Key Performance Indicators for Australian Public Mental Health Services: PI 15-Rate of seclusion (acute inpatient units), 2014-15; Quality statement

Identifying and definitional attributes

Metadata item type: Quality Statement

METEOR identifier: 624018

Registration status:

- AIHW Data Quality Statements, Superseded 04/05/2017

Data quality

Quality statement summary:

Definition:

Number of seclusion events per 1000 bed days in specialised public mental health acute inpatient units

Numerator:

Number of seclusion events in specialised public mental health acute inpatient units.

Denominator:

Number of accrued mental health care days in specialised public mental health acute inpatient units.

Computation:

Expressed as a rate. Calculation is: (Numerator ÷ Denominator) x 1000.

Use of restrictive practices during admitted patient care

Health Ministers endorsed the National safety priorities in mental health: a national plan for reducing harm (the Plan), Australia's first national statement about safety improvement in mental health, in 2005. The Plan identified 4 national priority areas for national action including 'reducing use of, and where possible eliminating, restraint and seclusion'.

In line with the Plan, the National Mental Health Seclusion and Restraint Project (2007–2009), known as the Beacon Project, was developed as a collaborative initiative to establish demonstration sites as centres of excellence aimed towards reducing seclusion and restraint in public mental health facilities. Key to this work has been translating international lessons and initiatives to the Australian environment and the development and implementation of policies, guidelines and staff training based on good practice. Project outcomes were positive, with several Beacon sites reporting significant reductions in the use, and/or duration of seclusion, thus providing the foundation for further change.

To maintain the collaborative approach and momentum from the Beacon project, states and territories agreed to host ongoing annual National Mental Health Seclusion and Restraint forums. These forums have provided opportunities to showcase initiatives, report on progress, share lessons with external stakeholders and identify areas for further focus.

More recently, the National Mental Health Commission has formed a multi-disciplinary research team and core reference group of experts to examine best practice in reducing, and where possible eliminating, restraint and seclusion. The project scope is broader than the original Beacon Project, extending scrutiny beyond hospitals to the use of restrictive practices in community, custodial and ambulatory settings. Consultation with people with a lived experience and their families, clinicians and people working in services, are considered key to the national project, especially in determining the extent of restrictive practices.

At present there is no formal, routine nationally agreed collection and reporting framework for seclusion events in specialised mental health public acute hospital services. Data are sourced from state and territory seclusion data collections for specialised mental health public acute hospital services via SQPSC a subcommittee, of the Mental Health, Drug and Alcohol Principal Committee (MHDAPC).

The Australian Health Ministers Advisory Council (AHMAC) mental health committees are in the process of formalising the current ‘ad hoc’ SQPSC seclusion data collection arrangements. The Mental Health Information Strategy Standing Committee (MHISSC) is working with AIHW to develop an aggregate seclusion and restraint Data Set Specification (DSS) to standardise the national collection of both seclusion and restraint data (and provide a more detailed data set) from the 2015–16 collection period.

Institutional environment: **The Australian Institute of Health and Welfare**

The Australian Institute of Health and Welfare (AIHW) is a major national agency set up by the Australian Government under the Australian Institute of Health and Welfare Act 1987 to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent corporate Commonwealth Entity established in 1987, governed by a management Board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, ranging from health and welfare expenditure, hospitals, disease and injury, and mental health, to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national datasets based on data from each jurisdiction, to analyse these datasets and disseminate information and statistics.

The Australian Institute of Health and Welfare Act 1987, in conjunction with compliance to the Privacy Act 1988, (Cth) ensures that the data collections managed by the AIHW are kept securely, under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website www.aihw.gov.au

Timeliness: State and Territory governments provide the data to the AIHW via SQPSC for national collation, approximately three months after the reference period. Data are published within six months of the close of the reference period.

Accessibility: Seclusion data are available at AIHW's Mental Health Services in Australia — annual publication (https://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices). Additional disaggregation of the seclusion data are in this AIHW publication.

Interpretability: Information is available for interpreting seclusion data from AIHW's Mental Health Services in Australia — annual publication (mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices).

Relevance: Seclusion is the confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented. A seclusion event commences when a clinical decision is made to seclude a mental health consumer and ceases when there is a clinical decision to cease seclusion. If a consumer re-enters seclusion within a short period of time this is considered a new seclusion event. The term 'seclusion event' is utilised to differentiate it from the different definitions of 'seclusion episodes' used across jurisdictions.

Data on seclusion events relate to all specialised mental health public hospital acute services. Wards or units other than specialised mental health services, such as emergency departments, are out of scope for this data collection. Specialised mental health acute forensic hospital services are in scope, regardless of which department manages the service, for example a health department versus a correctional services department.

Accuracy:

Estimated acute bed coverage for 2014–15 seclusion data was over 95% based on acute beds reported to the Mental Health Establishments National Minimum Data Set in 2013–14.

Occasionally, jurisdictions re-supply data for seclusion events or number of occupied bed days. Data re-submissions are highlighted in subsequent data supplies, with updated figures reported in the next annual publication. For 2014–15, historical data were re-supplied for 2 jurisdictions.

Integrity of the supplied seclusion data is tested by AIHW via a series of 'logical' validation checks. Any missing or unusual data is clarified with the supplying jurisdiction.

Some outliers (i.e. a small number of clients who have an above average number of seclusion events) are apparent in the data and were not removed, this has the effect of skewed the rates of seclusion for some jurisdictions.

A new data element, average time in seclusion was captured for the 2013–14 collection period and subsequent collections. As the average time in seclusion is significantly higher for forensic units, these units were excluded from average time in seclusion calculations to provide a more realistic estimation of seclusion duration.

The absence of unit record data limits the ability to undertake analysis to provide context around the incidence of seclusion events. For example, the analysis of consumer attributes which may indicate risk factors or a vulnerability to experiencing seclusion and restraint events (i.e., legal status, gender, date of birth, indigenous status, country of birth etc).

In addition, identifying the timing of seclusion events within an episode of admitted patient mental health care may be informative in mitigating/pre-empting patterns in the use of restrictive practices. Some jurisdictions have the capacity to record and report this information but the lack of cross-jurisdictional consistency restricts the collection and reporting of unit record data at a national level.

Within the aggregate reporting framework, collection of service unit level data is currently not feasible. Although data are collected at target population, collection at the service unit level would improve consistency and comparability with other mental health collections such as the Mental Health Establishment NMDS.

The use of restrictive practices also includes restraint events. However, no national restraint data are currently reported representing a substantial data gap. The AIHW is currently working with the AHMAC mental health committees and jurisdictional representatives to develop national restraint data standards to facilitate the collection and reporting of national restraint event data.

Coherence:

Variations in jurisdictional legislation may result in exceptions to the definition of a seclusion event. Data reported by jurisdictions may not be explicitly comparable, jurisdictional comparisons should therefore be made with caution.

Specific jurisdictional caveats are outlined below:

New South Wales

New South Wales does not have a centralised database for the collection of seclusion data. Services report seclusion rates regularly to the NSW Ministry of Health. Services are required to maintain local seclusion registers, which may be audited by NSW Official Visitors who function with legislative authority to raise issues in relation to patient safety, care or treatment. Seclusion rates are a Key Performance Indicator (KPI) in regular performance reporting to NSW Local Health Districts. Importantly, NSW seclusion rates include bed days for some forensic services managed by correctional facilities.

Note that in calculating seclusion rates at LHD and State level, all acute bed days are included in the denominator, as per national KPI specifications. This includes facilities where no seclusion occurs, since excluding these facilities would falsely increase the seclusion rate.

No seclusion episodes or bed days were provided for facilities which had not yet opened in the earlier part of the collection period.

The proportion of episodes with a seclusion event may be underestimated in some facilities containing multiple acute units, due to the duplicate counting of hospital stays at facility level. The method used in the seclusion collection for the admitted mental health separations will be reviewed.

Victoria

Victoria have comparably lower bed numbers than other jurisdictions, and as such, it may be useful to view the rate of seclusion events in a broader population context (rates per capita).

Seclusion events per 10,000 population in Victoria was 7.2 in 2011–12, 5.8 in 2012–13, 5.5 in 2013–14, and 4.5 in 2014–15.

Queensland

Queensland do not report any acute forensic services to the collection, however forensic patients can and do access acute care through general units.

Lady Cilento Children's Hospital commenced operation in December 2014 replacing the Mater Public Children's Hospital and Royal Children's Hospital. One hospital has activity that through the Patient Administration System is classified as having psychiatric care for children and adolescents. However, these beds are not classified as specialist mental health beds as reported by the hospital to the Mental Health Establishments (MHE) NMDS. Therefore there will be a mismatch of information between the establishment characteristics listed here and those listed in the MHE NMDS.

There are a number of extreme outliers in regards to duration that have significant impact on duration data. These are a combination of data entry error on legal documentation and actual long seclusions. Due to the timeframe required for submission, 2014–15 data is preliminary and includes imputed episodes of care where source data is not yet available.

Western Australia

It should be noted that Western Australia does not have a centralised data base for the collection of seclusion data. Services provided seclusion data from their own data bases. The Chief Psychiatrist in WA has requested, from 1 July 2014, quarterly reporting of seclusion and restraint rates by all current reporting services.

Western Australia has noted two methodologies for calculating “Accrued mental health care days” to the Mental Health Establishment NMDS and to the Seclusion and Restraint ‘ad hoc’ collection denominator. Each has used their own data source and methodology to calculate “Accrued mental health care days”. Western Australia will investigate these differences further and work towards resolving the discrepancies for future data supplied.

In supplying 2014–15 Seclusion and Restraint data, the same methodology has been used as in 2013–14 for consistency, however as mentioned, there will be differences between the MHE NMDS. The “N Accrued Care Days” for Seclusion and Restraint is supplied from the state data collection which counts the number of beds occupied every midnight. Please note the following inclusions and exclusions that apply to the number of accrued care days for WA:

- Excludes same-day separations
- Excludes leave days where the bed is counted as not occupied at midnight, or where the bed is occupied by another patient at midnight during the leave period
- Includes all specialised mental health inpatient wards
- Includes hospital in the home wards
- Includes only those care days within each financial year, and includes patients admitted through the entire financial year.

South Australia

Recent data reporting improvements will impact on South Australian data. Importantly, bed days used to calculate South Australia’s seclusion rates are estimated based on 100% occupied bed numbers, which are fluctuating in relation to new infrastructure projects. During 2010–11, a substantial number of seclusion

events in one particular hospital were for a small number of patients with over half of these being patient-requested events. This may have impacted on the overall seclusion rate reported for the state for 2010–11.

South Australia was unable to supply seclusion data for 2008–09. Information on seclusion duration is only available in 4 hour blocks, therefore averages cannot be calculated and seclusion duration figures for South Australia are not included in national totals.

Tasmania

The increase in the state-wide Tasmanian seclusion rate for 2012–13 and 2013–14 data is due to a small number of clients having an above average number of seclusion events.

Australian Capital Territory

When interpreting these data, the relative small size of the Australian Capital Territory should be noted, with a total of between 63 and 70 acute inpatient beds reported between 2008–09 and 2013–14.

Work is progressive and ongoing as part of a larger process of providing a place of improved safety and security, both for people experiencing an acute episode of mental ill health leading to an inpatient admission, visitors and for the staff who work in this challenging environment.

Northern Territory

The Northern Territory was unable to supply seclusion data for 2008–09.

The NT is unable to segregate Forensic Inpatient Episodes and Events from general events. Therefore all NT totals, wherever stated, are comprised of both General & Forensic Inpatient Episodes and Events. As this may artificially inflate NT data, caution should be used when comparing or interpreting this data.

Due to the low ratio of beds per person in the NT compared with other jurisdictions, the apparent rate of seclusion is inflated when reporting seclusion per patient day compared with reporting on a population basis.

Due to the low number of beds in NT, high rates of seclusion for a few individuals have a disproportional effect on the rate of seclusion reported.

NT seclusion data is therefore not directly comparable with other jurisdictions.

Source and reference attributes

Steward: Australian Institute of Health and Welfare

Reference documents: Key Performance Indicators for Australian Public Mental Health Services, Third Edition

A report produced for the Australian Health Ministers Advisory Council's Mental Health Drug and Alcohol Principal Committee (MHDAPC) by the National Mental Health Performance Subcommittee (NMHPSC)

Relational attributes

Related metadata references: Supersedes Key Performance Indicators for Australian Public Mental Health Services: PI 15-Rate of seclusion (acute inpatient units), 2013-14; Quality statement

- AIHW Data Quality Statements, Standard 02/12/2014

Has been superseded by Key Performance Indicators for Australian Public Mental Health Services: PI 15-Rate of seclusion (acute inpatient units), 2015-16; Quality statement

- AIHW Data Quality Statements, Standard 04/05/2017