
Legal issues

Editor: Bernadette McSherry*

DEFINING SECLUSION AND RESTRAINT: LEGAL AND POLICY DEFINITIONS VERSUS CONSUMER AND CARER PERSPECTIVES

The practices of seclusion and restraint may be used in a variety of health settings to control behaviour. Laws and policies that seek to regulate these practices define seclusion and restraint in various ways and there are gaps as to which practices are regulated and in what circumstances. This column provides an overview of consumer and carer perspectives as to what is meant by these practices.

INTRODUCTION

The use of seclusion and various forms of restraint to control behaviour occurs in a wide range of institutional and other settings, yet is controversial due to the adverse physical and psychological effects that may result. While all Australian jurisdictions have laws regulating the use of seclusion (confinement in a room from which a person cannot freely exit) in mental health and disability settings, legal frameworks for regulating the different forms of restraint differ markedly across the Australian States and Territories.¹ Regulation occurs primarily under mental health and disability services legislation as well as through a range of policy directives and guidelines.

Part of the challenge for law reform in this area is that, while seclusion has been defined through legislation, what is meant by “restraint” can vary according to context. This column explores how seclusion and restraint are currently defined in legislation and policy (if at all) and how this may differ from the perspectives of those with lived experience of these practices² and their family members/carers. It is argued that there is a need for a new way of defining seclusion and restraint which takes into account consumer and carer perspectives. These perspectives are often embedded in and inseparable from personal examples of negative consequences of seclusion and restraint. As set out later in this column, this mirrors research indicating that seclusion and restraint are overwhelmingly experienced as causing harm over the short and long term.

EXISTING DEFINITIONS

Section 3 of the *Mental Health Act 2013* (Tas) defines seclusion as “the deliberate confinement of [a person], alone, in a room or area that [the person] cannot freely exit”.³ This is sometimes, however, referred to as “environmental restraint” in disability laws and policies.⁴

The term restraint is difficult to define because it may be used to cover a number of interventions. Section 3 of the *Mental Health Act 2013* (Tas), for example defines three different types of restraint:

* BA (Hons), LLB (Hons), LLM (Melb), PhD (York), Grad Dip Psych (Mon); Professor and Foundation Director, Melbourne Social Equity Institute, University of Melbourne.

Correspondence to: bernadette.mcsherry@unimelb.edu.au.

¹ Surabhi Kumble and Bernadette McSherry, “Seclusion and Restraint: Rethinking Regulation from a Human Rights Perspective” (2010) 21 *Psychiatry, Psychology and Law* 551; Bernadette McSherry, “The Legal Regulation of Seclusion and Restraint in Mental Health Facilities” (2013) 21 *JLM* 251.

² It is recognised that there are different ways of describing those who use mental health services. This column will use the terminology of the National Mental Health Consumer and Carer Forum <<http://nmhccf.org.au/>>.

³ See also definitions set out in *Mental Health and Related Services Act* (NT) s 62; *Mental Health Act 2000* (Qld) s 162J; *Mental Health Bill 2015* (Qld) cl 253; *Mental Health Act 2014* (Vic) s 3; *Mental Health Act 2014* (WA) s 212.

⁴ See, for example, *Disability Services Act 2011* (Tas) s 34; Australian Capital Territory Government Health Directorate, *Restraint of Patients Policy Statement* (June 2011).

Legal issues

- 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”; and
- mechanical restraint: “a device that controls a person’s freedom of movement”.

Other forms of restraint have been referred to in policy materials. A position statement by the National Mental Health Consumer and Carer Forum refers to:

- emotional restraint: “the individual consumer is conditioned 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”.⁵

Only mechanical restraint is regulated in every State and Territory under mental health legislation.⁶ Physical restraint is regulated under policies and/or mental health legislation in the six States and the Australian Capital Territory, but is not regulated at all in the Northern Territory. The Victorian Office of the Senior Practitioner has stated that chemical restraint was the most commonly used form of restraint⁷ and it appears to be widely used on people with dementia.⁸ While it is specifically regulated under disability legislation in Queensland, the Northern Territory and Victoria, it is not regulated under mental health legislation except in Tasmania.

In the disability sector, Pt 6 of Queensland’s *Disability Services Act 2006* regulates the use of chemical, physical and environmental restraint (the latter is referred to as containment), while the Northern Territory’s *Disability Services Act 2012* regulates chemical restraint (s 34) and “restricting access” to a “thing” at a facility for the purpose of behaviour control (s 35). Part 7 of Victoria’s *Disability Act 2007* regulates mechanical and chemical restraint, while Pt 6 of Tasmania’s *Disability Services Act 2011* regulates “restrictive interventions” in general which are defined as “any action that is taken to restrict the rights or freedom of movement ... for the primary purpose of the behavioural control of the person” (s 4). New South Wales and South Australia use guidelines and a policy respectively to regulate “physical restraint”, “exclusionary time-out”, “response cost”, “restricted access” and “psychotropic medication” (New South Wales guidelines), “detention”, “exclusion”, “aversive restraint”, “chemical restraint”, “physical restraint” and “mechanical restraint” (South Australian policy).⁹

While the terms physical, mechanical and chemical restraint appear to be used widely in the aged-care sector,¹⁰ these forms of restraint are not regulated by aged-care legislation or licensing mechanisms, although there is a “tool-kit” to support a restraint-free environment in residential aged care.¹¹ There is a heavy reliance on clinical discretion; there are no set minimum standards for use of different forms of restraint and there are no penalties or incentives for compliance.¹² This has led to calls for greater regulation and auditing of restraint in the aged care sector.¹³

⁵ National Mental Health Consumer and Carer Forum, *Ending Seclusion and Restraint in Australian Mental Health Services* (2009) 6.

⁶ McSherry, n 1.

⁷ Victorian Office of the Senior Practitioner, *Chemical Restraint: What Every Disability Support Workers Needs to Know* (Government of Victoria, 2008).

⁸ Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) 244.

⁹ New South Wales Government, Family and Community Services, Ageing, Disability & Home Care, *Behaviour Support: Policy and Practice Manual, Guidelines for the Provision of Behaviour Support Services for People with an Intellectual Disability*, Part 1: Policy and Practice (January 2009); Government of South Australia, Department for Communities and Social Inclusion, *Safeguarding People with Disability Restrictive Practices Policy* (July 2013).

¹⁰ Senate Community Affairs References Committee, Parliament of Australia, *Care and Management of Younger and Older Australians Living with Dementia and Behavioural and Psychiatric Symptoms of Dementia* (2014).

¹¹ Department of Health and Ageing, *Decision-Making Tool: Supporting a Restraint Free Environment in Residential Care* (Commonwealth of Australia, 2012).

¹² Senate Community Affairs References Committee, n 10, [6.22], [6.45].

¹³ Australian Law Reform Commission, n 8, 258.

Emotional restraint is not referred to in laws or policies in Australia. Other jurisdictions such as Pennsylvania in the United States regulate “psychological restraints” which are defined in s 3.9 of the *Pennsylvania Code* as including “those therapeutic regimes or programs which involve the withholding of privileges and participation in activities”.

Given the use of differing terms across sectors and the lack of consistent regulation across jurisdictions, it is little wonder that practitioners and consumers alike may be confused about what is and what is not permissible. Added to this is that while the idea of reduction in seclusion and restraint, however defined, has been central to government policy at a national level, many individuals who have lived experience of these interventions advocate for elimination. The next section outlines perspectives of a selection of consumers and carers on what is meant by seclusion and restraint.

FOCUS GROUPS ON CONSUMER AND CARER PERSPECTIVES ON WHAT IS MEANT BY SECLUSION AND RESTRAINT

As part of a larger study on reducing seclusion and restraint conducted by the Melbourne Social Equity Institute, University of Melbourne and funded by the National Mental Health Commission, five focus groups for consumers and five focus groups for carers were conducted in four capital cities and one regional centre.¹⁴ The consumer focus groups consisted of 30 adults (13 men and 17 women), all of whom had either experienced seclusion or restraint directly, witnessed these practices as inpatients or were consumer advocates who had directly supported people who had experienced seclusion and restraint. The carer focus groups consisted of 36 participants (29 women and seven men) who had experienced a family member or person they support being secluded or restrained. These included parents, siblings, marital partners and two people who had advocacy roles.

Amongst other questions, consumers and carers were asked what seclusion and restraint meant to them. The responses have been divided according to type of group.

CONSUMER PERSPECTIVES ON WHAT IS MEANT BY SECLUSION AND RESTRAINT

Participants from this group generally referred to the *effects* of seclusion and restraint in defining what these practices meant to them. One consumer described the experience of physical, mechanical and chemical restraint during a psychotic episode as follows:

I’m obviously unarmed, I’m obviously harmless, I’m obviously in deep distress and what do they do, they call in these hefty blokes who physically hold me down and push me onto the bed and strap me onto the bed and forcefully inject me with an IV. Like was that really necessary, really, really.

Physically being “held down”, “wrestled” and “pushed down” were phrases used by participants to describe physical restraint. Another participant described an experience of restraint as follows:

A whole heap of people come around, I’ve got one on each arm, one behind here, one on this leg, get carried through the hall and then a big jam in the leg, and then when you wake up again suddenly all these people rush at you and it’s another jab in the leg ... some of these times I actually didn’t even know who I was, I’d had this big amnesia of who, what my name was, where I was, what was going on, so I couldn’t have any, it’s like you’re totally disassociated from everything, so you’re quite confused, but no one said your name is so and so, this is where you are, this is what we’re doing, there was no explanation.

The distress caused by mechanical restraint was emphasised by two separate participants:

It’s quite claustrophobic it’s sort of like being in one of those MRI machines where you’ve got to sit in there straight for an hour ... If you’ve got your hands tied and you can’t move it’s awful. It’s very distressing.

And we deal with a lot of people brought in by the police and the ambulance that are restrained, on the, in the ambulance it’s a 6 point restraint across the chest, here, on your arms and on your legs, and you

¹⁴The project obtained ethics approval from the University of Melbourne (Ethics ID 1340647). Melbourne Social Equity Institute, *Seclusion and Restrain Project Report* (Prepared for the National Mental Health Commission, August 2014) <[http://www.mentalhealthcommission.gov.au/media/123598/1408%20Seclusion%20and%20Restraint_Uni%20Melb_final%20Report%205%20Sep%202014%20\(D15-333268\).PDF](http://www.mentalhealthcommission.gov.au/media/123598/1408%20Seclusion%20and%20Restraint_Uni%20Melb_final%20Report%205%20Sep%202014%20(D15-333268).PDF)>.

can't get out, once you're in there you can't get out. And I tell you what it's not very nice when you have that, when you're locked in with that locked mount, not very nice.

Chemical restraint may be used to sedate inpatients as an adjunct to seclusion, as one participant describes:

But they do give you injections in that seclusion room as well, if they think that ... you're not going to take the medication and they want to sedate you.

One participant in the consumer focus groups reiterated the notion that chemical restraint went beyond management of an immediate risk:

I just wanted to say something about medication too, you were talking about that's a form of restraint too when you get hospitalised. I was put on, because I was going through a psychotic episode, I was put on antipsychotics and I've remained on those since I've been hospitalised, and I haven't been able to get off them because of the side effects of trying to come off, and they've been too difficult for me to deal with, so I now feel restrained in my lifestyle because I'm taking this medication which I don't need any more but I can't get off them.

Emotional restraint was discussed by consumer participants as being a practice that enforces compliance through "bullying", with two consumers observing:

so I think it is that, I think it's about a threat as well, I think it can be about just that threat, that knowledge, that you can have power taken from you. That's to me the essence of it, it's the power, the power differential that comes into play. It's something that you have no control over whatever it is and just the threat of it can screw you or it can coerce you to do things that you don't want or that ... aren't going to be okay for you.

I was just going to say I think it's really sad that emotional restraint isn't currently recognised by psychiatric bodies because of the way that emotional restraint is used interactively with those other forms of restraint, so emotional restraint being forms of cohesive and manipulative practices that lead you to comply and if you don't comply then other forms of restraint and seclusion then kick in.

Another participant recounted being threatened with seclusion:

I found the nurses' approach was at times very cold and intolerant, once I was told that if I didn't stop crying that I would be placed in a cell with no toilet and only a very tough mattress and a canvas sheet, with the bright lights left on for unknown hours.

The negative consequences of seclusion and restraint were thus viewed as integral to how these practices were defined. This reflects research indicating that experiences of physical and mechanical restraint are overwhelmingly negative, associated with immediate escalation of distress, and intense feelings such as despair, shame, terror and rage.¹⁵

CARER PERSPECTIVES ON WHAT IS MEANT BY SECLUSION AND RESTRAINT

In comparison to the effects of seclusion and restraint, an overarching theme of control and risk management underpinned many comments made by this group about how they understood seclusion and restraint. As one participant noted in general regarding restraint:

It's sold as a safety and protection strategy, but it's a management strategy ... every person who's been restrained or seen a person restrained behaves differently in the future, so it's a management strategy, not just for that moment, but it continues along in time, and that it holds a person in fear.

Seclusion and restraint were identified as being used as a way to control the behaviour of consumers during a crisis by ambulance staff and in psychiatric hospitals. Participants identified multiple forms of restraint including chemical restraint. This was described in the carer focus groups as a common response to crisis in an acute setting:

As soon as somebody's like that the first thing they do is sedate and that may or may not be appropriate and that's the first thing everybody seems to do.

One carer participant suggested that any behavioural intervention that was not therapeutic was by definition a form of seclusion or restraint:

¹⁵ B Christopher Frueh et al, "Special Section on Seclusion and Restraint: Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting" (2005) 56 *Psychiatric Services* 1123.

Anything that's not therapeutic, locking them in a locked unit, drugging them, threat of tying them down and injecting them, anything that's not therapeutic.

Participants identified chemical restraint as being consistent with the overarching theme of control and managing risk in two ways. The first is to manage an acute scenario as the quote above suggests, incapacitating a patient from a period of a few hours to days. The second way is when medication is prescribed and given without the person's consent while they are in the community.

Another participant equated "chemical restraint" with over-medication:

There's chemical restraint, that's huge you know, and I think that we don't pay as much attention to chemical restraint as we should, I think often people are over-medicated.

One participant described psychotropic medications as "chemical straightjackets", referring to medication as an agent of behaviour control rather than a recovery-based treatment.

Emotional restraint was also identified as a method of behavioural control. It featured frequently in the carer focus group discussion and was considered by one participant to be "where a lot of the [change] work needs to be done". Another participant described emotional restraint as:

A coercive type of action or behaviour, and it's using something that is close to that person, withdrawing it, saying they can't have it unless they do x y z, you know it's utilising – and emotionally taking, it might be that your family can't come and visit you today unless you are doing x y z.

Threatening to withdraw privileges from patients was seen by one participant as a taking away of rights, while another commented on an example of emotional restraint when her daughter "didn't behave properly" and mental health services withheld activities which "aggravated the situation". According to participants, the threat of seclusion was a form of emotional restraint:

People are threatened, do that again and you'll go into seclusion.

Participants were concerned that emotional restraint was inconsistent with their ideas about good care:

I'd like to talk about an emotional restraint for voluntary patients is if you leave this facility you will be made involuntary ... and that is one of the most powerful emotional restraints that is used in public and private facilities.

Participants spoke about mechanical and physical restraint. Two carers had been exposed to extreme events including one person whose child had been shot and killed by police and another whose son's arm was broken in the context of physical restraint. Another participant spoke of her husband being tied to a bed and her frustration about this happening over a prolonged period.

Seclusion was identified as the end result of behaviour modification and/or a risk management strategy for inpatients. Participants likened seclusion (and by extension involuntary admission) to putting people in isolation:

Certainly some of them have been involuntary patients, and they didn't think they should've been, but they weren't restrained, they were like isolated, secluded ... I know that the mental health system is a very complex one, and I know that carers need to be protected as well as staff, etc. But at the same time you've also got to consider the needs I believe of the patient too.

Overall, control and risk management were seen by carers as integral to what they thought was meant by seclusion and restraint.

CONCLUSION

There is a lack of uniform definitions and regulation of seclusion and restraint across Australia. While seclusion and mechanical restraint are defined and regulated in mental health legislation across Australia (although definitions differ), physical and chemical restraint are only defined and regulated in a few jurisdictions and emotional restraint as identified by the National Mental Health Consumer and Carer Forum is not defined in laws or policies.

As part of a larger study for the National Mental Health Commission, participants in a series of focus groups gave rich and varied responses to what they viewed as seclusion and restraint. Consumers described a continuum of coercion of which seclusion and restraint are examples. These included emotional, physical, mechanical and chemical restraint. Seclusion included not only

seclusion rooms in hospitals but any situation when someone was forcibly isolated from others. Restraint included not only physical restraint, but implied restraint such as staff blocking an entrance to prevent a person from leaving hospital. Emotional restraint included the withholding of freedoms or privileges in addition to threats that more coercive practices would take place unless behaviour changed. In the Carer focus groups, the use of seclusion and restraint was discussed as being a response to the need to manage risk and control the person's behaviour, but participants commonly expressed reservations regarding the links this enabled to unnecessary levels of coercive practice and less compassionate care.

Many members of the focus groups spoke about seclusion and all forms of restraint as being about control, coercion and risk management. They tended to emphasise the practices of chemical and emotional restraint and a lack of recognition of them. The majority of focus group participants across both groups identified that seclusion and restraint were harmful over both short and long term, even in instances where these interventions may have been seen as a "necessary evil".¹⁶ This is consistent with findings from other studies focused on consumer perspectives, contributing to a growing body of evidence that restraint and seclusion are harmful practices that should be at the very least reduced, if not eliminated, from mental health care.¹⁷ Law and policy reforms can contribute to these efforts to reduce these practices, by regulating their use and improving accountability.¹⁸

The findings from the focus groups suggest that there is a need to grapple with the subtleties and complexities surrounding consumer and carer definitions of seclusion and restraint without diluting regulatory power. Where the disjunct between the legal definitions and consumer and carer perspectives of seclusion and restraint is great, there is a risk of unacknowledged harms and the risk of missing opportunities for ameliorating harm and for more effective regulation.

Cath Roper

Consumer Academic, University of Melbourne Centre for Psychiatric Nursing

Bernadette McSherry

Professor and Foundation Director, Melbourne Social Equity Institute

Lisa Brophy

Senior Research Fellow, University of Melbourne School of Population and Global Health

Director of Research at Mind Australia,

The authors would like to thank Andrew Butler for providing research support in the writing of this column.

¹⁶ Melbourne Social Equity Institute, n 14, 140.

¹⁷ Bradley Foxlewin, *What is Happening at the Seclusion Review that Makes a Difference? A Consumer Led Research Study* (ACT Mental Health Consumer Network, 2012) <http://www.actmhc.org.au/images/documents/Research/2012-06_REPORT_SRRM_RESEARCH_incl_Executive_Summary.pdf>; Christina Katsakou et al, "'Psychiatric Patients' Views on Why their Involuntary Hospitalisation was Right or Wrong: A Qualitative Study" (2012) 47 *Social Psychiatry and Psychiatric Epidemiology* 1169; Caroline Larue et al, "The Experience of Seclusion and Restraint in Psychiatric Settings: Perspectives of Patients" (2013) 34 *Issues in Mental Health Nursing* 317; Cynthia Robins et al, "Special Section on Seclusion and Restraint: Consumers' Perceptions of Negative Experiences and 'Sanctuary Harm' in Psychiatric Settings" (2005) 56 *Psychiatric Services* 1134.

¹⁸ Australian Department of Health, *National Standards for Mental Health Services* (Commonwealth of Australia, 2010) <<http://www.health.gov.au/mhsc>>; Melbourne Social Equity Institute, n 14, 146; Inti Qurashi et al, "Reduction in the Use of Seclusion in a High Secure Hospital: A Retrospective Analysis" (2010) 6 *Journal of Psychiatric Intensive Care* 850.