ADVOCACY BRIEF

SECLUSION AND RESTRAINT (RESTRICTIVE PRACTICES) IN MENTAL HEALTH SERVICES

Introduction

Seclusion is defined in mental health legislation as the deliberate confinement of a person, alone, in a room or area that he or she cannot freely exit.

The term restraint is more difficult to define and can refer to:

- physical restraint: where bodily force is used to control a person’s freedom of movement
- mechanical restraint: where a device, i.e. straps, harnesses, safety vests or mittens, is used to restrict a person’s freedom of movement
- chemical restraint: where medication is given for the purpose of controlling a person’s behaviour, i.e. sedation
- psychological coercion: the individual consumer is emotionally constrained to such an extent that there is a loss of confidence in being able to express their views openly and honestly to clinical staff for fear of the consequences.

It is the position of the NMHCCF, in line with its position statement Ending Seclusion and Restraint in Australian Mental Health Services, that the practices of seclusion and restraint:

- are not in accordance with the United Nations Rapporteur’s edict
- remain at unacceptable levels
- can cause short and long term psychological and physical harm to consumers and/or clinical staff
- can be dramatically reduced with genuine effort
- promote distrust and disrespect between consumers, families/support persons/carers and clinical staff and decrease the likelihood of a consumer seeking treatment
- can have a negative impact on recovery.

Importantly, recovery principles, as outlined in A national framework for recovery-oriented mental health services: Policy and theory, should underpin all mental health service delivery. The adoption of recovery and trauma-informed principles empowers people throughout their recovery process and assists services to reduce and eliminate the use of restrictive practices.

People with mental health issues are at risk of severe ongoing mental trauma, physical injury and in some instances, death resulting from seclusion and/or restraint.
Discussion

People with mental health issues are at risk of severe ongoing mental trauma, physical injury and in some instances, death resulting from seclusion and/or restraint. Healthcare workers also risk both physical and psychological harm during the course of restraining and/or secluding a person.

In some cases protection from harm may be viewed as a plausible reason for the implementation of these practices, however it is recognised that in some cases seclusion and/or restraint may be ways that staff choose to control the people in their care. For consumers and carers there can be the perception that these restrictive practices are imposed as a means of coercion, discipline, convenience, or retaliation by staff. Furthermore, as far back as 1994, a literature review found that 'non clinical factors, such as cultural biases, role perceptions, and attitude, are substantial contributors to the frequency of seclusion and restraint.'

In February 2013, the United Nations Special Rapporteur called for an ‘absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities …in all places of deprivation of liberty including in psychiatric and social care institutions.’ Whilst the statement is not legally binding in Australia, it indicates that, from a human rights perspective, these practices are no longer acceptable.

In his Foreword to the NMHCCF position statement Ending Seclusion and Restraint in Australian Mental Health Services, Professor Ian Hickie notes that, 'the frequent requirement to seclude and restrain people with an acute mental illness highlights the ongoing failure of the mental health system to provide high quality care.'

The past decade has seen a number of national initiatives, including the Beacon Project, the National Mental Health Commission’s position statement on seclusion and restraint, the University of Melbourne’s Seclusion and Restraint Project report, and the annual National Seclusion and Restraint conferences, focused on reducing and/or eliminating seclusion and restraint in Australia. While statistics indicate that there has been a decrease in seclusion events over the past six years, there has been consistently higher rates of seclusion in the child and adolescent services.

In 2017, the Australian Institute of Health and Welfare (AIHW) released national data on the use of restrictive practices. Its key points were:

- 7.4 seclusion events per 1,000 bed days in acute specialised mental health hospital services in 2016-17, down from 13.9 in 2009-10.
- 5.8 hours was the average seclusion duration in 2016-17.
- 8.3 physical restraint events per 1,000 bed days and 0.9 mechanical restraint events per 1,000 bed days in 2016-17.

There are many viable ways to reduce seclusion and restraint. The importance of “environment” is widely reported to have a significant influence on a person’s psychological wellbeing and far greater emphasis needs to be placed on providing quality, community based care allowing a person to remain, wherever possible, in his/her own home/environment rather than being placed in an alien and often unsettling involuntary setting.

Bradley Foxlewin’s consumer-led research study into seclusion illustrates the importance of collaboration and the inclusion of the consumer voice in seclusion incident reviews, stating it develops ‘a culture in which difficult situations can be discussed without blame, where every point
of view is valued, every voice is heard and respected; where practices of exclusion, such as values that privilege staff over consumers, or beliefs that rob consumers of agency and dignity, are rigorously investigated.'

The National Principles for Communicating about Restrictive Practices with Consumers and Carers\(^4\) are based on the understanding that ‘Communicating effectively can improve mutual understanding between consumers, carers and health service providers, to prevent and/or reduce the likelihood of a restrictive practice occurring.’ The document notes that ‘Information provided to consumers, carers and family members about restrictive practices must be communicated with dignity, respect, courtesy and compassion. This includes communicating with other people who may not be directly involved in the incident but may be indirectly affected.’

**Recommendations**

The NMHCCF has identified the following strategies to reduce seclusion and restraint in Australian mental health services:

- Provide quality ongoing psychosocial and clinical support in the community for consumers and carers.
- Ensure representation and involvement of consumers, family, support persons, and carers in all aspects of mental health care including legislation, regulation, incident reviews and policy.
- Implement the 2017 National Principles\(^5\) to support the goal of eliminating seclusion and restraint in mental health services.
- Establish stringent accountability measures and legitimate deterrents.

**References**