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Editorial

Mechanical restraint and seclusion: earning a place at the debating table

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Recently, the *Journal of Psychiatric Intensive Care* has observed increased energy in the long-standing debates around the use of mechanical restraint and seclusion. These two issues may well represent one of the longest running debates in healthcare. During the 1790s, Phillippe Pinel caused a storm when he demonstrated that his Asylum La Bicêtre in Paris could operate without profound reliance on the use on the padded room, manacles and chains. In the UK, the early nineteenth century bore witness to a wave of reformist pioneers in mental health services aiming to deliver humane treatments and significantly improve upon the often brutal regimes evident in many mental health institutions.

When it came to the use of seclusion and restraint however, there seemed to be a continuing acknowledgement that the use of neither could be completely eradicated. Commenting on the views of two early reformist pioneers, William Tuke and John Conolly, another Tuke (Daniel Hack) suggested in 1881 that if Conolly believed that the Tukes attached too much emphasis to the use of seclusion, then the other extreme of considering the padded room as never useful must also be a very questionable position to take.

Tuke's words of 1881 resonate through the centuries as strongly today as they did then. Just as in the year 1881, in 2014, there is little intellectual challenge to the notion that many would much prefer do without the use of seclusion and mechanical restraint. At the same time however, close to 150 years later, there appears to be little advancement beyond the position of the Victorian pioneers. Practitioners now as then seem unable to conclude that either mechanical restraint or seclusion are 'never useful' and if some amongst them do, then this may still be an 'equally questionable position to take.'

I wonder if any other debate in healthcare has lasted as long? It is difficult to imagine that in any other area of clinical practice a debate seems to have remained almost completely static from 1881 to 2014. With over a century to decide, most other healthcare clinical debates have been long resolved as a result of advances in treatment, empirical process and the sheer weight of evidence favouring the success of one approach over another. It is difficult to imagine that a Victorian general physician would do as well at the hot clinical issue of the day debating table as Dr Tuke

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may fair in debating seclusion and restraint with one of our modern acute mental healthcare clinicians.

As we progress into the twenty-first century, it would seem that the use of seclusion and mechanical restraint has shown huge resilience as an issue that has been almost impenetrable to be moved beyond the simple position of 'never say never'. While this may be an over simplification, it does, never the less, seem to be where we are.

Should we now in the clinical community consider throwing our hands in the air and conceding that there is no way to advance beyond the notion that while all effort should be taken to avoid it, mechanical restraint and seclusion cannot be considered wholly avoidable?

Colleagues in Norway took the initiative of publishing in this journal the provocative editorial 'Mechanical restraint – philosophy of man, philosophy of care, or no philosophy at all, a question from Norway' (Cabral Iversen, 2009). In the UK, seclusion remains widely practiced with some NHS trusts recording episodes of seclusion in excess of many weeks duration. The pages of the *Journal of Psychiatric Intensive Care* again today occupy themselves with issues of seclusion and restraint (Pogge et al. 2014, this issue).

While seclusion remains in use in around 50% of British mental health units, mechanical restraint also remains widely practiced in a number of Scandinavian countries, the United States and elsewhere. For people working in services that may not use mechanical restraint, it involves the use of specially designed straps to fix a service users' limbs to a bed so that they can be prevented from doing harm to others or themselves. As with seclusion in the UK, episodes of mechanical restraint have also been known to go on for days or even weeks.

How may we, the twenty-first century global PICU clinical community, successfully lay siege to the seeming fortress of the need for the most coercive interventions in acute mental healthcare and, in particular, mechanical restraint and seclusion? The *Journal of Psychiatric Intensive Care* is aware that front line clinicians in Copenhagen have mobilised themselves to make a determined attempt to advance and take ground towards mental healthcare's most resilient issue.

A form of 'coalition of the willing' has come together. It involves psychiatrists and senior nurses embarking on an adventure. The mission is to see whether or not a couple of wards at an acute psychiatric inpatient facility can implement a firm no mechanical restrain position and use alternatives instead. A pilot policy will be implemented very soon. I have been privileged as well as inspired to meet with Dr Lykke Pedersen and her colleagues from Copenhagen. This group of doctors and nurses are looking to make ground in the hardest of debates, and they seem to mean business.

If successful, this could mark a major attempt to alter the strategic course of mechanical restraint use in Denmark. This initiative, led from the ground up, has been months in the planning. Intelligence gathering for support of a non-mechanical restraint trial has been energetic and meticulous. Visits by the Copenhagen team to Gloucestershire in the UK and Reykjavik in Iceland have all been part of the preparation for trying something new. Simultaneously, the new closed ward in Copenhagen (fulfilling the function of a PICU) has been eagerly anticipated.

To test how the new ward might feel for service users, a group of the ward's medical and nursing staff slept in the unit themselves overnight, to identify the environment's strengths and areas for development in preparation for its final opening. With this kind of motivation and commitment, one would not be surprised to see significant success in breaching the fortress of mechanical restraint use in Denmark and even taking significant ground for understanding an issue which has seen out two centuries of mental healthcare.

Whether your service uses mechanical restraint or not, I am sure that you will join us in wishing Dr Peterson and the Copenhagen team well in their renewed efforts to better understand the issue of mechanical restraint use and to find out more about the need for its future use in Denmark.

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One must be cautious not to arrive at too simplistic a judgement as to whether or not seclusion, mechanical restraint and other coercive interventions are symbolic of a particular service's unwillingness to change. Indeed, virtually all mental health services around the world will have their own particular form of coercive intervention, whether it be the use of mechanical restraint and seclusion, a reliance on psychoactive medication or interpersonal restraint.

Maybe time is not best used in judging other services when comparing them to our own, but rather in adding our voice and support to any service that is taking the significant step of trying to advance practice and improve the experience of service users.

Like the reformist pioneers of centuries past, the main responsibility for all mental health service leaders is that they remain restless. Complacency is the first step towards stagnation. An inner restlessness that practice must be continually developed and at no point should the members of any particular mental health service believe that they have arrived at the end game in terms of best practice. Mental healthcare should only ever be considered as a journey, never a destination. The *Journal of Psychiatric Intensive Care* will be supporting the efforts of the Copenhagen team in developing the practice, and only the highest commendation can be given for those who have taken the initiative, not necessarily to abolish an old practice, but to ensure that complacency is held at bay, and restlessness for improvement is maintained.

Whether or not it is ever possible for us to reach back into past centuries and invite the pioneers Pinel and Tuke to our debating table, we should at least ensure that we would have something new to tell them.

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