for all target populations (Figure RP.4).

For physical restraint during 2020–21, the rate for *Forensic* services (59.9 events per 1,000 bed days) was more than twice that of *Child and adolescent* services (27.2) and over 6 times that of *General* services (9.2). The rate of mechanical restraint was also highest for *Forensic* services (Figure RP.4.1). For the period 2015–16 to 2020–21, the use of physical and mechanical restraint was more common for *Forensic* services than other service types.

Figure RP.4: Rates of seclusion (2008–09 to 2020–21) and restraint (2015–16 to 2020–21), by target population

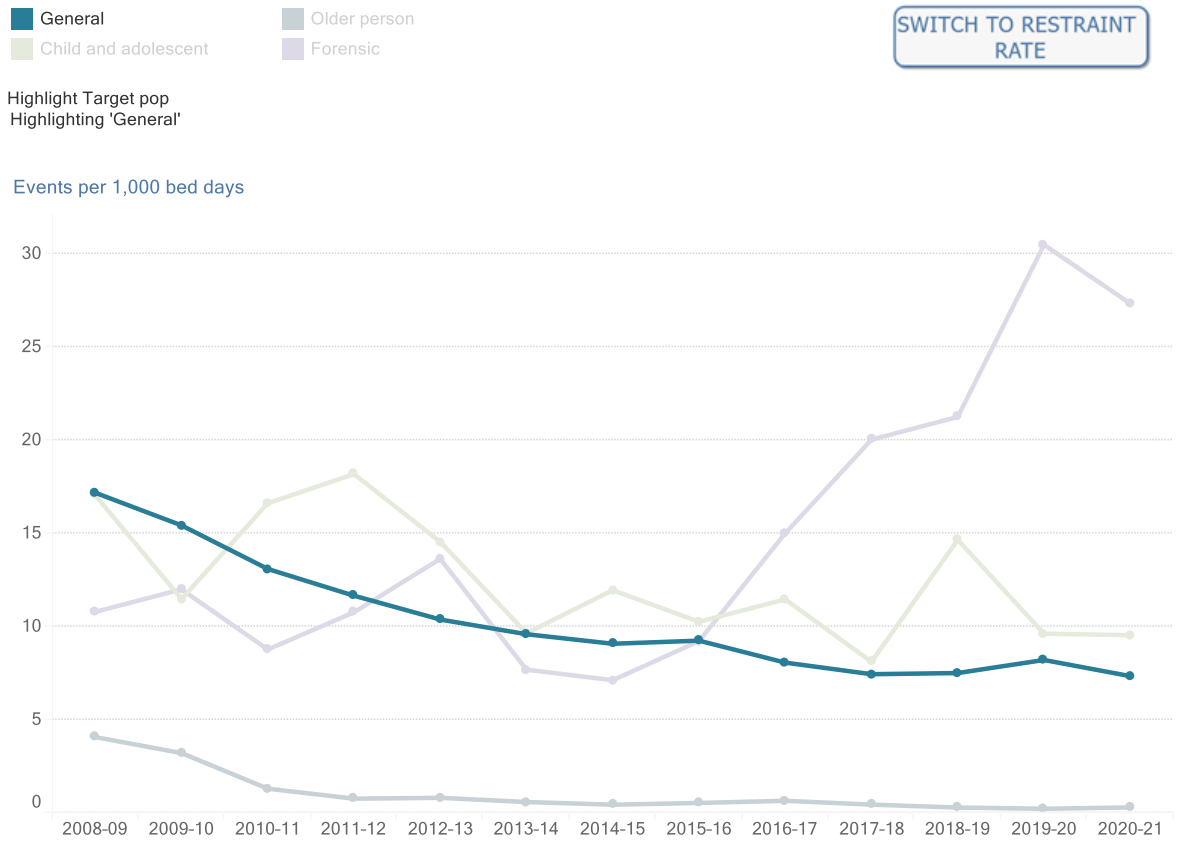

Figure RP.4: Rate of seclusion, public sector acute mental health hospital services, by target population, 2008-09 to 2020-21
http://www.aihw.gov.au/mhsa

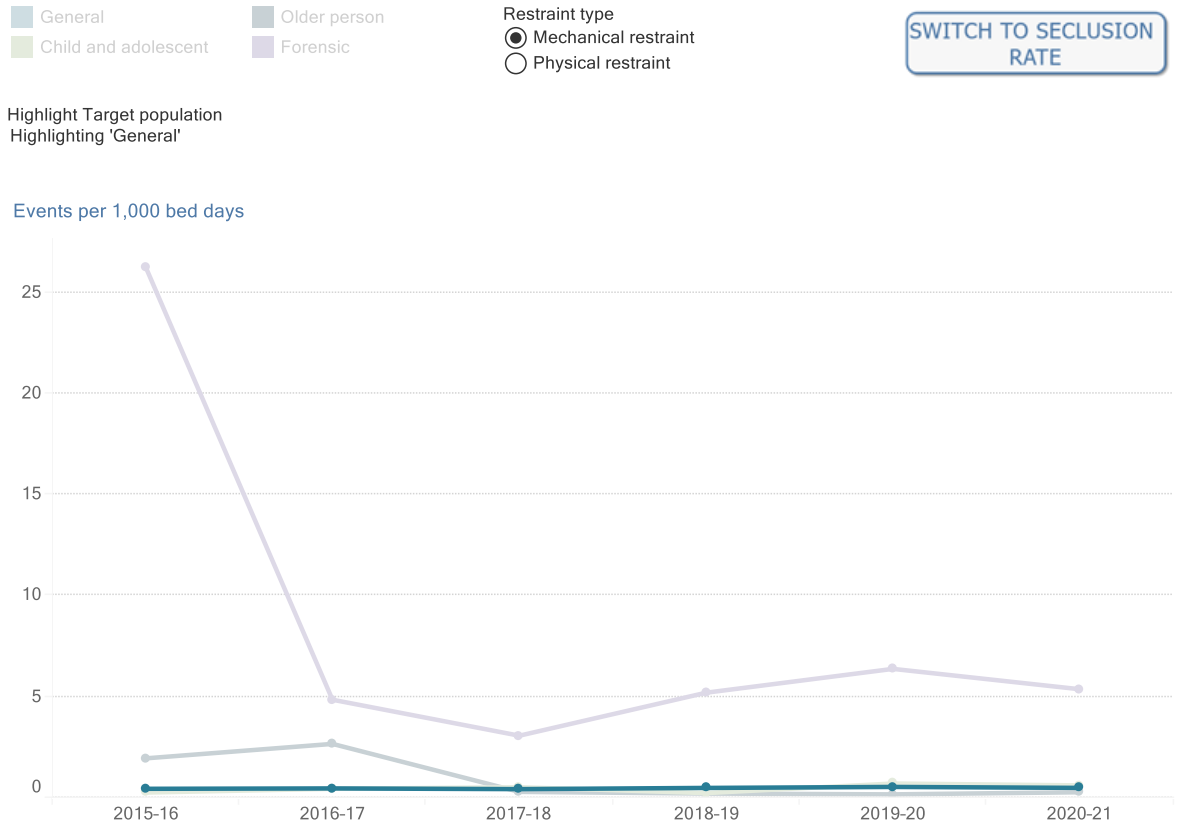

Figure RP.4.1: Rates of restraint, public sector acute mental health hospital services, by target population, 2015-16 to 2020-21
http://www.aihw.gov.au/mhsa

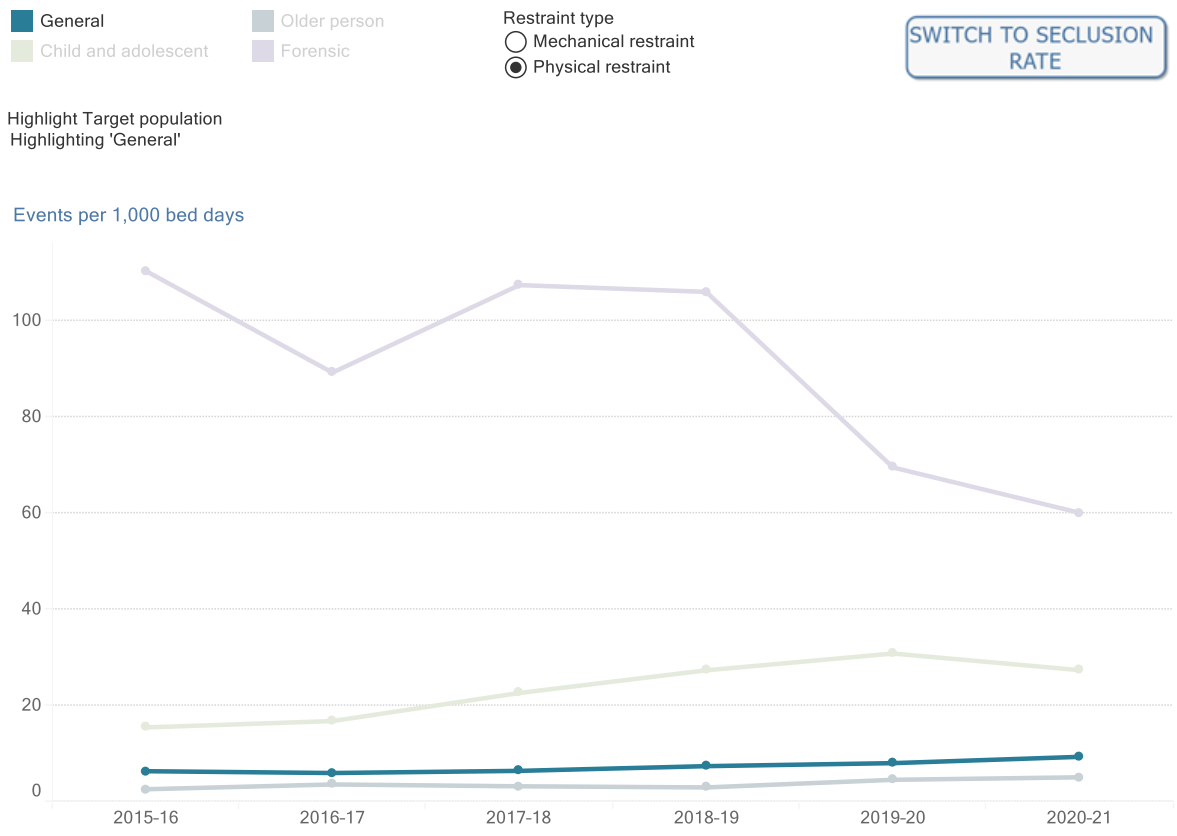

Figure RP.4.1: Rates of restraint, public sector acute mental health hospital services, by target population, 2015-16 to 2020-21
http://www.aihw.gov.au/mhsa

Note: Queensland did not collect information on physical restraint events prior to 2017–18.

Source: National Seclusion and Restraint Database, Tables RP.6 and RP.9

More about frequency and duration of seclusion by target population

Forensic services had the highest proportion of episodes of care involving seclusion events, with 21.9% of all mental health-related episodes involving at least one seclusion event during 2020–21. This was followed by *General* (3.7%), *Child and adolescent* (2.6%), and *Older person* (0.5%) services (Table RP.6). *Forensic* services also had the highest frequency of seclusion, with an average of 9.2 seclusion events per episode when seclusion was used at least once during an episode of care.

Seclusion events that occurred in *Forensic* services had the longest average duration of 21.2 hours per seclusion event. *General* services reported an average time of 5.5 hours per seclusion event, followed by *Child and adolescent* services (1.4 hours).

Rates of seclusion and restraint by remoteness

During 2020–21, hospitals located in *Major cities* had a seclusion rate of 7.6 events per 1,000 bed days. This rate was higher than *Inner regional* facilities (5.4), and lower than *Outer regional*

and Remote area facilities which had the highest seclusion rate (8.9). Similarly, facilities located in *Major cities* had a higher proportion of care episodes with a seclusion event (3.7%) than *Inner regional* areas (3.0%) and lower than *Outer regional and Remote* areas (4.1%). Seclusion events in facilities in *Major cities* were of longer average duration (5.5 hours) than *Inner regional* (4.1 hours) and *Outer regional and Remote* areas (3.6 hours) (Table RP.7).

During 2020–21, hospitals located in *Major cities* had a physical restraint rate of 12.0 events per 1,000 bed days, and a mechanical restraint rate of 0.7. These rates were higher than for *Inner regional* facilities (8.8 physical restraint and 0.4 mechanical restraint). *Outer regional and Remote* area facilities had the highest physical restraint rate of 13.4 and the lowest mechanical restraint rate of 0.1 (Table RP.10).

Rates of seclusion and restraint by hospital

Rates of seclusion, physical restraint and mechanical restraint are available for hospitals containing in-scope specialised acute mental health units (excluding forensic units). During 2020–21, the highest rates by hospital were 54.1 for physical restraint, 47.1 for seclusion, and 4.7 for mechanical restraint. Of the 134 reported hospitals, 86 (64.2%) had a rate of zero for mechanical restraint, 20 (14.9%) had a rate of zero for seclusion, and 9 (6.7%) a rate of zero for physical restraint.

Rates are presented for all reported hospitals and states and territories in Figure RP.5; to select a specific hospital refer to Figure RP.5.1.

Figure RP.5: Seclusion and restraint rates, by states and territories and hospital, 2020–21

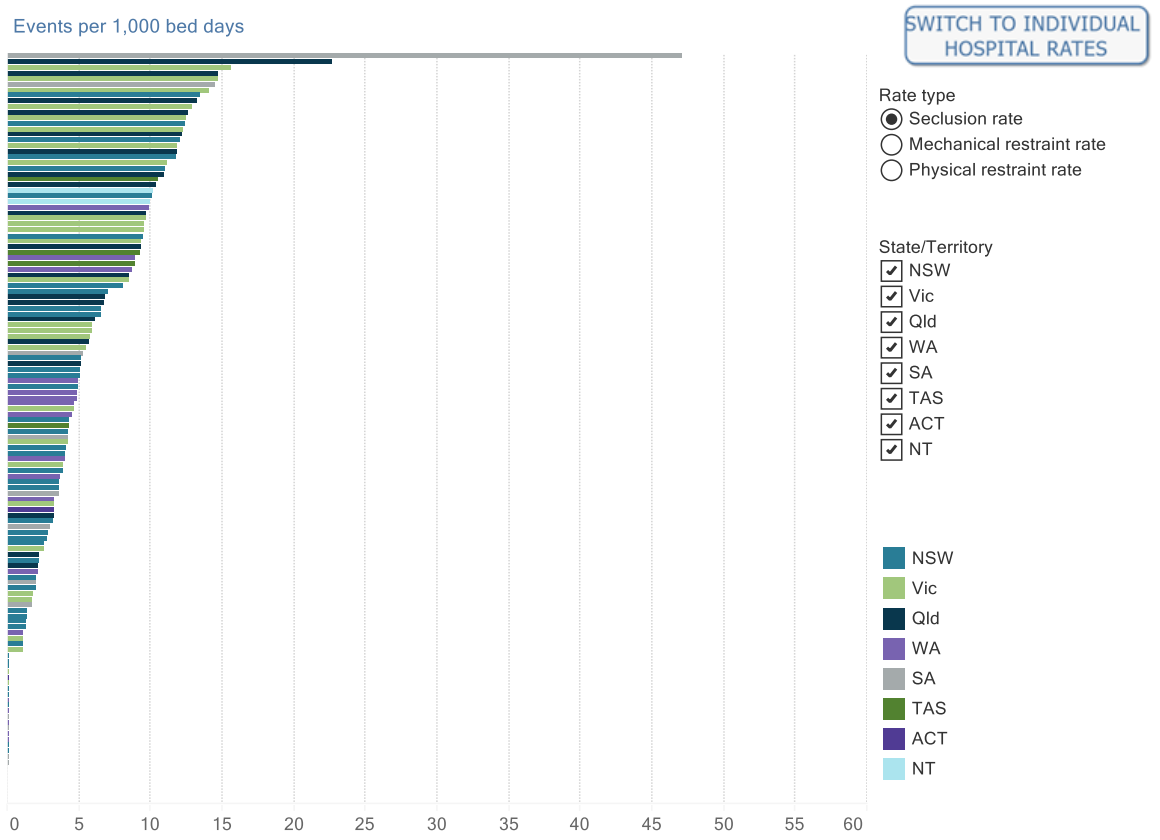

Figure RP.5: Hospital rates of seclusion and restraint, public sector acute mental health hospital services, hospital level, 2020-21
http://www.aihw.gov.au/mhsa

State/Territory
NSW

Hospital name
Armidale and New England Hospital

SWITCH TO HOSPITAL OVERVIEW

In 2020-21, Armidale and New England Hospital in NSW had:

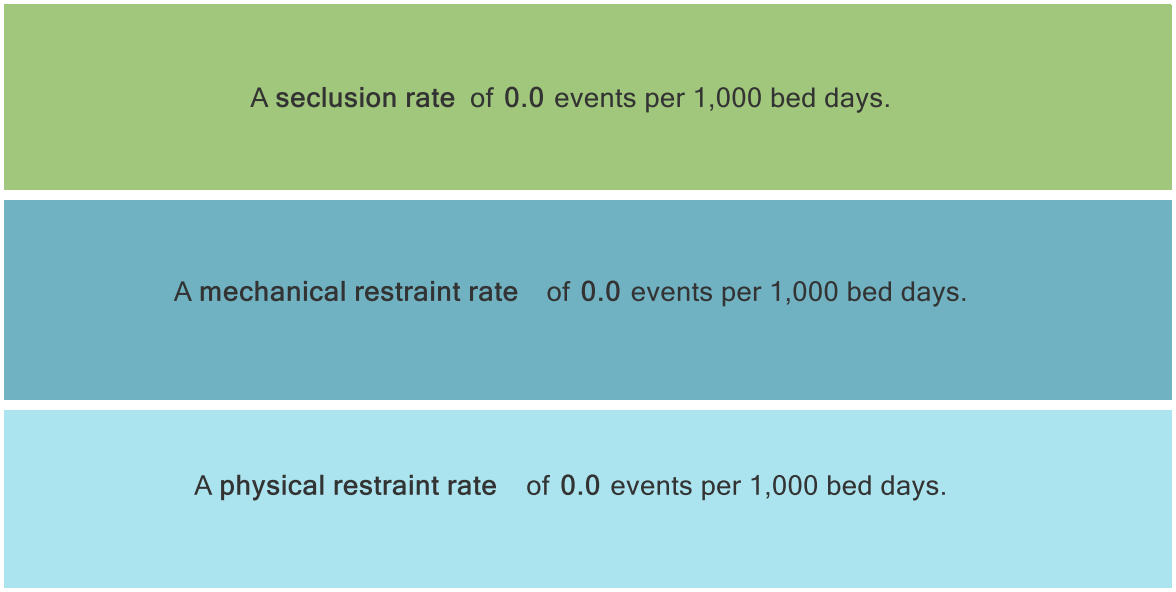

Figure RP.5.1: Rates of seclusion and restraint for selected hospital, public sector acute mental health hospital services, 2020-21
http://www.aihw.gov.au/mhsa

Source: National Seclusion and Restraint Database, Table RP.11

Data source

On this page

Involuntary care data quality information

Each state or territory has legislation relating to the treatment of people with mental illness. A summary of the criteria for involuntary treatment for each Australian and New Zealand Mental Health Act is available from the Royal Australian and New Zealand College of Psychiatrists website (RANZCP 2017a).

Information on mental health legal status data are collected by state and territory governments and supplied to the AIHW for national reporting. Mental health legal status is recorded for service contacts, episodes, hospital separations, or admitted hospital patient days, depending on the service setting (data source) as specified below.

National Community Mental Health Care Database

Mental health legal status information is collected for the National Community Mental Health Care Database (NCMHCD)—which has coverage from 2000—and is collected for each service contact. Mental health legal status is recorded as involuntary if the person was given legislated involuntary treatment at the time of the service contact. It does not collect how much of their care involved involuntary treatment.

Data for the NCMHCD are supplied under the Community Mental Health Care National Minimum Data Set (CMHC NMDS) agreement. Data Quality Statements are published annually on the Metadata Online Registry (METeOR). Statements provide information on the institutional environment, timelines, accessibility, interpretability, relevance, accuracy and coherence. Refer to the Community mental health care NMDS 2019–20: National Community Care Database, 2021; Quality Statement. Previous years' data quality statements are also accessible via METeOR.

National Residential Mental Health Care Database

Mental health legal status has been collected for the National Residential Mental Health Care Database (NRMHCD) since 2004 and is collected for each episode of care. Mental health legal status is recorded as involuntary if the resident was given legislated involuntary treatment at

any time during an episode of care. It does not collect how much of their care involved involuntary treatment.

Data for the NRMHCD are supplied under the Residential Mental Health Care National Minimum Data Set (RMHC NMDS) agreement. Data Quality Statements are published annually on METeOR. Statements provide information on the institutional environment, timeliness, accessibility, interpretability, relevance, accuracy and coherence. Refer to the Residential mental health care NMDS 2019–20: National Residential Mental Health Care Database, 2021; Quality Statement. Previous years' data quality statements are also accessible in METeOR.

National indicator set: Involuntary hospital care

Under the Fifth National Mental Health and Suicide Prevention Plan (2017–2022) the proportion of involuntary admissions to admitted patient specialised mental health services was introduced as national Performance Indicator (PI) 23: Rate of involuntary hospital treatment.

To facilitate a better understanding of the amount of involuntary treatment occurring in mental health hospitals, two involuntary treatment indicators under PI 23 were developed.

- *Involuntary hospital treatment* measures the proportion of public mental health hospital separations in which a person was given involuntary care under existing legislation at any time during their treatment (proportion of separations with a mental health legal status of involuntary). Distinction between acute and non-acute units is possible. It does not measure how much of the care received was involuntary.
- *Involuntary patient days* measures the proportion of public mental health admitted patient days in which a person received care on an involuntary basis (NMHC 2020). Distinction between acute and non-acute units is possible.

These indicators were developed by pertinent committees of the day under the former Australian Health Ministers' Advisory Council (AHMAC) structure. The indicators were developed and established by the former Safety and Quality Partnership Standing Committee (SQPSC) and former Mental Health Information Strategy Standing Committee (MHISSC), with MHISSC's former National Mental Health Performance Subcommittee (NMHPSC) having undertaken the technical development of the indicator specifications.

The two involuntary indicators have been included in the Key Performance Indicators for Australian Public Mental Health Services (Jurisdictional level) indicator set since 2021.

These indicators are published online annually on *Mental health services in Australia,* see Key Performance Indicators for Australian Public Mental Health Services.

For more detail on the indicators, refer to KPIs for Australian Public Mental Health Services: PI 17aJ – Involuntary hospital treatment, 2021 and KPIs for Australian Public Mental Health Services: PI 17bJ – Involuntary patient days, 2021.

Seclusion and restraint data quality information

The Royal Australian and New Zealand College of Psychiatrists notes that "…seclusion and restraint should only be used in accordance with approved protocols and best practice by properly trained professional staff in an appropriate environment…" (RANZCP 2021). Summary criteria for definitions, when and where seclusion and restraint may be used, and the authorisation of seclusion and restraint under the various Australian and New Zealand mental health legislation are available from the RANZCP website (RANZCP 2017b, 2017c).

Working towards 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 were supported by the former AHMAC, through key mental health committees of the time, the SQPSC and MHISSC (Allan et al. 2017, SQPSC 2017). The National Towards Eliminating Restrictive Practices (TERP) Forum—the 12th most recently held in November 2018—is a collaborative initiative supported by all governments to share results and best practice and support broader change to remove seclusion and restraint practices in mental health. The National Mental Health Commission's Statement on seclusion and restraint in mental health (NMHC 2015) called for leadership across a range of priorities including "…national monitoring and reporting on seclusion and restraint across jurisdictions and services".

National Seclusion and Restraint Database

Seclusion and restraint data reported in this section are from the National Seclusion and Restraint Database (NSRD). Data are supplied by each Australian state and territory, under the Mental health Seclusion and Restraint National Best Endeavours Data Set (SECREST NBEDS) agreement. Historical data are available from 2008–09 for seclusion and 2015–16 for restraint. Data on the use of seclusion and restraint by hospital were reported for the first time in December 2018. Public reporting enables services to review their individual results against other states and territories, national rates and like services, thereby supporting service reform and quality improvement agendas.

Although seclusion and restraint may occur across a range of mental health service settings, the scope of the NSRD and SECREST NBEDS is acute specialised mental health hospital units—this service setting has been the focus of many associated quality improvement initiatives, including data collection and reporting developments.

Data Quality Statements are published annually on METeOR. Statements provide information on the institutional environment, timeliness, accessibility, interpretability, relevance, accuracy and coherence. Refer to the National Seclusion and Restraint Database; Mental health seclusion and restraint NBEDS 2015-, 2021; Quality Statement. Previous years' data quality statements are also accessible in METeOR.

Interpretation of seclusion data

States and territories have different policy, regulatory and legislative requirements regarding seclusion practices. Direct data comparisons between jurisdictions should be made with caution.

High numbers of seclusion events for a few individuals can have a disproportional effect on the rate of seclusion reported. For example, the increases in the state-wide Tasmanian seclusion rate between 2012–13 and 2013–14, for the ACT from 2017–18 to 2019–20, for SA in 2017–18 and 2018–19, and for WA in 2018–19, are due to a small number of clients having an above average number of seclusion events.

Data on the frequency and duration of seclusion events were collected for the first time for 2013–14. The ACT was unable to provide the number of admitted patient care episodes prior to 2018–19; as such, the national results for the frequency of seclusion during episodes of care up to 2017–18 exclude the ACT and include the ACT from 2018–19 onwards. Duration data for SA are excluded from the national average duration from 2013–14 to 2017–18, due to issues with the data recording methodology used in SA. SA has been included in the national average duration for 2018–19 onwards.

Interpretation of restraint data

States and territories have different policy, regulatory and legislative requirements regarding restraint practices and different systems in place for collecting data. There are also differences in the types of restraint that are reported. Unspecified restraint was reported from 2015–16 to represent combined restraint or when data providers were unable to disaggregate mechanical and physical restraint events.

The first release of data occurred in May 2017 and it is expected that data quality will continue to improve over time as information systems are refined and definitions are better understood by the sector. As such, caution should be exercised when interpreting this data and comparing results between states and territories and over time.

High numbers of restraint events for a few individuals can have a disproportional effect on the rate of restraint reported.

Target population

The data presented is the target population of the service unit; that is, the age group that the service is intended to serve, not the age of individual patients. For the 2013–14 reporting period improvements were made to the reporting of target population categories. The *Mixed* service category was removed as an option for reporting. Data for the *Mixed* category most commonly involved a combination of *General*, *Child and adolescent* and/or *Older person*

services. Time series data by target population should therefore be approached with caution. Seclusion and restraint data for a small number of *Youth* hospital beds reported by Victoria, Western Australia, and the Northern Territory are also included in the *General* category.

Forensic services provide services primarily for people whose health condition has led them to commit, or be suspected of committing, a criminal offence or make it likely that they will reoffend without adequate treatment or containment. The average duration of a seclusion event is reported excluding *Forensic* services, as forensic seclusion events are typically of longer duration, and substantially skew the overall duration average.

Remoteness

Due to the small number of hospitals located in *Outer regional* and *Remote* geographical areas, for the purpose of analysis these categories have been combined. There were no hospitals in the seclusion or restraint dataset located in *Very remote* areas.

National indicator set: Rate of seclusion and restraint

The Key Performance Indicators for Australian Public Mental Health Services (KPIs) were developed for the purpose of improving public mental health services. In keeping with the national priority to reduce the use of seclusion and restraint, KPI 15 *Seclusion rate* and KPI 16 *Restraint rate* draw on the National Seclusion and Restraint Database for reporting. These indicators contribute to measuring the performance and progress of mental health services in Australia.

The original KPI set was released in 2005, with the aim to measure and improve the performance of public mental health services. The indicators have been revised over time through the former National Mental Health Performance Subcommittee (NMHPSC) of the former Mental Health Information Strategy Standing Committee (MHISSC), to drive and incorporate improvements made to data sources, jurisdictional implementation and results of nation-wide projects (NMHPSC 2013).

Rate of seclusion was added to the national KPI set in 2011 (NMHPSC 2013) and Rate of restraint was added in 2018. Both indicators fall under the priority area of safety in mental health services, in which reducing the use of seclusion and restraint is considered a key aspect (CHC 2017; National Mental Health Working Group 2005 as cited in NMHPSC 2013).

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Key Concepts

Restrictive practices -

Key Concept	Description
Admitted patient mental health care	**Admitted patient mental health care** refers to a specialised mental health service in a psychiatric hospital or specialised mental health unit in an acute hospital that provides overnight care (METeOR identifier 409067). There are two types of admitted patient care. *Acute* care admitted patient programs involve short-term treatment for individuals with acute episodes of a mental disorder, characterised by recent onset of severe clinical symptoms that have the potential for prolonged dysfunction or risk to self and/or others. *Other* or *non-acute* care refers to all other admitted patient programs, including rehabilitation and extended care services (METeOR identifier 288889).
Community mental health care	**Community mental health care** refers to government-funded and operated specialised mental health care provided by community mental health care services and hospital-based ambulatory care services, such as outpatient and day clinics.
Episodes of residential care	**Episodes of residential care** are defined as a period of care between the start of residential care (either through the formal start of the residential stay or the start of a new reference period (that is, 1 July)) and the end of residential care (either through the formal end of residential care, commencement of leave intended to be greater than 7 days, or the end of the reference period (that is, 30 June)). An individual can have one or more episodes of care during the reference period.
Hospitalisation	**Hospitalisation** is the term used to refer to the episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation).
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 identifier 722675).
Patient days	**Patient day** means the occupancy of a hospital bed (or chair in the case of some same day patients) by an admitted patient for all or part of a day. The length of stay for an overnight patient is calculated by subtracting the date the patient was admitted from the date of separation and deducting days the patient was on leave. A same-day patient is allocated a length of stay of 1 day. Patient day statistics can be used to provide information on hospital activity that, unlike separation statistics, account for differences in length of stay. The patient day data presented in this report include days within hospital stays that occurred before 1 July provided that the separation from hospital occurred during the relevant reporting period (that is, the financial year period). This has little or no impact in private and public acute hospitals, where separations are relatively brief, throughput is relatively high and the patient days that occurred in the previous year are expected to be approximately balanced by the patient days not included in the counts because they are associated with patients yet to separate from the hospital and therefore yet to be reported. However, some public psychiatric hospitals provide very long stays for a small number of patients and, as a result, would have comparatively large numbers of patient days recorded that occurred before the relevant reporting period and may not be balanced by patient days associated with patients yet to separate from the hospital.
Residential mental health care	**Residential mental health care** refers to residential care provided by residential mental health services. A residential mental health service is a specialised mental health service that: • employs mental health trained staff on-site • provides rehabilitation, treatment or extended care to residents for whom the care is intended to be on an overnight basis and in a domestic-like environment • encourages the residents to take responsibility for their daily living activities. These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing. However, all these services employ on-site mental health trained staff for some part of the day.
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 themselves 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 themselves or endangering others or to ensure the provision of essential medical treatment.
Seclusion	**Seclusion** is defined as the confinement of a person 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 person 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 person 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 person agrees or requests the confinement. The awareness of the person 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 people to High Dependency sections of gazetted mental health units, unless it meets the definition. More information can be found in the data source section about jurisdictional consistency with this definition.

Service contacts	**Service contacts** are defined as the provision of a clinically significant service by a specialised mental health service provider for patients/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals and residents in 24-hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question. Any patient can have one or more service contacts over the relevant financial year period. Service contacts are not restricted to face-to-face communication and can include telephone, video link or other forms of direct communication. Service contacts can also be either with the patient or with a third party, such as a carer or family member, other professional or mental health worker, or other service provider.
Target population	Some specialised mental health services data are categorised using 5 **target population** groups (see METeOR identifier 682403): • 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 provide 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.