Commentary: Can Seclusion and Restraint be Person-Centered?

Physical confinement – particularly seclusion and restraint – of people with mental illness is associated with a longstanding debate about coercion of these individuals for the sake of (protecting) others and themselves. Vishnivetsky et al. (1) report a study that examined what are some attitudes (and their predictors) of adolescents toward seclusion and physical restraint in an Israeli inpatient setting. Their main finding that participants preferred seclusion to physical restraint is important, primarily by raising more questions rather than providing definitive answers. For instance, how would such participants respond if given the option to generate effective alternatives to any form of coercion, be it physical confinement (such as the studied seclusion or physical restraint) or chemical restraint? This question may require a more qualitative data collection and analysis approach, such as using semi-structured individual interviews and focus groups. Furthermore, would such attitudes change per individual over time, both in the short term and in the long term (particularly considering the participants studied were adolescents, whose attitudes in general may change as they mature)? This question may require a longitudinal study design. And would such attitudes differ across cultures? This question may require a multi-site study design.

Coercion in mental health care raises additional questions, such as ethical and political ones. Relevant policy makers to date have usually been people without formally identified (or at least publicly disclosed) mental illness; excluding people with mental illness from full participation in such policy making may risk ignoring some of their rights as well as their valuable input on strategies to provide mental health care while addressing the safety of all involved. Such participation can enhance a person-centered approach to mental health care (2), in line with the recent recovery movement’s influence on mental health reform, which is in progress in various countries (3-5). Being person-centered is both a (humanistic) end in itself and a means to other valued ends, such as more effective care; for instance, shared (health care) decision making with people who have mental illness can result in their enhanced adherence to beneficial treatment, although the benefits of shared decision making for adherence to mental health care are less conclusive than in general medicine (6). A person-centered approach may mean various things; one way to address this complexity is to characterize a person-centered approach as a multi-dimensional construct, which may consist of self-determination as well as other ways of addressing a person’s needs when he or she cannot self-determine his or her needs in a fully capable manner (7). Using a multi-dimensional approach may facilitate and maintain respect for persons with mental illness while accommodating realistic constraints, such as legislation that defaults to coercion for safety and that may not change in the near future (recognizing that advocacy for more progressive legislation may be required in many jurisdictions).

A person-centered approach that goes beyond self-determination addresses dimensions such as context-sensitivity, which refers to the person’s past and present circumstances and experiences, as well as his or her anticipated future circumstances and experiences and their likely alternatives when these are predictable (as they often are). This approach may facilitate the consideration of the person’s preferences even when that person is constrained internally as well as externally, resulting in mental health care planning and provision that is person-centered and realistic. When the person poses a significant safety risk to others or to him or herself, due to his or her mental illness, using such a person-centered approach may reduce if not eliminate the need for seclusion and restraint, particularly if this approach is used proactively and regularly. For instance, a person-centered approach may apply knowledge of past cognitive cuing and social support that helped a person with mental illness in order to reduce if not eliminate dangerous behavior. And when seclusion or restraint is considered necessary, it can be done in the least disruptive manner possible if it is informed by the person’s past, present and anticipated future, e.g., if the person was traumatized by men, his or her seclusion or restraint can be conducted by women staff as much as possible. Indeed, such person-centered mental health care planning is coming to the fore lately (8). Although robust data on the outcomes and processes...
of this approach are not yet available, particularly in relation to risk reduction and alternatives to seclusion and restraint, it can be considered promising, based on conceptual argumentation and emerging evidence. For instance, Multisensory environmental intervention (Snoezelen) has been shown to calm agitated patients and reduce the length of time and number of seclusions and restraints in an Israeli study (9), which may be particularly relevant to Vishnivetsky et al.’s report (1), as the latter was also conducted in Israel.

More generally, a multitude of clinical and other interventions may be required as a sound alternative to seclusion and restraint. Such a multi-pronged approach may include state-level support, state policy and regulation changes, leadership, examinations of the practice contexts, staff integration, treatment plan improvement, increased staff to patient ratios, monitoring seclusion episodes, psychiatric emergency response teams, staff education, monitoring of patients, pharmacological interventions, treating patients as active participants in seclusion reduction interventions, changing the therapeutic environment, changing the facility environment, adopting a facility focus, and improving staff safety and welfare (10). Much of this involves advance planning, so some of it may not help in the short term, but in the long term it may reduce if not eliminate seclusion and restraint; after all, prevention is often more effective than treatment.

Coercion may be applied to intents other than safety. For instance, some have argued that it applies to habilitation too (11). Psychiatric rehabilitation typically aims at assisting people with (usually serious) mental illness to establish and achieve their life goals (12). It has been counter-argued that psychiatric rehabilitation cannot involve coercion, as – by definition – life goals are personally determined and hence cannot involve coercion (13). A caveat may be when, by law, a person with mental illness may be deemed incapable to decide on his or her housing, which is the case in Ontario, Canada. Still, this situation may be related to safety (of maintaining activities of daily living required for survival, such as eating), in which case it does not refute the argument that psychiatric rehabilitation as such cannot involve coercion. Be that as it may, even when safety is addressed, and even if coercion is deemed necessary, such as in situations that are still viewed by some as requiring seclusion and restraint, a person-centered approach may be applicable, using a multi-dimensional construct (7). Further theoretical and empirical study of this approach is needed.

Acknowledgement/ Disclosure: The author reports no relevant conflict of interests.

References

Abraham Rudnick, MD, PhD, CPRP, FRCPC
Associate Professor, Department of Psychiatry, University of British Columbia, Canada.
harudnick@hotmail.com