Seclusion and Restraint
Position Statement

Defining seclusion and restraint

There are no consistent definitions of seclusion and restraint, which relates to inconsistencies in legislation in each jurisdiction in Australia. The following definitions apply for the purpose of this Position Statement:

- Seclusion: the deliberate confinement of a person, alone, in a room or area that he or she cannot freely exit.
- Physical restraint: bodily force that controls a person’s freedom of movement.
- Chemical restraint: medication given primarily to control a person’s behaviour, not to treat a mental illness or physical condition.
- Mechanical restraint: a device that controls a person’s freedom of movement.

The National Mental Health Carer and Consumer Forum (NMHCCCF) also include emotional restraint which they define as being when an individual consumer is conditioned to such an extent that there is a loss of confidence in being able to express views openly and honestly to clinical staff for fear of consequences.¹

In 2005 Health Ministers endorsed the National safety priorities in mental health: a national plan for reducing harm, which identified four priority areas including reducing use of, and where possible eliminating, restraint and seclusion. Since 2008-09 a number of seclusion data collections have been conducted by the Australian Health Ministers Advisory Council’s (AHMAC) Safety and Quality Partnership Standing Committee (SQPSC) with states and territories. AHMAC have formalised the Seclusion and Restraint Data Set Specification which standardises the national collection of seclusion and restraint data from 2015-16.²

Research

There is very limited research to support the value of seclusion and restraint, and also on strategies to deal with behavioural emergencies for people experiencing acute mental health difficulties.

The NMHC Position Statement on seclusion and restraint in mental health³ notes that research into the prevention and safe management of these emergencies is essential, and should consider all ages and include people with lived experience of these difficulties, their families and carers. This should add to the body of evidence supporting the need to change, reduce and eliminate seclusion and restraint practices.

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1 National Mental Health Consumer and Carer Forum (2009), Ending Seclusion and Restraint in Australian Mental Health Services. NMHCCCF.
The United States of America (USA) has produced the largest body of work on efforts to reduce or eliminate seclusion and restraint and associated literature. There is consensus in the literature about best practices which include:

- national direction
- independent advocacy
- organisational leadership and oversight
- organisational culture change
- workforce development
- service user development and participation
- using practical tools
- debriefing
- information collection and use
- funding
- timeframes – refers to the timeframe to achieve a significant reduction

**Best practice**

The following principles have been shown to be effective in assisting services to implement least restrictive practices and reflects findings from USA work:

- *Clear organisational goal of prevention* - is consistently lead, communicated and has associated evidence.
- *Implementation of a personal restraint prevention strategy and plan* - actively implement a personal restraint prevention strategy and plan.
- *Person-centred care models, principles and strategies* - a key focus of mental health inpatient teams
- *Best practice alternatives* - thoroughly considered and implemented.
- *Personal restraint techniques only used as safety intervention of last resort* - is in accordance with all applicable legal obligations and approved team training.
- *If personal restraint techniques are used, the focus is on safely ending restraint as soon as possible*
- *Follow-up clinical interventions, reporting mechanisms and systems for review and prevention* - review occurs with the service user, family, frontline staff members, clinical leaders on what occurred and how future episodes might be prevented.
- *The use of personal restraint is considered an adverse event and organisational quality improvement processes aim for prevention and reduction* - the organisation’s strategic goal of personal restraint elimination is supported and evidenced by a quality improvement pathway that implements and supports practices known to prevent and reduce restriction.

Reduction of seclusion and restraint has been demonstrated to be possible without additional resources. The main barriers to reducing seclusion and restraint include:

- identified good practice/agreed clinical standards;
- quality improvement activity and clinical review;

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5 Te Pou (2015), Towards restraint-free mental health practice: supporting the reduction and prevention of personal restraint in mental health inpatient settings. Te Pou o Te Whakaaro Nui, Auckland.
• inappropriate use of interventions and variation in practice;
• staff knowledge or skills to prevent use and identify alternative interventions, and appropriately triage mental health presentations;
• staff training and knowledge on early warning signs of agitation and interventions to prevent using seclusion and restraint;
• staff education and training; and
• availability of resources and poor facilities.  

**Alternatives to seclusion and restraint**

There are alternative techniques to using seclusion and restraint emerging, although, as noted above, an evidence base on these techniques and approaches are required. Alternative techniques include:

- A short-term approach, where behaviour may escalate in a predictable manner, is de-escalation. These techniques are based on communication theory and utilise a variety of verbal techniques to calm a person.  
- A longer-term approach is the use of behavioural contracts which are based on social learning theory and address patient behaviours or symptoms rather than and are mutually negotiated by consumers and healthcare professionals.  
- Sensory modulation uses a range of tools to provide consumers with sensory input to help regain a sense of calm during high states of distress. Tools may include the use of music, soft or pleasant materials, pleasant aromas or weighted blankets, and occurs in dedicated rooms or in parts of in-patient wards.

A study on sensory modulation noted it was one component of an organisational change process required to have an impact on seclusion and restraint rates, along with strong policies, leadership and training for it to be effectively used as a routine addition to practice.

Models have also been developed which provide direction for dealing with behavioural situations. The Safewards model examines the factors which influence rates of conflict and containment on wards, and why some wards have significantly less conflict and containment than others.

**Key factors to reduce seclusion and restraint**

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8 Ibid
9 Te Pou, Sensory Modulation: using sensory modulation to support service users at times of distress, Te Pou o Te Whakaaro Nui, The National Centre of mental Health Research, Information and Workforce Development. www.tepou.co.nz
10 Ibid
The available literature and position statements from other relevant mental health organisations consistently identify particular factors and strategies to reduce and eliminate seclusion and restraint which include:

- National direction and oversight
- Cultural change and organisational leadership
- Physical changes to the environment
- Using data and research to inform practice
- Supporting the workforce, including training and care planning
- Involving consumer, family and carers
- Reviewing relevant legislation

The NMHC’s recommendation in their position paper on seclusion and restraint outline a course of action to reduce and eliminate seclusion and restraint:

- Educate mental health practitioners about multi-intervention strategies.
- Agree to uniform definitions, targets and reporting frameworks.
- Ensure seclusion and restraint practices and interventions are evaluated.
- Adopt a national approach to the regulation of seclusion and restraint.

The NMHC developed a Seclusion and Restraint Declaration for individuals and organisations to demonstrate a commitment to being a part of achieving change in the use of seclusion and restraint. The declaration highlights that use of seclusion and restraint is a human rights issue; is not therapeutic; that there are alternatives; and that Australian governments must take a leadership role in addressing its use and reporting on progress.

**Position Statement**

It is the position of the Australian College of Mental Health Nurses (ACMHN) that:

- In order to succeed in reducing/eliminating seclusion and restraint, the prevailing attitude must be (or become) one that considers an incident of seclusion or restraint as a ‘failure in care’
- The use of seclusion and restraint – as defined in this document - in acute and all mental health services settings, is a harmful practice that is traumatic for consumers, their families as well as staff, which should be reduced and ultimately ended.

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14 National Mental Health Consumer and Carer Forum (2009), Ending Seclusion and Restraint in Australian Mental Health Services. NMHC.
15 The Royal Australian and New Zealand College of Psychiatrists (2010), Position Statement 61, Minimising the use of seclusion and restraint in people with mental illness, June 2010.
Restrictive practices are never ‘therapeutic’, should ultimately be considered a ‘treatment failure’, and only implemented as a last resort. They should never be used for the purposes of punishment, discipline, negative inducement, coercion or staff convenience, or where less restrictive practices are accessible and achievable.

‘Last resort’ means that all other less restrictive therapeutic interventions have been tried and failed, and there is imminent danger to self/others and safety needs to be maintained.

The following principles guide action on seclusion and restraint:
1. The least restrictive intervention possible must be used during the crisis
2. In the event where seclusion and/or restraint become necessary, safe and approved techniques must be used at all times, and these must only be implemented by competent, trained mental health nurses or staff.
3. Consumers have the right to be treated with dignity and respect, in a culturally appropriate manner and have their choices respected. Staff must act to maintain the person’s dignity and emotional wellbeing at all times.
4. The person’s physical needs must be met – for example, access to food and drink, access to a bathroom.
5. All legal requirements must be met (e.g. relating to duration of the intervention) as well as monitoring, assessment and review, including medical assessment and physical observations.
6. The person needs to understand under what circumstances the restrictive practices will be discontinued, and these practices need to be discontinued at the earliest possible time.
   After such occurrences a review should be undertaken with the consumer, carers and/or family and staff involved, to diminish the harmful and traumatising effects that seclusion can have.

Efforts to reduce and eliminate seclusion and restraint must be led by government at the national, state and territory level in Australia to achieve agreement on:
- definitions on seclusion and restraint;
- consistency in legislation;
- targets and reporting frameworks for consistent data; and
- a national approach to the regulation of seclusion and restraint.

This will enable consistent monitoring of seclusion and restraint and assist in researching evidence-base prevention and management of behavioural emergencies and alternatives to seclusion and restraint.

There must be research into examining evidence-based practices on the prevention and safe management of behavioural emergencies and alternatives to seclusion and restraint.

Mental health services must provide safe and supportive environments for consumers receiving care and mental health nurses and all staff providing care. Consumers, carers and families must be collaboratively involved in developing policies and processes on dealing with behavioural emergencies.

The culture of an organisation has a significant impact on the processes used and there must be shared ownership among leaders to create a work environment that supports ending seclusion and restraint to enable this to be realised.
• Mental health nurses must be supported by mental health service administrators and nursing leaders, through access to and provision of:
  o appropriate training in de-escalation techniques and critical incident management
  o opportunities to implement alternatives to seclusion and restraint
  o implementation of changes to the physical environment wherever possible, to provide a calming milieu and access to quiet, safe spaces for consumers who are distressed
  o policies, procedures and adequate staffing levels to prevent and manage behavioural emergencies and implement alternatives to seclusion and restraint

• Mental health nurses play a central role in the provision of mental health care in all settings, and therefore have a crucial role in reducing, and ultimately ending, the use of seclusion and restraint. This requires nurses to take leadership in changing the organisational culture of mental health service settings, and demonstrate a commitment to implement recovery oriented approaches and alternative techniques to seclusion and restraint practices.

• The ACMHN supports the NMHC Seclusion and Restraint Declaration and the principles it articulates.