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Regulating seclusion and restraint in health care settings: The promise of the Convention on the Rights of Persons with Disabilities[☆],[☆☆]

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1. Introduction

Seclusion and restraint are interventions that are used in many mental health services and other settings to control or manage a person's behaviour. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2017: 2) defines the different forms of restraint and seclusion as follows:

(a) physical restraint (i.e. staff holding or immobilising a patient by using physical force – "manual control")
(b) mechanical restraint (i.e. applying instruments of restraint, such as straps, to immobilise a patient);
(c) chemical restraint (i.e. forcible administration of medication for the purpose of controlling a patient's behaviour);
(d) seclusion (i.e. involuntary placement of a patient alone in a locked room).

Seclusion may sometimes be referred to as "environmental restraint" and some forms of restraint may be used on persons with mental or intellectual impairments[1] in prisons, remand centres, emergency departments and by police and emergency transport providers.

Many countries have introduced strategies to reduce seclusion and restraint and the "six core strategies" developed in the United States by the National Association of State Mental Health Program Directors (2005, updated 2006, 2008) have been influential in this regard. These strategies are based around leadership, the use of data, workforce training, the use of specific reduction tools, consumer roles and debriefing. As outlined below, some studies have indicated decreases in seclusion and restraint rates following the introduction of the six core strategies (e.g. Barton, Johnson, & Price, 2009; Putkonen et al., 2013; Sullivan et al., 2005). However, despite efforts to reduce the use of seclusion and restraint, they are sometimes justified as a "necessary evil" (Brophy, Roper, Hamilton, Tellez & McSherry, 2016a, p. 4; Romijn & Frederiks, 2012). This view is primarily based on occupational health and safety concerns (Chan, 2016). That is, there appears to be a presumption that when those with mental or intellectual impairments display behaviours of concern, such behaviours are an "occupational hazard" that need to be managed through "restrictive interventions" (Chan, 2016, p. 209).

This article focuses on how a human rights framework challenges the use of seclusion and restraint as a necessary evil. Using Australia as an example of a country which has endeavoured in recent years to reduce seclusion and at least some forms of restraint in health care settings, it examines the relevant Articles set out in the Convention on the Rights of Persons with Disabilities (CRPD) and how they may be used to drive reforms. It is argued that because seclusion and restraint can lead to adverse consequences, they fall within the ambit of Article

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[1] This article uses the words of Article 1 of the CRPD in referring to persons with "mental" or "intellectual impairments" while recognizing that other terminology may be used in the literature.

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16's focus on the prevention of all forms of exploitation, violence and abuse. Further, because persons with mental or intellectual impairments are more likely to have experienced significant trauma in their lives than others, the obligation placed on States Parties under Article 16 to protect persons with disabilities from all forms of exploitation, violence and abuse should be read as promoting alternatives to the practices of seclusion and restraint.

The next section outlines the most relevant CRPD Articles for practices in health care settings and argues that together they provide a framework for reducing the use of coercive practices in general and seclusion and restraint in particular.

2. The human rights framework

There are a number of Articles in the CRPD which provide a framework for the provision of health care and the way in which it is delivered. The emphasis in Article 3 on “[r]espect for inherent dignity and individual autonomy including the freedom to make one's own choices” as underlying principles assists in the interpretation of the ensuing articles.

The CRPD addresses health in Article 25 which provides: “States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.” Paragraph (d) of this Article further specifies that State Parties shall “[r]equire health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent …”

Intersecting with Article 25 of the CRPD is Article 12, which deals with equal recognition before the law. It requires States Parties to “recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life” (Article 12(2)) and to “take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity” (Article 12(3)).

Articles 12 and 25 are supplemented by Article 15, which provides that “[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment”; Article 16 which requires States Parties to protect persons with disabilities from and prevent “all forms of exploitation, violence and abuse” and Article 17, which provides that “[e]very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.”

Most of the debates concerning issues of health care have focused upon whether health interventions can ever be permitted without consent. Anna Bruce has pointed out that this question was one of the most controversial issues during the negotiations that led to the final version of the CRPD (Bruce, 2014, p. 160). General Comment No 1 of the CRPD Committee on Article 12, while focusing on equality before the law, states in relation to health:

> The right to enjoyment of the highest attainable standard of health (art. 25) includes the right to health care on the basis of free and informed consent. States parties have an obligation to require all health and medical professionals (including psychiatric professionals) to obtain the free and informed consent of persons with disabilities prior to any treatment. In conjunction with the right to legal capacity on an equal basis with others, States parties have an obligation not to permit substitute decision-makers to provide consent on behalf of persons with disabilities (para. 41).

This statement suggests that all individuals, irrespective of their ability or disability, must give individual consent for medical treatment and, while supported decision-making is permissible for those individuals who need it, substituted decision-making will always be regarded as incompatible with the CRPD. Peter Bartlett points out in this regard that “the CRPD appears to proceed on the basis that disability cannot be used as a factor in determining whether compulsion may be imposed” (Bartlett, 2012, p. 753).

Most of the current debates about interpretations of the CRPD have centered upon Article 12(3), which is set out above, and whether this Article requires the immediate abolition of substituted decision-making regimes (e.g. Callaghan & Ryan, 2014; Dawson, 2015; Dute, 2015; Flynn & Arstein-Kerslake, 2014; Freeman et al., 2015; Series, 2015; Stavert, 2015). This has kept attention focused on the scope of compulsory detention and treatment rather than opening up opportunities for alternatives to it (McSherry & Wilson, 2015).

In the debates leading up to the CRPD, while the focus was on the (im)permissibility of health interventions without consent, there was also discussion about institutionalization in general. In relation to a 2004 draft of Article 16 (it was then draft Article 12: Freedom from Violence and Abuse), there was specific reference to an obligation to take measures that “should prohibit, and protect persons with disabilities from, forced interventions or forced institutionalisation aimed at correction, improving or alleviating any actual or perceived impairment.” The World Network of Users and Survivors of Psychiatry referred to the need for “forced interventions” such as “medical interventions performed to control behaviour” to be prohibited under this Article (Ad Hoc Committee, 2004).

In January 2006, the New Zealand delegation pointed out that:

> [t]here has been a growing awareness throughout the negotiation of this treaty that there are many and serious abuses regarding forced institutionalizion [*sic*] and forced interventions for [persons with disabilities]. Despite concerted efforts to ensure that these issues are adequately defined and addressed in the convention, an accepted solution remains elusive (Ad Hoc Committee, 2006).

Early drafts of what is now Article 17 dealt with issues of institutionalization and forced interventions, but these were omitted because of a lack of agreement as to whether or not involuntary detention and treatment should be permitted (McSherry, 2008). What is perhaps of most importance is that the CRPD as a whole should be interpreted as moving away from an acceptance of coercive practices in general (McSherry & Freckelton, 2013). The articles in the CRPD should be seen as intertwined, with respect for the inherent dignity of persons with disabilities as a foundational principle.

Australia took an active role in the drafting process of the CRPD, signed it on 30 March 2007 and ratified it on 17 July 2008. Over the past decade or so, there has been an emphasis placed on reducing the use of seclusion and restraint in mental health and disability settings in Australia, but there are concerns that rates of these practices vary considerably across facilities, jurisdictions and age groups.

The next sections examine what Article 16 in combination with other relevant CRPD Articles indicates in relation to how seclusion and restraint should be addressed in health care settings. It looks in particular at the situation in Australia and what the UN Committee on the CRPD has stated in this regard.

3. Defining seclusion and restraint in human rights terms

Article 16 places obligations on States Parties to protect persons with disabilities from and to prevent the occurrence of exploitation, violence and abuse. The threshold question is whether seclusion and the different forms of restraint can be seen under these terms.

There is some indication that seclusion and restraint are seen more as forms of inhuman and degrading treatment under Article 15 rather than forms of exploitation, violence and abuse under Article 16. The United Nations Committee on the CRPD has expressed its concern with “restrictive practices” being used in Australia (United Nations Committee, 2013). It stated in response to Australia's Report to the Committee under the heading “Freedom from torture and cruel, inhuman or degrading treatment or punishment”: