“On Relationships with Restraint & Reduction”

[Observations & Thoughts of a Minor Functionary* in the Field]

Lee Hollins

[in a private capacity]

*Certification Body Implementing Restraint Reduction Training Standards across the UK

The 4 Ages of Restraint [in England]

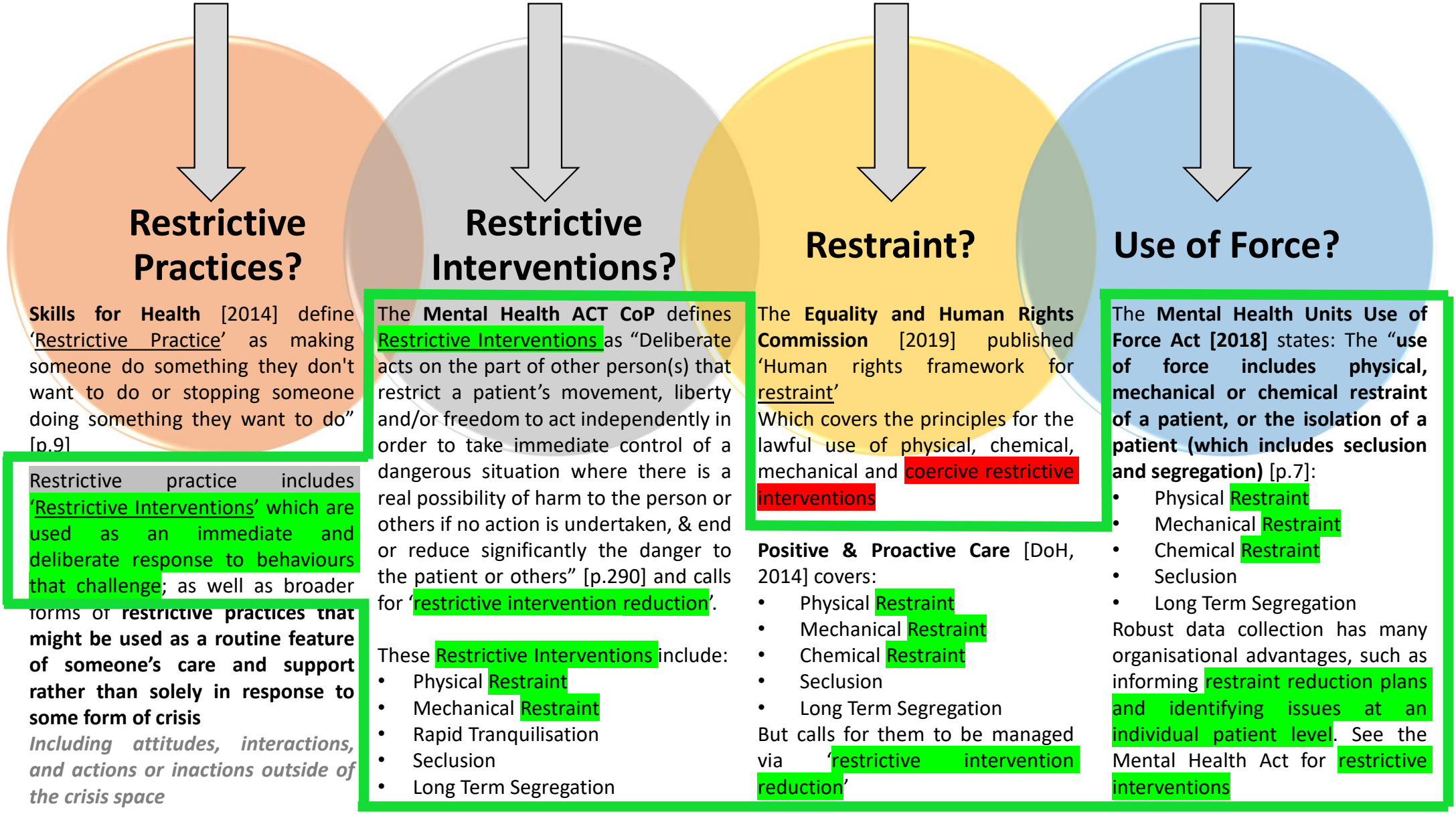
Anti Restraint

Efficient Restraint

Safe Restraint

Less Restraint

1839 1970's 1980's 1990's 2000's 2010 Now


Restrictive Practices?
Skills for Health [2014] define 'Restrictive Practice' as making someone do something they don't want to do or stopping someone doing something they want to do" [p.9]
Restrictive practice includes 'Restrictive Interventions' which are used as an immediate and deliberate response to behaviours that challenge; as well as broader forms of restrictive practices that might be used as a routine feature of someone's care and support rather than solely in response to some form of crisis
Including attitudes, interactions, and actions or inactions outside of the crisis space
Restrictive Interventions?
The Mental Health ACT CoP defines Restrictive Interventions as "Deliberate acts on the part of other person(s) that restrict a patient's movement, liberty and/or freedom to act independently in order to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, & end or reduce significantly the danger to the patient or others" [p.290] and calls for 'restrictive intervention reduction'.
These Restrictive Interventions include:
• Physical Restraint
• Mechanical Restraint
• Rapid Tranquilisation
• Seclusion
• Long Term Segregation
Restraint?
The Equality and Human Rights Commission [2019] published 'Human rights framework for restraint'
Which covers the principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions
Positive & Proactive Care [DoH, 2014] covers:
• Physical Restraint
• Mechanical Restraint
• Chemical Restraint
• Seclusion
• Long Term Segregation
But calls for them to be managed via 'restrictive intervention reduction'
Use of Force?
The Mental Health Units Use of Force Act [2018] states: The "use of force includes physical, mechanical or chemical restraint of a patient, or the isolation of a patient (which includes seclusion and segregation) [p.7]:
• Physical Restraint
• Mechanical Restraint
• Chemical Restraint
• Seclusion
• Long Term Segregation
Robust data collection has many organisational advantages, such as informing restraint reduction plans and identifying issues at an individual patient level. See the Mental Health Act for restrictive interventions

Data Coverage

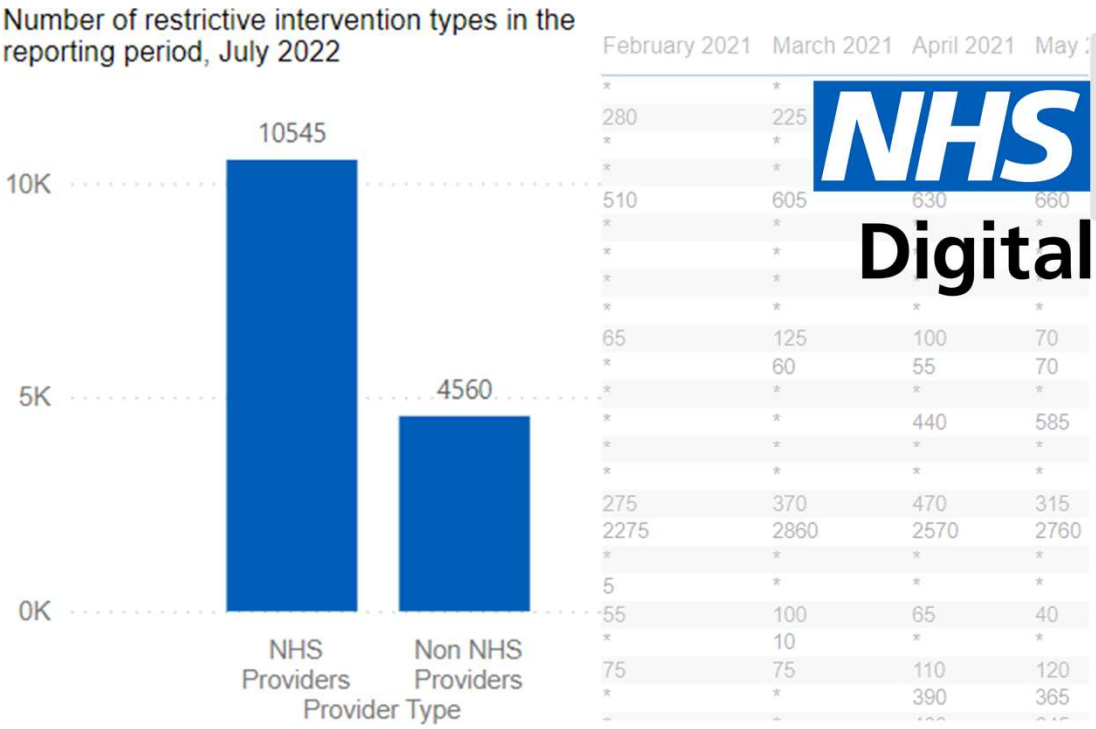
The providers in the table are based on a pre-determined list of specialist providers which are currently active (i.e. commissioned) and in scope for MHSDS to submit specialised activity. This list also includes any non-specialist providers who have submitted data to the 'Restrictive Intervention Type' table in any month of the previous financial year (20/21).

Providers submitting data to 'Restrictive Interventions Type' table by month

Select a single Restrictive Intervention Type

- Chemical restraint - Injection (Non Rapid Tranquillisation)
- Chemical restraint - Injection (Rapid Tranquillisation)
- Chemical restraint - Oral
- Chemical restraint - Other (not listed)
- Mechanical restraint
- Physical restraint - Kneeling
- Physical restraint - Other (not listed)
- Physical restraint - Prone
- Physical restraint - Restrictive escort
- Physical restraint - Seated
- Physical restraint - Side
- Physical restraint - Standing
- Physical restraint - Supine
- Seclusion
- Segregation
- UNKNOWN

Provider	September 2020	Octobe	February 2021	March 2021	April 2021	May 2
	*	*	*	*		
	150	195	280	225		
	*	*	*	*		
	*	*	*	*		
	695	565	510	605	630	660
	*	*	*	*		
	*	*	*	*		
	*	*	*	*		
	*	*	*	*	*	*
	60	*	65	125	100	70
	55	75	*	60	55	70
	*	*	*	*	*	*
	*	*	*	*	440	585
	*	*	*	*	*	*
	*	*	*	*	*	*
	230	210	275	370	470	315
	2710	2310	2275	2860	2570	2760
	*	*	*	*	*	*
	5	*	5	*	*	*
	70	115	55	100	65	40
	*	*	*	10	*	*
	40	140	75	75	110	120
	*	*	*	*	390	365



Rounded Figures relate to how many rows of data were submitted to the 'Restrictive Interventions' Table as a final year submission up to and including March 2022. Rounded figures after March 2022 relate to how many rows of data were submitted by the provider as a performance submission.

Prior to October 2021, figures presented are from MHSDSv4.1 in the MHS505RestrictiveInterventionTable. From October 2021 onwards, figures presented are from MHSDSv5 in the MHS515RestrictiveInterventionType table.

'*' indicates that the provider submitted restraints data, but the number of rows submitted were less than or equal to 5 or that the Provider did not submit data to the 'Restrictive Interventions Type' table for that month. Therefore, if the Provider is marked with a '*' there will be no data in this dashboard for the provider, as any figure which is less than 5 has been removed from the data driving the dashboard.

Less

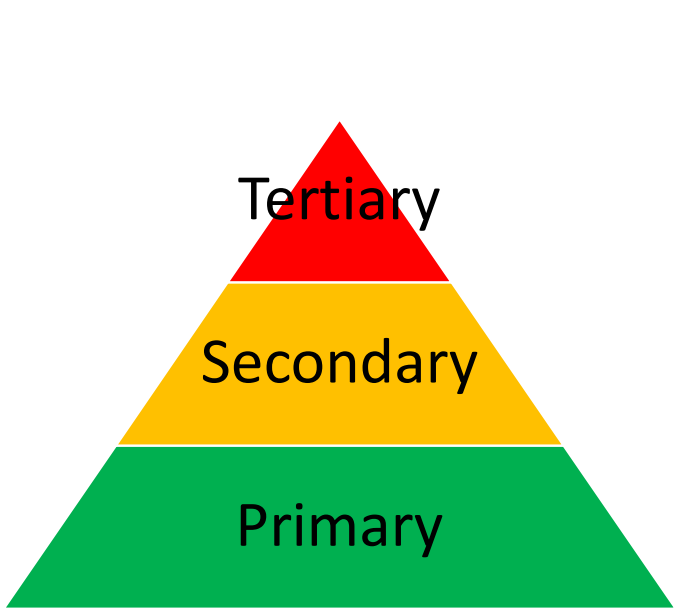
ENGLAND: According to the Restraint Reduction Network, “Our vision is to deliver restraint-free services to each individual we support”

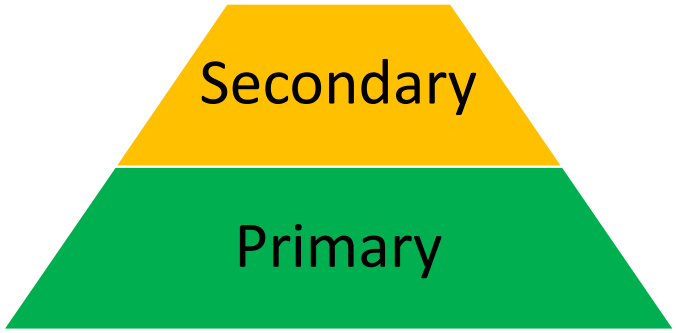
SCOTLAND: “The aim of Restraint Reduction Scotland is to eliminate the misuse of restrictive practices, including physical, chemical, **environmental** and mechanical restraints, and seclusion”

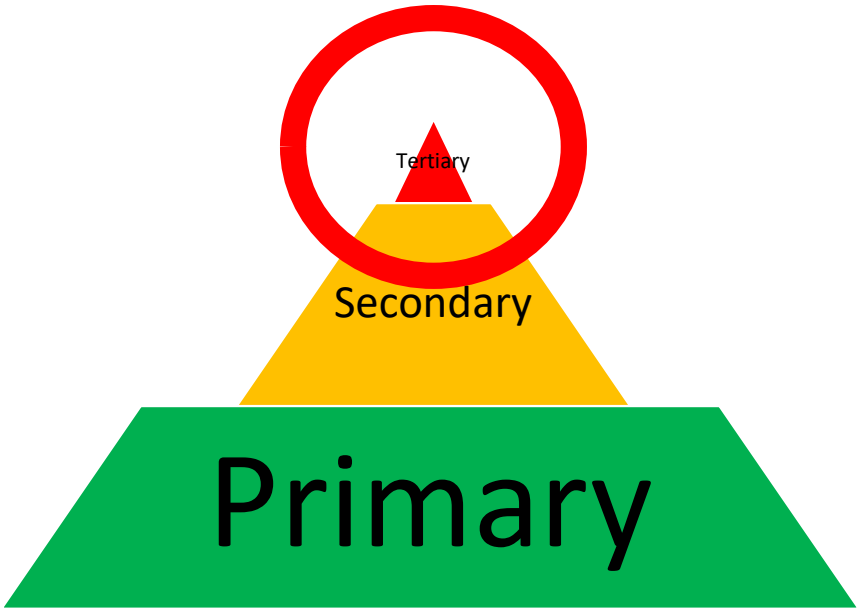
NORTHERN IRELAND: When launching the policy outlining the expectations on the use of restrictive interventions, restraint and seclusion in health and social care settings the Permanent Secretary of the Department of Health stated, “the emphasis should always be on elimination of the use of restrictive practices, therefore we must ensure that their use is minimised and only used when absolutely needed”

WALES: In the ‘Reducing restrictive practices framework Guidance on reducing restrictive practices in childcare, education, health and social care settings’, it states the ‘framework is intended to promote measures that will lead to the reduction of restrictive practices. The framework also seeks to ensure that where restrictive practices are used, as a last resort, to prevent harm to the individual or others, that this is informed by person centred planning within the context of the service setting and in a way which safeguards the individual’

What Does “Restraint Reduction” Look Like?







1. **Restraint will NEVER be a NEVER Event, as long as there is a legal 'Duty of Care', Common Law rights, the Mental Capacity Act, Mental Health Act, & Criminal Law Act**
2. **The commodification of training programmes has led to uncharted diversity in the range of techniques and procedures being taught to staff. Unsurprisingly each system 'owner' believes there's is the best [whatever 'best' is] but we don't know enough…**
3. **Restraint is mediated by force and the personality, mood and thought processes of individuals, NOT just 'techniques' or 'procedures' [or even positions] in isolation**
4. **Restraint techniques 'as taught' are often forgotten –The retention of techniques was found to be questionable [Dickens *et al*, 2009; Rogers *et al*, 2006]**
5. **Responses can involve more than a pre-defined technique – 'Field Modification' [Paterson, 2007]**
6. **Responses can be involve less than a pre-defined technique – 'Forced, Gentle, Protective & Compassionate Touch' [Bailey, 2015]**
7. **NOT all restraint is unwelcome - 'Why didn't you f*cking restrain me' [Radoux, 2019]**

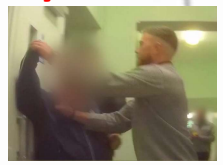
"**Institutionalised Repression**"
[Shenton & Smith, 2021]

"It's **Barbaric!**" [Morrison]

Restraint should be "considered a **Treatment Failure**"
[Ashcraft & Anthony, 2008]

"**Evil**"
[Wilson *et al*, 2017]

"Physical restraint is an **Extreme** response to managing someone's behaviour when they are in a mental health crisis. It can be **Humiliating**, cause **Severe Distress** and at worst it can lead to **Injury** and even **Death**" [MIND, 2013]



"Physical Restraint can be **Degrading**…. [and cause] **Fear** and increase **Anxiety**"
[Millfields Charter, 2006]

Tertiary

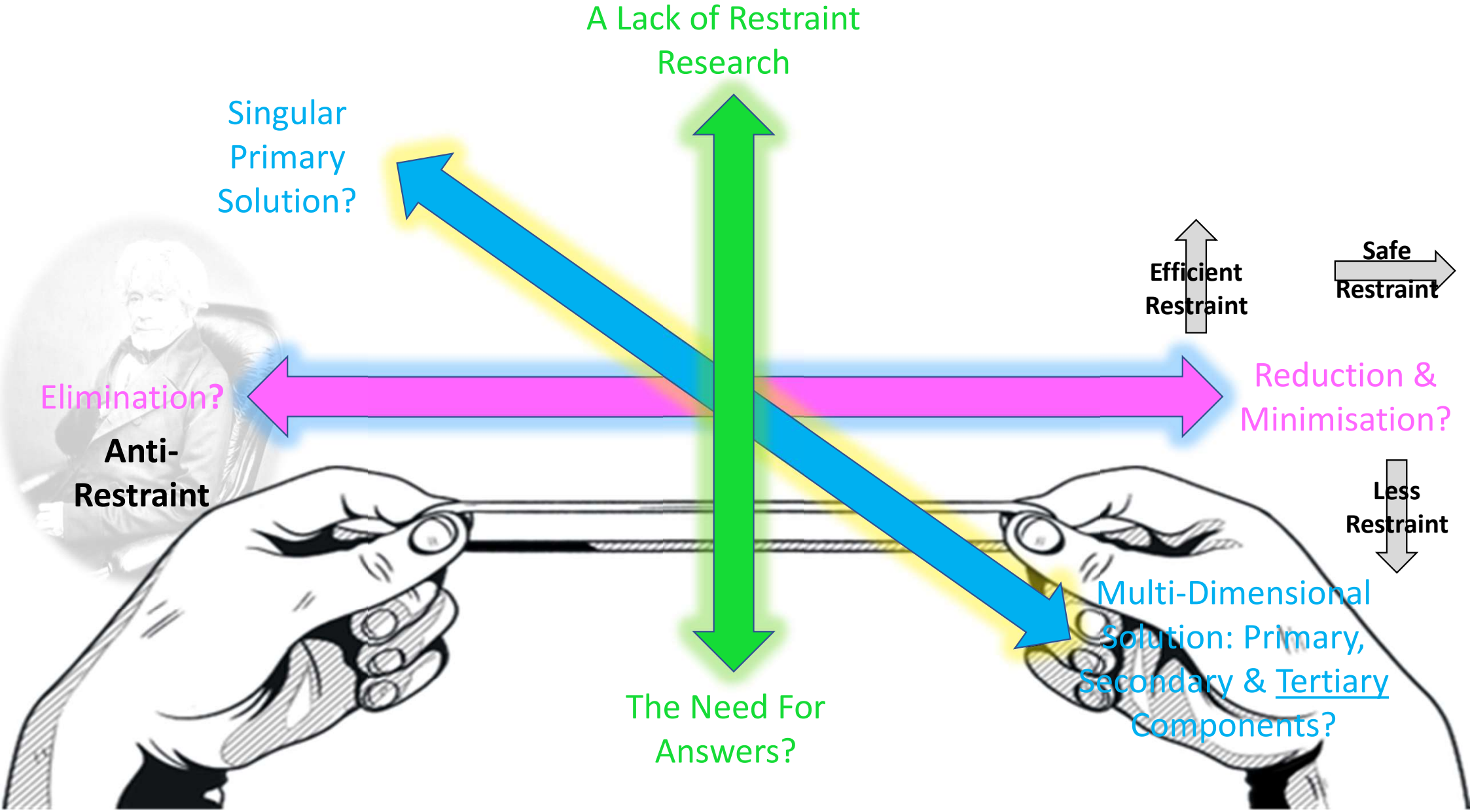
"**Abusive** and **Harmful**"
[Tolson & Morley, 2012]

"Our research shows that some trusts have a **shameful** over-reliance on physical restraint"
[MIND, 2013]

Sneer
Eye Roll
Tut
Personal Criticism
Disdainful Glance
Repetition of Hearsay
Head shake
Dismissive or Disrespectful Remarks
Disapproval
Condemnation
Snort
Derision
Heavy Sigh
Stereotyped remarks

"Cultural <u>Restraint</u>"
[RRN, 2023]

"Psychological <u>Restraint</u>"
[RRN, 2023]


A Lack of Restraint Research
Singular Primary Solution?
Efficient Restraint
Safe Restraint
Elimination?
Anti-Restraint
Reduction & Minimisation?
Less Restraint
Multi-Dimensional Solution: Primary, Secondary & Tertiary Components?
The Need For Answers?

- Research on restraint at present seems to focus in large part on the adverse impacts, i.e., the negative physical and psychological impacts e.g., asphyxia and trauma [& increasingly the moral distress experienced by staff]
- Restraint training syllabuses have decreased in size, and the complexity of techniques have reduced – a pragmatic response to 'retention' failings by the training sector, rather than the result of research
- Much work is done daily by dual-role trainers in the practice space to adapt and modify techniques to take into account an individuals medical and social history. This relies on practice wisdom rather than research per se
- The descriptive category of 'restraint' obscures other physicality and physical interactivity that may serve de-escalation and even consolidate trust and therapeutic/developmental relationships. Something that isn't currently meaningfully examined by researchers
- If we don't talk about restraint and don't undertake research, evidence will not be gathered, and lessons won't be learned or disseminated. And the reduction goal [via the minimisation goal] will not be served
- It will also keep the door open to **Force-full** [Legal] Interventionists, as opposed to **Care-full** [Ethical] interventionists
- **The only person who pays the price for this reluctance or unwillingness to talk or look for pragmatic answers is the person who experiences restraint. This makes it an ethical issue**

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