Redefining restrictive practices: evidence for policy change in child and adolescent mental health care

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Abstract:
The national definition for physical restraint applies to all mental health units and does not differentiate between child, adolescent and adult populations. All data are reported together; the absence of context within these data makes it impossible to know whether there are important differences between child, adolescent and adult consumers that should be considered.

A review of restrictive practices data in two child and adolescent mental health (CAMH) units in New South Wales reported 484 episodes of restraint and/or seclusion from 2015-2018. Our findings revealed several types of physical restraint. These included: brief holds for <10 seconds, walking escorts from one place to another, and 5-point restraints on the floor, demonstrating that not all physical restraints are equivalent.

Physical restraint in CAMH consumers is potentially compounded by the inherent need for children/adolescents to be comforted by being touched or held, particularly when distressed. The touching/holding of a distressed child by CAMH nurses may be interpreted as physical restraint and reported as such. A paediatric-specific definition of physical restraint, where comforting distressed children/adolescents through touch is *not* considered restraint, would provide more meaningful data and assist mental health nurses in understanding their practice in the ongoing effort to minimise restrictive practices.

Learning Objective: to understand why a paediatric-specific definition for restraint would add meaningful context to the national data, rather than relying on the current nationally reported data which has limitations when being used for benchmarking across adult and CAMH units.

References:

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