Restrictive interventions

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Reducing the use of restrictive interventions in mental health care

Abstract

The use of restrictive interventions is common in mental health care settings. As well as being detained in hospital against their will, patients can be physically or chemically restrained and placed in isolation or seclusion. Such interventions can have negative consequences for both patients and staff. This article examines the use of restrictive interventions in clinical practice, and explores how staff and services can seek to reduce their use in mental health care settings.

Aims and learning outcomes

The aim of this article is to introduce the professional, practical, ethical, moral and legal issues around the use of restrictive interventions in mental healthcare settings. After reading this article and completing the time out activities you should be able to:

1. Recognise restrictive interventions including the five types of restraint described
2. Apply the principles of Trauma Informed Care to the use and avoidance of restrictive interventions
3. Understand the three-tier public health model approach to restrictive interventions and prevention
4. Discuss the legislation that governs the use of restrictive interventions

Introduction

Assessing and maintaining safety is a key role for mental health professionals. However, maintaining safety can mean applying restrictions to patient behaviour. Detaining people against their will or locking doors to prevent free movement restrict people's freedoms. When patients pose a risk to themselves or others, interventions are employed that limit or restrict what they can do. Restrictive interventions include:

- Enhanced Observations: Staying with a patient within eyesight or at arm's length to restrict their freedom to act
- Restraint (physical, mechanical, chemical, environmental and psychological): 'The intentional restriction of a person's voluntary movement or behaviour' (Restraint Reduction Network 2016 p.2)
- Seclusion: 'the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving' (Department of Health and Social Care, 2017, p.300).

Enhanced observations, also known as therapeutic observations, are perhaps the least invasive restrictive intervention. Despite being called 'therapeutic', patients' experiences of them can be counter-therapeutic. Some patients report that they feel safer and less anxious with enhanced observations (Reen 2020), but for others it can be a harmful and negative experience, leaving people

feeling isolated or coerced (Collins *et al* 2022). Despite their widespread use, there is only limited evidence for their efficacy in maintaining safety (Reen 2020).

Restraint can take many forms. Physical restraint is when a person is held or blocked from moving by one or more members of staff. Mechanical restraint involves using equipment (e.g. straps or buckles) that can restrict movement. Chemical restraint, which includes rapid tranquilisation, is 'the use of medication which is intended to prevent, restrict or subdue movement of any part of the patient's body' (Department of Health and Social Care 2021 p.7). It is sometimes inappropriately used to control behaviour, especially with older adults (Robins *et al* 2021) and people with learning disabilities (Glover and Williams 2015). Some forms of restraint are inextricably tied to inpatient mental health settings. Environmental restraint entails restricting a person's free access to their environment (Negroni 2017), e.g. locked ward doors. Psychological restraint involves constantly telling a person that they cannot or should not do something that they want to do, or depriving a person of lifestyle choices such as when to eat or sleep. Where most forms of restraint are used reactively in response to, for example, patient violence, psychological and environmental restraints are more often used proactively and applied to all patients whether deemed a risk to themselves or others, or not (Tomlin *et al* 2020). This means that patients are likely to experience coercion even when staff do not believe they are acting coercively.

Seclusion often occurs in a dedicated room or area, which is defined and regulated by the Mental Health Act (1983). Any situation where a patient is kept away from others and prevented from leaving whether by a locked door or because staff do not allow them to leave, would be classed as seclusion. When this occurs on a long-term basis it would be described as segregation. Patients often report that seclusion is unhelpful and can feel like a form of punishment, although it appears to be more acceptable than forced medication (Chieze *et al* 2019).

The potential harms of restrictive interventions are far-reaching. Between 2004 and 2014 there were 26 deaths of mental health patients within 24 hours of them being restrained (University of Manchester 2016). Patients report re-traumatisation as a result restrictive interventions (Judd *et al* 2009) and physical trauma is commonplace; the most common cause of staff injuries in mental health settings is involvement in the physical restraint of patients (Renwick *et al* 2016). Restrictive interventions are a significant factor in delayed recovery (Social Care Local Government and Care Partnership Directorate 2014). Restraint can be distressing for staff, who often experience negative psychological responses, whilst violence incidents and restraints can trigger thoughts of previous incidents (Cusack *et al* 2018), suggesting a cumulative effect.

Recent UK legislation has sought to address restrictive interventions and the harm they cause. The Mental Health Units (Use of Force) Act 2018, known as 'Seni's Law', named after Olaseni Lewis who died after being physically restrained by 11 police officers in a mental health unit (Rethink 2022), was brought in to reduce the use of force and to ensure accountability and transparency (Department of Health and Social Care 2021). The hope is that the act will ensure that patients are treated fairly and with dignity, regardless of the ethnicity, gender or any other characteristics (Rethink 2022). Guidance on the act details the statutory obligations of organisations and individuals in relation to the use of force. This includes that all relevant health organisations appoint a responsible person to ensure that the organisation is compliant with the act, have an up to date policy on the use of force and properly train staff to provide safe, trauma-informed care. Moreover, the act highlights the need to have a diverse staff group that reflects the local community.

Restrictive interventions are not necessarily wrong or unacceptable in themselves. They constitute a use of power, and all power is open to abuse and misuse, but for the most part, healthcare staff use

them to keep people safe. This often means quickly making difficult decisions. The risk of using a restrictive intervention has to be balanced against the risk of not using it; given the potential for harm, restrictive interventions should only be used as a last resort (National Institute for Health and Care Excellence (NICE) 2015). The decision to restrain or seclude a patient is not one that nurses take lightly and there are legal, ethical, practical and professional issues that need to be weighed up. This article will examine the empirical evidence and frameworks that can inform nursing practice in order to maintain a safe and therapeutic milieu.

Time out 1

List examples of restraint that you have used or witnessed. Pick one and reflect on:

- What were the risks and benefits of the intervention?
- In the short and long term how did it make you feel?
- How might it have made the service user feel?

Coercion

The use of coercion – forcing someone to do something that they don't want to do – is not unusual in mental health systems across the world. Coercion can be formal, as regulated by legislation, professional guidelines and policies, being the measures that limit patient freedoms, e.g. involuntary hospitalisation, community treatment orders and restrictive interventions (Paradis-Gagné et al 2021). Informal coercion is less visible and is often applied whether people are receiving involuntary or voluntary treatment. This type of coercion can include persuasion, leverage, inducement and threats (Cabeza et al 2017).

Coercion in mental health care is normally used with good intentions – to keep patients and others safe, but there have been several reports in recent years detailing the use and abuse of coercion, such as using restrictive interventions as a form of punishment, for example. These include 'Transforming Care: A National Response to Winterbourne View Hospital' (Department of Health 2012) and 'Mental Health Crisis Care: Physical Health in Crisis' (Mind 2013). In response the Department of Health (2014) prepared 'Positive and Proactive Care: Reducing the Need for Restrictive Interventions'. This provides a framework for services to transform the culture, leadership and practices of services to ensure that care delivery is supportive and safe.

Trauma-informed care

Inpatient care can expose an already vulnerable population to psychological trauma (Berry *et al* 2013). The incidence of post-traumatic stress disorder may be as high as 25% to 47% for patients after experiencing seclusion or restraint (Chieze *et al* 2019). Female patients may be more likely than male patients to experience restrictive interventions as traumatic, in part at least, because the prevalence of childhood abuse in women is higher (Mauritz *et al* 2013). Yet around one in five women admitted to mental health facilities are physically restrained and in some UK trusts women are substantially more likely to be restrained than men (Agenda 2017). Girls and young women under the age of 20 experience the highest levels of restraint (NHS Digital).

There is also evidence of disparities due to ethnicity. Black people and people of mixed ethnicity are more likely to experience restrictive practices than their white counterparts (Payne-Gill *et al* 2021b). Furthermore, the institutional racism that McKenzie and Bhui (2007) described 15 years ago in mental healthcare, being 'the collective failure of an organisation to provide an appropriate and

professional service to people because of their colour, culture, or ethnic origin', is still in place today. The outcomes of this are observed in the increased chances that black and minority ethnic people have more negative care pathways, poorer access to effective intervention, and poorer outcomes (Nazroo *et al* 2020). These experiences may further compound trauma as experienced by black and minority ethnic people. Such differential experiences need to be acknowledged and discussed before care can be trauma-informed (Sweeney *et al* 2016).

Responding to trauma requires a trauma-informed approach. This means finding out from patients 'what has happened to you?' rather than 'what is wrong with you?' (Centre for Health Care Strategies 2021). SAMHSA (2014) identifies the six principles of a trauma-informed approach:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, historical and gender issues

Restrictive interventions may feel at odds with a trauma-informed approach but they can be trauma-informed. Showing respect for people's past and present wishes is detailed in Seni's law. This includes identifying how wishes, especially written statements, beliefs and values may influence decision-making when determining a patient's best interests where they lack capacity. There should be an understanding of past trauma, which should be reflected in care planning. Gender issues are highlighted; staff working with girls and young women in particular are required to consider the relationship between mental health, trauma, discrimination and inequality. When restrictive interventions are deemed necessary, thinking about the gender mix of the team, who communicates with the patient during the intervention and how communication takes place are just some of the ways that staff actions can be more trauma-informed.

Time out 2

Reflect on a time when you used a restrictive intervention and consider how you could have applied the SAMHSA's six principles of a trauma-informed approach to make the intervention trauma-informed. You can find more details of the principles here: https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf.

Reducing the need for restrictive interventions

Prevention is key in reducing the need for restrictive interventions. The public health model of prevention is a widely recognised model used in violence prevention (or preventing the behaviours that challenge), described in terms of primary, secondary and tertiary prevention, see Figure 1. Whilst secondary and tertiary prevention focus on imminent and actual violence, reducing the need for restrictive interventions means focusing on primary prevention. Much of what happens within inpatient settings, whilst not necessarily described as such, could be framed as primary prevention. This can include direct actions, such as activities to reduce boredom, patient education and training, and staff training (Hallett 2018). But more nebulous concepts such as the 'social climate' are likely to play an important role. The social climate can be described as the interplay between system, staff, patient, ward and environmental factors (Doyle *et al* 2017).

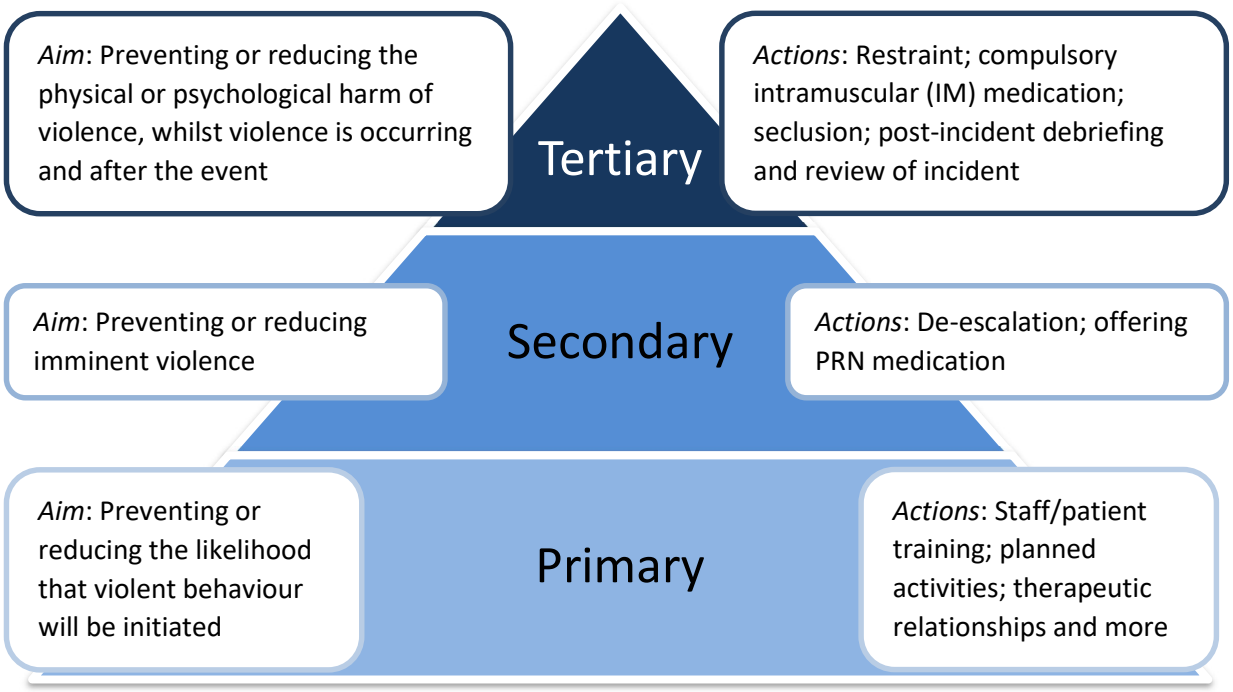

Figure 1. Levels of prevention (Hallett 2018)

There is some evidence that social climate is associated with patient aggression, particularly patients' feelings of safety, cohesion between patients, the 'atmosphere' of the environment and how open the environment is (Robinson *et al* 2016). It may be unsurprising to learn that staff and patients often have differing views about the atmosphere; the things that staff do to improve the atmosphere tend to be viewed more highly by staff than by patients (Hallett and Dickens 2021). The 15 Steps is one method of assessing the first impressions of a ward (NHS England 2017). It involves asking questions about whether the ward feels welcoming, safe, caring and involving, and well organised and calm. Getting staff and patients involved in a 15 Steps assessment could be one way of reducing the differences between staff and patient views.

One package of ten interventions that is gaining traction in mental health services is Safewards (Bowers *et al* 2015). Primary prevention interventions include daily meetings to promote the ward as a social community and clear mutual expectations. Secondary interventions include 'talk down', which provides a model of de-escalation, and calm down methods comprising a box of equipment to help lower arousal or agitation. There is growing evidence that Safewards is effective in reducing conflict and its associated restrictive interventions in general mental health settings (Finch *et al* 2022).

Whereas Safewards focuses on individual wards, a 'whole service approach' (Department of Health 2014 p.21) can further promote therapeutic engagement and avoid situations that may induce behaviours that challenge, thus creating a safe environment. Doing so can act as a preventative measure, contributing to primary prevention. Using a recovery-focused model is a key aspect of reducing restrictive interventions (Department of Health 2014). Recovery-based approaches include:

1. Promoting human rights based approaches
2. Enhancing personal independence
3. Promoting and honouring choices

4. Increasing social inclusion.

Many organisations have developed Quality Improvement (QI) programmes with the aim of reducing violence and restrictive interventions. The Safety Bundle developed by East London NHS Foundation Trust, for example, uses four interventions to reduce violence and aggression: daily safety huddles, use of the Broset Violence Checklist, use of a Safety Cross, and having a safety discussion with patients in the ward community meeting (Taylor-Watt et al., 2017).

Time out 3

Look at the four elements of a recovery-based approach. Identify one element that your service does well in relation to these approaches. Identify one element that your service could improve. Consider:

- What needs to be done to make improvements?
- Who would be responsible for the changes?

You might want to consider changes that can be made by individuals, teams, people in leadership positions, or service-wide changes that are needed.

Restrictive interventions in relation to COVID-19

The COVID-19 pandemic created massive shifts in the way services were run. It is unlikely that the true impact of the pandemic on mental health services will be known for some time, but there is already an exploration of its impact on violence and restrictive intervention use. Some, but not all, early reports suggest that patient violence increased during the pandemic, in the United States of America (Bellman *et al* 2022) and China (Xie *et al* 2021) at least. An examination of incidents of violence in one UK mental health trust showed a sharp upward trend in rates of violence immediately after the start of the first lockdown in March 2020 with rates returning to pre-lockdown levels after non-essential shops reopened in June 2020 (Payne-Gill *et al* 2021a). In one Irish high dependency ward, incidents of challenging behaviour fell by 26%, whilst episodes of seclusion and restraint fell by 53% and 56% respectively (Feeney *et al* 2022).

The mental state of acutely unwell patients is likely to increase behaviours that increase the risk of COVID-19 transmission, particularly the need for physical and chemical restraint, and one-to-one nursing (Skelton *et al* 2020). The National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU) produced guidance on carrying out restrictive interventions in the context of the pandemic (NAPICU 2020). This included guidance on how to manage physical interventions in relation to COVID-19, recommending that physical interventions should be carried out by the smallest team possible. Furthermore, personal protective equipment (PPE) should be used, including face masks, eye/spit protection, aprons and gloves. PPE was recommended during some physical interventions prior to COVID-19, for staff safety as well as infection control. Padded clothing has been shown to reduce staff injury during physical restraint in paediatric neuropsychiatry settings (Daraiseh *et al* 2018). PPE use is detailed in pre-COVID mental health trust policy where there is a likelihood of spitting and an infection control risk exists (Birmingham and Solihull Mental Health NHS Foundation Trust 2017). It is possible that PPE may add to the feelings of dehumanisation and distress in some patients when being restrained.

Time out 4

As shown in the study by Feeney et al. (2022), episodes of seclusion and restraint fell at a greater rate than incidents of challenging behaviour during the COVID-19 pandemic. This could be because

ward occupancy also decreased, reducing crowding, but it could also be due to COVID-related factors such as social distancing and a shared sense of purpose on the ward. They found that there was an emerging cultural shift. Identify the ways that the Covid-19 pandemic impacted your response to managing challenging behaviours. You could consider whether there has been an increase/decrease in the use of restrictive interventions and the factors that might account for such changes.

Post incident support

Restrictive interventions, and the incidents that lead up to them, can be harmful to the people involved, including patients, staff and witnesses. Therefore it is important that everyone involved has the opportunity to reflect and learn. NICE guidelines recommend that there should be immediate post-incident debrief after every use of restrictive interventions, except for enhanced observations (NICE 2015). Whilst these guidelines provide a framework by which debrief can happen, NICE indicates that despite the importance of debrief from a dignity and human rights perspective, limited empirical evidence exists to guide the development and implementation of debriefing interventions.

The literature exploring post-incident debrief consistently finds that patients and staff value the opportunity for debrief but that it happens infrequently for staff and even more rarely for patients (Sutton *et al* 2014). Whilst debriefing may be poorly defined within the literature, there are some defining features. For example it should be non-punitive and supportive (Wilson 2015), strength-based, person-centred, trauma-informed and recovery-oriented (Hammervold *et al* 2019). NICE guidelines describe the aim of debrief as 'to identify and address physical harm to services users or staff, ongoing risks and the emotional impact on service users and staff, including witnesses' (NICE 2015 p.37).

Witnessing restrictive interventions take place can also be distressing (Cusack *et al* 2018). Therefore patients who witness such incidents should also be offered an opportunity to debrief. The ward community meeting can be an excellent forum in which to discuss the impact of incidents on both patients and staff and the ward atmosphere. This can be done in a way that avoids breaking patient confidentiality, for example, by talking about how the incident made people feel rather than sharing confidential information about the patient.

Time out 5

The NICE (2017) quality standard 'Violence and aggression behaviours in people with mental health problems [QS154]' states that 'People with a mental health problem who experience restraint, rapid tranquillisation or seclusion are involved in an immediate post-incident debrief'. List the barriers to implementing this within your setting or service and discuss with colleagues how these barriers could be addressed.

Ethical dilemmas

Ultimately restrictive interventions involve one human being having power over another. The driving principle of restrictive interventions is to give power back to the patient as soon as it is safe to do so. It is therefore crucially important that organisations monitor the use of restrictive interventions to ensure that they are only being used as a last resort, and to support their reduction in use.

The Six Core Strategies is a widely used programme enabling services to reduce the use of restrictive interventions, more specifically seclusion and restraint (Riahi *et al* 2016). One of the six strategies

described is to use data to inform practice. Robust data collection around restrictive interventions is now enshrined in UK law; Seni's law requires trusts to collect data on each use of force including the reason it was used, whether it was in the patient's care plan and efforts made to avoid it. Such data can act as a catalyst to improve future practices (Riahi *et al* 2016).

Legislation, such as the Human Rights Act (1998) and The Care Act (2014), has also, quite rightly, developed greater protections for vulnerable adults who receive mental health care. Human rights forms a key element of the background against which recent UK mental health legislation has been introduced (Kelly 2012). Within mental health, however, it can be difficult, if not impossible, to balance rights of autonomy with rights of protection (Department of Health and Social Care 2018). For example, the Restraint Reduction Network (2019) describe a 'positive obligation' under the UK Human Rights Act (1988) to protect people from immediate risk of serious harm. Moreover, the European Convention on Human Rights (ECHR), which is part of UK law, places great importance on protecting the life of vulnerable people; this has been used as justification for compulsory detention. This is, however, at odds with the right to liberty, enshrined within the ECHR. Moreover, numerous legal cases have been brought, and won, by people arguing that their rights under Article 3 of the ECHR, Prohibition of torture, have not been met whilst as patients within mental health settings (Curtice 2010).

To reduce the need for restrictive interventions and to protect the rights of patients, staff should be open to the idea of examining and reflecting on their use of power, both individually and as a team. Participation in ethics reflection groups, for example, has been shown to increase awareness of formal and informal coercive practices, and may lead to staff taken a more reasoned approach when they are challenged by patients and patient behaviours (Hem *et al* 2018). Furthermore staff participating in such groups report a more critical attitude towards coercion and more user involvement around coercion.

Time out 6

Try to put yourself in a patient's shoes. Do you think that there are any aspects of the care that they receive within your setting that they might consider to go against their human rights, as defined by the European Convention on Human Rights (ECHR)? You can access the ECHR online: https://www.echr.coe.int/documents/convention_eng.pdf.

Time out 7

Identify how reducing the use of restrictive interventions applies to your practice and the requirements of your regulatory body.

Time out 8

Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account. See https://rcni.com/nursing-standard/revalidation/reflective-accounts/write-areflective-account-90981.

Conclusion

This article has examined the complex issue of restrictive interventions in mental health care. Mental health services should seek to foster a positive culture that actively works to reduce their use as much as possible through monitoring and reduction programmes. When they are used this should be as a last resort, and staff should ensure that they are carried out safely, respecting the human rights of the patient. Staff and teams should be encouraged to reflect on the use of power that

carrying out restrictive interventions entails, and have regular opportunities to discuss their impact both on themselves and on their therapeutic relationship with patients.

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