



Restraint and Seclusion in Scottish Mental Health Care

Autistic Perspectives and Analysis of Proposed Updates to the Code of Practice for the Mental Health (Care and Treatment) (Scotland) Act 2003



EXECUTIVE SUMMARY

The Autistan Diplomatic Organization presents this study as a contribution to the Scottish consultation on updates to the Mental Health (Care and Treatment) (Scotland) Act 2003 [Code of Practice](#). Its principal focus is the proposed chapter on restraint and seclusion, with related observations on cross-border transfers and excessive security. The study combines research, first-person testimony, independent inspections and human-rights sources, and translates its analysis into proposed wording and implementation tools. The different evidential status of those sources is retained throughout. [\[1\]](#) [\[2\]](#) [\[5\]](#) [\[6\]](#)

The draft already recognises important safeguards: autism alone does not justify restraint; sensory overload and communication difficulties must not automatically be interpreted as aggression; prevention, environmental adjustment, supported communication, recording and review are required. Autistan's contribution seeks to make these commitments more precise and operational. The central distinction is between stopping an immediate danger, suppressing its visible expression and genuinely relieving distress. Those are different outcomes. [\[2\]](#)

The analysis reconstructs crisis from its antecedents: sensory, interpersonal, communication and institutional conditions; the person's attempts to regulate, escape or communicate; and the responses of others. Direct descriptions of what was seen or heard, interpretations of those observations, inferred intention and actual risk are treated separately. Physical illness, pain and other causes remain part of the assessment.

Throughout the study, possible aggression is not treated as aggression and suspected dangerousness is not treated as proven danger. For autistic people in particular, unfamiliar movement, tone, withdrawal, insistence, distress or refusal may be misread through non-autistic expectations and then converted into an allegation about intention. Coercive restriction must therefore rest on current, specifically described facts that establish a concrete risk meeting the applicable threshold, not on an interpretation of appearance or demeanour as aggression, a speculative prediction, staff unease or a demand that the person prove that they are harmless.

A further distinction concerns appearance rather than acts. A person may look intensely irritated or angry and be perceived by observers as 'aggressive' even when no aggressive act is alleged; that perceived aggression may then be converted almost immediately into presumed dangerousness. These are separate propositions. Visible intensity, perceived aggression, actual aggressive conduct and a current serious danger must not be collapsed into one another, especially where non-autistic observers are interpreting autistic expression.

The phrase 'danger to self or others' therefore requires special scrutiny. In its Article 14 guidelines, the UN Committee on the Rights of Persons with Disabilities uses the more revealing formulation 'perceived danger they allegedly pose to themselves or to others' and states that disability-related detention based on such perceived danger is incompatible with Article 14. The Committee also notes that people with intellectual or psychosocial impairments are frequently considered dangerous when they refuse or resist treatment. This is the Committee's treaty-body interpretation and should not be confused with a domestic

judicial ruling on every emergency intervention, but it directly exposes the danger of converting a prediction or professional impression into a substitute for evidence. [\[119\]](#)

Precaution must also operate in both directions. The relevant comparison is not only the harm imagined if staff do not restrain or isolate a person, but also the physical, psychological, traumatic and liberty-related harms that the coercive response itself can produce. European case-law requires strict necessity and proportionality in individual cases; systematic evidence documents serious physical harm and death; and violence-risk research demonstrates that predictions can generate substantial false positives. A feared future harm must therefore be weighed against the known and possible harms of the intervention, rather than allowing the label 'precautionary' to end the analysis. [\[123\]](#) [\[124\]](#) [\[128\]](#) [\[129\]](#) [\[130\]](#)

WHO's current rights-based position reinforces the same preventive direction. WHO/Europe states that restraint and seclusion can cause severe injury and death, are often experienced as traumatic and damaging to recovery and trust, and can arise from communication failures and systemic conditions. It specifically notes that staff may interpret frustration or stress as challenging or aggressive. WHO now frames ending coercive measures - rather than preserving them culturally as a normal 'last resort' - as the objective, while its crisis-services guidance documents support delivered without force or coercion. [\[120\]](#) [\[122\]](#)

The evidence for alternatives is not limited to aspirational guidance. International psychiatry itself now calls for practical implementation of alternatives to coercion; randomised evidence from Norway shows that an open-door policy can be implemented without increased coercion or staff violence; crisis-planning trials show fewer compulsory admissions; and recent English trial evidence on Open Dialogue reports lower inpatient use and better service-user outcomes despite no improvement in its primary relapse endpoint. These results concern different populations and interventions and must not be merged into a single effect estimate. Together, however, they make it untenable to treat coercion as the only serious safety strategy worth testing. [\[139\]](#) [\[141\]](#) [\[142\]](#) [\[143\]](#)

Autistan's analytical framework holds that the overwhelming majority - and, in its strongest formulation, the quasi-totality - of the sources of autistic suffering can ultimately be traced to sensory, mental (psychic) or other socio-generated impingements: externally generated disturbances that violate or micro-violate natural harmony and/or equilibrium. The proposition concerns suffering; autistic nature, medical conditions, functional difficulties and support needs are distinct questions. Where a crisis expresses suffering, causal reconstruction therefore starts by tracing these impingements. External research independently documents sensory, social, emotional, communication and environmental contributors to autistic distress. [\[64\]](#) [\[65\]](#) [\[66\]](#) [\[67\]](#) [\[68\]](#) [\[71\]](#) [\[72\]](#)

This makes the response to a crisis part of the causal analysis. A person already affected by overload, unwanted demands, misunderstanding, injustice or loss of control may then be surrounded, touched, held, pressed, prevented from leaving or moving, or confronted by several staff members. Those responses can add new sensory, bodily and psychological harms to the harms that preceded the crisis. Autistan describes this as a possible escalation from first-order to second-order socio-generated impingements: an attempt to suppress the visible reaction may multiply the conditions producing distress. The appropriate objective is

therefore not merely to make the person look calm, but to reduce the sources of suffering while protecting against concrete danger. [67] [68] [69] [70] [73]

Restraint can be experienced as confinement applied directly to the body: a person may remain acutely aware, frightened and driven to move while being unable to leave, protect themselves, change position or relieve a distressing sensation. Patient research describes powerlessness, humiliation, perceived injustice, suffocation and fear. The cessation of struggle may reflect exhaustion, medication, fear, withdrawal or resignation rather than restored safety. Qualitative evidence records substantial variation between people while repeatedly identifying these domains of harm. [8] [9] [10] [11] [15] [16] [17]

At its most extreme, bodily immobilisation can be understood as confinement whose boundary has contracted from a room to the body itself: there may be no usable distance from the force, no way to reposition or protect oneself, and no immediate route of escape. International anti-torture analysis describes powerlessness as loss of effective capacity to resist or escape and identifies domination, dependency, humiliation and attacks on self-determination among mechanisms capable of producing severe psychological suffering. Those mechanisms belong in assessment alongside the distinct legal evaluation of whether a particular act reaches the threshold for torture or other ill-treatment. [45] [46]

Autistan uses the descriptive expression psychological suffocation for a related form of psychic violence: the person remains conscious of distress or perceived injustice while effective avenues of escape, movement, protest, self-protection and influence over what happens to their body appear closed. The crushing is therefore psychological as well as bodily. It can injure agency, self-trust and the felt possibility of affecting events, until outward submission becomes a strategy for surviving an inescapable situation. International anti-torture analysis, parliamentary evidence and psychiatric monitoring reports all describe severe psychological harm, helplessness or humiliation that cannot be reduced to visible bodily injury. [46] [87] [89]

Autistic testimony and research on [stimming](#) show why movement, predictable surroundings, accessible communication and the ability to withdraw voluntarily may be essential means of remaining well. Removing those resources can contribute to the distress subsequently invoked to justify restriction. The study therefore distinguishes a quiet space freely chosen, with a genuine ability to leave, from enforced isolation. It also distinguishes useful voluntary movement from the unsupported assumption that aggressive catharsis necessarily reduces anger. [12] [14] [27]

Physical safety depends on what actually happens during the intervention, including effective observation and response to deterioration. Restraint, sedation and seclusion may be experienced as one continuous sequence and should be assessed together as well as separately. The study addresses breathing, swallowing, vigilance, immobility, access to help and the risk of overlooking physical illness. Observational studies identify serious complications, while the Melun inspection demonstrates the importance of reliable records and responses to warning signs. [18] [19] [20] [21] [44]

Position can materially affect airway and swallowing in susceptible people. Restraint guidance prioritises airway, breathing and circulation; separate sleep and swallowing research documents clinically relevant effects of supine posture, head extension and low trunk angles. A known positional breathing or swallowing problem, or a contemporaneous

report that breathing or swallowing is becoming impossible in the imposed position, should trigger immediate clinical reassessment. [\[18\]](#) [\[53\]](#) [\[54\]](#) [\[55\]](#)

Scottish and international evidence supports examining the organisation of services alongside individual distress. Current Scottish oversight has identified gaps in safeguards and data, inconsistent restraint recording and training, and routine daytime confinement arising directly from staffing and operational pressures. International research links restrictive-practice variation to staffing, relationships, freedom of circulation, meaningful activity and service culture. Preventive resources such as outdoor access, sensory options, movement and ordinary sources of comfort should be available according to individual preference. [\[22\]](#) [\[23\]](#) [\[25\]](#) [\[26\]](#) [\[28\]](#) [\[76\]](#) [\[77\]](#) [\[78\]](#)

A specific design proposal in this study is a dedicated single-person crisis regulation and expression room intended to be available at the point when physical or mechanical restraint would otherwise be considered, not merely as a general ward improvement or ordinary sensory room. Its purpose is to make bodily compression unnecessary where danger can instead be managed by engineered environmental safety: enough protected space for movement and vocal expression, together with a distinct restorative area offering chosen light, sound, images, comfort, nature-related content and other sensory resources. The person should retain a real ability to leave; otherwise the intervention becomes seclusion. Existing comfort-room, sensory-room and healing-environment research supports several components, but the complete model remains a proposal for co-designed evaluation. [\[18\]](#) [\[58\]](#) [\[96\]](#) [\[107\]](#) [\[108\]](#)

A legally distinct crisis-containment variant should also be studied for the narrower situation in which an immediate serious danger remains and the applicable legal threshold for preventing departure is met. The draft itself uses inconsistent formulations as to whether seclusion may respond to danger to the patient as well as to others; this proposal does not resolve that inconsistency by widening the ground. If departure is temporarily prevented, the intervention must be expressly classified and governed as seclusion under the applicable legal and human-rights framework rather than relabelled as voluntary use. The design objective would nevertheless remain fundamentally different from bodily restraint: preserve movement, expression and meaningful choice within the protected environment, and restore wider freedom progressively according to the disappearance of the specific danger, not according to social conformity or apparent calm. [\[2\]](#) [\[80\]](#)

The study also treats the institutional function of coercion as an empirical question. An explicit declaration that staff intend to 'break' a person is not a realistic evidential threshold. Qualitative evidence shows that some staff have understood containment as punishment or as a means of enforcing compliance, and that staff fear, powerlessness and beliefs about the weakness of less restrictive responses can favour containment. The relevant inquiry is therefore what outcomes the system actually rewards - safety and relief, or silence, immobility, obedience and easier management - and whether psychological defeat or loss of vitality becomes a tacitly learned operational advantage even when it is never named as a clinical objective. [\[106\]](#) [\[110\]](#)

The practical proposals connect prevention, accessible response, recovery and independent review. They require a factual account of the risk; preservation of harmless means of self-regulation; alternatives that are actually available; review of psychological as well as

physical harm; retention of the person's account and unresolved disagreement; and verification that corrective changes prevent recurrence. Staff education should combine survivor-led input, scenario-based perspective-taking and evaluation of later practice.

The study also proposes an independent, ethics-approved research programme on experiential education: carefully bounded voluntary restraint experience for medically screened professionals, co-designed with survivors and compared with survivor-led and non-physical simulation approaches, followed by measurement of later clinical practice rather than immediate impressions alone. The research question is whether experiencing loss of movement and control changes recognition of distress, escalation and less restrictive alternatives. [\[29\]](#) [\[74\]](#) [\[88\]](#)

The study contains twelve proposed additions or clarifications for the Code, a correspondence with all fifteen consultation question groups, and a causal incident-review record. It distinguishes immediate improvements within the Code from wider institutional and legislative change. Success should be assessed through safety, freedom, experienced distress, trust, availability of support and sustained prevention, not apparent compliance alone. Reductions in one restrictive practice must not conceal substitution by another.

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1. Purpose, scope and evidential approach

1.1. The question this study addresses

The central questions are why the situation reached the point of restraint, what the intervention does to the person experiencing it, and which changes could have prevented the apparent need for coercion. Physical control, immediate protection from harm and genuine relief of distress are separate outcomes and should be assessed separately.

The Autistan Diplomatic Organization presents this study as a contribution to the Scottish Government's consultation on updates to the [Mental Health \(Care and Treatment\) \(Scotland\) Act 2003 Code of Practice](#). It concentrates on restraint and [seclusion](#) affecting autistic people, while drawing on wider research and the knowledge of people who have experienced psychiatric [coercion](#). It also considers relevant implications for transfers and excessive security. [1] [4]

Autistan's purpose is to improve understanding of autism and prevent avoidable harm. The study treats autistic people as people with their own ways of perceiving, communicating, moving and making sense of events. Autistic characteristics are distinguished from coexisting illness, expressions of suffering and the factual or legal grounds invoked for restrictive intervention.

The organising proposition is that an intervention intended to contain danger can itself become a powerful source of danger and distress. Where an institution has contributed to a crisis through inaccessible conditions, imposed demands or removal of effective means of self-regulation, further bodily or environmental restriction may compound the original problem. Incident review therefore reconstructs the preceding conditions, the person's responses and the effects of each institutional action.

1.2. What the Scottish consultation can change

This consultation concerns [statutory guidance](#), rather than the enactment of a replacement mental health law. Section 274 establishes the [Code of Practice](#) and requires those discharging relevant functions to have regard to its applicable provisions. The Government describes the proposed update as limited in scope, alongside wider reform work. [3] [4]

The consultation comprises a new restraint-and-[seclusion](#) chapter, revised Chapter 14 on cross-border transfers, and Chapter 17 on excessive security. The questionnaire has 15 question groups. Question 12 invites views on more detailed guidance; question 13 allows further observations. Appendix A maps this study to those questions without making the questionnaire the limit of the analysis. [1]

The draft already recognises trauma, environmental and communication needs, the patient's perspective, and the need for prevention. It states that autism is not itself an indication for restraint. This study seeks to make those commitments testable in practice, while also examining the wider rights-based objective of ending [coercive](#) responses. [2]

Three routes are distinguished throughout: amendments that belong in the Code itself; operational requirements suitable for supplementary guidance, commissioning and inspection; and matters requiring wider legislative or service reform. A limit on the present

Code's scope is not a reason to omit an important finding. It is a reason to identify the appropriate route for acting on it.

1.3. How the evidence is used

This evidence-informed international study combines peer-reviewed research, first-person testimony, official investigations, statutory guidance, United Nations and European human-rights materials, survivor-led contributions and current Scottish oversight evidence. Sources are used according to the questions they can answer and are identified by type in the text and references.

First-person and qualitative sources illuminate experience and possible mechanisms; observational research identifies associations and service patterns; intervention studies evaluate specified approaches; and legal or human-rights sources establish standards, findings and policy positions within their respective mandates.

This is an evidence-informed, targeted international study, not a systematic review claiming exhaustive coverage of all publications. A personal account can establish what an experience meant to its author, but cannot estimate its frequency in a population. Observational studies can identify associations without removing every alternative explanation. A randomised trial can evaluate a specified intervention in a specified setting, without establishing that it will work identically elsewhere. Human rights recommendations establish legal and policy positions, not measured clinical effects. Conversely, the absence of an autism-specific randomised trial does not justify disregarding an autistic person's account of pain, fear or a lost means of self-regulation.

Recommendations and proposed clauses are Autistan's policy proposals. Autistan analytical propositions are identified explicitly. General psychiatric evidence is used for the questions it directly addresses, while autism-specific conclusions draw on autism-specific evidence, Autistan's methodological sources and the person's own account.

2. Autism, socio-generated harm and the construction of an incident

2.1. Start with the person and the situation, not a behavioural label

Autistan uses socio-generated impingements to describe sensory, mental (psychic) or other externally generated disturbances produced or amplified by social arrangements, human interactions, institutional rules or failures of accessibility. In Autistan's vocabulary, these impingements violate or micro-violate natural harmony and/or equilibrium. Concrete forms include avoidable sensory overload, humiliation, contradictory demands, unnecessary confrontation, exclusion, communication barriers, injustice and unjustified interference with bodily autonomy.

Causal reconstruction also includes pain, illness, bereavement, trauma, coexisting conditions and multiple causes. Its practical purpose is to expose modifiable external sources that disappear when explanation focuses only on the autistic person's visible reaction. Preventive action addresses those sources before making the reaction itself the primary target.

[Normocentrism](#), as used here, describes treating customary non-autistic ways of behaving and communicating as the unquestioned standard against which an autistic person is judged. An unfamiliar movement, refusal to make eye contact, intense voice, need for repetition or insistence on a factual inconsistency may then be interpreted as defiance, manipulation or aggression. The relevant question is whether there is evidence of significant harm, not whether the person's expression is socially conventional.

The method separates direct description of observable features or actions from the interpretations attributed to them, and separates both from causal explanation and evaluative judgment, drawing in part on the Autismology framework. Empirical, legal and clinical claims are supported by the corresponding external sources cited in this study. [\[64\]](#)

In the Autismology framework and related Autistan analyses, the Organisation argues that the quasi-totality of the sources of autistic suffering can ultimately be traced to sensory, mental (psychic) or other socio-generated impingements. The object is suffering: autistic nature, medical conditions, functional difficulties and support needs remain distinct analytical categories. Accordingly, when an autistic crisis expresses suffering, Autistan expects its causal chain almost always to lead back to such impingements. External research independently supports the importance of environmental, sensory, social, emotional and communication factors; the quasi-totality proposition remains an Autistan analytical thesis rather than a population estimate derived from that research. [\[64\]](#) [\[65\]](#) [\[66\]](#) [\[67\]](#) [\[68\]](#) [\[71\]](#) [\[72\]](#)

The practical consequence is a change in the unit of analysis. Instead of isolating the final movement or shout, examine the relationship between the person, the environment, the sequence of demands, the person's attempts at regulation or communication, and the responses of others. This keeps the causal chain visible when the most conspicuous event is the person's reaction.

2.2. Separate facts, interpretations, intentions and risks

A record stating that a person was "aggressive" may leave unanswered what they actually did. Did they strike someone, raise an arm to protect their head, move rapidly towards an exit, object verbally to unwanted touch, or make movements that looked unfamiliar? These are materially different events. A conclusion cannot replace the observations on which it should depend.

Irritation, anger, aggression and dangerousness are not interchangeable categories. Irritation or anger is an internal affective state and may be expressed through tone, facial expression, pacing, repetitive movement, withdrawal, protest, crying or a raised voice without any aggressive act. Intensity of emotion is therefore not evidence of aggression.

Even where aggressive conduct has actually occurred, that does not by itself establish dangerousness. Aggression should be described in concrete behavioural terms, including what was done, towards whom or what, with what force and with what consequence. The separate question is whether those facts create a sufficiently serious, likely and immediate risk of harm to justify a restrictive intervention. A brief defensive movement, a shouted insult, striking an object or another forceful act may require a response without necessarily establishing the legal threshold for deprivation of liberty.

The analytical sequence should therefore remain explicit: first, what state or distress is being expressed; second, what conduct actually occurred; third, what specific harm is realistically at risk now. No step should be inferred automatically from the previous one. In particular, irritation must not be relabelled as aggression, and aggression must not be relabelled as dangerousness without a separate evidential assessment.

The preceding distinction between irritation and aggression must also be made at the level of perception. An observer can think that a person 'looks aggressive' because of facial expression, tone, posture, pacing, proximity, intensity, unusual movement or visible anger even when no aggressive act has occurred and no threat has been made. In that situation, 'aggressive' describes the observer's interpretation, not the person's conduct. This study refers to that as perceived aggression and keeps it separate from actual aggressive conduct.

A second interpretive jump can then occur before any harmful act: perceived irritation becomes perceived aggression, and perceived aggression becomes presumed dangerousness. The chain may feel immediate or intuitive to staff, but each transition requires its own evidence. The record should identify who perceived aggression, which observable features produced that perception, which alternative explanations were considered, and what independent facts establish any claimed danger.

Autistan proposes four separate fields in risk assessment and incident review: directly observed actions; the specific harm feared and its imminence; interpretations concerning intention or motivation; and plausible alternative explanations. The record should identify the information available at the time, rather than retrospectively presenting an interpretation as something that had already been established.

Immediate physical risk and harmful intention are separate questions. Harm may be possible without malicious intention. Conversely, a suspicion of hostile intention does not establish an immediate physical danger. Protective decisions must address the concrete risk; they should not require the person to prove good intentions or conventional emotional expression.

An interpretation may also be factually wrong, rather than merely different from the patient's interpretation. For example, an allegation that a person attempted to hit someone is not equivalent to a verified observation that the person withdrew an arm from painful contact. Where evidence remains disputed, the disagreement must remain visible and open to examination. Institutional authorship should not automatically give one account the status of fact.

An intention attributed to a person is an inference, not an observed fact. The same applies to a prediction that the person 'might become aggressive'. Precautionary reasoning can become circular if unfamiliar autistic expression is first interpreted as hostile, that interpretation is then treated as evidence of future violence, and the resulting restriction is later cited as proof that the original suspicion was justified. The record should preserve each inferential step and the uncertainty attached to it.

Risk assessment should not reverse the burden of proof. A person should not lose liberty because they cannot reassure staff, appear calm, explain themselves in conventional language or disprove a speculative fear. Previous incidents, diagnosis, intense affect or staff anxiety may be relevant context, but none substitutes for evidence that the present situation meets the applicable threshold for coercive intervention.

The expression 'danger to self or others' is particularly vulnerable to becoming a conclusion that conceals its own evidential steps. The CRPD Committee's Article 14 guidelines deliberately refer to the 'perceived danger' a person is alleged to pose. They further observe that refusal of or resistance to treatment can itself lead people with intellectual or psychosocial impairments to be regarded as dangerous. Whatever legal framework applies in Scotland, this international rights analysis is a warning against allowing disagreement, resistance, distress or diagnostic status to become a proxy for danger. [\[119\]](#)

Prediction also creates a false-positive problem. Fazel and colleagues' meta-analysis covered 73 samples, 24,847 people and 13 countries. For instruments predicting violent offending, the median positive predictive value was 41% while the median negative predictive value was 91%; the authors concluded that use of such instruments as sole determinants of detention, sentencing or release was not supported by the evidence. The populations and time horizons were mainly forensic and criminal-justice related, not acute autistic crisis in a Scottish ward, so the 41% figure must not be imported as an estimate for this setting. Its relevance is methodological: a label of elevated risk can include many people who will not produce the predicted outcome, and the cost of that false positive becomes ethically critical when the consequence is loss of liberty or coercive treatment. [\[129\]](#)

A 2023 meta-analysis of violence-risk instruments in forensic psychiatric populations similarly found variable predictive performance across 36 tools and 50 publications involving 10,460 participants; 49 of the 50 publications were rated at high risk of bias. Again, this is not evidence about minute-to-minute crisis prediction in autistic people. It does show why a score, structured tool or professional forecast must never be allowed to acquire the status of an observed fact merely because it is formalised. [\[130\]](#)

Accordingly, a prediction of dangerousness should remain visibly labelled as a prediction. The record should state the concrete outcome predicted, the time horizon, the facts supporting it, reasonable alternative explanations, the applicable threshold, and what evidence would count against the prediction. A risk instrument, if used, should be identified together with the population and outcome for which it was validated. No score should become, by itself, sufficient evidence for restraint, seclusion or deprivation of liberty. [\[129\]](#)
[\[130\]](#)

2.3. A possible self-reinforcing sequence

Incident review should begin before the point formally recorded as escalation. It should reconstruct the environment, demands, requests, attempts to escape, regulate or communicate, staff interpretations, and the consequences of each response. This chronology can show whether an initially manageable difficulty became dangerous through accumulated interaction.

A published French survivor collective's submission to the Committee against Torture describes a related circularity: protest against coercive intervention can be interpreted as further evidence supporting coercion, while apparent compliance may become a strategy for obtaining release. It is cited here as survivor analysis and civil-society evidence relevant to causal review. [\[33\]](#)

The review should continue after the restraint because fear, mistrust or anticipatory panic produced by one intervention can become part of the circumstances surrounding the next.

Prevention therefore includes what the service changes between incidents, not only what staff do at the next crisis.

Documented case example - Timothee Dincher. A 2014 Alliance Autiste account by Eric Lucas, supported by a preserved audio recording of the Tribunal du contentieux de l'incapacite hearing, provides a concrete example of interpretive escalation. The incident discussed at the hearing involved Timothee, an autistic adolescent, holding his school support assistant in a close embrace while distressed and biting his own hand. During the hearing, the event was successively described as biting the assistant, attempted biting, strangulation or aggression, and then as putting himself and others in danger. The Alliance Autiste account disputes that he bit or strangled the assistant and presents the self-bite as a stress response. [\[112\]](#) [\[113\]](#)

The surrounding context also matters. Alliance Autiste reported that the school assistant involved was the fifth in three weeks, and described the original gesture as non-aggressive; it also reported that a complaint was closed without further action. Eric Lucas, who personally spent approximately one week with Timothee and his family in 2014, later wrote that he had observed him living freely in that family environment and not presenting danger. These are organisational and first-person reports, not an independent judicial finding, but they are directly relevant to the possibility that institutional descriptions can amplify an event while losing its context. [\[114\]](#) [\[115\]](#)

The later trajectory shows why such labels matter. In 2015, United Nations experts publicly challenged Timothee's psychiatric institutionalisation and medication without his and his mother's consent; a French Senate report later cited the case as illustrating deficiencies in safeguards surrounding psychiatric admission ordered by a juvenile judge. An Alliance Autiste submission hosted by OHCHR reported that during one psychiatric hospitalisation he was tied to a bed for at least two days and received high doses of two neuroleptics. Later advocacy reporting described continued institutional placement, heavy sedation, further psychiatric admission and repeated confinement, including reports of isolation in his room for up to sixteen hours per day. [\[116\]](#) [\[117\]](#) [\[118\]](#)

Autistan's Secretary-General also reports that, after Timothee returned to his family, he experienced severe difficulties with medication withdrawal and later died after a choking episode while with his family. The public material reviewed for this study does not establish a medical causal link between that death and the earlier restraint, seclusion, medication or withdrawal process, and this study does not make such a causal claim. The documented lesson does not depend on that claim: a disputed interpretation of distress can become part of a long sequence of increasingly coercive responses, while the coercion, trauma, medication burden and loss of ordinary life can themselves become new sources of distress.

This is one case, not proof that every autistic person or every service follows the same sequence. Its relevance is the mechanism. Labels can escalate faster than facts, and later institutions can inherit earlier labels as if repeated description had converted inference into proof. When a record says that a person is 'aggressive' or 'dangerous', reviewers should therefore ask what event originally generated the label, what was directly observed, what was inferred, what changed in later retellings, and whether the current risk has been demonstrated independently.

2.4. From first-order impingement to second-order impingement: the escalation paradox

A response to visible crisis can reproduce the same categories of harm at far greater intensity. A person already overwhelmed by noise, unwanted demands, misunderstanding, injustice or loss of control may then be surrounded by several people, touched without permission, held, pressed, prevented from leaving or moving, and told to become calm while the possibility of escape is progressively removed. Autistan describes these added harms as second-order impingements: harms generated by the response to a reaction that may itself have arisen from an earlier impingement.

This creates an escalation paradox. The system attempts to suppress a crisis by adding sensory input, bodily intrusion, social pressure and psychological domination to a state already characterised by overload or distress. From the person's perspective, the intervention can feel less like calming than crushing: the social environment becomes physically closer, more powerful and less escapable. Additional struggling may then be read as evidence that stronger control is necessary, creating a self-confirming loop. The chronology and the person's account should be used to test whether this mechanism occurred in the individual incident.

External evidence supports important parts of this model. Autistic adults describe meltdowns as states of overwhelm involving sensory, informational, social and emotional stress; sensory research documents the importance of touch, predictability and control; and emergency-psychiatry guidance warns that crowding and increased staff presence can escalate agitation. A UK parliamentary committee also recorded evidence that inappropriate inpatient environments can produce a 'vicious cycle of increasingly restrictive practice' and that restraint, seclusion, tranquilisation and long-term segregation can aggravate aggressive or destructive behaviour. [\[66\]](#) [\[67\]](#) [\[69\]](#) [\[70\]](#) [\[75\]](#)

The effect of pressure or touch depends on choice, predictability, who initiates it, whether it can be stopped immediately, intensity and the person's sensory profile. Chosen deep pressure or close contact may be regulating for some autistic people; imposed holding can be experienced as intrusive or threatening. Patient interviews also show that manual holding can be experienced as highly intrusive. [\[67\]](#) [\[73\]](#)

Patient interviews also caution against assuming that manual holding is inherently less intrusive than mechanical restraint. [\[67\]](#) [\[73\]](#)

Social inconvenience must also be separated from danger. Shouting, pacing, lying or sitting on the floor, unusual movement, refusal to move on command, or attracting public attention may be disruptive or embarrassing without creating an immediate risk that justifies force. De-escalation guidance emphasises actual risk, personal space, a non-provocative stance and preserving an exit; even conduct such as striking an object does not by itself settle whether restraint is required. At the same time, distance should not become abandonment. For an autistic person whose distress includes communication breakdown, being misunderstood or receiving no intelligible response can intensify distress. A practical aim is therefore space without encirclement, together with calm, low-demand and unmistakable availability for communication. [\[68\]](#) [\[69\]](#) [\[70\]](#)

3. What restraint can feel like from inside the body

3.1. Bodily confinement is more than being kept in a room

For explanatory purposes, Autistan describes extreme immobilisation as a form of confinement whose boundaries are applied directly to the body. In an ordinary locked room, a person may still walk, turn, cover their face, adjust clothing or choose where to sit. Under restraint, even those small acts of self-protection and self-comfort may become impossible.

This comparison is not a claim that every restraint technique is identical to imprisonment or that every person has the same response.

The comparison concerns the loss of immediate bodily options: freedom to reposition, protect a painful place, cover the face, withdraw from touch or create distance from the force applied to the body. A painful position, an itch, an intolerable surface or an urgent need to move away from contact can remain fully present while the person's ability to act on that need has been removed.

A further analogy helps make the loss of freedom concrete. In extreme immobilisation, the 'prison' can seem to shrink from the walls of a room to the outline of the body. A locked room may still leave some capacity to pace, sit up, turn away, cover the face or protect a painful place; restraint can remove even that minimal distance. The harm is therefore not only loss of locomotion but loss of the ordinary ability to answer one's own bodily needs.

A French [qualitative study](#) by Carré and colleagues describes powerlessness, loss of autonomy, loneliness, humiliation and the experience of punishment. It gives concrete content to the difference between being uncomfortable and being unable to do anything about discomfort. Its findings concern the experiences of interviewed psychiatric patients; they are not prevalence estimates for all restrained people or for autistic people specifically. [\[9\]](#)

The implications for care are substantial. A person should not have to demonstrate an injury before their inability to change position, communicate distress or obtain basic assistance is taken seriously. Nor should the fact that a technique is familiar to staff be confused with its being tolerable to the person receiving it.

3.2. The impulse to act can persist while action is prevented

In an Iranian [qualitative study](#), Yahyavi and Shahvari interviewed 20 inpatients with experience of restraint. Captivity, insult, oppression and punishment were central themes. Participants described restricted movement and suffocation; one asked, "What do you do with all your pent-up energy?" The study also contains accounts of the reactivation of earlier traumatic experiences. [\[10\]](#)

That question captures a problem which the instruction to "calm down" can conceal. The person may remain intensely mobilised to escape, protest, protect themselves or change an intolerable sensation, while every attempt at movement is opposed. The intervention does not necessarily remove the need to act. It may instead make that need impossible to satisfy.

Autistan's interpretation is that, for some people, the conflict between urgent action and imposed immobility can contribute to escalating internal distress. The person may feel they

are boiling inwardly, with no acceptable route for expression. This description should be explored with the person; it should not be converted into a universal physiological theory of stored energy, or an assumption that destructive action is necessary for recovery.

The relevant preventive question is therefore not simply how to suppress movement. It is which safe, voluntary forms of movement, distance, communication or environmental change would allow the person to regain a workable relationship with their body and surroundings.

3.3. Suffocation, panic and bodily claustrophobia

A sensation of suffocation can be experienced as an immediate threat to life. Actual impairment of breathing and a subjective feeling of being unable to breathe are not the same finding, but neither should be dismissed. Painful pressure, frightening proximity, an inability to change position and uncertainty about release may coexist with a genuine medical emergency. Reports of breathing difficulty require prompt assessment, not an assumption that they are merely another expression of agitation. [\[10\]](#) [\[18\]](#)

Being pinned down by several adults is a direct application of force to the body, not simply a firmer form of reassurance. Body weight or pressure that compromises breathing introduces a medical danger independently of anyone's intention. The person's struggle may be an attempt to escape frightening or painful contact rather than evidence that the contact is helping. This possibility must remain visible in the assessment. [\[18\]](#)

Bodily claustrophobia is used here as a descriptive expression for having no usable distance between oneself and the force restricting one's body. One cannot step away from the source of fear; even an attempted adjustment may bring further resistance from those holding or restraining the person.

The United Nations Special Rapporteur on torture provides a useful analytical concept for one part of this experience. A/HRC/43/49 describes 'powerlessness' as arising when a person under direct physical or equivalent control has effectively lost the capacity to resist or escape pain or suffering, explicitly including situations such as institutionalisation and hospitalisation. The report also analyses domination, dependency, humiliation, sensory manipulation and isolation as attacks on basic psychological needs. These categories are used here as questions for assessment, not as an automatic legal label for every restrictive intervention. [\[46\]](#)

An Italian study of narratives from 99 people across seven services identified prominent metaphors involving animals and war or imprisonment, alongside sadness, anger and fear. These narratives show why neutral procedural language can fail to convey an experience of objectification or captivity. Metaphors are meaningful evidence about experience, although they do not establish that all episodes have the same psychological consequences. [\[11\]](#)

For an autistic person who experiences certain touch, pressure or bodily proximity as especially distressing, the added contact may be part of the threat rather than a route out of it. This must be established individually. Staff should not assume that a contact described professionally as containing or reassuring is experienced in that way by its recipient.

Pau Perez-Sales and colleagues' 'torturing environments' framework similarly shifts attention from an isolated technique to the total environment and to the human functions placed

under attack: control, safety, identity, bodily needs, sensory conditions and meaningful relations. The framework was developed and evaluated in the context of torture survivors, not validated as a psychiatric-restraint scale. Its relevance here is analytical: the complete sequence and environment should be examined rather than treating a strap, hold, room or injection as though it were disconnected from what surrounds it. [49] [50]

3.4. Injustice and violation of personal integrity

The meaning of an intervention matters. A person who understands and freely accepts assistance is in a different situation from someone who believes they are being overpowered for protesting against pain, refusing an unnecessary demand or trying to leave an intolerable environment. In the latter situation, distress includes the experience of being wronged, disbelieved and made dependent on the decisions of those imposing the intervention.

A person may experience this as a profound violation of bodily integrity and personal autonomy: their body is still felt as their own, yet control over it has passed to other people. Where there is a history of assault or other [coercion](#), the intervention may also acquire meanings connected with earlier events. The international qualitative literature documents humiliation, fear, helplessness and [retraumatisation](#), while also recording some accounts of perceived protection or reassurance. Individual experience must not be presumed in either direction. [8]

Unwanted intimate contact, exposure of the body or a forced procedure can also be experienced in sexualised terms or reactivate memories of sexual violence. The Iranian interviews include such a traumatic association. The person's meaning should be recorded in their own terms, without either dismissing it or automatically assigning an identical legal classification to different acts. [10]

A reassuring explanation is important, but explanation alone cannot make an unnecessary [coercive](#) act necessary or undo the absence of consent. Likewise, an assertion that the intervention was intended to help does not answer whether its actual effects included terror or degradation.

The allegation of injustice requires a factual response. What was the legal and practical basis? What less restrictive action was possible? Was the person's objection accurately understood? Was release made dependent on agreement, apology or an appearance of compliance, rather than the disappearance of the specific danger? These questions should be answerable without requiring the person to adopt the institution's interpretation.

3.5. When the outward struggle ends

Stopping movement is not a reliable measure of inner safety. A person may stop because they feel safer, but also because they are exhausted, frightened of further force, unable to continue, sedated or deliberately concealing their distress. An observation of quietness does not decide between these possibilities.

The [defence cascade](#) literature describes several responses to threat, including active defence and forms of immobility when escape is unavailable. It offers a framework for understanding why stillness need not indicate security. It is not direct evidence that a particular restrained person experienced [tonic immobility](#) or [dissociation](#), and those states must not be diagnosed from silence alone. [16]

Qualitative work on [autistic shutdowns](#) describes reduced capacity to speak, move or engage, sometimes accompanied by intense internal difficulty. Such research is relevant to the danger of equating diminished expression with reduced suffering. It does not establish that restraint causes every [shutdown](#), or that [shutdown](#), [dissociation](#) and [tonic immobility](#) are interchangeable phenomena. [\[15\]](#)

Autistan therefore proposes that records distinguish three observations: whether the immediate danger has ended; whether the person can communicate and exercise meaningful choice; and whether the person actually reports or shows a reduction of distress. Only the first concerns the continuation of an emergency restriction. None should be made contingent on the person agreeing that the intervention was justified.

When the same institution applying the restriction also decides when freedom will be restored, outward submission can become the only perceived route to release. A person may stop resisting because resistance appears futile, because they fear additional force, or because they have concluded that their account will not alter what happens. That resignation must not be mistaken for agreement. Where restriction is not strictly necessary, or continues after the specific danger has ended, the domination is no longer justified by the emergency rationale invoked for it. [\[46\]](#) [\[61\]](#) [\[62\]](#)

3.6. Psychological suffocation, inner breaking and what may remain after release

The phrase "breaking a person" can describe an injury to the person's sense of agency, security, dignity and trust. Removing a strap or opening a door does not automatically restore those experiences.

Some people may describe the consequence in terms of inner destruction. That expression need not imply irreversible damage or a new diagnosis. It can name an injury to the felt continuity of agency, bodily ownership, security and trust: the person remains conscious of what they need or believe to be unjust, while learning that neither movement nor protest can change the situation. The outward appearance may be acceptance while the inward experience is defeat. [\[13\]](#) [\[46\]](#)

Autistan uses psychological suffocation to describe an experience in which every usable psychological route appears closed: the person cannot escape, move freely, make the intervention stop, obtain recognition of what they are communicating, or influence the decision controlling their body. Actual respiratory compromise is a separate medical danger addressed in section 5; psychological suffocation concerns the experienced closure of agency and escape while consciousness of the situation remains.

Autistan uses the metaphor of an 'inner spring' for another aspect of the same experience: vitality, spontaneous initiative, the impulse to move or speak, the capacity to protest, and the expectation that one's action can still alter what happens. Repeated domination can leave the person outwardly quieter because this spring has been damaged or inhibited rather than because the underlying suffering has resolved. In the person's own terms, something may feel as if it has broken inside. This is not proposed as a diagnostic category; it is a subjective and functional outcome that services should be capable of detecting rather than misclassifying as successful calming. Melzer's analysis of domination, submission, helplessness and dependency and UK evidence describing a 'broken spirit' provide external

human-rights and testimonial parallels for studying this form of psychic devitalisation. [\[46\]](#)
[\[87\]](#)

A serious evaluation should therefore ask what happens to initiative and agency after coercion: whether the person still seeks help, communicates disagreement, initiates activity, trusts their own perceptions, uses self-regulation freely and expects that communication can influence care. A reduction in visible resistance accompanied by withdrawal, fear, passivity or loss of initiative should not be counted automatically as improvement. The distinction between calming and breaking is central to the study's concern with psychological suffocation. [\[46\]](#) [\[87\]](#) [\[89\]](#)

The object of analysis should also be the whole coercive environment rather than the restraint device in isolation. Physical immobilisation may occur together with multiple staff surrounding the person, commands, observation, locked space, sensory assault, uncertainty about release, disbelief, forced medication and the knowledge that resistance may prolong control. Mendez's analysis of health-care practices, Melzer's analysis of psychological torture and the Perez-Sales 'torturing environments' framework all support examining the cumulative configuration through which powerlessness and severe suffering can be produced. [\[45\]](#) [\[46\]](#) [\[49\]](#) [\[50\]](#)

In this state, crushing can be psychological as well as bodily. The injury may concern the person's relation to their own agency: movement, protest, explanation and even factual accuracy can come to feel powerless against institutional force. Melzer's analysis of psychological torture describes domination and subjugation as attacks on control, autonomy and self-determination that can consolidate into despair and dependency. Parliamentary evidence concerning detained children records a 'broken spirit', retraumatisation and restraint that can be profoundly psychologically damaging even without visible physical injury. [\[46\]](#) [\[87\]](#)

The CGLPL's thematic report on isolation and restraint in psychiatry likewise records humiliation, anguish, anger, incomprehension and powerlessness, including the inability to satisfy elementary bodily needs while restrained. These accounts support treating serious psychic injury as a substantive harm in its own right, capable of changing trust, self-protection, willingness to seek help and the person's future relationship with institutions. [\[89\]](#)

Chieze and colleagues' [systematic review](#) found evidence of adverse physical and psychological consequences. Individual studies included estimates of [post-traumatic stress disorder](#) after restrictive interventions ranging from 25% to 47%. These are not a pooled risk estimate, are affected by study design and prior trauma, and must not be presented as the proportion of all restrained autistic people who will develop the condition. They do, however, make it untenable to assume that harm ends when the intervention ends. [\[17\]](#)

A serious account of outcome must allow for nightmares, intrusive recollections, avoidance, fear of future contact, loss of trust and difficulty seeking help. It must also leave room for recovery, the person's own interpretation and the possibility that they do not wish to recount the experience immediately. Support should restore choice rather than require another compulsory retelling.

More recent qualitative synthesis strengthens the conclusion that psychological consequences cannot be treated as secondary. A 2025 meta-ethnography of 27 papers on

adult inpatient restrictive practices identified four overarching constructs: anti-therapeutic and dehumanising experiences, a vicious cycle, abuse of power, and the critical role of support and communication. These are qualitative constructs, not prevalence estimates, but they make power and relationship part of the harm analysis rather than an optional contextual note. [\[132\]](#)

A 2026 systematic review and metasummary assembled 291 qualitative studies published from 1991 to 2025. At least one negative experience was reported in 279 studies, while mixed experiences appeared in 166 and positive experiences in 167; the categories overlap, and the review does not imply that every person experiences every coercive intervention in the same way. Its scale is nevertheless important: adverse experience is a recurrent international finding across a very large qualitative literature, not an isolated anecdotal theme. [\[133\]](#)

Recovery after coercion also requires more than the end of the physical measure. A 2024 meta-ethnography of 23 studies identified dignity and respect, safety, empowerment, a facilitating environment, information and reciprocal communication as important in processing coercive experiences. This supports post-incident work aimed at restoring agency and trust, not merely documenting that the straps were removed or the door was opened. [\[134\]](#)

4. Autistic testimony and the removal of ways to remain well

4.1. An institutional sequence described to Parliament

In evidence to the House of Commons in February 2021, Alexis Quinn described a sensory-charged environment, an inability to use running to regulate herself, and repeated restraint, injections and [seclusion](#) following overload. She also described fresh air being treated as a reward for appearing more conventional. Her testimony is a first-person account of the removal of ordinary means of regulation, not simply a description of an otherwise unexplained behavioural crisis. [\[12\]](#)

Its policy relevance is the sequence. When access to movement, predictable conditions and relief from overwhelming stimulation is removed, the person's ability to remain well may be undermined. A service must examine whether it then responds coercively to the consequences of those restrictions. The individual's account should be investigated alongside contemporaneous evidence, not accepted or rejected solely because it differs from the clinical narrative.

In a further first-person account published in October 2026, Quinn described prolonged solitary confinement, panic followed by exhaustion, and the feeling: "I feel like a horse who has been broken." This is an account of defeat and confinement, not a validated measure of therapeutic benefit. It makes the distinction between reduced outward resistance and genuine relief particularly stark. [\[13\]](#)

These accounts support a precise preventive question: was a person's established means of regulating their state made unavailable, and was the resulting deterioration then attributed entirely to that person?

4.2. Movement can be regulation, not misconduct

Kapp and colleagues' [qualitative study](#) with 32 autistic adults identifies [self-regulatory](#) and expressive functions of [stimming](#), together with pressure to suppress it. This supports taking the person's own explanation seriously when repetitive movement helps them manage emotion or sensory experience. It does not imply that every movement during a crisis is [stimming](#) or that any harmful action must be allowed. [14]

Autistan proposes a presumption in favour of preserving harmless [self-regulation](#). Walking back and forth, rocking, moving hands, changing position or vocalising should not become grounds for restraint simply because the behaviour is unusual, conspicuous or inconvenient. The assessment should identify a specific risk and consider whether space, distance or adaptation can remove it without suppressing the activity.

Visually alarming actions also require graded rather than categorical assessment. Biting one's own hand can range from controlled pressure or sensory regulation with no significant injury to serious tissue-damaging self-injury; the word 'self-biting' does not decide where on that spectrum an individual event lies. Staff should record force, duration, injury, escalation, the person's known pattern and whether a safer substitute is available. The same principle applies to object-directed or brief interpersonal acts: a push, a slap or a broken object may require an immediate proportionate safety response, but it does not automatically establish continuing dangerousness after the specific hazard has ended. The response should match the actual harm and current risk, not the most alarming possible extrapolation.

The same principle applies to people who cannot explain their needs through conventional speech. Their known preferences, previous successful arrangements and communications through other means should inform support. Absence of a spoken explanation is not evidence that movement lacks a function.

4.3. Do not make access conditional on appearing non-autistic

If fresh air, familiar objects, communication devices, contact with trusted people or a quiet space are necessary for a person to function, withholding them as rewards for compliance reverses the logic of accessibility. Autistan recommends treating necessary supports as supports, not bargaining tools.

Scotland's own 2024 consultation analysis recorded sharply different views about [Positive Behaviour Support](#). Some respondents defended it as a way of improving support; others described restrictive plans which misread autistic responses to poor care. The report did not resolve that disagreement. This makes it particularly important to specify acceptable objectives and safeguards rather than rely on the reassuring name of a framework. [7]

The criterion should be reduced suffering and actual harm, increased communication, [agency](#) and quality of life. A plan should not seek to eliminate harmless autistic characteristics solely because they are atypical. A reduction in visible autistic expression is not, by itself, evidence of improvement. People should be able to challenge a plan and obtain a review independent of those who designed it.

5. Physical harms, medication and the loss of ordinary self-protection

5.1. An immobilised person may be less able to detect, communicate or respond to danger

A person who cannot reposition themselves, reach a call device or readily communicate pain is dependent on others for functions that would ordinarily be under their own control.

Sedation can add a further reduction in the ability to report deterioration. Autistan recommends assessing these dependencies as risks created by the intervention, rather than treating surveillance as a sufficient assurance that the risks have disappeared.

The [NICE](#) guideline on violence and aggression specifically addresses protection of breathing and circulation and monitoring after [rapid tranquillisation](#). These safeguards matter, but they are not evidence that restraint is risk-free when a protocol exists. What matters is whether a competent person actually detects and responds to deterioration. [\[18\]](#)

Clinical assessment must not explain away pain, respiratory symptoms or altered responsiveness as autism or behavioural disturbance. The term [diagnostic overshadowing](#) describes the risk of attributing a new problem to an existing diagnosis and overlooking another cause. In this study, avoiding that error is a proposed safeguard, not an assertion that a particular diagnosis explains every missed complication. [\[44\]](#)

A systematic review focused specifically on physical harm and death found 67 eligible studies, mostly heterogeneous case reports and case series. Death was the most frequently reported harm: the review identified reports of cardiac arrest associated with chest compression in 14 studies, cardiac arrest associated with strangulation in nine and pulmonary embolism in eight; injuries and venous thromboembolism were also reported. Because the underlying evidence is heterogeneous and does not provide reliable denominators, these counts do not establish an incidence rate. They do establish that the intervention invoked to prevent danger can itself introduce serious and sometimes fatal danger. [\[128\]](#)

This creates a two-sided safety obligation. A team considering coercion should not compare a vivid hypothetical harm from non-intervention with an intervention implicitly treated as harmless. It should compare the concrete and time-specific risk without coercion against the foreseeable physical, psychological and liberty-related risks created by restraint, seclusion, medication and the complete coercive sequence. [\[17\]](#) [\[20\]](#) [\[123\]](#) [\[128\]](#)

5.2. Respiratory distress and aspiration

Actual impairment of breathing may arise in connection with position, external pressure or other clinical factors. Reduced vigilance and impaired protection of the airway are also relevant when evaluating [aspiration pneumonia](#), in which material entering the lungs contributes to infection. These concerns require individual medical assessment; a prevention study should not prescribe restraint techniques or medication regimens.

Respiratory risk is not confined to one mechanism. A scientific review of the physiological literature found that restraint position can impede life-maintaining functions, while also

emphasising that effects differ between positions and techniques and that the mechanisms of restraint-related deaths are not fully resolved. A separate 2013 case report documented cessation of breathing, unconsciousness and cyanosis after prone floor restraint with substantial weight on the torso. The case is not a prevalence estimate; together the sources support attention to position, pressure, exertion and individual vulnerability rather than a generic declaration that a technique is safe. [51] [52]

Funayama and Takata examined 1,308 psychiatric inpatients in Japan, including 110 exposed to [physical restraint](#). Their observational analysis reported associations with [deep vein thrombosis](#) and [aspiration pneumonia](#), with [odds ratios](#) of 6.0 and 4.1 respectively. These are [odds ratios](#), not absolute risk increases; differences in patients' illness and other factors limit causal conclusions. The study nevertheless identifies serious complications that must be included in safety evaluation. [19]

The policy implication is not simply to monitor more intensively after choosing restraint. It is to include intervention-related medical risks in the decision whether the proposed action is justified at all, to minimise exposure, and to establish an effective response to symptoms. Breathing complaints should never have to compete with a demand that the person first become more compliant.

Guidance commonly prefers supine to prone restraint if a person must be taken to the floor, but lying face-up is not physiologically neutral for every person. Sleep-medicine research shows that upper-airway obstruction and airway collapsibility are greater in the supine position for many people with obstructive sleep apnoea. This is sleep physiology, not a restraint trial. The narrower policy implication is that a known history of positional breathing difficulty, or a contemporaneous report that breathing is becoming impossible in the imposed position, should trigger immediate clinical reassessment and repositioning as appropriate. [18] [53]

Drinking and swallowing are also position-dependent. In healthy adults, Hanamoto and colleagues found that head extension and mouth opening impaired swallowing in the supine position; Lu and colleagues found swallowing easier at 60 to 90 degrees than at 30 degrees or fully supine. These small studies in healthy adults do not establish a universal protocol for restrained patients. They do show why it is unsafe to assume that any immobilised person can simply be made to drink while fully supine or with the head extended. A reported inability to swallow safely requires reassessment of position, airway and hydration. [54] [55]

Laryngospasm is a separate acute airway mechanism in which reflex closure of the larynx can severely obstruct airflow. The cited literature is primarily from anaesthesia and does not establish that restraint commonly causes laryngospasm. Its relevance here is precautionary: sudden airway closure, inability to breathe or inability to swallow must be treated as possible medical danger, not dismissed as behavioural resistance. [56]

5.3. Immobility and [thromboembolic complications](#)

A Danish population-based study published in the [BMJ](#) in 2026 reported a 30-day cumulative incidence of [venous thromboembolism](#) of approximately 3.5 per 1,000 after [mechanical restraint](#), compared with 1.7 per 1,000 after [chemical restraint](#). The adjusted comparison suggested roughly twice the risk. This is an observational comparison between exposed

groups, not proof that [mechanical restraint](#) caused every event or that [chemical restraint](#) is a generally safe alternative. [20]

[Deep vein thrombosis](#) and [pulmonary embolism](#) belong in the assessment of prolonged immobilisation and its aftermath. The relatively small absolute frequency of a severe complication does not remove the need to consider it. Services should also avoid using one category's apparent reduction as evidence of progress when another [coercive](#) exposure has increased.

5.4. The combined intervention must be examined

A record may separate a manual hold, an injection, [mechanical restraint](#) and [seclusion](#) into different categories while the person experiences them as one continuous event. Autistan proposes recording both the individual components and the complete sequence. A drug's intended therapeutic purpose should be distinguished from use primarily to restrict movement or secure control; mixed purposes should be documented rather than concealed by a single label.

The safety review should examine pain or injury, breathing, circulation, swallowing, alertness, hydration, access to toilets, sleep disruption and the person's ability to request help. It should also review medication effects and interactions through the appropriate clinical expertise. This is a proposed minimum review framework, not a claim that every complication will occur or that every medicine carries the same risks.

Rapid tranquillisation can add risks that interact with exhaustion, dehydration, struggle and pre-existing illness. Scottish NHS guidance warns about respiratory depression with benzodiazepines, QT-related and other cardiac risks, neuroleptic malignant syndrome and additive effects when medicines are combined. The relevant risk depends on the actual medicine, dose, combination and person. A post-incident review should therefore reconstruct cumulative pharmacological and physical exposure rather than record 'medication given' as a neutral separate event. [18] [60]

The European Court of Human Rights case *V v Czech Republic* illustrates why the complete intervention sequence and the service's preparedness matter. The patient died after a sequence involving attempts at prone restraint, repeated Taser use by police and tranquillising medication. The Court found Article 2 violations, including a failure to put in place an adequate framework and strategy to prevent and limit recourse to restraint. The judgment did not establish that restraint alone caused the death; its relevance here is the cumulative risk of escalation when a service cannot manage a crisis safely with its own trained resources. [126]

5.5. Why a register is not enough: the Melun inspection

Urgent recommendations concerning Melun by the French independent detention monitor, the [Contrôleur général des lieux de privation de liberté \(CGLPL\)](#), were published in March 2026 after an August 2025 inspection. They documented seven inpatient deaths between 1 January 2024 and 1 August 2025, five during involuntary care. Three occurred during stays in isolation or lockable rooms, with important uncertainty about the precise restrictive status in individual cases. The report identified serious shortcomings in physical-health care,

monitoring and traceability, including failures to record and act on warning signs. These findings do not establish seven deaths caused by restraint. [21]

The lesson for Scotland is that the existence of a legal recording duty is different from a reliable record. Autistan recommends independent checks comparing clinical notes, medication records, observation charts, incident registers and the person's account. Unexplained discrepancies should trigger investigation. A missing entry cannot be treated as evidence that a restriction did not happen, and missing documentation must not make the person less able to obtain review.

A broader CGLPL opinion published in September 2026 reinforces this point. It reported that French health authorities could not ensure exhaustive, homogeneous and real-time counting of deaths during or after psychiatric hospitalisation or systematically identify deaths during involuntary care; some deaths had occurred while patients were isolated and restrained. The CGLPL also identified deficiencies in somatic assessment, medical and paramedical surveillance, staffing and traceability that may have contributed to deaths of some patients, sometimes in isolation and restraint. A register is therefore only as protective as the observation, response, reconciliation and independent learning behind it. [59]

6. Seclusion, prolonged segregation and genuinely voluntary retreat

6.1. Solitude chosen by the person is not enforced isolation

Three situations should remain conceptually distinct: freely choosing a quiet place with a real ability to leave; using a safe space for movement or expression with support accepted by the person; and being prevented from leaving. Scotland's Mental Welfare Commission defines seclusion by the person's actual prevention from leaving, including situations where a door is open or unlocked but staff block departure. [80]

Conversely, an autistic person's request to be alone should not automatically be treated as pathological withdrawal.

Autistan proposes recording the practical conditions of choice: whether the person can leave, how they request assistance, whether they retain communication and comfort items, and what happens if they change their mind. Actual freedom includes staff conduct, physical blocking and credible instructions or threats, not only the design or lock state of the room. [80]

An adaptation can also become restrictive through its rules of use. A sensory room that is available only after permission, a garden whose access depends on displaying conventional calm, or a retreat space that staff routinely block may not function as the promised alternative. The person's ability to control entry, exit and the sensory conditions is therefore a central design question.

6.2. Prolonged isolation can become a problem maintained by the service

The Hollins report, published in England in 2023, examined reviews of 191 autistic people or people with a [learning disability](#) in [long-term segregation](#). It rejected a therapeutic rationale for the solitary confinement examined and described damaging institutional conditions, inappropriate interventions and barriers to leaving hospital. Its conclusions concern that programme and those prolonged situations; they should not be presented as an experimental finding about every brief [seclusion](#) episode in Scotland. [\[30\]](#)

The report nevertheless changes the preventive question. Once segregation has become prolonged, services must not ask only how to manage the person within it. They must ask what is maintaining it, which supports and living arrangements are missing, and who has the authority and resources to end the impasse.

Autistan proposes a senior, independent escalation route whenever repeated or prolonged restrictions are attributed to unavailable placements, staffing or community provision. An organisational shortage should be recorded as an organisational failure requiring action, not converted into an apparently enduring property of the patient.

6.3. Isolation can affect relationships and the surrounding environment

A person may experience isolation as abandonment, punishment or proof that their presence is intolerable. A review should ask whether they had meaningful contact, information about what was happening, access to a trusted person and a credible opportunity to be heard. These are proposed questions for evaluating the intervention, not assumptions about everyone's preference for company.

Services should also examine effects on witnesses. Hearing cries or seeing someone overpowered may influence other patients' sense of safety. For autistic people, the sound, unpredictability and visible threat may be particularly relevant. This is a precautionary issue to assess locally; the study does not claim a quantified autism-specific rate of harm among witnesses.

The end of isolation should not depend on a person endorsing the institution's account of events. A person can remain angry about an injustice while no longer presenting an immediate danger. A review that requires emotional conformity risks extending confinement for reasons other than the risk originally invoked.

7. Evidence on prevention, organisation and safeguards

7.1. Differences between institutions are part of the evidence

The French [IRDES](#) study published in March 2026 combined quantitative analysis of 204 establishments with fieldwork in four establishments characterised by low use of restrictive practices. Patient characteristics alone did not explain the differences. The analysis identified associations involving nursing resources and described the importance of staff availability, stable teams, freedom of circulation, activities and organisational commitment. These are observational and qualitative findings, not isolated causal estimates for each component. [\[22\]](#)

Autistan proposes that Scotland study services with consistently low [coercion](#) alongside those with high rates. The comparison should include [case mix](#) and recording quality, but also practical conditions: who can go outside, who is available to accompany them, how refusals are handled, how frequently unfamiliar staff intervene, and whether ordinary needs have to become emergencies before assistance is provided.

It is not enough to tell individual staff to be more empathetic while leaving them without time, continuity, space or alternatives. Equally, more staff alone will not solve a culture that interprets distress principally as disobedience. Resources and the purpose for which they are used must be examined together.

The present use of restraint and seclusion is not the product of a single clinical discovery or a single motive. Historically, restraint was defended as a means of controlling or calming people considered violent or irrational. The nineteenth-century non-restraint movement demonstrated that mechanical restraint could be abandoned, but history also shows a substitution problem: seclusion could expand when mechanical restraint was removed. This matters because a reduction in one visible technique is not sufficient if the underlying function of containment simply migrates to another method. [\[91\]](#) [\[92\]](#)

Contemporary decision-making is likewise shaped by more than the patient's condition. Duxbury and Whittington found that patients emphasised environmental conditions and poor communication as precursors of aggression, while nurses placed greater weight on mental illness; both groups described a restrictive, under-resourced provision generating interpersonal tension. Research on professional socialisation and ward practice shows that local psychiatric culture influences how staff evaluate containment methods, while staff perceptions of safety, aggression and team climate are associated with seclusion and restraint use. Qualitative synthesis also identifies the absence of less coercive alternatives as part of nurses' experience. [\[93\]](#) [\[94\]](#) [\[95\]](#) [\[102\]](#)

An evidential test based on an explicit admission that a service intends to 'break' a person's will would be unrealistically narrow. Institutional practices can have tacit functions that are learned empirically, rewarded operationally and reproduced culturally without being written as therapeutic objectives. The EDITION qualitative evidence synthesis found that some staff described containment as punishment considered necessary to moderate conflict, while some regarded less restrictive techniques as too weak and opted for containment to enforce compliance; staff fear and feelings of powerlessness could also favour containment over de-escalation. Taxis likewise describes a restraint-reduction programme as a paradigm shift toward collaboration, empowerment and ethical practice, implying that the preceding organisational logic was materially different. [\[106\]](#) [\[110\]](#)

The relevant hypothesis is therefore not confined to formal intention. Through repeated practice, staff and institutions may acquire tacit knowledge that coercion can rapidly stop shouting, movement, protest and resistance and can make a person easier to manage after fear, exhaustion or defeat. That operational knowledge can exist without appearing in a protocol and without being described as a therapeutic aim. Autistan proposes treating the possibility of a 'broken inner spring' as an empirical institutional question: whether reduced initiative, compliance or psychological defeat is sometimes recognised, consciously or half-consciously, as useful to order even when the person's internal state has worsened. The EDITION findings on punishment, compliance, fear and recourse to containment make this

hypothesis legitimate to investigate rather than dismiss for lack of an explicit admission. [\[46\]](#)
[\[106\]](#)

Incident review and service audit should therefore record what outcome was actually treated as success: prevention of a specific injury, reduction of the person's reported distress, restoration of agency, cessation of shouting, immobility, obedience to an instruction, return to ward routine or reduced staff anxiety. These outcomes are not interchangeable. A system can become highly efficient at suppressing expression while remaining ineffective at relieving the suffering that generated it. [\[101\]](#) [\[102\]](#) [\[106\]](#)

Large differences between services, together with restraint-free and no-restraint programmes, show that coercion is not determined solely by an unavoidable level of patient danger. In Italy, 14 of 24 general-hospital psychiatric units committed to a no-restraint approach reported zero restraint episodes in 2022. A US behavioural-health unit reported nearly two years without restraint after a culture-change programme, alongside reduced as-needed sedative-hypnotic medication. An adolescent implementation of the Six Core Strategies eliminated seclusion and substantially reduced restraint in the studied ward. These are not proofs that every setting can immediately reach zero coercion, but they make institutional design, culture and available alternatives legitimate causal variables rather than peripheral considerations. [\[98\]](#) [\[100\]](#) [\[105\]](#)

The assumption that less coercive care must necessarily consume more resources also requires testing against whole-system costs. In one adolescent service, LeBel and Goldstein reported a 91% reduction in restraint episodes and a 92% reduction in restraint-related costs during a reduction initiative; staff time devoted to restraint-related activity fell from 23% to 4%, allowing time to be redirected to non-restraint care. Results from one programme cannot be transferred mechanically to Scotland, but economic evaluation should compare the full cost of coercion - staff time, injuries, sickness absence, turnover, litigation, prolonged admission and damaged therapeutic relationships - with the capital and staffing costs of alternatives. [\[99\]](#)

The French CGLPL's 2025 annual report provides a useful national comparison. It reports an average isolation rate close to 37% among patients receiving involuntary psychiatric care, with some establishments close to 50% and durations in extreme cases measured in thousands of hours. It also reports that one establishment pursuing a deliberate reduction policy reduced its isolation rate from 44% to 28% between 2023 and 2024. These are oversight data rather than a controlled experiment, but they reinforce the importance of institutional policy, organisation and available alternatives as variables that can change practice. [\[111\]](#)

A 2025 international systematic review of mechanical restraint included 83 articles reporting 73 studies from 22 countries. Reported prevalence varied from below 1% to 51%, with much of the variation appearing related to national or regional protocols governing the choice between restraint and other restrictive practices. Indications were often broad - such as violence/aggression or danger to self or property - while ward and staff factors were inconsistently examined and high-quality outcome evidence remained limited. The review therefore cautions against treating restraint rates as a simple read-out of patient dangerousness. [\[138\]](#)

The Italian National Bioethics Committee reached a related conclusion from an ethical and organisational perspective. Its 2015 opinion describes mechanical restraint as a residue of asylum culture, states that service culture, organisation and staff attitudes can be more decisive than patient severity or psychopathological profile, and sets an objective of overcoming restraint. Even within its exceptional-necessity framework, it states that mere agitation is insufficient: justification requires a grave and current danger, proportionality, the least invasive means and cessation when the danger ends. This is an Italian bioethics opinion, not Scottish law, but it provides a useful comparative formulation of proportionality and institutional responsibility. [\[135\]](#)

External legal control can also change practice, while creating a risk of substitution. After the German Federal Constitutional Court required an immediate judicial decision for mechanical restraint lasting more than 30 minutes, a population-based study covering all 32 relevant hospitals in Baden-Wuerttemberg found that the proportion of patients exposed to mechanical restraint fell from 4.8% in 2017 to 3.6% in 2019 and overall restraint-or-seclusion exposure fell from 6.6% to 5.8%. At the same time, seclusion increased from 2.9% to 3.3%. This is important for Scotland: a safeguard can reduce one coercive practice, but evaluation must detect whether another restrictive practice is simply substituted for it. [\[136\]](#)

7.2. Relational and organisational change can reduce restrictive responses

The [Safewards cluster randomised controlled trial](#) involved 31 wards in 15 hospitals. Its corrected findings reported reductions of 15% in conflict events and 23.2% in containment events on shifts with such events. Containment was a [composite category](#): the result must not be described as a 23.2% reduction in [physical restraint](#) alone. The study supports the proposition that everyday ward relationships and practices can affect restrictive responses; it does not establish an autism-specific effect. [\[23\]](#)

A review by the [Swedish Agency for Health Technology Assessment and Assessment of Social Services \(SBU\)](#), subsequently reported in *The Lancet Psychiatry*, examined interventions in psychiatric and residential care for children and young people. It found the more promising evidence around organisational culture, staff practice and combinations of measures, while identifying significant limitations in the evidence. The included settings and age groups were varied. It should inform adaptation and evaluation, not be treated as proof that a named programme can be transferred unchanged to all Scottish services. [\[24\]](#)

Autistan's proposed use of these findings is practical: make prevention an organisational responsibility, select interventions with the people affected, measure implementation and outcomes, and stop treating a reduction in visible behaviour as the sole measure of success. A programme should be judged by what changes in daily life, not merely by completion of a training package.

A 2024 systematic review of 41 studies on reducing mechanical restraint grouped interventions into four broad families: calm-down methods, staff resources, legal and policy changes, and changes in staff culture. The review found promising results but substantial heterogeneity, inconsistent reporting and a shortage of controlled trials. This supports a multi-component prevention system rather than dependence on a single de-escalation technique, training package or room. [\[57\]](#)

A second systematic review, focused on reducing seclusion, identified 48 reports covering five broad approaches: hospital or unit restructuring, staff education and training, sensory-modulation rooms, structured risk assessment and management, and comprehensive multi-component programmes. The evidence was generally low-certainty, but the range is important: less restrictive care is not one substitute technique. It can involve physical redesign, open-door or recovery-oriented organisation, different staff-patient interactions, sensory resources, decision support and coordinated culture change. [\[96\]](#)

International guidance provides concrete examples showing that crisis support need not be conceptualised around force. WHO's 2021 technical package on mental-health crisis services presents services designed to support people in acute mental distress while respecting legal capacity and other human rights and without resorting to force or coercion. WHO QualityRights also maintains a dedicated training module entitled 'Strategies to end seclusion and restraint'. These sources do not validate one universal replacement technique; they support redesigning the service, relationship and crisis pathway rather than searching for a softer form of bodily control. [\[121\]](#) [\[122\]](#)

The World Psychiatric Association's position statement adds an important professional perspective. It describes coercion as including detention, treatment without consent, seclusion, physical or mechanical restraint and chemical restraint, including interventions undertaken in response to perceived harm to self or others. It recognises that coercive practices can cause trauma, re-traumatisation, physical injury and death, undermine therapeutic relationships and discourage future help-seeking. While acknowledging continuing professional disagreement about complete abolition, the WPA states that coercion is over-used and calls for implementation of viable alternatives, including Safewards, Six Core Strategies, open-door policies and WHO QualityRights, together with recovery-oriented and trauma-informed systems of care. This is therefore evidence that the move towards alternatives is not confined to survivor advocacy or treaty-body interpretation; it is also an explicit programme within international psychiatry. [\[139\]](#)

Randomised evidence also challenges the assumption that opening wards necessarily creates more danger. In a 2024 pragmatic randomised non-inferiority trial in Norway involving 556 admissions, 73-75% of them involuntary, open-door wards were non-inferior to treatment-as-usual wards for exposure to coercive measures. Coercion occurred in 26.5% of stays in open-door wards and 33.4% in treatment-as-usual wards; reported violence against staff was 0.15 versus 0.18 incidents per stay, and no suicides occurred during the trial period. The study does not establish that every ward can safely open its doors without adaptation, but it directly contradicts a blanket presumption that greater freedom must produce greater violence or coercion. [\[143\]](#)

Prevention can also begin before admission or the final crisis decision. A meta-analysis of five randomised trials found that crisis-planning interventions involving the person in planning future crisis care were associated with a 25% reduction in compulsory admissions compared with usual care. A separate 2024 systematic review of 140 studies on shared and supported decision-making found favourable evidence for improvement in several health and care outcomes and identified effects including hospital admission, treatment engagement, recovery and use of coercion. These findings do not make a written plan or shared-decision tool sufficient by itself; they support treating the person's knowledge,

preferences and advance planning as active safety resources rather than optional courtesies. [142] [146]

7.3. Outdoor access as a preventive resource

Liu and colleagues examined temporary loss of outdoor spaces in two psychiatric units. In the general adult unit, closure was associated with an increase of about 0.63 restraint-or-seclusion orders per day and increased [intramuscular as-needed medication](#) orders. The geriatric unit did not show the same significant increase in restrictive orders. The study was [retrospective](#), assessed orders rather than a complete measure of lived exposure, and cannot exclude other explanations. [25]

The finding supports evaluating space, movement and relief from ward pressures as components of prevention. Access to outdoors should be monitored as a practical condition of care, including what happens when that access is withdrawn. [25]

A Scottish implementation standard could require services to explain what happens when outdoor access is unavailable: why it is unavailable, for how long, what equivalent choice is offered, and whether distress or restrictive interventions increase. A temporary closure should generate a preventive plan, not simply a new rule patients must endure.

7.4. Sensory resources help only when they are usable and chosen

Haig and Hallett's [systematic review](#) examined 18 studies of sensory rooms in adult psychiatric inpatient settings. It found insufficient evidence to conclude that sensory rooms reliably reduce restraint, [seclusion](#) or violence, although there were indications of benefit for distress and emotional regulation. This distinction matters: an intervention may improve experience without yet having demonstrated a reduction in every restrictive outcome. [26]

Autistan recommends sensory options controlled as far as possible by the person, alongside organisational change. A brightly equipped room is not necessarily soothing; silence, fewer objects, daylight or a familiar item may be preferable. The availability of a room should not become a reason to neglect noise, crowding or intrusive interactions elsewhere in the service.

A comfort-room study provides a more concrete, though lower-certainty, environmental example. An acute inpatient unit introduced a room with comfortable furniture, soothing colours, soft lighting, quiet music and sensory aids and reported reductions in stress and restrictive use relative to its earlier practice and a comparison unit. Because this was not a definitive randomised trial, it should inform design choices rather than be treated as proof that one room configuration will work for everyone. [58]

Sensory-modulation rooms have also been described by service users and providers as supporting self-management, emotional regulation and empowerment, although these qualitative findings do not establish a reduction in restraint by themselves. In a 2023 quasi-randomised trial involving 60 psychiatric inpatients, both a physical calm room and a virtual-reality calm environment were associated with improved self-reported wellbeing and reduced heart rate, with no significant difference between the two conditions and limited statistical power. These findings support testing environments that offer controllable restorative input rather than assuming that control of the body is the only response to escalating distress. [97] [104]

7.5. Movement, arousal and individual regulation

The urge to move, protest or strike something can be understandable during intense distress. Understanding that impulse does not require claiming that breaking objects or increasing physical arousal will necessarily reduce anger. A [meta-analysis](#) by Kjaervik and Bushman, covering 154 studies and 10,189 participants, did not support a general anger-reduction benefit from arousal-increasing activities; arousal-reducing activities performed better overall. The research question was anger management, not the suppression of autistic [self-regulation](#). [27]

Safe movement should remain available according to individual function and preference. Walking, running in an appropriate setting, rhythmic movement, stretching or quiet rest may serve different purposes for different people, and their effects should be evaluated with the person.

7.6. Animals and other ordinary sources of comfort

A 2026 pilot randomised trial involving 60 psychiatric inpatients compared visits by a dog and handler, visits by the handler alone, and usual care, reporting benefits on some immediate mood and anxiety measures. It supports including wanted animal contact among ordinary sources of comfort and connection where appropriate. [28]

Autistan proposes considering animal contact, nature, meaningful activity, music or silence, physical exercise and familiar relationships within a broader prevention plan. These should be ordinary opportunities for a person to live and regain [agency](#), not simply new techniques for making them compliant. Participation must be wanted; allergies, fears, sensory preferences and animal welfare require consideration. An animal should never be placed in an unsafe situation as a substitute for adequate human support.

7.7. From hospital adaptation to support in ordinary life

Preventing restrictive practices also requires preventing avoidable admission and prolonged stays. Suitable housing, accessible crisis support, reliable personal assistance, chosen family or peer support and continuity across services are part of the preventive infrastructure described in rights-based international guidance. [37] [38]

Community support should be evaluated through actual control over daily decisions, the ability to change or refuse assistance, relationships, meaningful activity and freedom of movement. Restrictive routines can otherwise be reproduced outside hospital under a different service label.

Recent English trial evidence adds a contemporary community-based example. The 2026 ODESSI cluster-randomised trial found that Open Dialogue did not improve its primary outcome, time to first relapse, but was associated with lower probabilities of psychiatric inpatient admission and re-referral to crisis or secondary mental-health services, together with better self-rated recovery, health-related quality of life and service satisfaction; no significant safety concerns were identified. The result should not be converted into a claim that Open Dialogue is a proven universal substitute for hospital care, but it supports testing relational and network-based crisis responses as part of a broader strategy for reducing dependence on restrictive settings. [141]

The physical and social form of alternatives also deserves research. A 2024 systematic review of Soteria houses and peer respites - described collectively as 'Healing Houses' - screened 849 documents in English, German and Hebrew and included 45 documents from seven countries. It identified design characteristics including atmosphere, scale, outdoor space, accessibility and a home-like environment, alongside service characteristics such as consensual treatment, living and working together, support for personal meaning-making and attention to power. The review does not establish a single validated architectural formula, but it reinforces the case for studying crisis environments as whole living systems rather than merely adding a calming room inside an otherwise coercive institution. [\[144\]](#)

7.8. Current Scottish evidence: organisational restriction and weak traceability

Current Scottish oversight evidence makes organisational causation an immediate implementation issue. The Scottish Human Rights Commission reported in September 2026 that safeguards, data and independent review for restrictive practices in adult mental healthcare remain insufficient, and emphasised that restraint must never be used for staff convenience, staff shortages or as a substitute for proper care. [\[76\]](#)

The joint 2026 national overview of Scotland's four specialist child and adolescent inpatient mental health units identified inconsistent recording of both the number and details of restraints, requirements concerning staff restraint training, staffing shortfalls and the need for national standardisation of restrictive-practice data. [\[77\]](#)

On 28 October 2026 the Mental Welfare Commission for Scotland reported that routine daytime confinement at the State Hospital was arising directly from insufficient staffing and associated operational pressures rather than individual clinical risk, and called for urgent action to reduce and eliminate it. Together, these Scottish findings show how staffing, operational design, recording quality and independent oversight can determine whether restrictions arise, persist and remain visible. [\[78\]](#)

8. A practical prevention framework for Scottish services

8.1. Build a personal account of what helps and what harms

Autistan proposes an accessible support plan prepared with the person, not merely about them. It should identify environmental conditions they find difficult; forms of touch they do not want; ways they communicate increasing distress; movements and activities that help; preferred people; and options for distance, quiet, outdoors and meaningful occupation. It should also record what has previously made a situation worse.

The plan should remain available across shifts and transfers, without becoming a fixed behavioural script. A preference can change. A person should not be challenged for needing something different today. Where conventional speech becomes difficult, agreed alternatives may include writing, a device, gesture, pictures or a trusted interpreter of the person's communication.

The plan should also record known positional or physical vulnerabilities relevant to restrictive interventions: positions in which the person cannot breathe comfortably, known

sleep-apnoea or airway problems, swallowing difficulties, forms of touch or pressure that create danger, and the safest ways to offer water, medication or physical assessment. Such information should be available before a crisis rather than discovered while the person is immobilised. [\[18\]](#) [\[53\]](#) [\[54\]](#) [\[55\]](#)

[Advance statements](#) and other expressions of preference should be distinguished according to their legal status, but useful information should not be ignored simply because it does not meet a formal statutory format. Staff should explain how the person's preferences affect real decisions and record any departure with its specific reasons.

8.2. Change the interaction before demanding that the person change

At early signs of distress, staff should consider whether demands can be paused, contradictory instructions clarified, an audience reduced, unwanted contact avoided, and one suitable person allowed to communicate without crowding. The aim should be to remove avoidable pressure and offer understandable choices, not to obtain an immediate display of compliance.

Explanations should be concrete and truthful. Promising an option that will not actually be provided can destroy the usefulness of subsequent reassurance. Giving time to process language, allowing a written response and avoiding demands for eye contact can be practical accommodations rather than concessions to be earned.

Staff should remain available to manage concrete danger while testing whether their own proximity, demands or communication are increasing distress. Withdrawing a non-essential demand, changing the communicator or allowing distance can be active protective decisions.

Where safety permits, reduce the visible intervention footprint: one person communicates; other staff move back or out of the person's immediate field rather than forming a human barrier; exit routes and voluntary movement remain visibly available; and nobody touches or holds the person merely to stop shouting, pacing, sitting or lying on the floor, or other non-dangerous conduct. Backup staff may remain available at a distance. This balance is consistent with de-escalation guidance warning that crowding and increased staff presence can themselves escalate agitation, particularly in autism, developmental disability and trauma. [\[69\]](#) [\[70\]](#)

Distance must remain responsive rather than punitive or indifferent. A person who is overwhelmed may need fewer words and fewer people while still needing unmistakable confirmation that someone has heard them, will respond to a concrete request and will not abandon communication. A 2026 scoping review of autistic communication during distress identifies calm supportive environments, communication aids and reduced communicative demands as practical facilitators, and describes a bidirectional cycle in which communication difficulty or being misunderstood can further increase distress. [\[68\]](#)

WHO/Europe now describes one of the interpretive errors at issue here in unusually direct terms: staff may interpret a service user's frustration or stress as challenging or aggressive, often in the context of stigma, may not understand what the person needs when anxious or stressed, and may feel unable to grant requests for safety reasons. This closely matches the sequence that a causal review should test in autistic care: distress or irritation, observer

interpretation, invocation of safety, and then restriction. Each transition must remain open to correction. [\[120\]](#)

8.3. Dedicated crisis regulation and expression room instead of restraint

The central proposal in this section is a dedicated single-person room available during an acute crisis specifically as an alternative to physical or mechanical restraint. General principles about movement, choice and sensory regulation below are prerequisites for that proposal, not substitutes for it.

Services should identify spaces where a person can walk, pace, make repetitive movements, vocalise or take time alone without encountering avoidable hazards or unwanted confrontation. Access should be based on individual need and specific risks, not a blanket expectation of conventional stillness. Where possible, routes outdoors and appropriately supported physical activity should be part of everyday provision.

Here, safe means a proportionate assessment of actual hazards with modifications that preserve as much freedom as possible. Removing hazards, creating distance and supporting an activity can be less restrictive than stopping the activity itself.

The person's own choice is central. Do not turn running, breathing exercises, a sensory object or a quiet room into a compulsory intervention. A person who wants movement should not automatically be ordered to remain still; a person who needs stillness should not be required to exercise. An option that is unavailable at the relevant time is not an alternative that has been tried and failed.

For some people, the least restrictive option may be a voluntary low-hazard movement space: enough room to pace, rock, jump or use large soft equipment; impact-reducing surfaces where useful; removal of avoidable hard hazards; a genuine ability to leave; and immediate access to help. Choice, exit freedom and the person's control over movement and sensory conditions are defining features of the space.

Providers should maintain several usable options at the time of need: outdoor walking or running where individually safe, pacing routes, a quiet or low-stimulation space, a voluntary movement or soft-equipment space, familiar objects, chosen music or silence, contact with a trusted person or peer, and meaningful activity. For review and accountability, availability should be recorded at the moment of need, including whether the option was accessible on that shift and whether staffing, permission rules or environmental conditions prevented its use. An option that is unavailable at the relevant moment is not an alternative that has been tried and failed. [\[25\]](#) [\[26\]](#) [\[57\]](#) [\[58\]](#)

A further research and design hypothesis is a voluntary regulation and expression environment: a protected space in which a person can express distress through movement, voice or withdrawal without being physically compressed, while also having immediate access to restorative sensory and relational options. It would differ from seclusion because the person would retain a genuine ability to leave and to request or refuse contact; prevention of departure would place the intervention back within the legal and human-rights framework for seclusion. It would also extend the usual comfort-room concept by accommodating active regulation as well as quiet relaxation. [\[58\]](#) [\[80\]](#) [\[96\]](#)

The proposal should be understood as a dedicated crisis-use room - provisionally described by Autistan in French as a 'salle d'extériorisation' - not as shorthand for general ward restructuring, open-door policy, staff training or an ordinary sensory room. It is intended as a direct practical alternative at the decision point when staff would otherwise consider bodily restraint. The design question is whether a crisis can be contained by controlling hazards in the environment while leaving the person's body substantially free. Its working principle is the opposite of compression: allow the person to externalise distress through voice, movement, posture and chosen sensory activity while preventing foreseeable injury. [\[18\]](#) [\[96\]](#) [\[108\]](#) [\[109\]](#)

The room should normally be used by one person at a time during the crisis, apart from a supporter or professional whose presence is wanted or concretely required for safety. Other patients should not be placed in the same crisis space. The person should ideally know the room before any crisis and be able to request it themselves; during escalation, access should be direct and simple, avoiding a procession of staff, crowding, unnecessary touch or a struggle simply to reach the alternative. If force is required to put the person into the room, that force requires its own justification and may defeat the purpose of the model. [\[18\]](#) [\[69\]](#) [\[70\]](#)

The following safeguards define the voluntary version. The room is not a renamed seclusion cell. The person must retain a genuine practical ability to leave. If staff lock the door, physically block departure or communicate a credible prohibition on leaving, the situation must be recognised and governed as seclusion rather than described as voluntary regulation. Where protection of other patients is a concern, the architectural response can include a temporarily cleared approach route, a buffer or observation area and, where feasible, direct access to a private protected outdoor extension, rather than converting bodily freedom into confinement. [\[80\]](#)

French independent monitoring provides a concrete warning against relabelling. The CGLPL reports that some spaces described as calming rooms are in reality renamed isolation rooms, sometimes with the door left open. The name, decoration or therapeutic intention of a room cannot determine its classification: the decisive question is whether the person remains genuinely free to leave. A Scottish alternative must therefore be designed against relabelling from the outset. [\[111\]](#)

Exit freedom defines the voluntary version of the regulation-and-expression environment. A second, legally distinct crisis-containment variant should also be studied for situations in which an immediate serious danger remains and the applicable legal threshold for preventing departure is met. Immediate unrestricted departure may, in some cases, return the person directly to the sensory, interpersonal or institutional conditions that precipitated or aggravated the crisis, recreate the specific danger, and lead back to the very bodily intervention the room is intended to avoid. Conceptually, the design question can arise where danger concerns the person or others; legally, however, the room creates no new authority to deprive a person of liberty. The current draft is internally inconsistent: its definition of seclusion refers to severe behavioural disturbance likely to cause harm to others, while its later lawful-limits section refers to an immediate and significant risk of harm to the patient or others. That inconsistency must be resolved separately and must not be widened by implication. If departure is prevented, the intervention must be expressly classified and governed as seclusion and, where applicable, as a deprivation of liberty under

the existing legal and human-rights framework. Under the current draft, seclusion should ordinarily be used only for patients detained under the Act; if an emergency involving a voluntary patient leads to seclusion, an immediate assessment of whether detention is necessary and appropriate is contemplated. The research question is whether, within those lawful limits, environmental containment can replace bodily immobilisation while preserving substantially more freedom, agency and psychological integrity. [\[80\]](#) [\[2\]](#)

In this second variant, freedom cannot be reduced to immediate access to the final exit. The objective is to preserve the maximum possible freedom of the body, movement, expression and choice within an environment engineered so that those freedoms remain compatible with immediate safety. Instead of holding the person down, tying them, surrounding them physically or requiring stillness, the environment should allow them to choose moment by moment among different regulation routes: walking or running, repetitive movement, vocalising, using large soft objects, deliberately landing onto mats or cushions, resting, curling up in a protected comfortable area, viewing selected images or audiovisual material, remaining in silence, listening to chosen music, using warm water where safely designed, seeking wanted contact with a trusted person, or, where risk permits and an established programme protects both the person and the animal, contact with a familiar or suitable animal through an appropriately protected or later-stage arrangement. The room should remove or protect, as far as engineering reasonably permits, breakable, sharp, detachable, ligature-forming or otherwise dangerous objects while avoiding an austere punitive atmosphere.

A further design hypothesis is progressive release. Exit need not be conceptualised only as a binary opposition between a locked door and complete return to the ordinary ward. Where temporary prevention of departure remains justified by a specific immediate danger, the environment could provide successive degrees of restored freedom as that danger diminishes: use of the main protected room; access to an adjoining buffer or transition space; contact with a chosen person; access to a protected garden or outdoor extension; and finally unrestricted return to the ordinary environment. The sequence should be individualised and capable of moving more quickly, more slowly or directly to full release according to the actual risk.

The release criterion must not be 'calm behaviour' in a conventional social sense. A person may still pace rapidly, rock, flap, vocalise, cry, express anger, refuse to speak, avoid eye contact or reject the institution's interpretation while no longer presenting the serious immediate danger that justified preventing departure. Requiring quietness, obedience, apology, eye contact, verbal reassurance or an appearance of normality would reproduce precisely the normocentric error this study criticises. The relevant question is whether the concrete danger has sufficiently diminished. Evidence of concrete risk and the person's outward style of expression must remain separate variables.

The progression could be made perceptible without requiring complex verbal reasoning during overload. Research could test visual, luminous, mechanical or spatial indications that the possibility of wider exit is approaching: for example a stable change in lighting, the progressive appearance of a simple visual signal, opening of access to an intermediate zone, a clearly visible change in a door or partition system, or another immediately intelligible architectural cue. The aim would be to reduce arbitrary uncertainty. Even when a human professional retains legal responsibility for the decision, the person should be able to

perceive that the situation is moving through a predictable process linked to the disappearance of the specific danger rather than to an unknowable change in staff mood or to submission to interpersonal authority.

Partially automated support for such a progression could be researched, but only with stringent safeguards. Automation must not become behavioural conditioning, a reward system for appearing compliant, or a mechanism that teaches people to mask distress in order to obtain release. Any machine-assisted indicator or transition should use safety-related inputs that are as objective, transparent and auditable as practicable; criteria should be explained in advance where this is possible and accessible; uncertainty should favour human review rather than automatic prolongation; and a competent person must remain able to override the system promptly when it is wrong, when the person's condition changes or when an exceptional circumstance requires a different response. No automated system should independently decide to initiate or prolong prevention of departure or otherwise determine a deprivation of liberty. No algorithm should be authorised to convert unusual autistic expression into a proxy for dangerousness.

The model should therefore be evaluated against both ordinary seclusion and bodily restraint, rather than assumed to be benign because the room is better designed. Relevant outcomes include injuries, duration of prevented departure, fear, experienced coercion, perceived predictability, bodily freedom, use of self-regulation, need for medication, staff and patient safety, later trust, and whether people learn to conceal distress to obtain release. The possibility of a less traumatising form of temporary environmental containment does not remove the obligation to prevent crises upstream or the wider objective of eliminating coercion. Studying this variant is a transitional harm-reduction question, not an endorsement of seclusion as a final model and not a retreat from Autistan's objective of eliminating enforced seclusion. Its purpose is narrower: where a real immediate danger has nevertheless arisen, test whether safety can be maintained with far less invasion of the body and far more retained agency.

This proposal is a design and research hypothesis, not a validated model. It should be co-designed and tested with people who have experienced restraint or seclusion, autistic people with diverse communication and support needs, human-rights specialists, architects, ergonomists, safety engineers, clinicians, occupational therapists and frontline staff. Particular attention should be paid to people who communicate danger or distress non-verbally and to the possibility that institutional observers may misread autistic movement or expression. Any application to children would require a separate child-specific legal and ethical assessment and the heightened protections described in section 10.1; adult-oriented design assumptions should not simply be transferred to children. The objective is not to create a more attractive form of confinement. It is to replace bodily compression wherever possible with an environment that preserves the greatest practicable amount of movement, choice, expression and self-regulation while a genuinely immediate danger is managed for the shortest necessary period.

The active part of the room should be designed around large-body movement. Possible elements for research include continuous impact-attenuating flooring; wall areas designed to reduce injury from accidental impact; large soft mats or mattresses covering substantial parts of the active zone; crash pads; robust soft modules; rocking or swinging equipment where safely engineered; therapy or fit balls; and enough unobstructed floor area for pacing,

running, repetitive movement, rocking, jumping and vocalisation. A low-risk rebound or trampoline-type element could be evaluated if it can be engineered so that falls, entrapment, structural failure and misuse are acceptably controlled. A padded striking target or bag could likewise be tested for people who specifically find it regulating, provided it cannot become a weapon or create injury; it should never be justified by a general theory that aggressive catharsis is inherently therapeutic. [\[27\]](#) [\[57\]](#) [\[96\]](#) [\[108\]](#)

A separate restorative or contemplative part should permit the person to change direction completely without leaving the protected environment. It could include comfortable sitting and lying positions, beanbags or similarly safe furniture, dimness or darkness, soft or dynamic lighting, silence or chosen music, and a protected large display or projection system showing content selected by the person - for example forests, ocean, animals, stars, galaxies, familiar places, films, visual patterns, astronomy imagery or virtual environments. A Dutch GGzE/Philips prototype has already demonstrated several related design elements in a high-care psychiatric setting: round-cornered support rooms, floor zoning, dynamic coloured light, nature audiovisual themes and an interactive wall giving the patient control over environmental settings and communication. [\[97\]](#) [\[107\]](#)

The room can therefore contain several distinct regulation routes rather than imposing one definition of calm. One person may need intense movement; another may need to lie still; the same person may move from running or jumping to darkness and music, then to a film or conversation. The environment should support that transition without requiring staff to decide in advance which state is acceptable. Existing reviews of alternative rooms describe sensory, multisensory, Snoezelen and comfort-room approaches and report potential benefits for distress, anxiety, self-management, communication and physiological arousal, while also showing that evidence on restraint and seclusion outcomes remains limited. [\[26\]](#) [\[96\]](#) [\[108\]](#)

Visual, auditory, tactile, thermal and olfactory options should be individually controllable. Coloured lights, protected light strips or garland-like lighting, projectors, interactive displays, tactile materials, weighted or pressure-based items, music, room temperature and scents may be soothing for one person and intolerable for another. Scent should therefore be optional, rapidly removable and screened for allergy, asthma, migraine and sensory aversion; flashing or rapidly changing visual effects require particular caution for people with photosensitivity, epilepsy or visual overload. Loose cords or decorative garlands should not create ligature or entrapment hazards. The person should control brightness, colour, sound level, temperature and content as far as practicable, with staff override reserved for a concrete safety reason rather than routine authority. [\[67\]](#) [\[71\]](#) [\[72\]](#) [\[104\]](#) [\[107\]](#)

A warm-water option can also be studied, including a purpose-built shower or other simple water-based sensory facility for people who find warmth and water regulating. It would require thermostatic anti-scald limits, slip-resistant and impact-conscious surfaces, protected drainage and fixtures, no ligature or entrapment points, no deep water, rapid shut-off and a monitoring arrangement that preserves dignity while allowing a response to collapse, respiratory difficulty or other danger. This is a design hypothesis rather than an established psychiatric treatment, and the person should never be forced to use it. [\[103\]](#)

The natural version of the same concept could include a directly connected protected outdoor area with grass, daylight, open air and enough room for walking or running. The point

is not decoration but usable freedom: a person in crisis may need physical distance, horizon, air and movement rather than a smaller and more artificial enclosure. Outdoor evidence is still limited, and the Italian no-restraint study cautions against treating any single architectural feature as sufficient; environment, staffing, culture and the way the space is actually used must be evaluated together. Temporary loss of outdoor space has nevertheless been associated with increased restrictive orders in one adult psychiatric unit, supporting direct evaluation of this component. [\[25\]](#) [\[98\]](#)

Animal contact can be designed as another optional route rather than an event improvised during danger. For a person known to benefit from animals, the programme could include specially selected, calm and appropriately trained dogs or other suitable animals with an experienced handler. Contact should be a freely chosen relationship offering connection and comfort, not an intervention imposed on either the person or the animal. It should occur through a protected arrangement giving the animal an immediate independent escape route; the animal must never be trapped with a distressed person or used where there is an uncontrolled risk of injury. The 2026 inpatient pilot trial supports possible short-term effects on mood and anxiety and justifies further study of this component. [\[28\]](#)

Observation should be deliberately non-invasive. The default could be one calm, familiar professional or supporter nearby, outside the person's immediate physical space, with other staff out of sight but available if a concrete danger develops. An observation window, two-way communication system or camera may reduce the need for staff to stand inside the room; camera use must be lawful, proportionate, privacy-sensitive and transparent, and it cannot replace the person's ability to summon immediate human assistance. The objective is security without the sensation of being surrounded. [\[18\]](#) [\[58\]](#)

Safety engineering should be treated as a design problem rather than as an automatic argument for tying the person down. The brief should seek to eliminate foreseeable injury pathways: sharp or hard projections, exposed ligature or entrapment points, breakable glass, detachable heavy objects, unsafe cords, hazardous fixtures, unprotected screens, uncontrolled hot water, dangerous falls, excessive acoustic load and inaccessible emergency assistance. Impact-attenuating walls or panels can be used where justified without turning the whole environment into an austere padded cell. Fire safety, ventilation, hygiene, cleaning, infection control and emergency access also require explicit engineering review. The room should be co-designed with autistic people and other survivors together with clinicians, occupational therapists, estates specialists and safety engineers. Absolute zero risk cannot be promised in any human environment, but residual risk should be measured and compared with the known physical and psychological risks created by restraint itself. [\[18\]](#) [\[51\]](#) [\[52\]](#) [\[103\]](#)

The idea of externalisation also has a limited precedent in existing psychosocial practice. The Australian Management of Acute Arousal Program placed 'ventilation' early in its intervention sequence, giving patients an opportunity to express fears, frustration, anger, anxiety and triggers before more restrictive steps. That programme did not reduce seclusion overall, so it is not evidence that expression alone resolves crisis; it does show that allowing expression rather than immediately suppressing it is already a recognised clinical concept. [\[96\]](#) [\[109\]](#)

Autistan proposes a restorative-counterweight hypothesis: when distress has been produced or amplified by socio-generated impingements, the appropriate counter-direction is to

restore what the crisis and the coercive response remove - comfort, pleasurable sensory experience chosen by the person, beauty, absorbing attention, warmth, nature, wanted social connection, bodily freedom and the capacity to act. These positive experiences may help refill or reactivate agency and vitality precisely because coercion compresses them. The dedicated room should therefore be designed not only to prevent injury but to offer genuinely attractive and comforting possibilities capable of competing with the sensory and psychological burden of the crisis. Existing calm-room, sensory-modulation and restraint-reduction studies provide partial support for components; the complete model should be co-designed and tested as a research programme rather than presented as an already established treatment. Research should test whether this combination can make bodily restraint unnecessary in episodes where restraint would otherwise have been used. [\[25\]](#) [\[28\]](#) [\[46\]](#) [\[97\]](#) [\[104\]](#) [\[107\]](#) [\[108\]](#)

Capital costs may be higher than purchasing straps or maintaining an empty seclusion room, but that comparison is incomplete. Economic evaluation should include the staff time consumed by restraint, injuries, sickness absence, medication and monitoring, damage, investigation, litigation, prolonged admission, trauma, loss of trust and future avoidance of care. Restraint-reduction programmes have reported substantial reductions in both restrictive events and associated operational costs, so the dedicated room should be assessed through whole-system cost and benefit rather than construction cost alone. [\[99\]](#)

8.4. Respond to immediate danger without losing the wider causal question

Urgent action may be required to prevent serious injury. It should be based on a concrete danger, continuously reassessed, carried out with the least additional harm, and ended at the earliest lawful point at which the specific danger no longer requires it.

The existence of an emergency does not retrospectively justify avoidable conditions that contributed to it. Two questions must therefore be answered separately: was the particular action defensible at that moment, and could the service reasonably have prevented that moment from arising? A finding that staff faced immediate danger does not close the second inquiry.

Similarly, continued anger, unusual movement or refusal to agree with staff should not automatically extend an intervention once the specific danger has ended. Ending an emergency restriction should not require the person to forgive the intervention or to accept the institution's explanation.

Operationally, the threshold should not be that the behaviour disturbs the ward, the public or the appearance of order. The record should identify the specific injury risk. Where conduct is noisy, unconventional or socially inconvenient but not dangerous, tolerance, space, discreet observation, removal of environmental stressors and a continuing communication channel may be less restrictive and safer than physical control. The purpose of crisis response is not to make the scene look normal; it is to reduce danger and suffering. [\[69\]](#) [\[70\]](#)

The same separation applies when the person is visibly irritated or even behaving aggressively. Irritation, anger and aggressive expression can be clinically and relationally important without necessarily amounting to an immediate danger. Restriction should

therefore be justified by the specific risk of serious harm, not by the emotional intensity of the person or by the mere use of an aggression label.

Precaution does not suspend the requirement for a factual threshold. Where emergency restriction is proposed because harm is predicted rather than already occurring, the service should state what concrete harmful event is feared, why the current facts make that danger sufficiently serious and immediate under the applicable test, and why less restrictive measures cannot manage it. Uncertainty must not be converted automatically into permission to deprive liberty, and the threshold must not be lowered for administrative convenience, public appearance, staff discomfort or defensive fear of criticism if an unlikely event later occurs.

For operational purposes, staff should distinguish four different propositions: the person appears irritated or angry; the person appears aggressive to an observer; an aggressive act has actually occurred; and there is a current serious danger. The first two are perceptions, the third is an event and the fourth is a risk conclusion. None should automatically populate the next. Where the language of 'aggression' or 'danger' is used, the record should make clear which level is actually being described.

Proportionality remains necessary even when an aggressive act is real. A brief push, a slap, damage to an object or a limited self-directed act can be unacceptable or require immediate protection without establishing a continuing serious danger or justifying prolonged coercion. Once the specific danger has ended, the emergency justification ends with it. The person's later irritation, protest or anger at what happened must not be treated as proof that the danger continues.

Stopping visible movement is not the same as calming a person. Coercive force can suppress an outward action while leaving irritation, panic, humiliation or perceived injustice unchanged or intensified. Where the problem is overload, fear or distress, an adapted response should reduce the sources of that state and preserve as much control as safety allows. Physical domination should not be recorded as successful de-escalation merely because the person has become unable or unwilling to continue moving.

European human-rights case-law supplies concrete examples of why the threshold cannot be replaced by precautionary language. In *Bures v Czech Republic*, the Court held that mere restlessness could not justify strapping a person to a bed and noted that no calming alternatives had been tried before routine restraint. In *Lavorghna v Italy*, the Court accepted the initial need for restraint but held that its continuation for almost eight days was not shown to be strictly necessary; it expressly stated that a merely 'potential' danger would not suffice and noted the Italian Court of Cassation's rejection of precautionary restraint. [\[123\]](#) [\[124\]](#)

M.S. v Croatia (No. 2) adds a different warning. The applicant was physically restrained for about fifteen hours; the Court treated the experience as capable of great distress and suffering, found Article 3 violations, and examined both the necessity of restraint and failures of practical protection. Her complaints were met by an unsupportive and passive response and were perceived as uncooperativeness, while her appointed legal representative had not effectively protected her interests. Formal safeguards therefore cannot be assumed to work merely because they exist on paper. [\[125\]](#)

The precautionary comparison must consequently be symmetrical. Decision-makers should ask both: 'What concrete harm is sufficiently likely and immediate if we do not impose this restriction?' and 'What physical, psychological, traumatic and rights-related harm may this restriction itself cause?' A low-evidence prediction on one side cannot rationally be balanced against an imaginary zero-risk intervention on the other. [123] [124] [128] [129] [130]

8.5. Recovery, not interrogation

Immediately afterwards, the person may need physical assessment, rest, privacy, a trusted supporter, food, water, familiar objects or the ability to move. Autistan recommends offering these according to need and preference, rather than making them conditional on participation in a [debrief](#).

The person's account should be invited at a time and through a method they can use. A delayed written account, an audio recording or [supported communication](#) can be as important as an immediate conversation. A person should be able to decline a conversation with the staff involved and speak to someone independent.

A 2026 realist synthesis of post-incident responses found that timing and readiness, relational repair, mutual learning and accountability, and team culture shape whether post-incident work is useful. Readiness for immediate support can differ from readiness for reflection; fixed debrief timing can undermine recovery and learning when it disregards emotional and physiological readiness. [79]

An incident review should result in an identifiable change, a responsible decision-maker and a date for checking whether the change occurred. Asking a person to describe a traumatic experience repeatedly while nothing changes is not an adequate learning process.

9. Survivor knowledge, international human rights and remedies

9.1. Survivor organisations are sources of analysis, not only illustrative stories

The [World Network of Users and Survivors of Psychiatry \(WNUSP\)](#), in its Human Rights Position Paper, places refusal of psychiatric interventions, autonomy, freedom from imposed restraint and the development of chosen support at the centre of its position. This is a survivor-led organisational stance, not an evaluation of one hospital programme. It challenges a starting assumption that the only policy choice is how to regulate [coercion](#) more carefully. [31]

The [European Network of \(Ex-\)Users and Survivors of Psychiatry \(ENUSP\)](#), in its account of its 2015 alternative report to the [CRPD Committee](#), explains that it drew on a member survey and analysis of the European Union's responsibilities. Its stated approach gives value to the knowledge of people who have experienced crisis and emphasises support respectful of autonomy and dignity. This is a direct reason to include survivor organisations in setting questions and evaluating services, rather than asking them only to comment on a completed professional framework. [32]

The French [Collectif Arrêt des traitements forcés](#) likewise frames the problem through rights, [coercion](#) and the experience of people who have undergone forced intervention. Its contribution should be considered as civil-society evidence and argument; submission to a [treaty body](#) does not convert every allegation into a [UN](#) finding. [\[33\]](#)

Autistic Minority International (AMI) has addressed restraint and seclusion directly as an autistic human-rights issue. On 4 April 2016 it organised a thematic briefing for members of the CRPD Committee on autistic behaviours and the use of physical and mechanical restraints and seclusion in schools, arguing that such practices were being used to manage behaviour and enforce discipline or compliance and could expose autistic children to abuse, degradation and severe harm. Later that year the Committee's General Comment No. 4 expressly identified restraints and seclusion among forms of violence and humiliating punishment affecting disabled learners. AMI's account documents the autistic advocacy intervention; the General Comment is the Committee's authoritative text. [\[82\]](#) [\[83\]](#)

AMI also reports that it provided input to the 2015 joint statement by the UN Special Rapporteurs on the right to health and on the rights of persons with disabilities. The official statement addressed autistic children and adults subjected to psychiatric placement and physical or chemical restraint, warning that these practices can deteriorate a person's condition and all too often amount to ill-treatment or torture. The episode is significant because an autistic organisation was contributing directly to the international human-rights framing of coercion, rather than being consulted only after professional policy had been formulated. [\[84\]](#) [\[85\]](#)

Autistan proposes paid, accessible participation by autistic survivors in research priorities, training, service design and oversight. People who cannot or do not wish to provide a public personal narrative must still be able to contribute. Participation should not depend on endorsing the service's philosophy or recounting traumatic details in front of strangers.

9.2. Current Scottish and United Kingdom human-rights safeguards

The Scottish Human Rights Commission's September 2026 briefing concludes that Scotland lacks sufficient safeguards to prevent, monitor and remedy excessive restrictive practices in adult mental healthcare. It calls for an investigation of scope and scale, specific legislative safeguards including mandatory and independent review, and stronger enforcement capacity for the Mental Welfare Commission. [\[76\]](#)

The [CRPD Committee](#)'s 2017 observations on the United Kingdom expressed concern about physical, mechanical and [chemical restraint](#), segregation and [seclusion](#) across settings. Paragraph 37 recommended measures to eradicate restraint for reasons related to disability and to prevent segregation or isolation that may amount to torture or inhuman or degrading treatment. The Committee also highlighted disproportionate effects on disabled people from ethnic minorities. These recommendations are directly relevant to a Scottish policy review, although they are not themselves a replacement for domestic legislation. [\[34\]](#)

Autistan recommends that the Government explain how the revised Code and its wider reform programme respond to this rights-based direction. An aspiration to reduce incidents is not a complete response unless there is also a plan to address the legal, environmental and service conditions that maintain [coercion](#).

The anti-torture concern predates the 2013 report. In 2008 Special Rapporteur Manfred Nowak reported that prolonged restraint can cause severe physical harm and exacerbate psychological damage, that prolonged restraint lacks therapeutic justification and may amount to torture or ill-treatment, and that prolonged seclusion may also reach that threshold. [\[81\]](#)

The UN Special Rapporteur on torture's 2013 report on health-care settings took a more categorical anti-coercion position. It called for an absolute ban on forced and non-consensual medical interventions against persons with disabilities, expressly including restraint and solitary confinement, and analysed circumstances in which restraint or seclusion may amount to torture or other ill-treatment. This is the Special Rapporteur's interpretive recommendation; it is not a judicial finding that every restraint in Scotland is torture. [\[45\]](#)

A second Special Rapporteur report, A/HRC/43/49 (2020), is particularly useful for understanding internal psychological suffering. It describes powerlessness as loss of the effective capacity to resist or escape and examines domination and submission, dependency, humiliation, sensory manipulation and isolation as attacks on core psychological needs. These concepts help make visible what a purely technical record of straps, holds or minutes can miss. [\[46\]](#)

A 2017 report of the UN High Commissioner for Human Rights on mental health placed the same issue within a broader rights-based analysis: forced treatment, solitary confinement, restraint, forced medication and overmedication in mental-health institutions violate free and informed consent, constitute ill-treatment and may amount to torture; it also records the CRPD Committee's calls to eliminate seclusion and physical and pharmacological restraint. [\[90\]](#)

The CRPD Committee's Article 14 guidelines make the danger justification itself a human-rights issue. The Committee states that detention linked to disability on the basis of the 'perceived danger' a person is alleged to pose to themselves or others is contrary to Article 14, and observes that people with intellectual or psychosocial impairments are frequently considered dangerous when they refuse or resist treatment. In the same guidelines, it calls for elimination of forced treatment, seclusion and physical, chemical and mechanical restraints and regards those practices as inconsistent with the Article 15 prohibition of torture or cruel, inhuman or degrading treatment or punishment. This is a strong treaty-body interpretation and should be attributed as such rather than presented as though every domestic court has adopted the same legal test. [\[119\]](#)

WHO/Europe's 2025 position is similarly abolition-oriented: it describes restraint and seclusion as non-therapeutic human-rights violations, identifies severe injury, death, trauma, impaired recovery and mistrust among the consequences, and states that countries should set ending all coercive measures as the goal rather than normalising them as a standing 'last resort'. [\[120\]](#)

9.3. Comparative findings on autism, forced treatment and institutional power

In its observations on France in 2021, the [CRPD Committee](#) expressly addressed isolation and chemical or [mechanical restraint](#) affecting children and autistic people. It also raised

concerns about forced interventions and treatments seeking to make autistic children non-autistic. The relevance is not that all services or interventions are identical, but that integrity, autonomy and protection from [normalisation](#) are human rights questions, not solely clinical preferences. [\[35\]](#)

On 1 October 2026 the CRPD Committee published CRPD/C/8, Guidelines on identifying and addressing disability-based violence, in an advance unedited version. It is the Committee's newest dedicated guidance on disability-based violence and post-dates most of the treaty-body material cited above. The Scottish Government's final rights review should therefore check the revised Code expressly against CRPD/C/8. This study does not infer from the document's title alone that every restrictive act has an identical legal classification. [\[48\]](#)

Power should also be examined as a relational and institutional variable. A Belgian qualitative study with former psychiatric patients described coercion as a process of de-subjection and found that power was experienced through interactions and non-interactions, broken contact, silence during coercive acts and pressure to conform. A 2025 meta-ethnography independently identified abuse of power as one of four overarching constructs in service-user accounts of restrictive practices. These studies do not prove a conscious desire to dominate in any particular professional; they do show that the structure and experience of power are legitimate objects of analysis. [\[131\]](#) [\[132\]](#)

This distinction matters when considering motives such as convenience, desire for control, fear, frustration or the psychological relief staff may experience when visible disorder stops. A rights-based review need not prove sadism or conscious enjoyment of domination in order to examine whether an asymmetrical system rewards silence, immobility and compliance, whether authority goes effectively unchecked, or whether professional interpretations become self-validating because the patient has little practical means to contest them. The relevant evidence is organisational pattern, decision process and consequence, not speculation about an individual's private mind. [\[46\]](#) [\[106\]](#) [\[127\]](#) [\[131\]](#) [\[132\]](#)

A wider human-rights comparison shows how far restraint can extend when power is effectively unchecked. Human Rights Watch documented shackling of people with real or perceived psychosocial disabilities in about 60 countries, including chains, ropes, cuffs and confinement in locked rooms, sheds or cages, sometimes for months or years. The report links the practice to stigma, lack of support, fear that a person may run away or harm themselves or others, and weak monitoring, and describes physical and psychological consequences including post-traumatic stress, nerve damage and muscular atrophy. These extreme practices are not factually equivalent to every episode of regulated hospital restraint in Scotland; their relevance is to expose the endpoint of a logic in which perceived danger, convenience and lack of alternatives can normalise severe restriction when independent safeguards are weak. [\[140\]](#)

The Committee's observations on Spain in 2019 criticised the wrongful justification of forced institutionalisation and [mechanical restraint](#) as therapeutic, and called for the elimination of disability-related restraint and respect for free and informed consent. Its 2022 observations on Japan addressed forced treatment, [seclusion](#), physical and [chemical restraint](#), independent monitoring and remedies. These country-specific observations illustrate the Committee's approach; they do not prove what happened in any Scottish incident. [\[39\]](#) [\[40\]](#)

The [Committee against Torture](#)'s 2025 observations on France are also pertinent. They address non-consensual treatment and prolonged restrictive practices, including concerns involving autistic children. The recommendations combine reform, monitoring, non-[coercive](#) interventions, investigation and redress with strict conditions for last-resort measures and an objective of eventual discontinuation. This wording is not identical to the [CRPD Committee](#)'s approach, and the distinction should remain explicit. [\[36\]](#)

9.4. Elimination, present safeguards and legal precision

The joint [WHO/OHCHR](#) guidance of 2023 recommends a transition away from [coercion](#) towards rights-based legislation and services. The [CRPD Committee](#)'s 2022 [deinstitutionalisation](#) guidelines similarly reject disability-based institutionalisation and emphasise community inclusion, choice, access to justice and support under the person's control. These are substantive reform directions, not evidence that simply closing a ward without support will protect people. [\[37\]](#) [\[38\]](#)

Autistan supports making elimination of avoidable [coercive](#) practices a concrete objective, while ensuring that immediate safeguards are not postponed until wider reform is complete. The two tasks should proceed together: protect people now, and change the conditions that repeatedly produce [coercion](#).

Autistan's policy position goes further than progressively improving the regulation of these practices. Restraint and enforced seclusion, when used as coercive psychiatric crisis-management practices, should be prohibited and replaced by non-coercive responses. The existence of present legal safeguards does not make coercion an acceptable final model of care; those safeguards remain necessary during transition precisely because people must not be left less protected while services are being transformed. [\[37\]](#) [\[38\]](#) [\[45\]](#) [\[90\]](#)

Elimination requires creativity rather than a search for a single substitute technique. The principal work begins upstream: identify and remove sensory overload, humiliation, incomprehensible or contradictory demands, unwanted proximity, communication barriers, boredom, loss of control, lack of movement, lack of privacy and other avoidable conditions before distress becomes a crisis. Alternatives can include trusted human presence, peer support, accessible communication, quiet or open space, freedom of movement, outdoor access, nature, wanted contact with animals, meaningful activity, music or silence, warm water, familiar objects, voluntary crisis spaces, community crisis support and ordinary living environments in which the person retains substantially more control. The relevant question is not how to reproduce restraint in a softer form, but how to make the situation that seemed to require restraint cease to arise. [\[25\]](#) [\[28\]](#) [\[37\]](#) [\[38\]](#) [\[58\]](#) [\[97\]](#) [\[104\]](#)

For the same reason, hospital admission should not be treated as an automatically neutral or therapeutic environment. For a person already experiencing distress, fear, overload or loss of control, an institutional setting can itself add isolation, sensory burden, dependency, unfamiliarity and loss of ordinary sources of comfort. Rights-based reform should therefore expand humane non-hospital and community options wherever the person's clinical and practical situation allows, rather than assuming that distress is best answered by progressively more restrictive environments. [\[30\]](#) [\[37\]](#) [\[38\]](#)

The legal descriptions must remain precise. Treaties, [treaty-body](#) interpretations, country observations, national guidance and individual court findings are not interchangeable. A

restraint may engage rights to liberty, dignity, integrity and protection against ill-treatment; calling it medical does not exempt it from scrutiny. At the same time, a legal finding that a particular act constitutes torture requires assessment under the applicable framework and facts. The study does not assert that every restrictive act has already been judicially classified as torture.

The UN Subcommittee on Prevention of Torture has separately addressed people institutionalised and medically treated without informed consent. CAT/OP/27/2 records that the Subcommittee encountered people involuntarily restrained by mechanical or chemical means in health-care settings and frames its guidance as part of the preventive obligation against torture and cruel, inhuman or degrading treatment. Its preventive mandate makes it directly relevant to monitoring and inspection systems. [63]

European standards provide a distinct present-safeguard route. The CPT's revised 2017 standards state that restraint is a security measure with no therapeutic justification, should be a last resort for imminent harm and used for the shortest possible time, and should never be used for punishment, staff convenience, staffing shortages or as a substitute for proper care. In *Makki v Denmark*, final in June 2026, the European Court of Human Rights reiterated ultimate necessity, proportionality, demonstrated failure of reasonable alternatives, strictly necessary duration, close supervision and proper recording; it found an Article 3 violation in relation to prolonged restraint. [61] [62]

9.5. Recognition, independent complaint and reparation

An account of harm should not disappear into a clinical record that only the institution controls. Autistan recommends accessible information, [independent advocacy](#), assistance obtaining records, preservation of the person's own account, and routes to investigation which do not require permission from the team complained about. A complaint should not be reframed automatically as a symptom or used to penalise the complainant.

The [Committee against Torture](#)'s General comment No. 3 explains redress through restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition. These are obligations and principles concerning torture and ill-treatment, not an automatic legal entitlement to a particular award after every restraint. They nevertheless show why acknowledging harm, restoring rights and preventing recurrence belong alongside medical aftercare. [42]

A meaningful response should explain what was found, what remains disputed, what was corrected and how recurrence will be prevented. When an account contains a demonstrable factual error, correcting it matters. When facts remain uncertain, preserving that uncertainty matters. A person should not have to accept a false institutional narrative as the price of receiving further support.

Recent European material also demonstrates why formal complaint rights are not enough. In *Strashunskyy v Ukraine*, the Court stressed that people dependent on institutional staff may have a significantly limited ability to protect themselves, complain or obtain evidence, and expressly recognised the imbalance of power inherent in the relationship between residents and institutional staff. It required serious investigation rather than hasty or ill-founded conclusions. [127]

The CPT's 2026 report on Georgia supplies a parallel monitoring example: many patients formally recorded as voluntary were in practice unable to leave locked wards, could be subjected to restraint, and lacked the safeguards applicable to formally involuntary patients. Legal classification and actual freedom can therefore diverge. Complaint, review and advocacy mechanisms must be tested by whether the person can really use them during and after a crisis. [\[137\]](#)

Research on involuntary psychiatric treatment also shows why formal legal status and practical understanding cannot be assumed to coincide. A 2024 scoping review comparing involuntary inpatient treatment with voluntary or other comparator groups found increased subjective and objective coercion, increased cost and lower patient satisfaction among the harms associated with involuntary admission, while also reporting greater improvement in symptoms and functioning in some involuntary groups, possibly reflecting greater baseline severity. Importantly for safeguards, the review identified substantial confusion among both voluntary and involuntary patients about their legal rights. A right that the person does not understand, cannot invoke or cannot practically exercise is not an adequate protection against an erroneous coercive decision. [\[145\]](#)

10. Children, complex health needs and unequal exposure

10.1. Protection must include the child's experience

Children require an approach that considers development, relationships, communication and longer-term security, not only control of the immediate scene. Autistan proposes that a child's view be sought in an accessible form before, during and after difficult care wherever possible. A distressed child's inability to explain events in adult language must not remove their perspective from the record.

Familiar adults can be valuable supporters, but their presence should not automatically replace the child's own communication. Services should also make [independent advocacy](#) available where the child needs it. Repeated restriction should trigger reconsideration of the environment, the support plan and the suitability of the placement, rather than becoming an expected part of childhood in that service.

A safeguarding review should consider whether the child has become frightened of particular rooms, clothing, gestures or staff approaches; whether sleep, communication or daily functioning has changed; and whether apparent cooperation is associated with fear. These are proposed domains of enquiry, not a checklist from which a diagnosis can be inferred.

The UN Committee on the Rights of the Child's 2023 concluding observations on the United Kingdom expressed deep concern about the large number of children continuing to experience pain-inducing techniques and seclusion, particularly disabled children and children from ethnic minority groups. It urged explicit prohibition of solitary confinement, isolation, seclusion and restraint as disciplinary measures in schools, alternative care and health-care settings. That qualification - 'as disciplinary measures' - should be preserved rather than inaccurately paraphrasing the recommendation as resolving every question about emergency intervention. [\[47\]](#)

Two additional UN strands reinforce this protection. CRPD General Comment No. 4 (2016) identifies restraint and seclusion by educational personnel as examples of violence and humiliating punishment affecting disabled learners. The Committee against Torture's 2019 observations on the United Kingdom state, in juvenile justice, that instruments of restraint and force may be used only exceptionally after other control methods have been exhausted and failed, and call for prohibition of solitary confinement for juveniles. [\[82\]](#) [\[86\]](#)

The UK Parliament Joint Committee on Human Rights' 2019 inquiry, which considered children in hospitals as well as custody, found substantial evidence of both physical and psychological harm. Its evidence included restraint experienced as profoundly psychologically damaging without visible injury, accounts of a 'broken spirit' and retraumatisation, and additional pressures on autistic children and children with communication or learning difficulties. [\[87\]](#)

10.2. Nasogastric feeding and other necessary physical care

The consultation expressly includes [nasogastric feeding](#) in the context of restraint. The fact that a procedure has a nutritional or other medical objective does not remove the need to examine consent, distress, alternatives and the cumulative effects of repeated force. Nor should serious physical risk be ignored when making a prevention plan. [\[1\]](#)

Autistan proposes early investigation of why eating or a procedure is difficult: sensory conditions, pain, swallowing problems, communication barriers, fear, previous experiences and the person's own explanation. These are questions for appropriate assessment, not grounds for assuming that a food-related difficulty has a single autistic or psychiatric cause.

Where urgent care is considered, the record should distinguish the medical need, the legal basis for acting without consent where applicable, the intervention proposed, and the additional justification for any physical restriction. A planned repeated procedure warrants a specialist prevention plan and independent review, not repeated reliance on an undifferentiated emergency rationale. The person should retain as much choice as possible over timing, preparation, communication, position and trusted support within clinical safety requirements.

10.3. Avoid inequalities hidden by aggregate figures

The [CRPD Committee](#)'s observations on the United Kingdom make unequal exposure an explicit concern. Autistan proposes examining differences by age, sex, ethnicity, communication requirements, coexisting impairments and service setting, while protecting privacy and avoiding [small-cell identification](#). [\[34\]](#)

An absence of formal autism identification should not prevent staff from responding to evident communication or sensory needs. Likewise, an autistic person who speaks fluently may still need processing time, written communication or support during overload. Services should not infer capacity to tolerate an intervention from outward verbal ability, nor infer absence of [agency](#) from unconventional communication.

11. Professional education, perspective-taking and institutional responsibility

11.1. The essential competence is prevention

Autistan proposes that competence be assessed through what staff notice and change before [coercion](#), not merely through their ability to perform approved techniques. Training should test whether a professional can distinguish observation from inference, identify an unnecessary demand, respond to communication differences, preserve harmless [self-regulation](#) and recognise when their own approach is increasing the threat.

Training should also test for false-positive judgments of aggression and dangerousness. Staff should be able to describe exactly what they observed, identify which part is interpretation, consider autism-consistent alternative explanations, and explain why a prediction of harm is or is not justified. The competence being tested is not confidence in 'reading behaviour', but disciplined awareness of how non-autistic expectations can produce false attributions of hostility, intention or future violence.

Scenario-based training should therefore include situations in which an autistic person looks intensely irritated, angry, unusual or physically expressive without committing an aggressive act. Staff should be required to describe the visible facts before choosing labels, and assessment should count false-positive classifications of 'aggressive' or 'dangerous' as safety errors rather than treating over-restriction as the safer default. Separate scenarios should test proportionate responses to low-level actual aggression without converting a limited act into a global judgement of dangerousness.

Training should also include false-positive risk reasoning. Staff should practise separating visible stress or frustration from perceived aggression, perceived aggression from actual aggressive conduct, and both from a sufficiently evidenced current danger. They should learn the limits of formal risk instruments and the effect of base rates: a structured score can organise information but cannot transform uncertainty into fact or substitute for the legal threshold governing an immediate restrictive act. [\[120\]](#) [\[129\]](#) [\[130\]](#)

Training should include the bodily and psychological experience described in this study: inability to relieve discomfort, panic, perceived suffocation, violation of autonomy, injustice, exhaustion, reduced expression without relief and the fear carried into later encounters. Autistic survivors should help determine the content and its assessment, with payment and control over how their contributions are used.

Staff also require supervision, support after difficult events and a protected way to challenge unsafe routines. Responsibility spans individual practice, supervision, management, commissioning and government. Training cannot compensate for missing space, staffing, continuity, community provision or usable alternatives.

11.2. Experiential training and survivor-led perspective-taking

A German exploratory study by Steinert and colleagues involved ten experienced professionals who voluntarily experienced conventional mechanical restraint and an experimental alternative, with six former patients consulted through a recording. The study provides limited evidence about supervised experiential learning because the volunteers

retained advance knowledge and an ability to stop which are absent from imposed restraint. [\[29\]](#)

Experiential education is most useful when it improves professionals' ability to recognise loss of control, personal-space violations, escalating interaction and viable alternatives. Survivor-led testimony can convey dimensions that a voluntary simulation cannot reproduce, including uncertainty about release, institutional dependency and the fear that protest may intensify control.

Autistan recommends survivor-led testimony and scenario-based perspective-taking as core components. Any physical simulation should be independently reviewed for ethics and safety, entirely voluntary, immediately stoppable and evaluated against less intrusive teaching methods. Participation must never depend on disclosing a trauma history.

Any physical simulation must not involve dangerous pressure, impaired breathing, forced struggle or attempts to reproduce terror. A tolerable simulation cannot be used to conclude that patients exaggerate their experience.

A 2024 bedside simulation programme involving more than 100 staff reported reduced restraint use together with increased staff preparedness and confidence after training. [\[74\]](#)

Autistan proposes that Scotland commission a separate independent study of experiential learning rather than assume either its value or its futility. One experimental arm should allow medically screened volunteer professionals, under independent ethical oversight and continuous clinical supervision, to experience a strictly limited and immediately reversible form of restraint. The purpose would be to study perception rather than endurance or restraint technique: subjective time, helplessness, inability to relieve discomfort, urge to escape, perceived threat or humiliation, trust, and the difference between outward stillness and internal distress. [\[29\]](#) [\[88\]](#)

The physical-experience arm should be compared with survivor-led education and non-physical scenario simulation, and ideally with a combined approach. Outcomes should extend beyond post-course attitude or confidence scores to later practice: restraint frequency and duration, use of alternatives, personal-space decisions, recognition of interactional escalation, patient-reported safety and trust, and substitution by medication or seclusion. Existing research on physical-intervention staff training is heterogeneous and methodologically weak, leaving this question open. [\[74\]](#) [\[88\]](#)

Voluntary exposure cannot reproduce the uncertainty of involuntary restraint, actual institutional dependency, inability to withdraw consent, or fear that protest may prolong coercion. Those differences should be explicit variables and limitations of the study, not reasons to avoid investigating whether embodied experience changes later professional judgment. Survivor co-design is essential because the central question concerns aspects of restraint that are easily invisible to an observer.

11.3. Evaluate changes in care, not only satisfaction with training

Autistan proposes measuring whether training changes access to alternatives, the quality of causal analysis, the preservation of patient accounts and the frequency and duration of each restrictive practice. Assessments should also examine injuries, experienced safety, trust and the possibility of unintended substitution between physical force, medication and isolation.

A staff member can report increased confidence without delivering more respectful care. Conversely, improved awareness may initially produce more complete reporting of incidents. Evaluation should therefore combine observed practice, reliable records and patient experience rather than interpret one number in isolation.

12. Proposed amendments to the Scottish Code

The following wording is proposed by Autistan for incorporation or adaptation within the revised Code and related guidance. Suggested locations are identified by subject heading because the consultation draft is organised through headings rather than a stable set of numbered paragraphs.

The clauses are intended to complement existing protections, not authorise new restrictive powers.

12.1. Direct observation, interpretation and justified risk assessment

Suggested location: the autism section, reinforced in general principles. Relevant questions: 1, 4 and 7.

Practitioners should distinguish direct descriptions of what was seen or heard, including appearance, tone, movement and actions, from interpretations such as 'aggressive' or 'threatening', and from assumptions about a person's intention, motivation, cooperation or understanding. Atypical communication, harmless movement, distress or refusal of a non-essential demand do not, in themselves, establish an imminent risk of significant harm. Risk may exist without harmful intention, but an assumption about intention does not replace evidence of a concrete risk. Reasonable alternative explanations, including the environment and staff interactions, should be considered and documented.

The purpose is a defensible factual basis for emergency decisions and a record in which disputed interpretation cannot become an apparent fact merely through repetition.

Suggested additional wording: The expression 'danger to self or others', or an equivalent risk label, should never be treated as a self-proving fact. The record should distinguish the behaviour or circumstances directly described, any interpretation of aggression or hostility, the specific harm predicted, its seriousness and imminence, and the evidence supporting that prediction. A structured risk score or historical risk category may inform assessment but should not, by itself, justify restraint, seclusion or another deprivation of liberty. [\[119\]](#) [\[129\]](#) [\[130\]](#)

The Code should state expressly that precautionary concern does not reverse the evidential requirement. Statements such as 'could become aggressive', 'appears threatening' or 'staff felt unsafe' are not self-proving grounds for deprivation of liberty. If coercive intervention is justified by predicted harm, the record should identify the present facts, the specific harm feared, the required degree of imminence or likelihood under the applicable legal test, and the less restrictive options considered. Diagnostic labels, previous incidents and atypical autistic expression must not operate as proxies for current dangerousness.

Practitioners should not treat an appearance of irritation, anger, intensity or aggressiveness as equivalent to aggressive conduct, nor aggressive conduct as equivalent to dangerousness. Where terms such as 'appears aggressive', 'looks threatening' or similar descriptions are used, the record should identify the observable features underlying that impression and distinguish them from any actual threat or harmful act. Any restrictive intervention requires a separate assessment of the specific current danger and the applicable legal threshold.

This distinction prevents an observer's emotional reaction from becoming a substitute for evidence. It also preserves proportionality when a real but limited aggressive act has occurred: the existence of an act does not by itself establish a continuing risk serious enough to justify deprivation of liberty.

12.2. Harm caused by the intervention itself

Suggested location: purpose and general principles. Relevant questions: 1, 4 and 7.

Assessment of any proposed restrictive intervention should include the additional physical, sensory, psychological and relational harm that the intervention may cause. Practitioners should consider whether it may intensify panic, feelings of suffocation, helplessness, humiliation, perceived injustice or trauma, or prevent a person's established means of [self-regulation](#). Protective intention does not establish therapeutic benefit or remove the requirement to assess these effects.

Suggested additional wording: Precaution must be applied to the proposed intervention as well as to the feared event. Before coercion is authorised, the decision-maker should compare the concrete risk of non-intervention with the foreseeable physical, psychological and liberty-related risks of the restrictive measure itself, including cumulative harms from restraint, seclusion and medication. A serious intervention should not be treated as the risk-free side of the comparison. [\[17\]](#) [\[20\]](#) [\[123\]](#) [\[128\]](#)

The recommendation is to evaluate the complete balance of consequences, not only the behaviour that prompted staff concern. Individual evidence and the person's known experience should inform that assessment.

That assessment should explicitly consider powerlessness, forced bodily proximity, inability to reposition or escape, known positional breathing or swallowing vulnerability, and the possibility that outward stillness reflects resignation rather than relief. A report of inability to breathe or swallow safely must trigger clinical assessment rather than be treated as evidence of non-compliance. [\[18\]](#) [\[46\]](#) [\[53\]](#) [\[54\]](#) [\[55\]](#)

The Code should also warn that the response itself may become a second-order source of distress. Unwanted touch, encirclement, blocked exit, forced bodily proximity and removal of self-regulatory movement can intensify the sensory or psychological state that staff are attempting to control. A soothing intention is not evidence of a soothing effect; the person's known sensory profile, choice and actual response must be considered. [\[67\]](#) [\[69\]](#) [\[70\]](#) [\[73\]](#)

12.3. Do not infer recovery from stillness

Suggested location: monitoring, release and post-incident review. Relevant questions: 7 and 9.

Cessation of movement, vocalisation or resistance should not, by itself, be recorded as evidence that distress has resolved or that the person consents. Reduced expression may have several causes, including exhaustion, fear, reduced responsiveness or medication effects. Staff should assess physical safety, communication and the person's experience separately. Continuation of a restriction must not depend on agreement with staff, apology or a conventional display of calm once its lawful justification has ceased.

The safeguard requires records to separate observable cessation of movement from the distinct questions of immediate danger, communication, consent and experienced distress.

12.4. Preserve harmless autistic self-regulation

Suggested location: autism and future care planning. Relevant questions: 5 and 7.

Care plans should identify and preserve safe means of self-regulation chosen by the person, including movement, changes of position, repetitive actions, vocalisation, access to quiet or open space and communication supports. Such actions should not be suppressed solely because they are atypical or inconvenient. Where a specific danger is identified, staff should first consider whether changing the environment, available space or support can remove that danger while preserving the activity.

The aim is neither unrestricted exposure to hazards nor compulsory exercise. It is the preservation of useful freedoms through individual adaptation.

12.5. Alternatives must be available, not merely listed

Suggested location: prevention, planning and service resources. Relevant questions: 5, 10 and 12.

Providers should ensure that preventive and less restrictive options are practically accessible when needed. Records should distinguish an option that was offered and ineffective from one that was unsuitable, declined, unavailable or not attempted. Lack of staffing, suitable space or accessible support should be identified as an organisational deficit requiring action, not represented as proof that an alternative failed. Access to necessary communication or self-regulation supports should not be conditional on behavioural conformity.

Suggested additional wording: Alternatives should include service-level crisis pathways that are designed from the outset to operate without force or coercion, not only techniques attempted in the final seconds before restraint. WHO guidance identifies rights-based crisis services and QualityRights training specifically directed towards ending seclusion and restraint. [\[121\]](#) [\[122\]](#)

Supplementary guidance should specify availability standards and responsibility for resolving deficits. England's use-of-force guidance provides a comparative reference for

examining psychological constraints and blanket restrictions; it is not law applicable automatically in Scotland. [\[41\]](#)

Less restrictive practice may sometimes mean doing less: tolerating non-dangerous shouting, pacing, sitting or lying on the floor; reducing the audience; stepping back; keeping an exit visible; permitting safe movement; lowering sensory input; and maintaining discreet observation and one calm communication channel rather than immediately imposing physical control. Social inconvenience, embarrassment or pressure to restore a conventional appearance should not be treated as an immediate safety risk. [\[69\]](#) [\[70\]](#)

Availability standards should include access, according to individual need and risk, to outdoor movement, pacing routes, voluntary low-stimulation space and, where appropriate, low-hazard movement or soft-equipment space. Such spaces must remain alternatives chosen by the person rather than locations of enforced isolation. These availability standards concern voluntary alternatives. If departure is prevented in the separately classified crisis-containment variant described in section 8.3, the space is no longer one of these voluntary alternatives and must be treated, recorded and reviewed under the legal framework applicable to seclusion and any resulting deprivation of liberty. [\[25\]](#) [\[26\]](#) [\[57\]](#) [\[58\]](#) [\[2\]](#) [\[80\]](#)

12.6. Reconstruct the full chain of events

Suggested location: incident review and future planning. Relevant questions: 5, 7 and 9.

Review should reconstruct the sequence before, during and after the intervention, including sensory conditions, requests for help, restrictions on movement, communication barriers and staff actions or omissions. It should distinguish patient actions from staff interpretations and consider whether decisions or conditions generated, amplified or prolonged the distress or risk. The review should identify changes that could prevent recurrence, assign responsibility and verify implementation.

This is a system-learning requirement without immunity from accountability. Finding a preventable cause should lead to correction; allegations of abuse require the appropriate independent investigation.

The reconstruction should identify the suspected first-order impingement and each possible second-order impingement added by the response: number and proximity of staff, crowding or encirclement, touch or holding, blocked movement or exit, imposed demands, threats, force, medication and isolation. It should examine whether the person's apparent escalation followed those additions and whether a lower-contact response would reasonably have reduced the danger. [\[68\]](#) [\[69\]](#) [\[70\]](#) [\[73\]](#)

12.7. Preserve the person's account and factual disagreements

Suggested location: recording, review and complaints. Relevant questions: 7 and 9.

The person's own account should be sought in an accessible way and retained distinctly from the professional account. Later written, recorded or supported contributions should be accepted when immediate discussion is unsuitable. Differences between accounts should remain visible; they should not be silently reconciled in favour of the institution. Communication that is delayed, non-speaking, unconventional or critical should not, on that basis alone, be treated as incapable of conveying evidence.

[Independent advocacy](#) should assist access to records and review. The person should be told how to correct factual errors or attach disagreement without having to secure agreement from the staff involved.

12.8. Psychological harm should trigger critical review

Suggested location: monitoring and recording. Relevant question: 9.

The draft specifically requires critical review following injury or adverse physical effects, alongside wider serious-incident reporting. Autistan proposes expressly including serious psychological harm rather than leaving it dependent on interpretation of a general category. [\[2\]](#)

A critical review should also be triggered by reported or observed serious psychological harm associated with an intervention, including severe panic, experienced psychological suffocation or crushing, profound helplessness, loss of agency, traumatic reactions or persistent fear, whether or not a physical injury is visible. The person's report should be recorded without requiring a prior formal diagnosis. The review should consider delayed effects and the need for independent assessment and support.

12.9. Clarify thresholds and prevent relabelling

Suggested location: definitions and lawful limits. Relevant questions: 3 and 4.

The draft's definition of [seclusion](#) focuses on harm to others, whereas a later threshold also refers to harm to the patient. These formulations should be reconciled with the applicable legal basis. Clarification must not become an unexamined expansion of the circumstances permitting [seclusion](#). [\[2\]](#)

Classification and reporting should reflect what the person was prevented from doing, rather than the name of a room or intervention. Services should identify restrictions maintained through staff action or credible threats as well as locked doors and physical devices. Threatened intervention used to obtain compliance should be addressed in monitoring guidance. Reduction in one restrictive practice should not be claimed as improvement without examining substitution by another.

The Government should state expressly how threats and restrictive episodes that do not culminate in physical force are to be recorded, while avoiding surveillance that captures harmless behaviour as an incident.

12.10. Support must not become normalisation

Suggested location: the reference to [Positive Behaviour Support](#). Relevant questions: 7 and 12.

Support strategies should aim to reduce suffering, prevent actual harm, enable communication and strengthen autonomy and quality of life. They should not seek to eliminate harmless autistic characteristics solely because these differ from ordinary social expectations. Plans should be developed with the person, made accessible to them, open to independent challenge and evaluated through outcomes that include their experience and choices.

These conditions make the person's suffering, autonomy, choices and practical outcomes the tests of support quality, including where a programme is described as Positive Behaviour Support.

12.11. Minimum competencies and independent oversight

Suggested location: staff training and national monitoring. Relevant questions: 7, 9 and 10.

Staff who authorise or carry out restrictive interventions should demonstrate competence in recognising autistic communication and sensory needs, attitudinal barriers, trauma-related reactions, erroneous assumptions about intention and the risk of confusing compliance with wellbeing. Training should be developed and delivered with autistic people who have experienced restrictive interventions. Independent oversight should examine recurring patterns by service, practice and circumstances, and require action on preventable causes.

Suggested additional wording: Independent review must be practically reachable and timely. A safeguard is not effective merely because legislation names a complaint body, lawyer or court if the person cannot contact it, obtain evidence or be heard while dependent on the institution. Where prolonged mechanical restraint is contemplated, Scotland should examine models of rapid external or judicial authorisation and should monitor whether reductions in one practice are offset by increases in another. [\[125\]](#) [\[127\]](#) [\[136\]](#) [\[137\]](#)

This extends the draft's training provisions into demonstrable competencies, including the understanding of the person's experience rather than technical proficiency alone. [\[2\]](#)

12.12. A route towards ending coercive responses

Suggested location: principles, implementation and supplementary guidance. Relevant questions: 1, 12 and 13.

Services should maintain a funded plan to prevent and eliminate avoidable restrictive interventions, developed with the people affected and linked to wider rights-based reform. The plan should address environmental accessibility, staffing and continuity, voluntary crisis support, community provision, access to justice and measurable changes in practice. Immediate protective safeguards should be strengthened while these changes are implemented; reform should not be deferred on the assumption that [coercion](#) is an inevitable feature of autism or disability.

Further legal changes required to fulfil international human rights recommendations should be identified separately and pursued through the appropriate reform process. The Code can initiate practical improvements without pretending that it alone resolves the wider legal debate.

13. Implementation, evidence quality and additional consultation chapters

13.1. An incident record designed to learn rather than justify

Appendix B proposes a recording structure. Its purpose is to make the chronology, evidence, alternatives, experience and corrective actions visible. It should not become a [retrospective](#) template in which every intervention is automatically labelled necessary because the form has been completed.

An investigator should be able to reconstruct what happened without relying on broad behavioural labels. They should be able to see when the person's account was obtained, whether it differed, how the disagreement was investigated and which facts remain uncertain. Staff should be supported to record uncertainty honestly rather than encouraged to produce a falsely seamless institutional account.

Services should audit false-positive restriction as well as missed danger. If a person was restricted because staff predicted aggression or serious harm that did not occur, review should examine whether the intervention plausibly prevented that harm or whether the prediction itself lacked an adequate factual basis; non-occurrence cannot automatically validate either conclusion. Repeated precautionary restrictions based on the same untested assumptions should be treated as a pattern requiring scrutiny rather than as cumulative proof that the assumptions were correct.

Where a structured risk instrument or score influenced the decision, the audit should record its name, target outcome, intended population, time horizon and result, together with the clinician's interpretation and the actual subsequent outcome. This permits services to examine calibration and false positives rather than assuming that the existence of a formal score validates the restriction. [\[129\]](#) [\[130\]](#)

Review should also distinguish between an alternative that failed despite appropriate use and an alternative that was inaccessible. Otherwise, a service can repeatedly describe unavailable options as ineffective and never face the need to provide them.

13.2. Measure freedom, experience and safety together

Autistan proposes reporting frequency, duration, repeat exposure, simultaneous interventions and the proportion of people affected by each form of restriction. Measures should have clear [denominators](#), such as occupied bed-days and admissions, so changes in occupancy do not masquerade as improvement. Serious complications, deaths and gaps in recording require separate examination.

The person-centred measures should include perceived safety, pain and fear, access to movement and outdoors, availability of communication supports, the ability to refuse an offered activity, trust in staff and whether the agreed preventive changes occurred. Measures

should allow accessible communication and delayed responses. Silence or non-response must not be automatically coded as satisfaction.

Staff and other patients' safety should also be measured. A credible prevention programme must not simply displace harm to another group or hide an increase in forced medication behind fewer physical holds. Equally, more accurate reporting after an improvement in transparency should not be mistaken automatically for worsening care.

The CGLPL goes further than recommending better counting. It expressly proposes reliable restraint-and-seclusion indicators tracking rates and change over time within each establishment, with the possibility of including them among indicators published annually by health establishments, using them as criteria for additional funding, incorporating them into multi-year objectives and resources agreements, and considering them in establishment certification. This is a concrete model for making reduction an institutional obligation rather than a statement of intent. Scotland should likewise connect transparent measurement to responsibility, resources and external scrutiny. [\[111\]](#)

Indicators must also detect substitution between coercive practices. The Baden-Wuerttemberg data after the German judicial-review requirement showed a fall in mechanical restraint alongside an increase in seclusion. A dashboard that celebrates one falling measure while ignoring another can therefore misdescribe the person's actual loss of freedom. Restraint, seclusion, forced medication, locked-door confinement and other relevant restrictions should be examined together as well as separately. [\[136\]](#)

13.3. What should be evaluated next

Priority questions include whether accessible movement and outdoor provision reduce distress and restrictive exposure for particular autistic people; how loss of [self-regulation](#) affects their experience during restraint; which conditions contribute to silent distress or withdrawal; and which organisational changes produce sustained reductions without substitution.

Research should include people with substantial communication and support needs, rather than recruiting only those able to complete conventional interviews. Outcomes should be chosen with survivors and should include longer-term trust, daily freedom and quality of life. Distinct interventions and populations must be described clearly enough to avoid attributing a combined programme's effects to one attractive component.

Research on professional perspective-taking should compare survivor-led education, non-physical simulation and any ethically approved experiential approach. It should measure later practice and patient experience, not only staff reports of increased understanding. No evidential gap justifies exposing participants to [coercion](#) or delaying straightforward removal of avoidable harms.

Scotland could also pilot the voluntary regulation and expression environment described in section 8.3. A co-designed controlled before-after or stepped-wedge evaluation could compare wards before and after access to the space, while documenting which components are actually used: active movement, low-stimulation retreat, controllable audiovisual or virtual nature content, outdoor access, chosen social contact and other sensory resources. The intervention should be available before a crisis as well as during early escalation, so that

evaluation does not reproduce the mistake of waiting until danger is already acute. [\[96\]](#) [\[97\]](#) [\[103\]](#) [\[104\]](#)

A separate research priority is the accuracy and consequence of dangerousness prediction in acute care. Existing violence-risk meta-analyses are largely forensic and often concern outcomes over much longer periods than an immediate ward crisis; they should not be transplanted uncritically into autism-specific acute decisions. Scotland should evaluate the false-positive and false-negative consequences of whatever tools, labels or informal prediction practices are actually used, including whether autistic expression changes staff estimates independently of concrete risk. [\[129\]](#) [\[130\]](#)

International mechanical-restraint evidence should also be improved at the ward and organisational level. A 2025 systematic review covering 73 studies from 22 countries found wide variation, broad indications and limited high-quality outcome evidence, while staff and ward factors were inconsistently studied. Research should therefore treat the service itself - staffing, culture, legal rules, available space, leadership and alternatives - as an exposure, not merely the patient's diagnosis or behaviour. [\[138\]](#)

The primary trial question should be explicit: among crisis episodes in which staff judge that physical or mechanical restraint would otherwise be considered, can transfer to or voluntary use of the dedicated room prevent restraint without increasing injury, seclusion, forced medication or delayed emergency treatment? Episodes should be prospectively logged at that decision point, including the concrete danger, whether the room was offered, accepted or refused, whether access itself required force, which zone or equipment was used, and why the episode ended. This distinguishes the proposal from studies that merely add a sensory room somewhere on the ward and then compare annual restraint totals. [\[18\]](#) [\[96\]](#) [\[108\]](#)

A distinct study arm should examine the temporarily exit-restricted variant described in section 8.3. It should prospectively record the concrete danger that justified preventing departure, the patient's detention status, the legal basis relied on, the applicable threshold and the evidence said to satisfy it, why immediate exit remained unsafe, each stage of restored freedom, the criteria and evidence used for progression, the person's understanding of those criteria, every human override of any automated or semi-automated element, and whether release depended in practice on genuine risk reduction or on behavioural conformity. Where the person was a voluntary patient, the study should record the immediate legal assessment required by any use of seclusion and must not treat the room itself as authority to detain. No automated element should be permitted to initiate or prolong prevention of departure on its own. Comparison should include bodily restraint and ordinary seclusion, with particular attention to duration, injury, fear, agency, masking of distress, medication, recurrence and later trust. [\[2\]](#) [\[80\]](#)

A parallel qualitative and organisational study should examine tacit professional knowledge about coercion. Confidential interviews, observation and post-incident reconstruction should ask what staff expect restraint to achieve in practice: immediate safety, silence, exhaustion, deterrence, compliance, reduced protest, restoration of therapeutic contact, or simply an easier ward routine. It should examine whether staff have learned empirically that some people become more passive or easier to manage after coercion, how that effect is

interpreted, and whether institutional incentives reward it. Formal policy statements alone cannot answer these questions. [\[101\]](#) [\[102\]](#) [\[106\]](#) [\[110\]](#)

The evaluation should also measure vitality and agency after the episode: willingness to communicate, self-initiated movement and activity, trust, perceived control, fear of staff, avoidance of the service and the person's own account of whether they felt restored, merely exhausted, or psychologically defeated. This directly tests the study's distinction between de-escalation and a 'broken inner spring'. [\[46\]](#) [\[87\]](#) [\[106\]](#)

Outcomes should include restraint and seclusion frequency and duration, forced medication, injuries to patients and staff, escalation after entry, subjective distress, agency, perceived safety, trust, time to recovery, later avoidance of services, staffing demands and total cost. Autistic participants should be analysed explicitly rather than absorbed into a general psychiatric sample, with sensory and communication profiles recorded. Substitution must be measured: a fall in mechanical restraint is not a success if seclusion, forced medication, surveillance or informal coercion rises instead. [\[57\]](#) [\[96\]](#) [\[99\]](#)

The pilot should also compare the regulation-and-expression environment with ordinary comfort or sensory rooms, because the proposed model adds a distinct hypothesis: for some people, safe freedom to move and externalise bodily activation may be more regulating than being asked to become still. That question should be tested empirically and individually, not assumed in advance. [\[26\]](#) [\[57\]](#) [\[97\]](#)

Research should also examine complete causal sequences rather than counting restraint events alone: what preceded distress, what the person attempted to communicate or escape, what staff added to the situation, and when danger rose or fell. Autism-specific work should test whether space-preserving, low-contact and communication-supportive responses reduce escalation compared with crowding or imposed holding where this can be studied ethically. Analyses should distinguish socio-generated triggers, medical causes, mixed causation and unresolved cases rather than assign causation from diagnosis alone.

13.4. Cross-border transfers: preserve the person, not just the file

Chapter 14 concerns transfers into and out of Scotland. Autistan proposes that the accompanying guidance make continuity of accessible support explicit: the person's communication methods, sensory needs, trusted relationships, preventive plan, [advance statements](#) and account of previous [coercion](#) should travel with them in an appropriate, confidential form. [\[5\]](#)

Distress about a transfer should not be treated automatically as evidence that more force is required. The review should consider notice, predictability, explanations, continuity of familiar support and the conditions at the destination. A transfer intended to resolve a service difficulty should not simply move a person into a more restrictive environment without explicit examination of that consequence.

The draft itself requires decision-makers to consider Article 8 ECHR and to evidence the likely impact of a cross-border move on private and family life, including mitigation such as support for family contact. Autistan recommends applying that requirement concretely to autistic support continuity: the effect of distance on trusted relationships, communication assistance, sensory predictability and access to familiar carers should be assessed before authorisation, rather than treated as a secondary logistical issue. [\[5\]](#)

13.5. Excessive security: distinguish the available remedies

The proposed Chapter 17 explains a route concerning the overall security level of the relevant hospital or unit. It also states that the Tribunal cannot use that procedure to adjust an individual security measure; the remedy concerns identifying a suitable alternative setting. This makes it important not to present that route as a complete answer to every individual restriction. [6]

Autistan proposes a clear, accessible explanation of the other routes for challenging a specific restraint, [seclusion](#) episode, communication restriction or alleged ill-treatment. Information should state who can assist, what records can be obtained and what urgent action is possible under the relevant legal framework. People should not be sent between services because a valid complaint has been put into the wrong procedural category.

The Chapter 17 route also contains an access condition that deserves explicit practical safeguards: an application must be accompanied by a supportive report from an Approved Medical Practitioner (AMP). Autistan does not suggest that the Code can remove a statutory requirement, but it should explain how a patient can obtain an appropriately independent AMP assessment, what assistance is available where communication or distress makes that process difficult, and how advocacy, reasonable adjustments and legal advice can be accessed. A remedy is not effective in practice if the person cannot reach the professional gateway required before the Tribunal can consider the application. [6]

The chapter appropriately states that the rationale for a continuing level of security should be based on current assessment rather than historical factors. That safeguard should be connected expressly to the evidential discipline proposed throughout this study. For autistic people in particular, visible intensity, unusual movement, refusal, communication differences or past incidents should not be allowed to become a proxy for present dangerousness. Decisions about continued high or medium security should identify the current risk, its factual basis and the relationship between that risk and the security level imposed, distinguishing observation from interpretation and historical concern from present necessity. [6]

A successful excessive-security application can nevertheless result in transfer to a lower-security hospital farther from the person's home area. Lower security is therefore not automatically less restrictive in the person's life as a whole. The decision should assess the consequences of distance for family contact, trusted relationships, communication support, familiar routines and preventive arrangements, and should consider whether loss of those supports may itself increase distress or future coercive exposure. The same continuity principles proposed in section 13.4 should apply when identifying the alternative placement. [6]

13.6. The standard for judging success

The intended outcome is not a service in which autistic people appear quieter while remaining frightened, deprived of [agency](#) or unable to use their own means of regulation. It is a service which creates fewer avoidable crises, responds to distress without adding unnecessary harm, respects the person's account, and makes genuinely less restrictive ways of living possible.

Understanding why someone struggles is not an optional preliminary to controlling the struggle. It is central to deciding whether control is necessary, whether it is making matters worse, and what must change so that the same situation does not recur. The competence of a system should be demonstrated by the freedoms and supports it makes possible, not simply by the force it can apply.

Autistan therefore invites Scotland to set a more ambitious destination than better-managed coercion: a system organised to make restraint and enforced seclusion unnecessary and to replace them with prevention, freedom, relationships, accessibility, nature, movement, communication, choice and genuinely safe alternatives. Innovation should be judged by whether help can be provided while preserving agency, dignity, bodily integrity and psychological integrity. [\[37\]](#) [\[38\]](#) [\[45\]](#) [\[46\]](#) [\[90\]](#)

The international materials do not all use the same legal formulation, and the distinction should remain visible. European Court of Human Rights judgments such as Bures, Lavorgna, M.S. and Makki scrutinise individual episodes through strict necessity, proportionality, last resort, duration, supervision and effective safeguards. The CRPD Committee and WHO articulate a broader rights-based direction towards eliminating coercive measures. These approaches should not be artificially collapsed into one rule; together they show both the minimum scrutiny required while coercion still occurs and the direction of structural reform beyond it. [\[62\]](#) [\[119\]](#) [\[120\]](#) [\[123\]](#) [\[124\]](#) [\[125\]](#)

Scotland has an opportunity to become an international example by demonstrating that safety does not require practices inherited from an archaic model of institutional domination. Autistan considers restraint and enforced isolation, as coercive psychiatric crisis-management practices, to be barbaric and degrading and incompatible with respect for physical and psychological integrity. Such practices should have no place in modern mental-health care. The constructive challenge is to be more inventive, more humane and more effective: prevent the crisis where possible, understand its causes when it occurs, and protect people without reproducing violence in the name of care.

This ambition now has explicit international support. WHO/Europe states that the goal should be to end all use of coercive measures rather than preserve them as a culturally normal 'last resort', while WHO's crisis-service guidance documents models of acute support without force or coercion. Scotland can therefore evaluate not only whether restraint becomes safer or rarer, but whether its system is genuinely moving towards coercion-free crisis support. [\[120\]](#) [\[122\]](#)

Appendix A. Direct responses to the consultation questions

This Appendix reproduces the subject of each official consultation question before stating the Autistan Diplomatic Organization's response. It is designed to be read directly; section references are provided only for supporting analysis. Support for safeguards while coercive practices continue must not be read as acceptance of restraint or enforced seclusion as a model of care. Autistan's objective is prevention and replacement by non-coercive responses.

Q1. General principles and purpose

Do you agree with the general principles and the purpose of restraint and seclusion, as described in the draft update? To what extent do you agree or disagree?

Response: No - Strongly disagree. Safeguards are necessary while restraint and enforced seclusion still occur, but Autistan cannot endorse them as continuing crisis-management practices. The objective should be prevention and replacement by non-coercive responses. See sections 2, 3, 9 and clauses 12.1-12.3, 12.12.

Q2. United Nations Convention on the Rights of the Child

How clear, accurate and useful do you find the section on the United Nations Convention on the Rights of the Child?

Response: Clarity - Agree; Accuracy - Agree; Usefulness - Disagree. The UNCRC framework is relevant, but the child's experience, accessible expression, relationships and psychological and long-term effects need to operate as practical safeguards. See section 10.1.

Q3. Definitions of restraint and seclusion

Do you agree with our definitions of restraint and seclusion? To what extent do you agree or disagree?

Response: No - Disagree. Definitions should follow actual freedom and coercion: chosen retreat must be distinguished from prevented departure, including blocking, credible prohibitions and relabelling of restrictive practices. See sections 6.1, 8.3 and clause 12.9.

Q4. Lawful limits of restraint and seclusion

Do you agree with our guidance on the lawful limits of restraint and seclusion? To what extent do you agree or disagree?

Response: No - Disagree. Restriction should depend on a specific current danger meeting the applicable threshold, not perceived aggression, attributed intention, diagnosis, history or speculative dangerousness. The inconsistent seclusion thresholds should be reconciled without widening them. See sections 2.2, 8.3, 8.4, 13.1 and clauses 12.1, 12.9.

Q5. Future care planning

Do you agree with our recommendations around future care planning? To what extent do you agree or disagree?

Response: Yes - Agree, with qualification. Planning should prevent crises, not pre-authorise coercion. It should record communication, sensory and environmental needs, useful self-regulation, preferences and whether alternatives were genuinely available. See section 8 and clauses 12.4-12.6.

Q6. Children and young people

Do you agree with our guidance for using restraint and seclusion with children and young people? To what extent do you agree or disagree?

Response: No - Strongly disagree. Autistan cannot endorse restraint and seclusion as a continuing model of care for children. Where they nevertheless occur, heightened safeguards and review of repeated exposure, support and placement are required. See sections 10.1 and 11.

Q7. Autistic people and people with learning disabilities

Do you agree with our guidance for using restraint and seclusion with autistic people and people with learning disabilities? To what extent do you agree or disagree?

Response: No - Strongly disagree. Useful protections in the draft do not justify normalising coercion. Autism and intellectual disability should not be conflated; communication, sensory experience, movement, agency and environmental causes are central. See sections 2-4, 7-8 and clauses 12.1-12.4, 12.7, 12.10.

Q8. Nasogastric tube feeding

Do you agree with our recommendations for using restraint and seclusion in the context of nasogastric tube feeding? To what extent do you agree or disagree?

Response: This cannot adequately be reduced to a simple Yes/No answer. The medical objective, legal basis for treatment and separate justification for restriction should be distinguished; repeated procedures requiring force should trigger preventive review. See section 10.2.

Q9. Monitoring and recording

Do you agree with our recommendations for monitoring and recording the use of restraint and seclusion? To what extent do you agree or disagree?

Response: Yes - Strongly agree as a safeguard while these practices continue. Records should reconstruct the causal sequence, include psychological harm, preserve the person's account and disagreements, and identify missing information and corrective action. See sections 5, 12.6-12.9, 13.1-13.2 and Appendix B.

Q10. Staff planning, training and welfare

Do you agree with our recommendations for staff planning, training and welfare? To what extent do you agree or disagree?

Response: No - Disagree with the present framing. Autistan supports staffing, welfare and preventive competence, but training should not normalise coercion as ordinary clinical technique. Prevention, accessibility, alternatives, survivor participation and protected challenge to unsafe routines are central. See sections 7.1-7.2 and 11.

Q11. Other groups or clinical contexts

Are there any other specific groups or clinical contexts that would need specific guidance in relation to the use of restraint and seclusion? If so, please tell us more.

Response: Yes. Guidance should address people whose distress reduces speech or visible movement, people without formal autism identification, people with trauma histories or relevant physical-health vulnerabilities, and those facing intersecting barriers. See sections 3.5 and 10.

Q12. Further detailed guidance

Would you be in favour of the development of further guidance that sets out the requirements for the use of restraint and seclusion in mental health settings in Scotland in greater detail? To what extent do you agree that further guidance is needed?

Response: Agree as transitional protection within the objective of eliminating coercive practices. Guidance should cover genuinely available alternatives, causal review, psychological-harm reporting, communication and sensory accessibility, independent scrutiny and corrective action. See sections 8, 11-13 and Appendix B.

Q13. Other comments on the proposed changes to Volume 1

Do you have any other comments on the proposed changes to the Code of Practice Volume 1?

Response: Autistan invites Scotland to move beyond better-managed coercion towards prevention and non-coercive crisis support. Review should include socio-generated causes of distress, harms created by confinement, survivor knowledge, institutional contributions and practical alternatives. See especially sections 2-9 and 12-13.

Q14. Cross-border transfers

How clear, accurate and useful do you find the revised Chapter 14 (Cross-Border Transfers)? Do you have any comments or suggestions to improve its clarity, accuracy or usefulness?

Response: Clarity - Agree; Accuracy - Agree; Usefulness - Agree, with additions. Transfers should preserve communication, sensory needs, preferences, trusted relationships and preventive arrangements, and assess destination restrictions and the effects of distance on support continuity. See section 13.4.

Q15. Detention in conditions of excessive security

How clear, accurate and useful do you find the new Chapter 17 (Detention in Conditions of Excessive Security)? Do you have any comments or suggestions to improve its clarity, accuracy or usefulness?

Response: Clarity - Agree; Accuracy - Agree; Usefulness - not rated as worded because the questionnaire's usefulness item appears mistakenly to refer to cross-border transfer processes. Chapter 17 should distinguish this Tribunal route from remedies for individual restrictions, ensure practical access to the AMP gateway and advocacy, and base security decisions on current evidence. See section 13.5.

Appendix B. Proposed causal incident-review record

This proposed structure is intended for supplementary guidance and local incident-review systems. It should be developed with autistic people and other survivors, tested for accessibility, integrated with mandatory clinical records, and audited for reliability and privacy.

B1. The situation before the event

Record the setting, time, people present and relevant conditions: noise, lighting, crowding, physical discomfort, unexpected changes, communication difficulties and restrictions on ordinary activity. Include relevant events earlier in the day or admission, rather than beginning only at the first visible expression of distress.

B2. Requests, needs and attempts at self-regulation

Record what the person requested or communicated, including non-speaking communication and previous known preferences. Identify attempts to move, withdraw, change an uncomfortable condition or obtain assistance, and how others responded. Record access to basic needs and chosen supports.

B3. Observed actions

Describe actions in concrete terms, with timing and sources. Avoid substituting labels such as aggressive, manipulative or non-compliant for what happened. Distinguish direct observation from second-hand reports and later reconstruction.

Before recording an emotional or aggression label, state whether it was self-reported by the person, directly observed as conduct, or inferred by an observer. 'Appeared irritated' and 'appeared aggressive' should be recorded as perceptions and should identify whose perception they were, together with the observable features on which it was based.

B4. Specific risk

Identify the harm feared, who was at risk, its immediacy and the factual basis. Record uncertainty. Distinguish possible danger from assumed intention, diagnostic category, disruption of routine or staff discomfort.

Use separate fields for perceived irritation or anger, perceived aggression, any actual aggressive act, and the specific danger alleged. The record structure itself should not allow one category to auto-populate or imply the next. Perceived aggression without an aggressive act remains an interpretation; an aggressive act without a sufficiently serious current danger does not by itself meet a legal threshold for coercive restriction.

Record separately whether staff observed irritation or anger, any concrete aggressive act, and any specific danger of injury. Do not collapse these into a single category. If aggression is recorded, describe the act itself and then assess separately whether it created a sufficiently serious and immediate risk to meet the applicable threshold for restriction.

Record whether the concern was actual injury risk or principally noise, disruption, public visibility, refusal, lying or sitting on the floor, contact with property, or staff/public

discomfort. Do not convert social inconvenience into a danger category without specifying the mechanism and imminence of the harm.

If intervention is based on predicted escalation, record the exact prediction, the facts supporting it, the time horizon, the specific harm feared and the applicable threshold. Record what evidence would have counted against the prediction. Do not retrospectively convert 'might become aggressive' into 'was dangerous' merely because restriction was imposed. Where the predicted event did not occur, review whether that was plausibly because the intervention prevented it or whether the original prediction was unsupported; preserve uncertainty rather than treating the intervention itself as confirmation.

If a structured risk instrument, checklist or score influenced the decision, record its name, result, target outcome, intended population and time horizon; identify who interpreted it and how. The score must remain separate from the factual observations and from the legal threshold. Record later outcome data so that false-positive predictions can be audited rather than disappearing from organisational memory. [\[129\]](#) [\[130\]](#)

B5. Staff and environmental contributions

Record instructions, refusals, physical approaches, changes of personnel, threats, blocked movement and any correction of contradictory or inaccessible communication. Consider whether staff could have withdrawn a non-essential demand or changed the environment. Do not presume either fault or irrelevance.

Record how many staff were visible and how close they were; whether the person was encircled; whether exits or intended movement were blocked; who initiated touch; each episode of holding or pressure; whether the person asked for distance; and whether staff presence appeared to increase or reduce distress. Distinguish safety backup kept at a distance from staff actively crowding the person. [\[67\]](#) [\[69\]](#) [\[70\]](#)

B6. Alternatives and availability

For each relevant option, distinguish offered and accepted, offered and declined, attempted without sufficient effect, unsuitable for an identified reason, unavailable, or not considered. Record why an option was unavailable and who is responsible for remedying the deficit.

Include 'doing less' among the alternatives to be considered: reducing the audience, stepping back, preserving an exit, permitting safe movement or lying/sitting on the floor, tolerating non-dangerous vocalisation, lowering sensory input, and maintaining one calm communication channel. Record whether distance remained communicatively responsive rather than becoming abandonment. [\[68\]](#) [\[69\]](#) [\[70\]](#)

B7. Decision and authority

Identify the decision-maker, applicable authority and contemporaneous reasons. Separate the justification for a treatment from the justification for the method used to impose it. Record review points and changes in the risk that originally justified intervention. Where departure from a crisis-regulation environment is prevented, also record the person's detention status, the legal basis for seclusion or any deprivation of liberty, the precise threshold relied on, the evidence that threshold was met, and any immediate assessment required because the person was previously voluntary. [\[2\]](#) [\[80\]](#)

Record separately any operational or social consideration that influenced the decision, including staffing, ward routine, embarrassment, pressure to restore order, or convenience of staff or other people. Such considerations may require service action, but they do not establish dangerousness and must not be presented as satisfying a legal threshold for deprivation of liberty.

B8. Complete restrictive sequence

Record each form of restriction, its timing and duration, concurrent medication and any movement between settings. Preserve the combined sequence from the person's perspective. Include relevant threatened intervention or [coercive](#) conditions in accordance with the reporting standard adopted.

B9. Physical monitoring and effective access to help

Record observations actually made, by whom and when, alongside clinical action taken in response. Include the person's ability to communicate breathing difficulty, pain or other needs and the practical method of calling for help. A ticked field should not replace a meaningful record of abnormal findings and response.

Record the imposed body position, head and neck position, relevant pressure or weight-bearing, any known positional breathing vulnerability, the person's reports of breathing or swallowing difficulty, whether oral fluids or medicines were offered and in what position, and every action taken in response. Sudden inability to breathe or swallow should be treated as a potential medical emergency rather than a behavioural event. [\[18\]](#) [\[53\]](#) [\[54\]](#) [\[55\]](#) [\[56\]](#)

B10. Psychological and sensory experience

Invite the person's account of fear, pressure, suffocation, humiliation, injustice, sensory distress, loss of control or other effects. Record their words or agreed communication, without requiring them to choose a clinical label. Distinguish their report from staff inference.

B11. Why and when the intervention ended

Record the change in danger and the reason for ending the intervention. Do not equate cessation of resistance with consent or emotional recovery. Identify whether release was delayed while agreement, apology or an unrelated behavioural expectation was sought.

Where a crisis-regulation environment temporarily prevents departure, record the specific immediate danger justifying that restriction, every intermediate increase in freedom, the observable evidence supporting or delaying each transition, and whether the person remained free to move, communicate and use self-regulation within the environment. Record explicitly whether any release decision was influenced by quietness, obedience, apology, eye contact, verbal compliance or masking of distress rather than by the disappearance of the danger itself.

B12. The person's account and disagreement

Record when and how the person could contribute, whether they wanted an independent supporter, and whether further information is expected later. Preserve contradictions,

evidence relevant to them and corrections made. Refusal of an immediate [debrief](#) should not be entered as proof of lack of insight.

B13. Wider and delayed effects

Consider effects on sleep, communication, trust, use of services and daily activity, as well as other patients or witnesses. Set a proportionate follow-up point and offer support without requiring repeated disclosure. Serious harm or suspected abuse should trigger the appropriate independent process.

B14. Corrective action and accountability

State what will change, who has authority to make the change, the resources required, the completion date and how the person will be informed. Separate individual practice issues from managerial or commissioning responsibilities; do not let the latter disappear into a general staff-training recommendation.

Where the person alleges unnecessary force, ill-treatment or an inaccurate institutional account, preserve contemporaneous evidence promptly: relevant clinical notes, restraint/seclusion records, medication records, observation logs, available video, witness accounts and the person's own account. Effective review should not depend on the restrained person being able to assemble evidence while still dependent on the institution.

[\[125\]](#) [\[127\]](#)

B15. Verification of prevention

Check whether the promised change occurred, whether the same circumstances returned, whether restrictive exposure decreased and whether another form of [coercion](#) replaced it. Ask the person whether their situation improved. Close a learning action only when its implementation has been verified, not when it has merely been written into a plan.

Appendix C. Terms and abbreviations

Definitions below explain specialised or study-specific usage. Legal terms retain the meaning applicable under the relevant law and guidance.

Aggression, apparent or perceived. An observer's interpretation that a person looks or seems aggressive because of tone, facial expression, posture, movement, proximity, intensity or other presentation. It is not the same as an aggressive act and does not establish dangerousness.

Aggression. A behavioural description that should be tied to concrete acts rather than inferred from irritation, anger, unusual expression or diagnostic status. Even verified aggression does not by itself establish dangerousness or the legal threshold for coercive restriction.

Advance statements. Recorded preferences about future care made before a crisis. Statutory statements and other preference records can have different legal status; both may contain important information about what helps or harms. [\[2\]](#)

Aspiration pneumonia. Lung infection associated with material entering the airways rather than being swallowed normally. Restraint, reduced responsiveness and other clinical factors must be examined rather than assuming a single cause. [\[19\]](#)

Autistic shutdown. An experience described by autistic people involving reduced ability to communicate, move or engage during overwhelming conditions. Outward inactivity does not establish inner comfort. It is not interchangeable with sedation or [dissociation](#). [\[15\]](#)

Behavioural normalisation. Attempts to make a person conform to ordinary behavioural expectations. The concern here is suppression of harmless autistic characteristics, rather than relief of suffering or prevention of actual harm. [\[35\]](#)

Bodily claustrophobia. A descriptive expression for confinement applied directly to the body, with no usable space to withdraw from the constraint. It is not a diagnostic label. See section 3.3.

Case mix. Differences in the people and clinical situations served by institutions. These may affect observed rates and should be considered without assuming they explain all institutional differences. [\[22\]](#)

Cathartic aggression. The hypothesis that expressing anger through aggressive action relieves it. The anger-management research cited here does not support treating this as a general rule; it is a different question from preserving autistic [self-regulation](#). [\[27\]](#)

CGLPL. The French independent monitoring authority for places of deprivation of liberty: Contrôleur général des lieux de privation de liberté. Its urgent Melun recommendations are an inspection source, not a controlled medical study. [\[21\]](#)

Chemical restraint. Medication used as a means of controlling or restricting a person. It is not a synonym for every medicine or sedating treatment: purpose, consent, context and applicable definitions matter. [\[2\]](#) [\[37\]](#)

Coercion. Force, threats or other imposed control overriding a person's choice. Its presence depends on what the person can actually choose, not only on the terminology used by a service. [\[37\]](#)

Committee against Torture (CAT). The [United Nations treaty body](#) monitoring the Convention against Torture. Country observations, general comments and individual findings are distinct kinds of document. [\[36\]](#) [\[42\]](#)

Composite outcome. An outcome combining different types of event. A change in the combined measure does not establish an equal change in every component. [\[23\]](#)

CRPD and the CRPD Committee. CRPD denotes the Convention on the Rights of Persons with Disabilities. The Committee is the independent treaty-monitoring body, not the Convention itself. Its observations and guidelines must be identified by document and date. [\[34\]](#) [\[38\]](#)

Debrief. A discussion after an incident to understand what happened and what support or change is needed. The proposed approach permits delayed, written or supported accounts and does not require immediate disclosure. [\[2\]](#)

Dangerousness. A shorthand that can obscure the need to identify a specific risk. In this study it is not treated as a stable personal trait inferred from diagnosis, irritation or aggression. Restrictive decisions require evidence about the nature, seriousness, likelihood and immediacy of the particular harm feared.

Danger to self or others. A common risk formulation. It should identify the concrete harm feared rather than function as a self-proving label. The CRPD Committee's Article 14 guidelines use the expression 'perceived danger' to highlight the risk that a disability-related prediction is treated as sufficient ground for deprivation of liberty. [\[119\]](#)

False-positive risk prediction. A prediction that classifies a person as likely to produce a harmful outcome that does not in fact occur. False positives matter especially when the consequence of the prediction is restraint, seclusion, forced treatment or loss of liberty. [\[129\]](#) [\[130\]](#)

Perceived danger. Danger attributed to a person by an observer or decision-maker before the predicted harmful event has occurred. It may sometimes be supported by strong evidence, but it remains an assessment rather than a directly observed future fact. The term is used explicitly in CRPD Article 14 guidance. [\[119\]](#)

Power asymmetry. A condition in which one party has substantially greater practical control over movement, treatment, records, evidence or access to remedies than the other. In institutional settings this asymmetry can increase the consequences of interpretive error and the difficulty of contesting it. [\[127\]](#) [\[131\]](#)

Precautionary coercion. Restriction imposed primarily because of a feared future event rather than a danger already demonstrated to meet the applicable threshold. The term is used here analytically; European case-law requires strict necessity in the individual case and Lavorgna records the rejection of merely potential danger as sufficient for continued restraint. [\[123\]](#)

Deep vein thrombosis. A blood clot forming in a deep vein. This is one of the complications examined in studies of immobilisation and psychiatric restraint. [\[19\]](#) [\[20\]](#)

Defence cascade. A framework describing defensive responses to threat, including escape or resistance and forms of immobility. It does not establish which response occurred in an individual restraint incident. [\[16\]](#)

Deinstitutionalisation. A rights-based transition from institutional arrangements to support and inclusion in ordinary life under the person's control. Moving to a smaller building without changing control and choice is insufficient. [\[38\]](#)

Denominator. The population or exposure against which events are counted, such as admissions or occupied bed-days. Clearly defined denominators prevent changes in service size from being mistaken for changes in practice.

Diagnostic overshadowing. Misattributing a new symptom to an existing diagnosis, so that another cause is overlooked. Here the concern is missed physical illness or intervention-related harm when the person is already labelled psychiatrically or as autistic. [\[44\]](#)

Dissociation. Disruption or detachment in the ordinary integration of experience, such as feeling disconnected from the body or surroundings. It is one possible response to overwhelming threat, not an inference justified by silence alone. [\[16\]](#)

European Network of (Ex-)Users and Survivors of Psychiatry (ENUSP). A European survivor network. Its account of the 2015 European Union alternative report is used here to explain the role of survivor knowledge and rights-based advocacy. [\[32\]](#)

Iatrogenic harm. Harm caused by a healthcare intervention or its conditions of delivery, rather than solely by the difficulty for which help was sought. [\[30\]](#)

Independent advocacy. Support to express views, understand options and assert rights without depending solely on the treating team. It should assist, not replace, the person's own voice and choices. [\[2\]](#) [\[37\]](#)

Intramuscular. Administered by injection into a muscle. The route of administration is distinct from the medicine's purpose, consent to it and its effects. [\[18\]](#)

IRDES. Institut de recherche et documentation en économie de la santé, a French health-economics research institute. The cited study combines quantitative analysis across establishments with qualitative fieldwork. [\[22\]](#)

Irritation or anger, apparent. An observer's interpretation of a person's visible affect or distress. Unless the person confirms it, it should be recorded as a perception rather than treated as direct knowledge of the person's internal state. It is distinct from perceived aggression, actual aggressive conduct and dangerousness.

Irritation. An affective state of annoyance, frustration or anger. It may be intense and visibly expressed without aggression, and it does not by itself establish danger.

Learning disability in UK usage. A lifelong condition affecting learning and everyday skills, with differing support needs. In this UK policy context it generally corresponds to intellectual disability, not a specific difficulty such as dyslexia. Autism is not synonymous with it. [\[43\]](#)

Long-term segregation. Extended separation from other patients or ordinary ward life. The precise category is jurisdiction-specific; the English review cited here concerns prolonged hospital isolation, not every brief episode of [seclusion](#). [\[30\]](#)

Manual or physical restraint. Bodily restriction imposed through physical force, including being held by others. Definitions and reporting categories differ between studies and legal frameworks; the actual intervention must be specified. [\[2\]](#) [\[18\]](#)

Mechanical restraint. Restriction of movement through devices or equipment. It should be distinguished from [manual restraint](#) and from an aid the person freely chooses and controls. [\[2\]](#)

Nasogastric feeding. Delivery of nutrition through a tube passing through the nose into the stomach. The medical objective and any additional restriction used during the procedure require separate consideration. [\[1\]](#) [\[2\]](#)

National Health Service (NHS). The public health services of the United Kingdom. The English use-of-force guidance cited in this study does not automatically apply as Scottish law. [\[41\]](#) [\[43\]](#)

National Institute for Health and Care Excellence (NICE). A UK guidance-producing body. NG10 is its violence-and-aggression guideline. It is used as a clinical reference; its provisions should not be confused with Scottish legislation. [\[18\]](#)

Normocentrism. The term used here for treating customary non-autistic behaviour and communication as an unquestioned standard. It is an analytical description, not a clinical category. See section 2.1.

Office of the United Nations High Commissioner for Human Rights (OHCHR). The [United Nations](#) human rights office, co-author of the 2023 mental health legislation guidance and host of the [treaty-body](#) documents cited here. [\[37\]](#)

Personal agency. A person's ability to act, make choices and influence what happens to them. In this study, it includes practical control over movement, communication, support and everyday decisions.

Powerlessness. In the anti-torture analysis cited here, a condition in which a person has effectively lost the capacity to resist or escape pain or suffering. Hospitalisation, institutional control, incapacitating medication and other coercive conditions can contribute depending on circumstances. The concept is analytically useful without predetermining the legal classification of a particular restraint. [\[46\]](#)

Positive Behaviour Support (PBS). A named approach to understanding behaviour and organising support. Its interpretation and use are contested in Scottish consultation evidence. A label does not establish respect for autonomy or prevent [normalisation](#). [\[2\]](#) [\[7\]](#)

Post-traumatic stress disorder. A clinical condition involving persistent trauma-related symptoms and impairment. Severe distress should be recorded and addressed without requiring this diagnosis. Estimates after restrictive interventions are not a universal risk rate. [\[17\]](#)

PRN / as-needed medication. PRN abbreviates the Latin pro re nata, meaning as needed. A medication order is not the same measure as a verified administration, dose received or subjective experience. [\[18\]](#) [\[25\]](#)

Pulmonary embolism. Blockage of a blood vessel in the lungs, often by a clot travelling from elsewhere. It is potentially serious and is included within venous [thromboembolic](#) disease. [\[20\]](#)

Rapid tranquillisation. Urgent medication intended to reduce acute agitation, generally by injection in the cited guidance. Assessment and monitoring are required; sedation is not proof that underlying distress has resolved. [\[18\]](#)

Retraumatism. Reactivation or intensification of trauma-related distress through a later experience. An intervention can be experienced in relation to earlier violence or loss of control. [8] [10]

Safewards. A ward-based programme of relational and practical interventions intended to reduce conflict and containment. Its trial used a composite containment outcome, not [physical restraint](#) alone. [23]

SBU. The Swedish Agency for Health Technology Assessment and Assessment of Social Services. Its review concerns [coercive](#) measures in psychiatric and residential care for children and young people. [24]

Seclusion. Enforced separation in a place the person is prevented from leaving. It is different from a freely chosen quiet space. The inconsistent risk thresholds in the Scottish draft are addressed in section 12.9. [2]

Self-regulation. Ways a person manages sensations, emotions or activation. This study emphasises safe methods chosen by the person, including movement, communication, environmental change or rest. [14]

Small-cell identification. The risk of identifying a person from a very small reported subgroup. Reporting should preserve meaningful scrutiny while protecting privacy.

Socio-generated impingements / harm. Autistan's analytical terms for sensory, mental (psychic) or other externally generated disturbances produced or amplified by social arrangements, interactions, institutional rules or failures of accessibility, understood as violations or micro-violations of natural harmony and/or equilibrium. See section 2.1. [64] [65]

First-order and second-order impingements. In Autistan's causal model, a first-order impingement contributes to the original suffering or crisis; a second-order impingement is an additional sensory, psychological, relational or bodily harm created by the response to that crisis. These are analytical terms, not clinical diagnoses. See section 2.4.

Escalation paradox. A mechanism proposed by Autistan in which the response to crisis adds sensory, bodily, social or psychological impingements to the conditions already producing distress, intensifying the reaction and potentially generating further justification for control. See section 2.4.

Statutory guidance. Guidance issued under legislation. The Scottish Code's legal basis requires relevant decision-makers to have regard to applicable provisions; it is not itself a replacement Act of Parliament. [3]

Stimming. Repetitive movements, sounds or other actions that may serve sensory, emotional or communicative functions for an autistic person. Their meaning and helpfulness must be understood individually. [14]

Supported communication. Assistance enabling a person to understand and express information using preferred methods. It can include time, writing, devices, pictures or trusted support, without transferring authorship of the account. [2]

Tonic immobility. An involuntary defensive state involving marked motor inhibition under extreme threat. Stopping resistance is not sufficient evidence to identify this state in a particular person. [16]

Torturing environment. A framework developed by Perez-Sales and colleagues for examining the combined environment, practices and attacks on human functions through which severe suffering and loss of control can be produced. The research cited here concerns torture survivors; the framework is used comparatively and has not been validated as a psychiatric-restraint scale. [\[49\]](#) [\[50\]](#)

Treaty body. An independent expert body monitoring a human rights treaty. A civil-society submission, a committee's recommendation and an individual judicial finding are not interchangeable. [\[34\]](#) [\[36\]](#) [\[42\]](#)

Venous thromboembolism. Conditions involving clots in veins and their possible movement to the lungs. The cited Danish study compared mechanically and chemically restrained groups; it did not establish that either intervention is harmless. [\[20\]](#)

World Health Organization (WHO). The United Nations specialised health organisation. Its joint 2023 guidance with [OHCHR](#) addresses rights-based mental health legislation and services. [\[37\]](#)

World Network of Users and Survivors of Psychiatry (WNUSP). An international survivor-led network. Its position paper is cited as organisational analysis and advocacy, not as a clinical trial or a ruling by a [United Nations](#) body. [\[31\]](#)

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Reference numbers match the citations throughout the study. Numbered citations link directly to the source; every entry below displays the full source URL. Source type and evidential role are identified where they affect interpretation. Web sources consulted for this edition on 28 October 2026.

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Brasília, 29 October 2026