

Use of seclusion, restraint and ECT all increased in 2013 according to the Mental Health Commission

The use of seclusion and physical restraint, and the administering of ECT to patients in inpatient mental health services have increased for the first time in years, according to the Mental Health Commission (MHC) which published 2013 data on these areas today.

Key findings:

- The use of seclusion increased for the first time in six years, by 12% in 2013.
- The use of physical restraint increased during 2013 up by 8% on 2012.
- There was an overall increase of 2% in the administering of ECT during 2013.
- In 14.5% of ECT programmes (which involve up to 12 separate treatments of ECT), one or more of those treatments was administered without consent.
- In numerical terms, there were 46 programmes of ECT where one or more treatments was administered without consent. This represents an increase from 27 programmes in 2012.

Commenting on the newly published data Mr John Saunders, Chairman of the Mental Health Commission said, "Over the past number of years we have seen a steady reduction in the use of practices such as seclusion and restraint. However the increases in their use of during 2013 is very worrying. I would urge those providing mental health services to study the Rules and Codes of Practices in these areas to ensure they are delivering the most appropriate level of care. Seclusion and restraint are emergency measures and should only be used in exceptional circumstances and only when in the best interests of the patient."

"What is most concerning is the percentage increase in the administering of ECT to patients who are either unable or unwilling to receive it. There were 46 programmes of ECT where one or more treatments of ECT were administered without consent. This increased from 27 programmes in 2012. This is an increase of 70%."

"The Commission has consistently said that it should not be possible to administer ECT to a patient who is unwilling to receive it. I know that this is something which the Minister and the Department are currently reviewing, with a view to changing legislation, and I would urge them to do so before the end of this year."

ECT

In 2013, there were 318 programmes of ECT administered to 257 individual residents. This represents a slight (2.3%) increase in the number of programmes of ECT recorded in comparison to 2012 (311). A programme of ECT refers to no more than 12 treatments prescribed by a consultant psychiatrist.

A total of 2,217 separate treatments or sessions of ECT were administered in 2013. The average number of treatments per programme was seven and most residents, 82.5%, were administered one programme of ECT in 2013.

In the majority (85.5%) of programmes, all ECT treatments were administered with the resident's consent. In 14.5% of programmes one or more ECT treatments were administered without consent. There was an increase in the number of programmes of ECT where one or more treatments of ECT were administered without consent in from 27 in 2012 to 46 in 2013. In 39 of these 46 programmes the consultant psychiatrists who authorised and approved them indicated the person was unable to give consent, and in the remaining seven programmes one or both consultant psychiatrist indicated the person was unwilling to give consent.

Of the 257 individuals who were administered ECT in 2013, the majority (63.4%) were female and 36.6% were male. Individuals ranged in age from 18 years of age to 93 years of age with an average age of 60 years of age.

Most programmes of ECT (81.8%) were administered to individuals with depressive disorders and resistance (refractory) to medication was the most frequent indication for ECT (62.9% of programmes). In over 90% of programmes of ECT the treating consultant psychiatrist reported that the treatment resulted in an improvement in the condition of the person receiving ECT treatment.

St Patrick's University Hospital (an independent service provider) administered the highest number of programmes (125) of ECT nationally in 2013. The Department of Psychiatry, Waterford Regional Hospital recorded the highest number of programmes (32) of ECT in a HSE managed service.

Seclusion & Restraint (mechanical & physical)

There were 4,886 episodes of restrictive practices in 2013, 9.4% more than the number reported in 2012 (4,466). Physical restraint accounted for 67.6% of interventions, seclusion 32.2% and mechanical means of bodily restraint 0.2% in 2013. As in previous years, the use of seclusion and physical restraint varied widely between approved centres.

Seclusion

Twenty nine approved centres recorded 1,575 episodes of seclusion involving 571 individual residents in 2013. There was a higher percentage of males (64.4%) than females (35.6%) placed in seclusion. Fourteen children were secluded in 2013.

Use of seclusion increased for the first time in six years, with 12.3% more episodes reported in 2013 in comparison to 2012. Although number of episodes increased, a higher percentage of episodes were of shorter duration in 2013, with 78.8% lasting less than or equal to eight hours in 2013, in comparison to 68.2% in 2012. A small percentage (3.8%) of seclusion episodes exceeded 72 hours and over three fifths (60.6%) of seclusion occurred between the hours of 8am and 8pm.

There were notable increases in the use of seclusion in two approved centres - the Department of Psychiatry, Waterford Regional Hospital saw the use of seclusion rise from 90 in 2012 to 270 in 2013 and

the Department of Psychiatry, St Luke's Hospital, Kilkenny saw the use of seclusion rise from 45 in 2012 to 226 in 2013. In both cases, a high proportion of these episodes related to a small number of individuals, four in Waterford Regional Hospital and eight in St Luke's Hospital, Kilkenny.

For the third year in a row, St Joseph's Intellectual Disability Service (a national mental health service for persons with an intellectual disability) reported a decrease in the number of seclusion episodes, from 231 in 2012 to 26 in 2013 - 205 fewer episodes.

Mechanical Restraint

There were eight episodes of mechanical means of bodily restraint in one approved centre, the Acute Psychiatric Unit, Tallaght Hospital, reported to the Commission in 2013, in comparison to zero in 2012.

Physical Restraint

There were a total of 3,303 episodes of physical restraint reported by 51 approved centres in 2013. This represents an increase of 7.8% on the number of episodes in 2012.

A total of 1,074 individuals were physically restrained on 3,033 separate occasions in 2013. A slightly higher proportion of males (51.4%) than females (48.6%) were physically restrained. Fifty one children were physically restrained in 2013.

There was a wide range of variation in changes between the two years, with a number of centres reporting notable increases or decreases, and others reporting little change over this time. Overall, 32 services reported an increase in episodes of physical restraint, and 22 a decrease. Over two thirds (69.9%) of physical restraint episodes lasted for five minutes or less, with 15.6% lasting one minute or less.

St Vincent's Hospital in Fairview, reported the highest number of episodes of physical restraint; 282 episodes which involved 62 individual residents, in 2013. The Department of Psychiatry, Waterford Regional Hospital reported the second highest use; 191 episodes of physical restraint involving 49 individual residents.

1. The Administration of ECT in Approved Centres: Activity Report 2013

<http://www.mhcirl.ie/File/The-Administration-of-ECT-in-ACs-Activity-Report-2013.pdf>

2. The Use of Seclusion, Mechanical Means of Bodily Restraint and Physical Restraint in Approved Centres: Activities Report 2013

<http://www.mhcirl.ie/File/The-Use-of-Sec-and-Res-in-ACs-Activities-Report-2013.pdf>

ENDS

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NOTES TO EDITOR

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.

The Commission has produced *Rules Governing the Use of Electro-convulsive Therapy (ECT)* and a *Code of Practice on the Use of Electro-convulsive Therapy (ECT) for Voluntary Patients*, which regulate the administration of ECT in approved centres. In addition the Commission has produced *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* and a *Code of Practice on the Use of Physical Restraint in Approved Centres*, which regulate the use of seclusion and restraint in approved centres.

An Approved Centre: An “approved centre” is a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder that is registered pursuant to the Mental Health Act 2001. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the 2001 Act.

ECT: Electro-convulsive Therapy (ECT) is a medical procedure in which an electric current is passed briefly through the brain via electrodes applied to the scalp to induce generalised seizure activity. The person receiving treatment is placed under general anaesthetic and muscle relaxants are given to prevent body spasms. Its purpose is to treat specific types of major mental illnesses.

A programme of ECT refers to no more than 12 treatments prescribed by a consultant psychiatrist.

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

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

Restrictive interventions/restrictive practices for the purposes of this report include the use of mechanical restraint, physical restraint and seclusion.

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