Seclusion and Restraint

Background Paper

Defining seclusion and restraint

The National Mental Health Commission (NMHC) in their position paper on seclusion, restraint and restrictive practices¹ notes that there are no consistent definitions of seclusion and restraint, which relates to inconsistencies in legislation in each jurisdiction in Australia. The NMHC use the definitions from the Tasmanian Mental Health Act 2013 which are:

- **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 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.²

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 2015-16.³ Data on rates of physical, mechanical and chemical restraint in Australia is not readily available.⁴

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) in their position statement *Minimising the use of seclusion and restraint in people with mental illness* state that while current initiatives to reduce seclusion and restraint focus on physical restraint, the use of chemical (pharmacological) restraint must have clear guidelines and protocols.⁵

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² National Mental Health Consumer and Carer Forum (2009), Ending Seclusion and Restraint in Australian Mental Health Services. NMHCCCF.
Under the available data set there has been a demonstrated reduction in seclusion rates in the majority of jurisdictions. The national figure was 7.8 seclusion events per 1,000 bed days in 2014-15, which was a decrease from 11.8 in 2010-11. The Northern Territory had the highest rate of seclusion with 31 events per 1,000 bed days and the ACT the lowest at 2.7 per 1,000 bed days. Seclusion rates had reduced in 6 of the 8 jurisdictions between 2010-11 and 2014-15.6

Along with the national plans and initiatives, reducing seclusion and restraint applies to Australia as a signatory to the Convention on the Rights of Persons with Disabilities in which Article 17 states that ‘every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others’. Article 15 also states that ‘no one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment’.7

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 health8 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.

An early Cochrane Collaboration review of seclusion and restraint studies found that there were no controlled studies evaluating the value of seclusion or restraint, or to support its continued use. There were reports of serious adverse effects of seclusion and restraint techniques in qualitative reviews. Cochrane recommended further research into seclusion and restraint practices9.

The American Psychiatric Nurses Association (APNA) note in their position statement The Use of Seclusion and Restraint10 that they support ongoing efforts to reduce and ultimately eliminate seclusion and restraint, but call for research supporting evidence-based practice for preventing and managing behavioural emergencies.

In New Zealand, nurses’ organisations have raised the issue of plans for a national approach to training in de-escalation and restraint minimisation techniques.11 The NMHC Position Statement on seclusion and

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Restraint in mental health recognises that people have the right to both receive care and work in safe and supportive environments, and that work and monitoring is occurring to understand what leads to seclusion and restraint.

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 2008 report Best practice in the reduction and elimination of seclusion and restraint by Te Pou in New Zealand noted that researchers have been able to consistently report best practices based on successful seclusion and restraint minimisation efforts. These reflect USA literature and includes:

- A national direction supporting seclusion and restraint reduction and elimination.
- Active, committed and high profile organisational leadership and oversight, and an organisational culture that demonstrates recovery oriented approaches.
- Workforce development including recruitment, education, supervision and staff involvement initiatives.

Other methods also include:

- service user development and participation,
- milieu (i.e. setting and environment) management and use of practical tools, such as meaningful activities, an atmosphere of listening and respect, de-escalation and sensory modulation, and
- effective debriefing and collection and use of information.

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.

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14 Ibid
• 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.¹⁵

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;
• 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.¹⁶

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.

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 and include observing for signs and symptoms of agitation, approaching the person in a calm controlled manner and allowing the person to maintain dignity. 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 diagnostic categories. Contracts provide a clear definition of the responsibilities of the patient and healthcare professional and are mutually negotiated.\textsuperscript{17}

Sensory modulation has been used as an alternative technique in New Zealand. 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.\textsuperscript{18}

A pilot study by Te Pou examined the use of sensory modulation in New Zealand acute mental health services. Participant responses reflected an overall high level of acceptability and a belief in the efficacy of sensory modulation. Both staff and service users as being effective in lowering distress and promoting calm, and the key outcomes identified supported de-escalation of distress which included:

- Was perceived as an effective tool for inducing a calm state in the majority of people that used it.
- Supported building trust and rapport.
- Enabled the development of service users’ self-management and ability to regulate their own emotional levels.\textsuperscript{19}

The study 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.\textsuperscript{20}

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, even with the same types of patients or are in the same hospital. With this model, conflict refers to patient behaviours that threaten their safety or others safety, and containment the actions taken by staff to minimise or prevent harmful outcomes.\textsuperscript{21} Key features of the model are:

- The set of originating factors that lead to and then can trigger a conflict incident.
- That containment has a reciprocal relationship with conflict and that its use can cause conflict rather than prevent it.
- Demonstrates that staff can influence rates of conflict and containment by:
  - Reducing or eliminating conflict originating factors
  - Preventing flashpoints developing from conflict incidents
  - Cutting the links between a flashpoint and conflict;
  - Not using containment when it is counterproductive; and


\textsuperscript{18} 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.

\textsuperscript{19} Sutton, D & Nicholson, E (2011), Sensory modulation in acute mental health wards: A qualitative study of staff and service user perspectives. Te Pou o Te Whakaaro Nui, Auckland

\textsuperscript{20} Ibid

\textsuperscript{21} Safewards Model, \url{http://www.safewards.net/model/easy}, Accessed 9 February 2016
Key factors to reduce seclusion and restraint

The available literature and position statements from other relevant mental health organisations consistently identify particular factors of strategies to reduce 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 NMHCCCF highlighted six key strategies to end seclusion and restraint:
1. Better Accountability – a measure to monitor the rate of involuntary seclusion and restraint in Australia and be established under national plans.
2. Implementation of Evidence Based Approaches to Ending Seclusion and Restraint.
3. Adherence to Standards and Public Reporting – regular monitoring of the application of relevant standards.
4. Support for Mental Health Professionals Towards Cultural and Clinical Practice Change.
5. Better Care Planning – consumers have individual and holistic assessments and are involved in the development of their own care plans.
6. Review Relevant Mental Health Legislation - assess the compatibility of each jurisdiction’s mental health legislation and policy to ensure consistency with international law protecting the rights of people with disabilities.

The NHMC position paper on seclusion and restraint discusses the USA National Association of State Mental Health Program Directors (NASMHPD) training curriculum, which has been used in sites around the world including New Zealand, which describes six core strategies to reduce the use of seclusion and restraint:

- ‘Leadership towards organisational change’ – outlining a philosophy of care that targets seclusion and restraint reductions
- ‘Consumer roles in inpatient settings’ – having an inclusive approach that involves consumers, carers and other advocates in reduction initiatives
- ‘Using data to inform practice’ – using data in to review, analyse and monitor patterns

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22 Ibid
25 National Mental Health Consumer and Carer Forum (2009), Ending Seclusion and Restraint in Australian Mental Health Services. NMHCCCF
26 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.
27 National Mental Health Consumer and Carer Forum (2009), Ending Seclusion and Restraint in Australian Mental Health Services. NMHCCCF.
- ‘Workforce’ – developing procedures, practices and education that promotes recovery
- ‘Use of seclusion and restraint reduction tools’ – assessments and other resources to develop individual aggression prevention approaches
- ‘Debriefing techniques’ – analysing why seclusion and restraint events occurred and evaluating the impacts on individuals with lived experience, families and carers and service providers.  

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 key features of the NMHC position statement on seclusion and restraint are:

- There is a lack of evidence to support seclusion and restraint, and that its use has resulted in harm.
- Acknowledges that it is a complex issue and that both consumers and health staff have a right to be in safe and supportive environments.
- Urges all Australian governments to support the commitments made in 2005 and that governments must provide leadership in achieving agreement on definitions on seclusion and restraint which is reflected in each jurisdictions legislation; targets and reporting frameworks that provides consistent national data; and a national approach to the regulation of seclusion and restraint.
- The need for research into the prevention and management of behavioural emergencies.
- Shared ownership, including consumers, carers, and health providers and staff, to reduce and ultimately eliminate 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.

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29 Ibid
