Background

Violence and aggression is reported to be prevalent in psychiatric inpatient settings and the frequency of aggression towards healthcare professionals well documented (Foster et al 2007, Stubbs and Dickens 2008). This can range from verbal abuse through to assault with violence and the reasons for it can be multifactorial. For example, Duxbury & Whittington (2005) suggested that factors that contribute to aggressive patient behaviour can be classed as internal (to the patient), external (environmental) and/or interpersonal (relational).

In response, it is widely accepted that effective inpatient care can sometimes include the use of coercive measures, such as seclusion and restraint (Whittington et al 2009). The use of restraint, broadly defined as 'the restriction of a person's liberty of movement (Mental Capacity Act p. 105), has been an accepted risk management strategy for the short-term management of aggression and violence for sometime (National Institute of Clinical Excellence (NICE) 2005). Restraint can take the singular or combined form of physical, mechanical, chemical or environmental, and has been cited as a contributory factor in the death of some individuals (Barnett et al 2012).

Whilst aggression may not be entirely avoidable, its incidence can and should be reduced significantly through prevention strategies and the minimisation of restrictive practices such as physical restraint (Department of Health 2014). This is particularly important amidst growing concerns about their use and impact, which is under significant scrutiny in a number of countries including the UK, other parts of Europe, America, Canada and Australia (LeBel et al 2014, Weiman et al 2013).

In the last decade a number of high profile serious incidents have occurred that have received media attention worldwide. In the UK this has included a report on restraint related deaths (Aiken et al 2011), the Francis Report on care deficits (2013), a post Winterbourne Review (DH 2012), and most recently the 2013 MIND report on Crisis in Care. The latter highlighted concerns about the use of physical restraint and it is reporting in a number of mental health services across England. Similar reviews have been conducted in Australia and America (National Alliance for the Mentally Ill 2000, Levinson 2006, McVilly 2008, Martin 2010, Equip for Equality 2011). The importance of minimizing the use of restrictive interventions of this sort therefore cannot be underestimated given their potential for harm to patients and staff, both physical and psychosocial.

As the 2014 award holder of the Eileen Skellern Award, I felt it was essential to speak about the impact of such interventions with a specific focus upon physical restraint. The importance of employing preventative strategies that are underpinned by a shift to more proactive approaches including 'trauma informed care' has never been greater with a view to minimizing the need for reactive and restrictive practices. In order to examine this issue further this paper outlines the presentation given by Professor Joy Duxbury at the Eileen Skellern Award in June 2014.

Aims

To explore three common 'defences' offered to account for the use of physical restraint.

To challenge each defence with regards to the evidence.

To identify how organisations are responding to the challenge of reducing the use of physical restraint and other restrictive interventions.

Thesis

Whilst the focus of this paper is physical restraint it is important to examine the broader overarching term restrictive practice, which denotes:

> *The implementation of a practice or practices that restrict an individual's movement, liberty and/or freedom to act independently without coercion or consequence. (DH 2014)*

Restrictive practices may be employed as planned interventions or in an emergency as a response to a person's behavior, which places him, herself or others at imminent risk of significant harm. Seclusion and restraint are both examples of restrictive physical interventions commonly referred to in the literature. Combined they have been described as an integrated intervention directed at managing and controlling a precarious situation (Gutheil 1980).

Physical restraint is the use of force involving the restriction of movement by physical holding (DH 2014). It should only be used as a 'last resort' and avoided if at all possible (NICE 2005). Staff undertaking restraint should be mindful of its potential to cause significant emotional and physical trauma and if used as part of a planned intervention, plans should seek to minimise such risks. Individual factors, which suggest a service user is more likely to suffer physical and / or emotional trauma, must be recognised and taken account of during any process of applying physical restraint.

Following a number of cases to highlight serious problems with regards to the use of physical restraint, a range of reports have been developed to offer guidance and standards for organisations to work towards. In the UK, a high profile case that set a path in motion was that of Winterbourne. Whilst this was more about the abusive behavior of staff towards residents in a care home, it did raise concerns about the use of restraint. Subsequent to and coupled with a DH report by Norman Lamb; Transforming Care 2012 and the MIND expose on the use of physical restraint in the UK, the need to address this issue was evident. As a result it seems timely to examine its efficacy and value in light of the evidence base. In order to do this, three key defences will be challenged using the literature to date.

Defence 1 Restraint keeps people safe

Whilst the use of restraint to maintain the safety of staff and patients is articulated as a reason for its current use, the evidence is not so convincing. Research instead has linked the use of restraint to a number of adverse outcomes, such as the further exacerbation of aggression, injury to staff or patients, increased costs, re-traumatization, and rupture of the therapeutic alliances between staff and patients (Ashcraft & Anthony, 2008; Foster et al., 2007, Duxbury et al 2011). Further, physical injuries ranging from those that are minor to major, have been reported including coma, broken bones, bruises, cuts requiring stitches, ffacial damage, dehydration, choking, circulatory and skin problems, loss of mobility, and incontinence (Paterson 2007).

The death of a patient during a physical intervention in a health care environment is the worst case scenario and adds an element of irony that makes the phenomenon all the more difficult to understand (Martin 2010). In a report by Aiken et al (2011) it was revealed that there had been 38 restraint related deaths in the UK in the previous 10 years. Those who had died were most commonly individuals with serious mental illness, those from Black and Minority Ethnic groups, men 30-40 years of age and those restrained in the prone position

Positional asphyxia was implicated as contributory in at least 26 of the 38 deaths due to: a struggle/physical stressors prior to restraint; the number of staff involved; the length of time of the restraint; and the position of the individual. Additionally, a number of factors were of note. For example, the number of staff involved in the restraint episode was between 2 and 15; the length of restraint was between 10 minutes and 1 hr. 40 minutes. The time held prone before collapse ranged from 2 to 12 minutes with an average time 5.6 minutes. This seems to echo the view of Martin (2010) who suggests that the three biggest contributory factors to restraint related catastrophes are the duration of the event, drug interactions and untrained staff and/or a chaotic response.

A review of the literature on the adverse impact of physical restraint by Barnett et al (2012) also identified positional asphyxia as problematic and in particular the 'forceful prone' position. This was reported to be hazardous because breathing can be reduced by 15% in a face down position. Furthermore the impact of the 'struggle', particularly the level of arousal and fatigue, and a number of cumulative stressors leading to the 'perfect storm' were identified as contributory. The authors as a result called for the screening of those who may be subject to restraint.

A number of high profile cases highlight the most devastating results that can occur during and following physical restraint.

A well reported case is that of David (Rocky Bennett) aged 38, who died in restraint in a UK hospital in 1998 (Norfolk, Suffolk and Cambridgeshire Special Health Authority 2003). He was racially abused by a white patient in the hospital and lashed out at a nurse. He was held in a prone restraint by 5 staff for 25 minutes and died.

Subsequent cases have been reported including that of Michael Goldwater who was 35 years old and suffered with schizophrenia. He died after having a heart attack whilst being restrained face down on the floor by staff in Runwell Hospital in April 2000 (Paterson et al 2003).

Kurt Howard aged 32 died in 2002 whilst being restrained in the prone position for 55 minutes by four members of staff in a hospital in Wales. He suffered 17 injuries. The jury found excessive prolonged restraint was one of the factors causing his death (www.lexisnexis.com).

In 2006 the UK National Health Service was blamed for the death of Geoffrey Hodgkins aged 37. He was a mental health patient in a Portsmouth Hospital. An inquiry commissioned by Hampshire and Isle of Wight Strategic Health Authority found that Mr. Hodgkins was held face down in arm and leg locks by three security guards, two nurses and two other members of staff. For 25 minutes he struggled when staff realized he had stopped breathing (Guardian 2006). Also in 2006, Care provider Castlebeck (Teesdale) Ltd was fined £100, 000 after a patient died while being restrained using an unauthorized technique at a Nottingham Mental Health hospital. Three support workers had restrained Mr. Lovegrove for a short period

whilst another lay on top of him after being pulled over (Health Safety Executive 2014).

A number of cases have involved more than one agency, commonly the police and mental health services. Sean Rigg, for example, aged 40, died at Brixton Police Station in 2008. An inquest found police used "unsuitable" force'. He was 'held face down'. More recently, Olaseni Lewis who was a 23-year IT graduate from Kingston University in the UK was subject to restraint. He had no history of mental illness. In 2010 within two days of uncharacteristic odd and agitated behavior and 18 hours after being brought to hospital he was all but dead. He was restrained 3 times by hospital staff who later called the police. Once transferred to a seclusion room, police held him forcefully face down on the bed and then on the floor. The restraint lasted 45 minutes and involved 11 officers. Further medication was forcibly injected and - no longer struggling - he was left on his own lying face down on the floor.

Such cases are not specific to the UK and numerous cases have been cited in the USA (Equip for Equality 2011). In New York, for example, in 2012 it was reported that Rasheen Rose died during a ten-minute prone restraint when a 250-pound member of staff sat on his 180-pound frame. The cause of death of this 33-year-old man was reported by the Chief Medical Examiner to be positional asphyxia (Higgins 2014).

Cases involving young children and adolescents have also been reported in America including that of Randy Steele who died during restraint, and 13 year old Stephanie Jobin who was forced to lie face down whilst staff put a beanbag on her top of her and pinned her down. After struggling for 20 minutes, Stephanie stopped breathing. Eleven year old also Andrew McClain died of traumatic asphyxia and chest compression four days after being admitted to a Connecticut psychiatric facility. Andrew had 'disobeyed' an instruction from an aide to move to another table at breakfast. Two members of staff subsequently restrained him, one by lying on top of him (Eastgate 2014).

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Given examples of this sort and existing research, the gravity of outcomes that can occur when a patient is physically restrained is clear. The impact upon and behavior of staff can also be of concern and costly. Staff have reported injuries resulting in physical and psychological strain, stress, lack of confidence, prolonged sickness and dissonance (LeBel 2011). The cost to the NHS and allied organisations when staff are injured, under threat or stressed as a result of threatening behaviour is significant and impacts upon staff turnover, burnout and litigation (Lebel et al 2003).

Suffice to say a reduction in the number of restraint episodes would certainly lead to a decrease in exposure to the risk for patients and staff. The question of safety is therefore called into question.

Defence 2 Restraint is a clinical intervention

Restraint is currently a recognised clinical intervention that continues to be used and provided for with regards to guidance and training in many countries (Bowers et al 2011, Kaltiala-Heino et al 2003). Whittington et al (2009) for example have stated that it is widely accepted that effective inpatient care can include the use of coercive measures, such as seclusion and restraint. Recommended as a last resort in many instances, it is seen as part of an interventional menu for practitioners subject to the right circumstances (NICE 2005, Paterson 2006). However its efficacy has been under scrutiny for some time (Salias and Fenton 2009, Kynoch et al 2009) and there

is a growing literature in contrast, indicating the potential counter-therapeutic effects of this practice other than the earlier reported physical effects (Borckardt et al 2011). It has even been suggested that a non-therapeutic culture can exist in some settings when using restrictive physical interventions. Whittington & Wykes (1994) some time ago referred to this as 'ggoing in strong', whilst Bowers et al (2012) have more recently referred to a 'show of force model'.

Whilst the previous defence that restraint is used primarily to keep people safe exists, some research has shown that decisions to use restraint are influenced by nurses' perceptions of patients, their own risk taking behaviour and the presence of others (Goethals et al 2012). Research indicates that cultural and social bias may also exist. For example studies have shown that young, male, and those from a Black or Hispanic descent are more likely to be restrained (*Donovan et al, 2003).* This may not necessarily reflect a therapeutic intent as a priority when making judgments. Of interest is also the lack of justification and reporting for the use of restraint as an intervention. For example, violence was rarely mentioned as a cause for restraint in records scrutinised by Ryan and Bowers (2006). Instead its use was commonly argued to be the result of attempts by patients to abscond, conflict over medication, and boundary setting. Allen (2004) refers to this as reactive and not constructive practice. Paterson (2006) goes as far as to say that patients have reported feelings of humiliation.

Patients can also become fearful and/or aggressive in response to their own perceptions of aggressive or controlling behaviour from staff. In a study by Duxbury & Whittington (2005) over 25% of patients felt that the staff significantly contributed to their displays of aggression. Furthermore, certain coercive practices can have negative connotations and outcomes and be perceived to be hostile and non therapeutic by patients. Studies have indicated that being restrained can lead to feelings of anger, fear, panic, and sense of feeling dismissed (Bowers et al., 2012; Sequeira & Halstead, 2004; Bonner et al.2002). Memories can include those of previous violent attacks, concerns and ambivalence from staff, punishment, panic, fear, hopelessness, anger and frustration, and a sense of injustice, which could lead to further aggression and resistance.

Further, without the appropriate education, training and clinical supervision, nurses can respond to inappropriate or aggressive behaviours in an unhelpful way. For example because of the powerful nature of anger as an emotion, people exposed to anger may feel fearful and intimidated. Nurses as a result may avoid patients (Smith and Hart 2004). Conversely they may 'go in strong' (Whittington 1994). Clearly, this is neither helpful nor therapeutic for nurse or patient. A number of studies have suggested that staff behavior can contribute to the development of patient aggression and staff themselves have expressed concerns about the use of restrictive practices. For example, in one survey, practitioners felt unrest with the techniques taught in relation to restraint particularly when trying to balance safety with service users' rights and less invasive procedures (Duxbury & Whittington 2005). In a survey of physiotherapists Stubbs and Hollins (2011) found that 5 out of 10 restraint positions reviewed would inflict pain, which lead to feelings of dissonance.

The impact of restraint practices can be devastating and therefore the use of them as a therapeutic intervention is unclear at best and counterproductive at worst. It is evident from the counter defenses outlined that physical restraint can cause serious trauma, both physical and psychological and even death in some instances (McVilly 2008, Paterson et al 2003). The importance of recognizing the damage that can be caused is highlighted and significantly brings into question the argument for the therapeutic use of physical restraint.

Defence 3 Restraint is only used as a last resort

The notion of last resort is commonly highlighted in the literature on physical restraint and advocated in guidelines (NICE 2005, DH 2014). However, it is yet to be truly defined. Some suggest that control and containment measures, such as restraint, are common first line interventions within healthcare settings (Cowin et al., 2003; Foster et al., 2007; Kynoch et al., 2009). In Canada, the Psychiatric Patient Advocate Office (PPAO) reviewed seclusion and restraint practices in a number of Ontario psychiatric hospitals. More than 50% of the patients stated at the time they were restrained or secluded that they had not posed a threat to themselves or others, nor was there any confrontation with another.

An exploration of the decision-making factors that influence the use of restraint as a last resort to the best of our knowledge has yet to be investigated. Some studies have examined the use of restraint and reported varied reasons for its use including violence, abscondment, staff denying a request, patient agitation, refusal of medication, self-harm, verbal aggression and property damage (Bowers et al., 2012; Ryan & Bowers, 2006; Gudjonsson et al., 2004; Southcott et al., 2002), Only a few studies have explored the reasons for its use (Moran et al., 2009; Bonner et al., 2002). Soininen et al. (2013) for example, explored patients' perceptions and found that they felt that seclusion and restraint were 'hardly' necessary and that their opinions were not included in treatment planning. In a recent freedom of information request of mental health hospitals in the UK, MIND (2013) found huge variation in use of restraint. For instance one service reported 38 incidents and another over 3000 incidents. There were 1000 incidents of physical injury following restraint. The question therefore of whether physical restraint is truly used as a last resort is yet to be determined. Deveau and McDonnell (2009) suggest the "reliance upon the 'last resort' principle has the major drawback that it is an easily voiced rhetorical device and very difficult to observe or challenge" (p.175).

Implications for Practice

In response to increasing concerns about physical restraint and restrictive practices, over recent years a number of domestic and international agencies have begun to embrace the use of 'reduction models' in order to minimise their use. Examples are the Six Core Strategies (6CS)(Huckshorn 2004), Safewards (Bowers 2014), No force First (Ashcraft & Anthony 2008), and REsTRAIN YOURSELF (RY)(LeBel et al 2014). To varying degrees these effectively focus on well-informed systems of governance, strong leadership, the use of prevention strategies, a focus on users' rights and ensuring that reflective models support learning from incidents where restrictive practices are used.

There are some small pockets of evidence of implementation in sectors of the UK, although their use remains far from universal. The strongest evidence base to date is from the international literature. A number of recent studies have demonstrated that it is possible to reduce the rate of some restrictive practices in various settings if an organization is committed to change their approach to aggression/ violence management from reactivity to a more proactive approach (LeBel 2011, Putkonen et al 2013, LeBel et al 2014). Some studies have linked the importance of clear leadership when targeting a reduction in the use of restrictive interventions (Huckshorn 2004, Wieman et al 2013). Growing evidence suggesting the value and positive impact of this approach in terms of achieving sustained reductions in

seclusions and re / or restraint episodes, across a range of service types has been reported (Abeam et al 2011, Putkonen et al 2013).

Multi-component approaches, which focus on substantial, cultural changes across organisations seem to be able to demonstrate the most impressive outcomes. For example, studies using a complex intervention approach with a focus on behavioural leadership, service user centered care and culture shift have reported significantly reduced frequency and duration of restraint and seclusion (Wale et al 2011, Weis et al 2013, Putkonen et al 2013). Unsurprisingly, a number of studies have also shown that various staff characteristics are linked to the development of aggression and violence in mental health service users, including negative interactional styles, provocative, authoritarian behaviour and poor communication skills (Bonner et al 2010, Tunde Ayinmode 2004, Wynaden et al 2002, Duxbury 2002). Hence, a substantial body of evidence suggests that many seclusion and restraint episodes may be preventable if these factors are addressed.

With regards to practice there are a number of implications and the iimplementation of standardised approaches based on evidence is required. A combination of interventions including advance planning tools, a recognition that there is a risk of trauma, injury and death and a trauma informed care philosophy is required. From a psychosocial perspective patients can be severely traumatised by the use of certain practices and this can affect both their needs and their road to recovery (Strout 2010). As a result there is an increasing drive to examine reflect upon and make specific efforts to reduce the use and impact of the restrictive practices using trauma informed care (TIC). This has been defined as the development of a culture where staff are competent and confident in knowledge of the impact of trauma and their responsibilities in mitigating against retraumatisation (Muskett 2014). Hummer et al (2011) found this awareness needed to start at the orientation of new staff and in ongoing staff development with a focus upon therapeutic safety and boundaries, establishing, maintaining and terminating therapeutic relationships, de-escalation, strength focus care planning and patient participation and empowerment (Ashcraft and Anthony 2008, Azeem et al 2011).

They suggest that the underlying principles of TIC are that service users need to feel connected, valued, informed and hopeful of recovery, that the connection between trauma and adult psychopathology is known and understood by all staff, and that staff work in mindful and empowering ways with individuals, families and friends and other agencies to promote and protect the autonomy of that individual.

In the UK, strategically the Department of Health has recently produced a new programme of guidance called Positive and Safe. The main principles include partnership working, the use of organisational models of restrictive practice reduction, demonstrable last resort interventions which are transparent, legally valid and ethical, best practice principles; and the prevention of the misuse and misapplication of restrictive practices. This reflects the importance of shared principles and organsiational ‘buy in’ with the necessary commitment to promote change through inclusivity.

Conclusion

Working with patients who express aggression and/or display violence arouses a range of emotions in those who care for them. Aggression and violence can reflect a sense of the powerlessness and frustration that both patients and staff may experience within the healthcare system. Nurses and their organisations need

special attributes, skills, education and training to prevent and to intervene when difficult situations arise; safely, therapeutically and in a least restrictive manner. Organisations however, need to ensure that strategies and clear directives are in place with regards to the minimization of restrictive practices including physical restraint.

There is growing evidence that much can be done to reduce services' reliance on the use of restrictive practices. Such approaches must be consolidated into practice through rigorous governance structures. Whole service restraint and seclusion reduction strategies can both reduce the incidence of violence and aggression and ensure that less detrimental alternatives are used (Wieman et al 2013).

Physical restraint should only ever be employed as a last resort. There can be no justification for the sustained and repeated use of the restraint of vulnerable people whilst services continue to neglect to embrace strategies, which can reduce the reactive and uncontrolled use of such approaches. Despite the growing evidence that physical restraint is potentially counter-therapeutic, traumatic, unnecessary and can be life threatening (Curran, 2007; Aiken et al., 2011), nurses continue to rely upon this practice. The use of restraint is seen as one of the few options clinicians view as effective in managing violence and aggression, in the absence of a real evidence base (Cutcliffe & Santos, 2012).

Instead, Elliot et al (2007) suggest best practice is to apply universal trauma precautions that nurses routinely use that are less likely to retraumatise those already exposed to interpersonal conflict. Many practices such as ward rules and restrictions, locked doors, mixed sex facilities and coercive practices such as restraint and seclusion are experienced by service users as emotionally unsafe, disempowering and therefore traumatizing (Foster et al 2007, Bowers et al 2011). Effective TIC services are those where the staff are aware of and sensitive to do no further harm and to make this their priority (Elliot et al 2007). Trauma informed care starts with and goes to the heart of the enabling nature of the nurse-patient relationship and the values services place on person centred care with a view to reducing conflict. This may allow for less defensive practice in light of current debates.

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