Position Statement 61
Minimising the use of seclusion and restraint in people with mental illness
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Purpose
The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is committed to the delivery of quality mental health services that seek to improve safe practice and promote optimal outcomes to those receiving care. Therefore, the RANZCP is committed to achieving the aim of reducing, and where possible eliminating, the use of seclusion and restraint in a way that supports good clinical practice and provides safe and improved care for consumers. Reducing the use of seclusion and restraint requires commitment and leadership to changing practices and continued investment in delivering high quality care.

Background
In recent years, there have been a number of Australian reviews in relation to seclusion and restraint, including:

- In 2005, Australian Health Ministers endorsed the National Safety Priorities in Mental Health: a National plan for reducing harm. The Plan identified four priority areas for national action including ‘reducing use of, and where possible eliminating, restraint and seclusion’ (National Mental Health Working Group, 2005).

- The National Mental Health Seclusion and Restraint Project (2007–2009), also 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. The Beacon Project published a suite of national documentation in September 2009 (Mental Health Standing Committee, 2009), which was endorsed by the Mental Health Standing Committee (MHSC) for use by Australian mental health services.


- In its 2012 Report Card on Mental Health and Suicide Prevention, the National Mental Health Commission recommended that action must be taken to eliminate the use of seclusion and restraint in mental health services. In order to carry out this recommendation, the Commission called on all states and territories ‘to contribute to a national data collection to provide comparison across states and territories, with public reporting on all involuntary treatments, seclusions and restraints each year from 2013’ (National Mental Health Commission, 2013).

- In 2015, the National Mental Health Commission published A Case for Change: Position Paper on seclusion, restraint and restrictive practice in mental health services to help identify best practice as well as the barriers to reducing or eliminating seclusion and restraint in mental health settings (National Mental Health Commission, 2015).
• All Australian jurisdictions have introduced laws, policies or guidelines, focusing on reducing seclusion and restraint events, time spent in seclusion and trauma associated with seclusion and restraint.

In New Zealand, Te Pou o Te Whakaaro Nui (Te Pou) released a report in 2008, *Best practice in the reduction and elimination of seclusion and restraint; Seclusion: time for change* (O’Hagan et al., 2008). The standards governing the use of seclusion and restraint in the *Health and disability services (restraint minimisation and safe practice) standards* were also revised in 2008 (Standards New Zealand, 2008). The intent of the standards is to ‘reduce the use of restraint in all its forms and to encourage the use of least restrictive practices’.

In 2010, the New Zealand Ministry of Health developed guidelines to identify best practice methods for using seclusion in mental health acute inpatient units in alignment with the specifications set out in the *Health and Disability Services Standards* to, over time, limit the use of seclusion and restraint on mental health patients. In addition, reducing (and eventually eliminating) seclusion is one of the goals of the Ministry’s service development plan *Rising to the Challenge* (Ministry of Health, 2012).

Subsequently, Te Pou has developed an evidence-based Six Core Strategies Checklist for reducing the use of seclusion and restraint practices. As research also shows that Tangata whai i te ora are over-represented in reporting of seclusion and restraint events, Te Pou has also developed recommendations to support better outcomes when working with Māori people using services. The work is drawn from Te Pou’s work with services and from the study *Strategies to reduce seclusion and restraint for tangata whai i te ora* (Wharawera-Mika et al., 2013).

Over the past decade, Trauma-Informed Care has emerged and encompasses strategies aimed at reducing coercive practices, including restraint and seclusion as a way of creating therapeutic environments that prevent retraumatising or traumatising consumers. The majority of consumers in inpatient settings have had past trauma experiences and as such ‘universal trauma precautions’ and nursing practices that are growth-promoting and recovery-focused are recommended to prevent further harm. Restraint and seclusion are experienced by consumers as emotionally unsafe and disempowering practices and, therefore, can be retraumatising (Musket, 2014).

Recent data shows that the seclusion and restraint rate in mental health services in both Australia and New Zealand is declining. In Australia, there were eight seclusion events per 1000 bed days in 2013–14, an average annual reduction of 12.2% since 2009–10. The highest rate of seclusion was for child and adolescent and general services with 9.6 and 9.5 seclusion events per 1000 bed days respectively. Older person services had the lowest rate of seclusion events (0.5), a reduction of 34.4% in five years (Australian Institute of Health and Welfare, 2014). In New Zealand, the use of seclusion in adult inpatient units is also in decline, with the number of people secluded decreasing by 29% since 2009 and the total number of hours spent in seclusion reducing by 50% since 2009. However, Māori people remain over-represented in the seclusion figures. In 2013, Māori people were 3.7 times more likely to be secluded than non-Māori in an adult inpatient setting (per 100,000 population; Ministry of Health, 2014).

**Definition**

Both seclusion and restraint have long been used as an emergency measure to manage violent behaviour or agitation in mental health settings. The primary aim is to reduce risk of traumatic experience and/or injury for both consumers and staff involved.

• **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.

• **Restraint** is the restriction of an individual’s freedom of movement by physical, chemical or mechanical means. Here, ‘physical’ means bodily force that controls a person’s freedom of movement, ‘chemical’ means medication given primarily to restrict a person’s movement not to
treat a mental illness or physical condition and ‘mechanical’ means a device that controls a person’s freedom of movement.

While this position statement applies to the use of seclusion and restraint in mental health settings, it should also be used to inform policy in all other health, welfare or disability settings. This includes the use of seclusion and restraint on individuals with intellectual disability and in aged care settings and those presenting in emergency departments.

Evidence

Seclusion and restraint are generally used in the hope of preventing injury and reducing agitation, but studies have reported substantial deleterious physical and more often psychological effects on both patients and staff (Fisher, 1994).

It is acknowledged that there are situations where it is appropriate to use restraint and/or seclusion but only as a safety measure of last resort where all other interventions have been tried or considered and excluded. Under these circumstances, seclusion and restraint should be used within approved protocols by properly trained professional staff in an appropriate environment for safe management of the consumer. Seclusion and restraint are not a substitute for inadequate resources (such as lack of trained nursing staff). They should never be used as a method of punishment.

There is considerable variation in the clinical standards governing the use of seclusion and restraint in mental health services and guiding the appropriate use of the interventions or the use of alternative strategies. The aim is to reduce the use of these interventions and the adverse events that accompany them. Reduction of seclusion and restraint is possible, as demonstrated in studies such as those in the United States which have reduced use considerably without additional resources (Huckshorn, 2005). Evidence also shows that de-escalation and debriefing strategies can help minimise the use of seclusion and restraint. It requires leadership, commitment and motivation, and a change culture underpinned by recovery with a focus on workforce and training, prevention and early intervention, good clinical care, and supporting practice change.

The main barriers to reducing seclusion and restraint are:

- lack of identified good practice/agreed clinical standards for the use of seclusion and restraint
- lack of quality improvement activity and clinical review – i.e. poor governance
- inappropriate use of interventions and variation in practice – e.g. using threat of restraint or exclusion to coerce particular behaviour
- lack of staff knowledge or skills to prevent, identify and use alternative interventions or to safely use restraint and seclusion interventions in emergency situations
- lack of staff knowledge or skills regarding appropriate triaging of mental health presentations
- lack of staff training and knowledge about early warning signs of agitation and aggression and effective interventions to prevent the use of seclusion and restraint
- lack of staff education and training, particularly in non-mental health care settings
- lack of resources and poor facilities.

Many of the barriers above are being addressed through the MHSC initiatives in Australia and the recent updates by Te Pou and Standards New Zealand. Common themes developed in all strategies for the reduction of seclusion and restraint include:

- national direction and appropriate funding
- leadership towards organisational, clinical and cultural change
- use of data to inform practice
- improved governance and review
- workforce development, including de-escalation and debriefing strategies
- use of practical and evidence-based seclusion and restraint prevention tools
• service user development and participation
• better care planning
• consumer roles in inpatient settings
• debriefing techniques
• review of relevant mental health legislation.

The RANZCP supports the development of these strategies and believes that an increased focus on developing good clinical care, governance, research and education will help reduce the use of seclusion and restraint in practice.

The RANZCP also supports measures to improve the environment and physical layout of mental health services to help consumers to feel as safe and secure as possible. These measures can, in turn, help services to reduce the need to utilise seclusion and/or restraint practices. Potential examples include having natural light and spaces specifically designed to provide comfort to people who are in crisis or distressed and enabling doors to the main wards to be unlocked (National Mental Health Commission, 2015).

Recommendations

• The RANZCP is committed to achieving the aim of reducing, and where possible eliminating, the use of seclusion and restraint in a way which supports good clinical practice and provides safe and improved care for consumers.

• Seclusion and restraint are interventions and not therapies. The RANZCP acknowledges that there are situations where it is appropriate to use restraint and/or seclusion but only as a safety measure of last resort where all other interventions have been tried, considered and excluded. Seclusion and restraint should never be used as a method of punishment but rather should aim to restore a collaborative patient–clinician relationship.

• If seclusion and/or restraint are to be used, they should only be used in line with formal policies in a safe, dignified and respectful manner as possible by appropriately trained staff.

• Prone (face down) physical restraint should only be used if it is the safest way to protect the patient or any other person. If face down restraint is used, it will be time limited. The maximum time a person will be held on the ground in face down restraint is approximately two to three minutes, the minimum amount of time necessary to administer medication and/or remove the person to a safer environment (NSW Ministry of Health, 2012).

• In the interests of consumer and staff safety, and the delivery of quality mental health services, the RANZCP fully supports systems-oriented activities such as Trauma-Informed Care that seek to minimise harm and promote improved outcomes for individuals receiving care.

• The RANZCP endorses the principles underpinning the entry on seclusion and restraint presented in National safety priorities in mental health: a national plan for reducing harm (National Mental Health Working Group, 2005) and in the Te Pou report (O’Hagan et al., 2008), and is encouraged to see progress in terms of the identified strategies.

• The RANZCP considers that the skills and attitudes of staff involved are the most critical aspect in reducing the use of seclusion and restraint and supports the principles of training and education for health staff in effective de-escalation and debriefing techniques.

• The RANZCP also supports environmental measures to help improve the design and physical layout of mental health services, which in turn may help reduce the need for those services to utilise seclusion and/or restraint.
The RANZCP will work to promote quality and safe practice within its training and continuing medical education programs to contribute to the reduction of seclusion and restraint.

The RANZCP supports a review of the term 'chemical restraint'.

References


Disclaimer

This information is intended to provide general guide to practitioners, and should not be relied on as a substitute for proper assessment with respect to the merits of each case and the needs of the patient. The RANZCP endeavours to ensure that information is accurate and current at the time of preparation, but takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.

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