Title: Restraining Good Practice: Reviewing evidence of the effects of restraint from the perspective of service users and mental health professionals in the United Kingdom (UK)

Abstract

Safeguarding, balancing the concept of risk with the need for public protection and its implication for the lives of individuals, is an important facet of contemporary mental health care. Integral to safeguarding is the protection of human rights; the right to live free from torture, inhuman or degrading treatment, and having the right to liberty, security, respect and privacy. Professionals are required to recognise all of these rights when delivering care to vulnerable people. In the United Kingdom (UK) there has been growing public concern regarding abusive practices in institutions, with a number of unacceptable methods of restraint being identified as a feature of care, particularly in mental health care. In keeping with the service user movement, and following a review of the literature, this paper discusses the evidence regarding restraint from the perspectives of service users and professionals within mental health services and considers the implications for future practice and research. In reviewing the literature findings revealed restraint can be a form of abuse, it's inappropriate use often being a consequence of fear, neglect and lack of using de-escalation techniques. Using restraint in this way can have negative implications for the well-being of service users and mental health professionals alike.

Key Words: abusive practice, de-escalation, human rights, mental health, restraint, safeguarding

1. Introduction

While safeguarding is an international issue, recent scandals in care settings in the UK have caused major public concern (Wainwright 2012). Undercover filming within care settings found abusive practices, with illegal and abusive restraint being a significant feature (Flynn 2012). The impact of such scandals can lead to a tendency for practitioners to adopt defensive practice, thus reducing opportunity for positive risk taking (Arnoldi, 2009), the latter playing a central role in assisting personal development and enhancing a person's quality of life (Sharland, 2006). Managing positive risk taking is a process of compromise and negotiation. It requires an increase in potential benefits, and a rigorous process for planning and monitoring risk taking strategies and reviewing the results (Titterton 2005). A lack of positive risk taking compromises service user involvement in risk assessment, at times the latter being unaware that a risk assessment has been carried out (Langan & Lindlow 2004). While service users are now recognised as experts in their own right (Lammers & Happell 2003; Warne & McAndrew, 2004), the issue of their involvement in risk assessment has, to date, not been adequately addressed (Langan 2009). In ignoring such expertise, the service user is confined to a state of anomie with little or no choice in terms of the interventions used to address their health and social care needs (Warne & McAndrew, 2006). For professionals, the unconscious nature of many of their responses to service user expertise regarding risk assessment, only serve to reinforce the traditional professional/client dichotomy, the former dominating the latter. This situation has the potential to lead to more social controls being put into place, restraint being one of them which, in essence, can impact negatively on a person's dignity, human rights and full citizenship (Morrall & Muir-Cochrane 2002).

1.1 Restraint: the legal and political context

The Mental Capacity Act (MCA) for England and Wales (2005) states that "someone is using restraint if they use force, or threaten to use force, to make someone do something they are resisting, or restrict a person's freedom of movement, whether they are resisting or not" (MCA 2005). Whilst legislation and policy attempts to define and outline when restraint may be used, the types of restraint employed by professionals vary in different situations. Different types of restraint include: physical, including holding a person or blocking movement; mechanical, using equipment or furniture to prevent/restrict movement; chemical, using prescribed medication on a regular basis to manage behaviour; technological, such as 'tagging', door pads; and psychological, depriving a person of possessions/equipment or constantly directing a person not to do something (Commission for Social Care Inspection, 2007). In using any of the aforementioned, professionals need to recognise that preventing a person from doing as they wish, may contravene their human rights (Owen & Meyer 2009). MIND (2009) echoed the need for a rights-based approach when providing services for those who have mental health problems, suggesting that systems tend to be paternalistic, failing to take account of preferences from the individual's perspective and disempowering people from making decisions that affect their lives. Guiding principles for the promotion of human rights for people with mental disorder were outlines by the World Health Organisation (WHO) (1996) however, where practices of restraint contravene such principles it could be interpreted as abusive restraint. For example, section 2 of Principle 8, 'Standards of Care', states, "Every patient should be protected from harm, including unjustified medication, abuse by other patients, staff or others, or other acts causing mental distress or physical discomfort" (WHO, 1996, p16). Data analysed from the National Audit Survey for people with learning disabilities, (Healthcare Commission for Audit Inspection, 2007), of facilities for people with learning disabilities in England, found a consistent trend of using medication as restraint over physical intervention, with 80% of services using Pro Re Nata (PRN), 'medication as required', excessively (Sturmey, 2009).

In the UK, the inception of policy that tried to address adult abuse and the management of risk was the Department of Health (DH) guidance, No Secrets, (DH, 2000). 'No Secrets' outlined adult protection (later referred to as safeguarding adults), offering guidance to agencies involved in incidents of abuse and providing a framework for the development of local policy. 'No Secrets' (DH, 2000) also defined adult vulnerability and abuse to help establish clear terms of reference that could be used in fieldwork settings. However, since the inception of 'No Secrets', other legislation has been implemented. The Deprivation of Liberty Safeguards (DoLS), introduced via an addendum to the Mental Capacity Act 2005 (Ministry of Justice 2008), provides a framework for people who need to be deprived of their liberty, such as those who are at risk of harm to self or others and who do not have mental capacity in relation to making decisions regarding their care and treatment (Ministry of Justice 2008). On 1st April 2015, The Care Act (2014) came into statue, overriding the policy around safeguarding set out in 'No Secrets'. The Care Act (2014) sets out a clear legal framework for how local authorities and other service providers should protect adults at risk of abuse or neglect. In the UK, on 19 March 2014, 'Deprivation of liberty' was defined by a Supreme Court ruling, when they unanimously ruled on two cases; *P v Cheshire West and Chester Council and P & Q v Surrey County Council* [2014] (UKSC, 19). In P v Cheshire West, P, a profoundly disabled man, was deprived of his liberty by the complete and effective control exercised over his life by those looking after him. In the second case, P & Q v Surrey County council, two sisters P, who had a moderate to severe learning disability, and Q, who had a mild learning disability were deemed to have been deprived of their liberty. Whilst P lived with her foster mother and Q resided in a funded NHS residential home, both did not have the option of leaving their respective care settings. The Supreme Court ruled that those who lack the capacity to make decisions about their care and residence and, under the responsibility of the state, are subject to continuous

supervision and control and lack the option to leave their care setting are unlawfully being deprived of their liberty.

In effect the ruling rejected the Appeal Court's decision, re-affirming the original decision made by the Court of Protection. In reaching this decision the Supreme Court identified that to determine whether a person who is mentally incapacitated is being deprived of their liberty, the following 'acid test' should be applied: Is the person subject to continuous supervision and control? Is the person free to leave? The focus is not on the person's ability to express a desire to leave, but on what those with control over their care arrangements would do if they sought to leave. The Supreme Court went on to clarify that in all cases, the following are not relevant when applying the test: The person's compliance or lack of objection; the relative normality of the placement (whatever the comparison made); the reason or purpose behind a particular placement.

While the Act defines situations that may constitute a deprivation of liberty, the use of restraint as outlined in the MCA (2005) may not be deemed to be a deprivation of liberty. The European Court of Human Rights states that a deprivation of liberty is dependent on the individual circumstances of each case and there is no single definition (Council of Europe/European Court of Human Rights 2014). In the UK the National Institute for Clinical Excellence (NICE) (2005) guidance regarding restraint advised that account be taken of 'necessity', with reference to the European Convention on Human Rights, including Article 2 (right to life); Article 3 (the right to be free from torture or inhuman or degrading treatment or punishment); Article 5 (the right to liberty and security of person save in prescribed cases); and Article 8 (the right to respect for private and family life), and the principle of 'proportionality' (HRA 1998). However, the MCA (2005) can be used to restrain a person under differing circumstances and conditions (RadcliffesLeBrasseur 2010), such as confining a person to an environment that has door locks

they are unable to open or allowing prescription drugs to be used in order to sedate someone.

1.2 Implications of legislation and policy on practice

Regardless of the subjective nature of the use of restraint being right or wrong, in a minority of cases it can be abusive, particularly when no formal risk assessment has been carried out or where there has been no exploration of alternatives, involving the restrained person and/or their relatives (DH, 2014). While the balance of risk and safety can be difficult to calculate, the use of abusive restraint can have negative implications for both service users and professionals alike. The remainder of this paper reports on a review of available evidence that specifically focuses on the implications of using restraint from the perspective of users of mental health services and professionals delivering such services in the UK.

2. Reviewing the literature

2.1 Search strategy

To elicit selective papers relating to the implications of using restraint from the perspective of users of mental health services and those implementing it, a systematic approach was used to search the data bases. Inclusion criteria comprised all papers published in English since 2000, this being the year that No Secrets (DH 2000) was implemented, those focusing on adults, 18 years and over, papers reporting on service user and/or professional perspectives of restraint and those studies undertaken in mental health and/ or an associated residential settings, usually for those with a learning disability, within the UK.

The terms ‘risk’ ‘abuse’ ‘restraint’ ‘adult service user perspectives’ ‘mental health services’ and ‘professional perspectives’, the latter making use of synonyms such as social worker, nurse, mental health worker, doctors, were listed to initiate the search. Using the terms generated, the following databases, MEDLINE, British Nursing Index (BNI) Cumulative Index

to Nursing and Allied Health (CINAHL); Social Care on Line, Social Sciences Abstracts (SSA), SWETSWISE, Cochrane Library, Applied Social Sciences Index and Abstracts (ASSIA), and PsychINFO were searched. Boolean techniques, using 'and' with the differing search terms allowed the search to be narrowed to a number of useful hits. In addition, Google scholar, having comprehensive coverage of academic literature in health and social care (Gehanno *et al.* 2013), was also searched. Additionally, hand searching was employed as referenced articles can often identify research for further exploration (Taylor *et al.* 2003).

With regard to restraint being considered an abusive practice from the perspectives of service users and those providing care, and the inclusion criteria identified above, the initial search yielded 13 papers. On further examination of the papers, two were duplicates and four were not related to mental health. The results of the search indicated that in the last 14 years relevant studies equated to seven published papers. Of the seven studies identified; four were qualitative studies (Bonner *et al.* 2002; Fish & Culshaw, 2005; Jones & Kroese, 2006; Perkins *et al.* 2012), one study used mixed methods (Duxbury *et al.* 2002), one study made use of a survey comprising of quantitative and qualitative questions (Lees *et al.* 2003) and one was a quantitative study (Foster *et al.* 2007). See Table 1 below for an overview of the studies.

Table 1

Author/s	Research Paradigm	No. of subjects	Data Collection	Data Analysis	Main Findings
Bonner, et al. (2002)	Qualitative	12 staff 6 pts	Interviews	Thematic Analysis	Problematic unsettled environment Service Users (Sus) alerted staff when disturbed but ignored SUs find restraint distressing Re-traumatisation can occur Staff only debrief Restraint common when unfamiliar staff on duty
Duxbury (2002)	Mixed Methods	80 pts 72 nurses 10 medics	Questionnaire Incident forms Interviews	Factor Analysis & Thematic analysis	Staff controlling Poor communication & environment factors equate to aggression Verbal aggression most common Medication/restraint/seclusion commonly used in response to aggression

					Patients (PT) & staff believed they were victims Inadequate organisation & management leads to restraint
Fish & Culshaw (2005)	Qualitative	7 nurse assistants 6 nurses 3 clinical team leaders 9 service users [SU]	Unstructured interviews - participatory approach participant-led	Phenomenological analysis.	Restraint: frustrating & re-traumatising. Staff – feel guilty in using restraint. SUs felt restraint was a punishment SUs knew restraint used to prevent harm SUs cited provocation and situational factors equated to aggression Staff felt aggression due to a factors built up over time
Jones & Kroese (2006)	Qualitative	10 SUs detained under MHA & restrained in last 6 months Managers selected people likely to engage	Semi-structured interviews	Thematic Analysis	SUs knew why restraint used, 50% said it did not help them calm down. Not being listened to prompted aggression Abusive restraint evident Restraint followed interaction with staff Being ignored after restraint difficult. SUs believed poor coping skills & poor understanding of restraint made them vulnerable to stress reactions following restraint. No de-briefing post-restraint problematic.
Lees et al. (2003)	Qual & Quant Survey	338 nurses	Survey	Thematic Analysis & SPSS for numerical data	Positive experience of restraint. Concern re opportunity for abuse. Negative attitudes of colleagues Using restraint is demeaning Staff have worse injuries than pts. Poor organisation & management contribute to use of restraint
Foster et al. (2007)	Quantitative	Nurses on 5 acute wards	Completion of SOARS-R	SPSS/ descriptive statistics	Staff often the target of aggression Provocation due to denial of item Staff fear likely to lead to restraint
Perkins, et al. (2012)	Qualitative	30 nurses	1:1 interviews & focus groups	Thematic Analysis	Triggers; self-harm, aggression, violence, ward demands, unknown SUs, unfamiliar staff. Restraint as deterrent for unacceptable behaviour and as first line management

2.2 Overview of the research strategies

The studies reviewed have some shared strengths and limitations. Five of the studies (Duxbury 2002; Lees *et al.* 2003; Fish & Culshaw, 2005; Foster *et al.* 2007; Perkins *et al.* 2012) gave voice specifically to mental health professionals regarding the use of restraint, while three (Bonner *et al.* 2002; Duxbury 2002; Jones & Kroese, 2006) offered a voice to the service user. In Perkins *et al.*'s (2012) study there was lost opportunity in exploring restraint from the service user perspective as this would have been a useful strategy to triangulate data. In Duxbury's

(2002) study the ‘Management of Aggression and Violence Scale’ (MAVAS) was formulated for the purpose of the study, and used to analyse participants’ views on patient aggression and subsequent action to manage such situations. The reliability of the MAVAS was established by using a test–retest procedure (Burns & Grove 1993), with, according to the researcher, factor analysis being used to determine its validity. However, this is misleading as factor analysis is used to reduce the number of variables that can then be tested for their construct or criterion validity. Additionally, although Duxbury (2002) used semi-structured interviews with four service users, four nurses and three doctors, the specific interview findings were not presented in the paper.

Five of the studies used small samples (Bonner *et al.* 2002; Duxbury 2002; Fish & Culshaw, 2005; Jones & Kroese, 2006; Perkins *et al.* 2012), while Lees *et al.’s* (2003) study had a low response rate and, focusing on the last incident of restraint, had the potential to create bias. Three studies (Duxbury, 2002; Fish & Culshaw, 2005; Foster et al., 2007) were carried out in one region, North-West England, making generalisations to other regions difficult, as they may have different policies, procedures and training, as well as different organisational cultures. However, regardless of sample size and where the studies took place, all have an important contribution to make in relation to gaining insight into the impact of using restraint from the perspective of professionals and service users who have experience of mental health and associated services.

3. Research findings

The findings from the studies can be organised into three themes (1) Triggers for restraint and taking control; (2) External forces and (3) Physical and emotional consequences.

3.1 Triggers for restraint and taking control

In four of the seven studies (Duxbury 2002; Fish & Culshaw, 2005; Foster *et al.* 2007; Perkins *et al.* 2012) incidents of violence and aggression were cited as the main trigger for using restraint. It was reported that the majority of incidents had been preceded by the service user either physically assaulting or attempting to assault someone, or had been threatening physical violence (Duxbury 2002; Perkins *et al.* 2012). Foster et al.'s (2007) study indicated 5.7 of the incidents reported related to acts of verbal and physical aggression, with staff being the most common target (57.1% of incidents). However, in Duxbury's (2002) study, 70% of incidents consisted of verbal abuse and threats, with verbal aggression accounting for most (84.1%) of the incidents. However, violence and aggression were not always directed at staff, and Foster *et al.* (2007) found no significant differences in service user and staff targeted incidents. In their study, 48 incidents, where other service users had been the target, were reported, with verbal aggression and use of hand pushing accounting for 45.8% of cases.

Whilst incidents of aggression, whether they are physical or verbal threats, both staff and service users had their own perspectives on what triggered such behaviour. Service users felt that approaches on the part of the staff were controlling in nature, believing that poor communication and environmental factors often precede episodes of aggression (Bonner *et al.* 2002; Duxbury, 2002; Fish & Culshaw, 2005; Jones & Kroese, 2006). The notion of using restraint as a way of controlling behaviour was evident in five of the studies (Lees *et al.* 2003; Fish & Culshaw, 2005; Jones & Kroese, 2006; Foster *et al.* 2007; Perkins *et al.* 2012). However, in Duxbury's (2002) study the service users believed the use of restraint to control and reduce symptoms of illness when only 13.5% of incidents involved actual violence is inappropriate. In Perkins *et al.'s* study (2012) staff viewed restraint as a 'necessary evil', used to control behaviour and prevent violence, while Fish and Culshaw (2006) revealed conflicting perceptions between staff and service users as to why restraint was used. Staff reported that they used restraint as a last resort, while service users believed it was used, on occasion, as a

punishment (Fish & Culshaw, 2006). Threats to ward stability and functioning were also offered as important reasons for the decision to restrain individuals, being explicated in terms of avoiding behavioural disturbances that could potentially impact on other service users. The issue of using restraint as a form of control in Perkins *et al.'s* (2012) study related to staff making a distinct association with the service user's mental illness and their inability to control their behaviour. This finding was somewhat contradictory to that of the service users in Bonner *et al.'s* (2002) and Jones and Kroese's (2006) studies, where service users reported they had alerted staff to their disturbance prior to restraint, but felt ignored.

Taking into consideration people usually get admitted to acute inpatient care when their illness is at its worst, and their ability to control their behaviour is reduced, restraint in acute mental health services could be accepted as normal practice (Perkins *et al.* 2012). However, it was also reported that fear of aggression may motivate staff to use physical means, such as restraint and/or seclusion, to manage what is considered to be unacceptable behaviour (Bonner *et al.* 2002; Duxbury 2002; Foster *et al.* 2007). With regard to fear as a motivator, the nurses in Perkins *et al.*'s (2012) study articulated how knowing a patient meant that they were aware of their pattern of behaviour and trigger points to aggression, making risk more predictable and de-escalation possible. Mirroring this, service users in Bonner *et al.'s* (2002) study suggested that staff who did not know them, for example agency staff, increased the likelihood of restraint being used.

While what staff might consider 'unacceptable behaviour' can be managed in a variety of ways, the evidence suggests that medication, restraint or seclusion are the most popular approaches (Duxbury 2002; Lees *et al.* 2003; Fisher & Culshaw, 2005; Jones & Kroese's 2006; Foster *et al.* 2007; Perkins *et al.* 2012). Having a de-escalation strategy, involving good communication, was reported as an important approach in dealing with unacceptable behaviour (Duxbury 2002; Fisher & Culshaw, 2005; Jones & Kroese's 2006; Foster *et al.* 2007; Perkins *et al.* 2012). In

Foster *et al.'s* (2007) study the main technique for managing staff targeted incidents was talking to the service user (42.1%), followed by seclusion (35.9% of incidents). However, Perkins *et al.* (2012) found that everyday de-escalation, using communication, often involved directing the service user to modify his/her behaviour. Ironically this was reported as the least useful approach when service users were suffering from acute symptoms, with staff recognising that this could be provocative and escalate, what they described to be, 'unacceptable behaviour' (Perkins *et al.* 2012). Likewise, Duxbury (2002) identified that only 25% of incidents involved de-escalation, while Foster *et al.* (2007) reported seclusion being employed in over a quarter of all incidents, with 22.83% resulting in the service user being physically restrained, as opposed to staff employing less restrictive methods. More concerning, Perkins *et al.* (2012) reported that while the nurses acknowledged that horizontal restraint should be used only as a last resort in a progressive step-wise approach, it was reported as the first method used by the majority of staff with no alternative restraint positions being tried. The main priority was to act swiftly, which tended to lead to the use of unsystematic restraint, rather than a progressive, graduated, sequenced response as recommended by NICE (2005).

While it is reassuring that the findings highlight communication being used to attain de-escalation (Duxbury, 2002; Perkins et al., 2012), the decision to use physical restraint, such as seclusion, remains a concern. Indeed some professionals reported a tendency to use restraint too quickly, with a 'deck people first' and a 'bouncer mentality' (Lees *et al.* 2003). Sadly, for some, the experience of being restrained prevented their future engagement with services (Bonner *et al*. 2002).

3.2 External forces

In four of the studies reviewed (Bonner *et al.* 2002; Duxbury 2002; Lees *et al.* 2003; Perkins *et al.* 2012) external forces were seen as contributing to the use of restraint. Organisational

demands and ward issues were considered partly responsible for creating an environment in which challenging behaviour developed and escalated (Duxbury 2002; Perkins *et al.* 2012). The ward environment was identified as a factor contributing to the use of restraint (Lees *et al.,* 2003; Fish & Culshaw, 2005). In Bonner *et al.'s* study (2002) staff cited an unsettled ward environment as a major contributor to using restraint, while Fish and Culshaw's (2005) study mirrored this finding from a service user perspective. There was also a mirroring of service user and staff views in terms of the unsettling nature of the ward environment being related to unfamiliarity (Bonner *et al.,* 2002; Perkins *et al.,* 2012). With regard to staff, changes in the service user population meant they became cautious in dealing with those who they did not know well (Perkins *et al.* 2012), while Bonner *et al.'*s (2002) reported unfamiliar staff, equating to an increase in the risk of restraint being used.

3.3 Physical and emotional consequences

Six of the studies (Bonner *et al.* 2002; Lees *et al.* 2003; Fisher & Culshaw, 2005; Jones & Kroese's 2006; Foster *et al.* 2007; Perkins *et al.* 2012) highlighted the physical and emotional consequences of restraint for staff and service users. It was suggested that physical interventions such as restraint often become a 'battleground' as each party tries to gain control (Perkins *et al.* 2012). As with any battleground, people get hurt and in Lees *et al.'s* (2003) study 13% of participants reported service user injury, whilst 21.6% reported staff injury as a consequence of restraint. Likewise, Foster *et al.* (2007) identified pain or injury being reported in 7.6% of incidents. However, the nature of injury differed between service users and staff; the former being reported as minor scratches and bruises, whereas the latter were reported as more serious injuries, including black eyes and broken noses (Lees *et al.* 2003). In contrast, in Foster *et al.'s* (2007) study incidents directed at other service users had severe consequences for those targeted, with a quarter reporting pain or the need for treatment. Considering that restraint is often used in response to aggressive behaviour, albeit physical or verbal, Foster *et*

al. (2007) estimated that a nurse, working in the units where their research took place, would need to work for 10 years to experience an injury stemming from service user aggression. However, the consequences of restraint do not only manifest in terms of physical injury, emotional trauma is also reported as being problematic.

Staff and service users alike were reported to have experienced emotional distress in relation to the use of restraint. For staff, the consequences of using restraint included feeling threatened (Foster *et al.* 2007) and causing them distress and discomfort (Bonner *et al*. 2002). In Lees *et al.'s* (2003) study participants suggested the experience of physically restraining a service user was demeaning , with 3% reporting the need to take sick leave following their last restraint use, due to the personal stress it caused.

Similarly, service users described powerful and distressing emotions relating to restraint (Bonner *et al.* 2002; Lees *et al.* 2003; Fish & Culshaw, 2005). For example a participant in Bonner *et al.'s* (2002) study reported having been left in 'wet urine soaked clothing for three hours', whilst in Lees *et al.'s* (2003) study excessively long restraint (up to 6 hours) was reported. Just as behaviour on the part of service users was deemed to be unacceptable, such behaviours on the part of staff are also demeaning, distressing and therefore also unacceptable. In addition, and what professionals need to be cognisant of is, for a number of service users restraint has the potential to re-traumatise, due to past experiences of abuse, many having experienced physical or sexual abuse in childhood (Bonner *et al.* 2002; Fish & Culshaw, 2005).

Dealing with the consequences of restraint can be difficult. Only Bonner *et al.* (2002) highlighted strategies used by staff to 'buffer' the consequences of restraint. These included helping each other out, good team work and having the facility for de-briefing. However, both Bonner *et al.* (2002) and Jones and Kroese (2006) reported de-briefing was not offered to service users, who reported feeling ignored post incident.

The seven studies reviewed above all suggest that restraint is a feature of practice in mental health and associated settings and has implications for those receiving and those delivering care. Each study identifies inappropriate use of restraint with negative consequences for service users and professionals alike. While restraint is used to control what staff deemed to be inappropriate behaviour, being controlling appears to give rise to verbal and physical aggression. Environmental factors may impact on the professional's decision to restrain, but there is a mismatch between the level of disturbance on the part of the service user and the response to such by staff invoking restraint. However, while both service users and those delivering care recognise the place of restraint in contemporary mental health care, the way in which it is sometimes used can breach human rights with negative consequences, such as fear, physical injury and emotional distress for both parties.

4. Discussion

The findings identified above can be discussed at three levels; the micro, individual level; the meso, an organisational level; and the macro level, within the wider socio-political context.

4.1 The micro level: individual level

At the micro level restraint being used inappropriately appears to be recognised by staff and service users alike. Professionals suggested that in some instances restraint was used too quickly and there was concern expressed about a 'bouncer mentality', (Lees *et al.* 2003), an attitude similar to that found in the Winterbourne Report (Flynn 2012). However, regardless of restraint being used inappropriately, some staff expressed being uncomfortable with using restraint per se, their own experiences of distress and discomfort mirroring those of service users (Bonner et al. 2002; Duxbury 2002; Lees *et al.* 2003; Fish & Culshaw, 2005). Participants in one study (Lees *et al.* 2003) believed restraint was demeaning for service users, raising the question as to why restraint is so readily used.

Restraint can have a negative impact on the interpersonal relationships between staff and service users, with both parties feeling victims of restraint (Duxbury 2002; Lees *et al.* 2003). While evidence suggests service users believed they were victims of controlling staff and staff believing they are victims of service user aggression; the juxtaposition of such beliefs creates problematic interactions for both parties (Duxbury 2002). It could be argued that users of mental health services are perhaps those who would benefit most from having a therapeutic relationship with those providing care (Warne & McAndrew, 2004). As a number of people diagnosed with mental health problems have experienced abusive relationships earlier in life, restraint has the potential to reassert distressing memories (Bonner *et al.* 2002; Fish & Cumshaw 2005). In terms of defensive practice, it has been suggested that one explanation is that people with a history of abuse seek restraint as a form of contact (Lees *et al.* 2003), however, the potential to re-traumatise must not be underestimated. It could be suggested that if the service user, in seeking out interpersonal contact creates vulnerability on the part of staff, this may lead to a feeling of discomfort, but one which outweighs the discomfort staff experience when using restraint. However, perhaps it is nurturance rather than restraint that could be more productive in such situations.

Fear was also a pertinent feature of restraint for service users and professionals alike. For service users fear engendered by previous restraint experiences led them to disengage from services (Bonner *et al.* 2002), while the use of restraint was motivated by staff's fear of potential aggressive behaviour (Duxbury 2002; Foster *et al.* 2007; Perkins *et al.* 2012). When professionals consider service users to be dangerous, aggressive, or difficult to manage, restraint and seclusion are reported to be used in an arbitrary way (Alldred *et al.* 2006). In some instances fear prompted staff to be over-cautious in responding to risk, by acting too hastily in respect of restraint (Bonner *et al.* 2002; Duxbury 2002; Lees *et al.* 2003; Perkins *et al*. 2012). Further, fear of incidents escalating to violence, resulted in an overestimation of the perceived

threat, preventing staff from looking for alternative ways of providing more therapeutic containment (Duxbury 2002: Foster *et al.* 2007; Perkins *et al.* 2012) and subsequently reducing future opportunity for positive risk taking (Arnoldi 2009).

Positive interpersonal interaction and good communication were recognised as preventative approaches in avoiding restraint, but were not always present. However, while the importance of therapeutic interaction was recognised, service users reported that they were often ignored despite alerting staff to their feelings of disturbance (Bonner *et al.* 2002; Lees *et al.* 2002; Foster *et al.* 2007). Similarly, evidence suggests that while staff value de-briefing following restraint, the same opportunity is not afforded to service users (Bonner *et al.* 2002; Jones & Kroese 2006). The need for better communication and the opportunity to talk to staff has been recognised as a good strategy for avoiding restraint (Fish & Culshaw, 2005; Owen & Meyer, 2009) and one that could easily be utilised within all mental health and social care settings.

4.2 The meso level: organisational issues

The ward environment was reported as problematic in five of the seven studies (Bonner *et al.* 2002; Duxbury 2002; Lees *et al.* 2003; Fish & Culshaw, 2005; Perkins *et al.* 2012). An environment that is unsettling for service users was considered a potential initiator of aggressive behaviour (Bonner *et al.* 2002; Lees *et al.* 2003; Fish & Culshaw, 2005). At a pragmatic level, lack of space and unsafe furniture were cited as attributes of a poor physical environment (Lees *et al.* 2003). At a more complex level, the atmosphere within the environment was said to have provoked incidents leading to restraint (Fish & Culshaw, 2005; Foster *et al.* 2007). For example, it was reported that some staff viewed restraint as a 'necessary evil' in controlling behaviour and preventing violence, thus leading to the normalisation of the practice of restraint (Perkins *et al.* 2012). Such beliefs often become enmeshed within the

pervading culture and may contribute to the difficulties of introducing changes in practice (Pereira *et al.* 2006).

Organisational issues such as understaffing and the regular use of agency staff were factors associated with the use of restraint (Lee *et al.* 2003; Perkins *et al.* 2012; Flynn 2012). It was suggested staff were cautious in dealing with service users who they did not know well, believing that a sense of knowing a person helped predict behaviours that might trigger aggression, but at the same time has the potential to perpetuate restraint as a first line approach (Perkins *et al.* 2012). Likewise, service users had a negative view of agency staff, believing that they were more vulnerable to restraint when in their care (Bonner *et al.* 2002). With regard to unfamiliarity between staff and service users, the subjective nature of risk assessment is also problematic. Risk assessment is not only dependent upon the values and confidence of the person assessing the risk, but it also calls into question who has the expertise to determine risk (Arnoldi 2009). With regard to the former, being free of such values could be interpreted as a positive asset of agency staff, but the confidence of such people may be compromised when they are in unfamiliar situations. Furthermore, there may be fear of recrimination should a person be injured whilst in their care, as the socio-cultural nature of organisations place absolute priority on a safety first approach (Titterton 2005). In terms of expertise in assessing risk, perceptions vary amongst individuals working with vulnerable people (Anderson, 2006). Four of the above studies (Bonner *et al.* 2002; Lees *et al.* 2003; Jones & Kroese, 2006; Foster *et al.* 2007) found that service users recognised and reported their own disturbance prior to being restrained. Other studies noted that, within the same organisation, some staff are more likely than others to use restraint (Jones & Kroese, 2006; Bowers & Crompton 2012; Perkins *et al.* 2012), demonstrating that not involving the service user and/or their carer in the risk assessment process is, in itself, a risky business and one that contravenes the latest guidance (DH, 2014).

However, while noting the above, it should also be considered that restraint itself has the potential to cause harm (Parkes *et al.* 2011; Stubbs & Hollins 2011). Staff's skills and knowledge of restraint have been called into question, with both service user and staff injury being partly attributed to the use of different restraint techniques (Jones & Kroese 2006). Indeed, within the literature a taxonomy of restraint is identified and includes the vertical and horizontal positions, the latter only deemed necessary as a last resort, but often being used as the first line of action (Whittington *et al.* 2006; Perkins *et al.* 2012), and the prone position now being banned due to its potential lethality (DH, 2014). Training and support for professionals who provide care is essential if inappropriate restraint is to be eliminated (Fossey *et al.* 2006; Jones & Kroese, 2006; Owen & Meyer 2009). It appears there is wide variation in policy, education and training and, where this does not exist, staff may not have the skills or direction to appropriately work with those who present with challenging behaviour (Deveau & McGill 2008; Owen & Meyer 2009). In the absence of appropriate training and policy, and where there is nothing in place for adequate monitoring of practice, organisations could be construed as neglectful.

4.3 The macro level: wider socio-political context

In the wider context, a 'risk society' can be seen as the catalyst for risk aversion (Beck 1992). Managers in organisations providing care to individuals are often challenged within the wider health and social care context. For example, if something goes wrong when risks are taken the media are likely to instigate a public outcry. Likewise, this often reinforces negative views of people who experience mental health problems, with relatives wanting a 'locked door policy' to prevent harm to their loved ones (Owen & Meyer 2009). The notion of professional responsibility attached to risk, may account for the need to control a situation that is perceived to be threatening (Beck 1992; Duxbury 2002; Foster *et al.* 2007; Perkins *et al.* 2012). The culture of using control to avoid risk is demonstrated in the above studies, for example using

excessive measures that are disproportionate to the threat posed or in keeping with an individual's needs (Duxbury 2002; Lees *et al.* 2003; Perkins *et al.* 2012).

The UK government's agenda to promote dignity and choice (DH 2007) are in contrast to findings where restraint was considered by staff as demeaning in nature, yet the practice normalised and/or excessive (Bonner *et al*. 2002; Duxbury 2002; Lees *et al.* 2003; Foster *et al.* 2007; Perkins *et al.* 2012). Such practices challenge human rights, such as that of having a life free from degrading treatment and not to have one's liberty deprived, (HRA 1998). The MCA (2005) clarifies that restraint, in the context of restricting a person's movements, is permissible only in order to prevent harm and should be a proportionate response in relation to the likelihood and seriousness of harm (MCA 2005). People have a right to live a life free from abuse, (HRA 1998) and institutions should intervene 'proportionately' to protect individuals, (Association of Directors of Social Services, 2005). However, while legislation and policy provide parameters with regard to the use of restraint, disproportionate responses in relation to aggression and threats were reported in several of the studies reviewed (Duxbury 2002; Lees *et al.* 2003; Perkins *et al.* 2012).

It is argued that we live in a neo-liberal society that promotes individual choice and control and that health and social care are conceptualised within this political and economic framework (Webb, 2006). However, the concepts of choice and personal control contrast with a culture of using restraint as a form of containment within institutions (Lees *et al.* 2003; Sturmey 2009; Perkins *et al.* 2012). While cuts in public sector expenditure may account for why organisations promote a risk aversive culture, it would appear from the evidence presented in this paper that what service users and professionals alike want, is opportunity to build a therapeutic environment that facilitates nurturance through risk taking, rather than one of enforced containment.

5. Conclusion

It would appear from the evidence available that the use of restraint in mental health and associated settings in the UK has detrimental effects for service users and professionals alike. At an individual level distress, physical injury and fear are common experiences for those receiving and delivering care, whilst at an organisational level environmental factors were identified as precipitants of aggressive behaviour and an over-zealous use of restraint. In the wider socio-political context the balance of risk and safety is difficult, particularly against a backdrop of public scandals, where unacceptable and, at times, unlawful methods of restraint have been perceived to be a prominent feature of care. People have the right to a life free from torture or inhuman or degrading treatment or punishment, the right to liberty and security, and respect and privacy. Professionals involved in delivering health and social care are required to recognise these rights, ensuring that the care delivered to vulnerable people is done so in a respectful, nurturing environment.

In addition to the recent Care Act (2014) and the Supreme Court ruling, the Mental Health Act (1983) code of practice (DH 2015) has also been updated, with emphasis on providing therapeutic and supportive environments, through using de-escalation approaches tailored to individual patient need, as a first line approach to minimise behavioural disturbances. In keeping with good practice, restrictions imposed on service users should be reasonable and proportionate to the risks associated with the behaviour being addressed and consistent with the guiding principles of the MCA (2005). Furthermore, professionals taking action to use restraint must reasonably believe that it is necessary to prevent harm and is a proportionate response to the likelihood and seriousness of harm to the person who lacks capacity. To achieve this health and social care professionals need to have a better understanding of the law and how it can best be implemented in the clinical setting, show service users respect by ensuring they have the same opportunities as staff with regard to communication, debriefing and decision

making, and to prioritise developing therapeutic relationships and the nurturance of those for whom they are providing respectful, sensitive care.

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