

## Restraint & Seclusion: past practices and future directions



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## The need for change

*Restraint and Seclusion* are now recognised internationally as practices which are:

- Unethical
- Ineffective in bringing about positive, long-term behaviour change
- Dangerous for both the persons restrained and those applying the restraint
  - immediate and cumulative effects
  - physical and psychological effects

## The long history of the "Non-restraints Movement"

- "The Retreat" at York, UK – 1792
- Bicetre Hospital & Salpetriere Hospital, France – 1793
- Lincoln Asylum, UK – 1838
- Hanwell Hospital, UK - 1839
- Northampton State Hospital and Danvers State Hospital, Massachusetts, USA - 1911

## Global imperatives for change in the 21<sup>st</sup> Century

### **United Nations Convention on the Rights of Persons with Disabilities** (December, 2006)

States are to:

- 'protect the physical and mental integrity of persons with disabilities, just as for everyone else' (Article 17);
- 'guarantee freedom from torture and from cruel, inhuman or degrading treatment or punishment' (Article 15); and
- 'enact laws and administrative measures to guarantee freedom from exploitation, violence and abuse' (Article 16).

## Local imperatives for change in 21<sup>st</sup> Century Victoria

### **Charter of Human Rights and Responsibilities Act 2006**

- all citizens of Victoria are guaranteed in law that they will not be 'treated or punished in a cruel, inhuman or degrading way' (Section 10).

### **The Disability Act 2006**

- detailed provisions concerning limitations on service providers concerning the use of restraint and seclusion (Part 7).
- the creation of a new offence whereby a 'disability service provider' who applies restraint or seclusion to a person with a disability, except as provided for in sections 140 or 147 of the Act, is guilty of an offence (Section 149).

## Reporting of restrictive practices

- Disability service providers are required to report on the use of restrictive interventions.  
(Disability Act, 2006)
- Reports are made to Senior Practitioner via the Restrictive Intervention Data System (RIDS).
- Restrictive Interventions:
  - Chemical restraint
  - Mechanical restraint
  - Seclusion

### Restrictive interventions

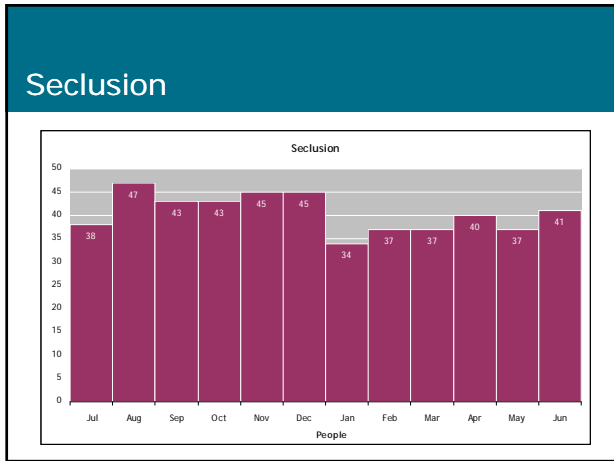
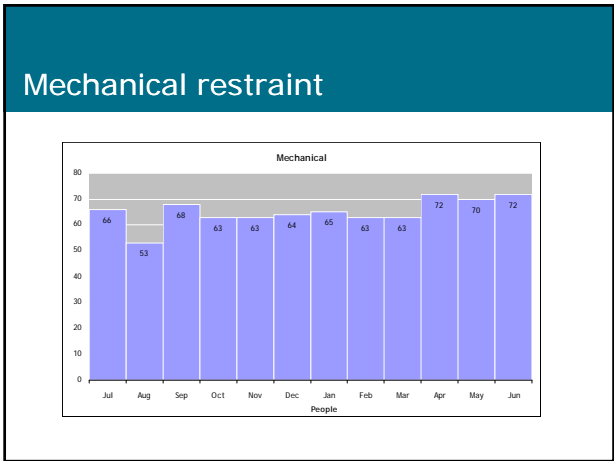
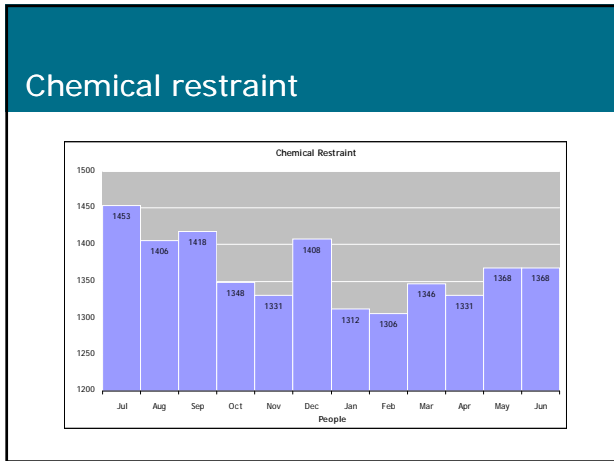
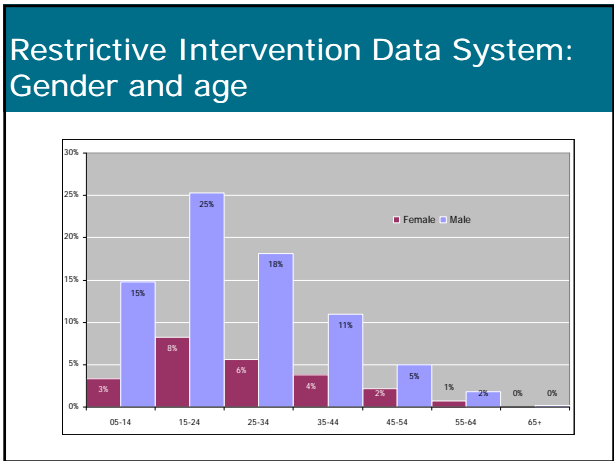
- *"Mechanical restraint"* - behavioural control of a person with a disability using devices to prevent, restrict or subdue a person's movement
- *"Chemical restraint"* - any chemical substances used for behavioural control of a person with a disability
- *"Seclusion"* - sole confinement of a person with a disability at any hour of the day or night

### Number of people in restraint

**July 2007 - June 2008**

- 2096 people were reported to have been restrained and or secluded at least once during the year
- 516 people were reported to be restrained and or secluded for all 12 months
- 9-12% of people who receive a funded disability service<sup>1</sup> subjected to restraint, seclusion and other restrictive practices

(Office of the Senior Practitioner  
2<sup>nd</sup> Quarterly Report, 2008)



**Caution: restraint & restrictive practices can take other more *insidious* forms**

- *Social Restraint*
- the use of verbal interactions which might reasonably be construed by the person to whom they are directed as intimidating or potentially abusive, and / or threats of social or other tangible sanctions (e.g., response cost programmes), which rely on eliciting fear to moderate a person's behaviour.

**There are evidence-based alternatives**

Monitoring and Auditing internally and externally is critical to raising awareness and can bring about immediate and substantial reductions in the use of restrictive practices, and increase in positive practices.

- Statistical Auditing
- Clinical Case Review
- Catching people getting it right and reinforcing 'good practice'!

(Miller, Hunt and Georges, 2006; NZ Mental Health Commission, 2004; Sciafani et al., 2008)

**There are evidence-based alternatives**

- **Multi-element systemic intervention** (e.g., Person Centred Planning; Positive Behaviour Support; Active Support)
- **Counter-intuitive Strategies** (e.g., high density, non-contingent reinforcement; avoid natural consequences; do not ignore behaviour; remove punishment; & use 'strategic capitulation')

**There are evidence-based alternatives**

- Sensory, alternative environments and activity based interventions
- Low arousal (demand reduction) techniques
- Intensive Interaction techniques
- Mindfulness techniques

**Staff education programmes**

- There are many systemic staff education programmes available
  - They include & emphasise different elements and procedures
  - There is minimal independent research evidence to support either the safety or effectiveness of any of programmes available
- Predict Assess Respond Training
  - The Mandt System
  - Nonviolent Crises Intervention
  - Therapeutic Options
  - Control and Restraint
  - Therapeutic Crisis Intervention
  - Crisis Intervention and Prevention
  - Person Focused Training
  - Studio III

**How to recognise 'good practice' in staff education programmes**

- Focus staff attention on the techniques of Positive Behaviour Support (PBS), including proactive preventative strategies.
- Focus staff attention on verbal and environmental de-escalation techniques
- Provide guidance on what constitutes a 'duty of care'
- Highlight the dangers (physical, psychological and legal) inherent in the use of restraint or seclusion
- Training programmes include personal accounts of persons with disability concerning their experience of restraint and seclusion
- Instructors individualise programmes, and include consultation with the person's GP and psychologist prior to the staff training

### How to recognise 'good practice' in staff education programmes

- Programmes do not include instruction in techniques that are explicitly designed to cause physical or psychological distress (or which rely significantly on techniques based on martial arts).
- Consideration could be given to the inclusion of 'break-away techniques' where these are specifically identified as relevant to the support of particular clients and where they have been developed by the instructor based on the individual clinical and support profile of an identified client.

### Recommendations where physical restraint is used as "a strategy of VERY last resort"

- Prone (face down) or 'hobble (hog) tying' restraint is not used.
- No physical or mechanical restraint that inhibits the respiratory and/or digestive system is used.
- No physical or mechanical restraint that involves compliance through the infliction of pain, hyperextension of joints, and pressure on the chest or joints is used.
- No use of 'takedown' techniques in which the individual is not supported and/or that allows for free fall as the individual goes to the floor.
- An individual's physical condition is evaluated throughout the restraint in order to minimise the potential of individual harm or injury.
- Physical restraint does not exceed prior approved time periods
- An individual is immediately released from physical restraint when they no longer present a danger to self or others.
- Support staff monitor the individual for signs of distress throughout the restraint process and for a period of time (up to two hours) following the application of a restraint.
- That observations conducted and recorded include vital clinical indicators such as pulse, respiration and temperature.

### The Role of the Disability Professional in 21<sup>st</sup> Century Victoria

- Our job is to redesign the counter productive and unfair environmental contexts that so many people, with and without disabilities, have to contend with every day of their lives
- Our job is to give people the skills, the coping strategies, and the desire to deal with the frustration that is an inevitable part of life, particularly the lives of people with disabilities
- We must give them and their loved ones the support they need to challenge and reconstruct systems that serve bureaucratic needs, rather than human needs

(Carr & Horner, 2007)