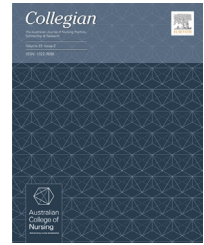




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# Seclusion and restraint use in adult inpatient mental health care: An Australian perspective

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## KEYWORDS

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Containment;  
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## Summary

**Background:** Australia is committed to reduce or eliminate the use of containment measures (seclusion and restraint) in mental health care. International research suggests that number of containment events and hours spent in containment are often concentrated in a small number of patients. Understanding the concentration of containment episodes can support the development of effective interventions.

**Objectives:** The purpose of this study is to explore the distribution and frequency of seclusion and restraint events and hours in adult inpatient mental health units in South Australia.

**Design:** A retrospective audit of seclusion and restraint events during the time period 1/1/2010–31/12/2011.

**Setting:** Eighteen (18) inpatient mental health units in South Australia.

**Results:** Containment events were concentrated among a relatively small proportion of patients (10% of patients accounting for nearly 40% of events), with the concentration even more evident for containment hours (10% of patients accounting for over 50% of hours). Rates of containment

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varied widely between units. The highest rates were in high dependency units, which also accounted for over 90% of patients with the highest percentage of events and hours. More males than females experienced containment, with a significantly larger proportion of males experiencing the highest number of hours in containment.

*Conclusions:* The concentration of containment events supports the validity of tailoring interventions, such as structured short-term risk assessment tools, reviewing repeat events and debriefing, to high-risk cases. These strategies should be used in conjunction with hospital-wide strategies with demonstrated efficacy, for example leadership, education, consumer involvement and data analysis.

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## 1. Introduction

Containment measures such as seclusion and restraint are used in mental health care to manage risk of harm to patients and staff (Perkins, Prosser, Riley, & Whittington, 2012); yet they are associated with negative physical and psychological effects. This includes an increased chance of physical injury and death among patients as well as staff injury (Evans, Wood, & Lambert, 2003; Rakhmatullina, Taub, & Jacob, 2013), and both patients and staff report trauma associated with the use of these containment measures (Frueh et al., 2005; Mohr, Petti, & Mohr, 2003; Robins, Sauvageot, Cusack, Suffoletta-Maierle, & Frueh, 2005; Sokol, 2010). Furthermore, the use of these measures raises ethical issues relating to patient rights and dignity, and runs contrary to recovery-oriented mental health care (Chang, Grant, Luther, & Beck, 2014; Mohr, 2010). Consequently there is an international mandate to reduce or eliminate these practices (Department of Health, 2008; Knox & Holloman, 2012). For example, in Australia the National Mental Health Seclusion and Restraint Project (2007–2009), known as the Beacon Project, was developed to establish centres of excellence aimed towards reducing seclusion and restraint in public mental health facilities.

Seclusion and restraint rates, duration and methods used in inpatient mental health care vary widely across countries and between units in the same hospital or area (Beghi, Peroni, Gabola, Rossetti, & Cornaggia, 2013; Knott, Pleban, Taylor, & Castle, 2007; Tekkas & Bilgin, 2010). These variations can be accounted for by characteristics of the settings and case mix, as well as different definitions and data collection techniques (Kruger, Mayer, Haastert, & Meyer, 2013). For the purposes of this study we have used the term 'containment' to refer to restriction of movement through physical (hands-on immobilisation), mechanical (the use of devices such as lap belts or jackets) or environmental (confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented; seclusion) means.

Researchers often use different methods to calculate rates of seclusion and restraint and/or are not explicit in how rates were calculated, making comparisons between studies difficult (Bowers, 2000). In spite of these shortcomings, recent international and Australian investigation sheds some light on the scope of the issue. A systematic review by Beghi et al. (2013) of 49 studies published between 1990 and 2010 reported the prevalence of restraint

as 3.8–20%. Male gender, young adult age, foreign ethnicity, a diagnosis of schizophrenia, involuntary admission, aggression or trying to abscond, and the presence of male staff on the unit were associated with the use of containment measures. In Australia, recent data on rates of seclusion from the Australian Institute of Health and Welfare (AIHW) reports 8.0 seclusion events per 1000 bed days in public acute hospitals in 2013–2014, a reduction from 15.5 events per 1000 beds days in 2008–2009 and attributed to the national commitment to reducing seclusion in mental health facilities across Australia (AIHW, 2014). For South Australia, the AIHW (2014) report a seclusion rate of 4.5 events per 1000 bed days in 2013–2014, a reduction from 10.1 events in 2011–2012.

Previous international research suggests that the majority of episodes of seclusion and restraint may be concentrated in a small percentage of patients. For example, Hendryx, Trusevish, Coyle, Short, and Roll (2010) explored the frequency and distribution of seclusion and restraint episodes at a state mental health hospital in the USA during the 2004 calendar year. The hospital included forensic, geriatric, and adult mental health units, and a unit for developmentally disabled adults with co-occurring mental illness. They found that almost 29% of all seclusion episodes and 63% of all seclusion hours were concentrated among 10 patients. Similarly, 10 patients with the most restraint hours constituted nearly 65% of total restraint hours and 48% of all restraint episodes.

Whitehead and Liljeros (2011) conducted a retrospective study of all seclusion and restraint episodes between September 1, 1997 and March 1, 2005 in the Utah State Psychiatric Hospital in the USA. The hospital provided acute services for children, adolescents, and adults with severe mental illness, as well as forensic services. The study aimed to explore the distribution of patients who required one or more seclusion or restraint episodes. They found that 20% of patients with the most seclusion and/or restraint episodes accounted for approximately 75% of the total number of events. Ten percent of patients accounted for 61% of events, and 1% accounted for 21% of events. Knutzen et al. (2014) retrospectively explored the use of pharmacological and mechanical restraint in three Norwegian acute mental health units over a 2-year period (2004–2005). They found 9.1% of patients accounted for 39.2% of all restraint episodes. To our knowledge there are no published studies exploring whether the number of containment events and hours are similarly concentrated in the Australian inpatient setting.

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