CONTROL AND RESTRAINT: CHANGING THINKING, PRACTICE AND POLICY

Brodie Paterson and other experts advocate the need for a shift in the way nurses think about, and are trained in, violence reduction and management. They call for a new national policy with a focus on lessening the use of restraint

Summary

The term control and restraint (C&R) has been in common use in mental health practice for the past 20 years. This article explores the appropriateness of its continued use, drawing briefly on frame theory – a subtype of discourse analysis. The authors conclude that, apart from a brief period in the 1980s, when the prison service oversaw training in physical interventions in the NHS, there has been confusion over the meaning of the term. Its continued use reflects an attribution whereby the primary source of violence is seen as 'within' the patient, instead of being seen as 'co-created', a more appropriate view in light of the public health model of violence prevention. However, any change in language must be accompanied by a shift in thinking and practice. The article puts forward a rationale for stopping the use of the term and calls for a radical change and the adoption of restraint reduction as a policy objective.

Keywords
Control and restraint, violence and aggression, policy, training, frame theory

THE ORIGINS of the term control and restraint, abbreviated to C&R, lie in the prison service. Its assimilation into the vernacular of mental health care happened via the training of health service staff by prison service instructors, first in Falkirk in Scotland, and then via the English special hospitals in the 1980s (Turnbull *et al* 1990). The term originally referred to a programme of physical intervention training designed by the English prison service in response to inquiries into serious and sometimes fatal injuries sustained by prisoners during physical confrontations.

The health service training programmes were initially rigidly controlled by the prison service, but were later allowed to proliferate throughout the NHS independent of any central regulation. Consequently, although the phrase C&R came into common use in the health service, at almost no point did it describe any coherent national training programme. Instead, it served to conceal the widespread local *ad hoc* adaptation of physical breakaway and restraint procedures. These adapted training programmes, which had not been subjected to any quality assurance arrangements (Duxbury and Paterson 2005).

The underlying perception of physical interventions implicit to C&R was of a skill that needed to be taught to staff, rather than an intervention done to service users. Such skills in physical interventions were sometimes taught without any attempt to teach violence prevention in services that had inadequate insight into their culture, leading to serious abuses.

One consequence of the lack of central control in the NHS was that a large-scale, uncontrolled experiment into the effects of training staff in physical interventions was allowed to happen. This has now lasted two decades and unfortunately the dependant variables have been staff and service user safety.

While much has been written on the risks to service users during restraint, there have also been numerous instances of serious injuries to staff during C&R training, owing to poor technique design and unsafe teaching methods.

Mike Wilkinson

Skills in physical interventions were sometimes taught without any attempt to teach violence prevention

The terms control and restraint, and C&R, continue to arise in discussions and debates regarding violence and aggression in the NHS, and in the literature of the many companies that offer training. It also continues to feature in articles in professional journals. The term is sometimes used as a euphemism for blocks, and escape or restraint techniques, a range of procedures more accurately described as 'physical interventions' (National Institute for Clinical Excellence 2005). Much more worryingly, however, it appears that the term is sometimes still used to describe aggression and violence prevention and management training more generally, including any theory or non-physical skills taught.

Cognitive frames

Umberto Eco (1979) argues that people perceive the world through cognitive frames that are present in their culture or memory. Such frames can be so familiar that they can 'operate transparently' on those affected, so people are effectively blinded to such influences on their thinking and behaviours (Shapiro 1988).

However, they exist – and are reflected in – the discourses we use to describe what we do. If how we speak about something is indicative of how we think, then one interpretation of the use of the term 'control and restraint' to describe all such training is that at least some nurses continue to think that the key means of delivering safer environments in mental health is restraint.

Training goals

Given that training must now address the *NHS Security Management Service* (*NHSSMS*) *Promoting Safe and Therapeutic Services* curricula mandatory outcomes (Paterson and Miller 2005) and/or the NHS Scotland Education standards (NHS Education Scotland 2006), the continued use of the term suggests that the significant cultural shift anticipated by such guidance and training is perhaps, at best, a work in progress.

It might be argued that the term C&R is well understood by a nurse who is sent on a three or five-day course, and that its communicative value justifies its continued use. Society and social norms, including language, however, change, so that words that were once in common use are no longer considered appropriate because of their negative connotations (for example with reference to race gender or sexuality). This is also the case with the term C&R: its connotations are redolent of a culture of coercion that we should have long since moved on from, rather than of the present era in mental health with its emphasis on partnership and recovery (Fisher 2003).

Consider the service user who is told by the staff nurse that he or she will not be around next week because they will be doing their 'control and restraint training'. The effect of such language would be far from reassuring to the service user, even if the content of the training reflected appropriate values and best practice. Staff must however, also be careful that they do not seek to obscure the reality, recognising that we may, on occasion, even with extreme reluctance, have to resort to physical force in some mental health settings. This means that alternative euphemisms, such as 'care and responsibility', which obfuscate rather than clarify what is being done and why, are also undesirable.

Staff in mental health settings are required by authoritative European Council guidance (European Council 2004) to emphasise primary and secondary prevention as the main response to the issue of violence, complemented only when necessary by training in physical interventions identified as appropriate to the setting by training needs analysis. This emphasis should therefore be reflected in the words used to describe the training delivered in the mental healthcare setting, and 'violence prevention and management training' seems apt and simple.

Unacceptable terminology

The term C&R in the context of health care is therefore an anachronism. Use of the term continues to suggest some form of consensus in regard to the practice when this does not exist and, in the worst instances, it may serve to lend a degree of credibility to highly questionable and sometimes abusive thinking and practices (Commission for Social Care Inspection/Health Care Commission 2006).

Therefore, the time has come to decide that the term C&R is no longer acceptable and for mental health care to move on in both language and thinking.

Changing the language will certainly not resolve all the problems with regard to how staff conceptualise and respond to aggression in services, or address the problems arising when cultures of care become corrupted (Wardhaugh and Wilding 1993). Corruption happens when the explicit aims of care – that is, individualised care based on the principles of partnership and recovery in practice – become secondary to the needs of staff striving to maintain predictable routines, rules, order and status. Restraint in such cultures is then used to enforce compliance as opposed to its proper purpose, which is as a last resort in managing dangerous behaviour.

Use of physical interventions should be proportionate to the risk posed. High-level interventions, such as the standing shoulder lock restraint (below), should only be used where de-escalation and lower-level interventions, such as the standing figure four restraint (left), do not offer sufficient security

Mental health nurses are often the immediate victims of violence, and the language of control and restraint perhaps resonates only too easily with those whose emotional response may be of anger, and whose unacknowledged emotional response can lead to a need to 'teach' service users that violence to staff is unacceptable (Paterson 2008). Mental health nurses are, however, increasingly sophisticated in their knowledge of the complex and multidimensional origins of violence in services to recognise and reject such thinking as dangerous.

So it is time to see journals summarily rejecting articles using the term control and restraint, to see health service trusts deleting the term from policies and to hear practitioners responding to the phrase when it crops up in conversation saying: 'You know that that is really not an appropriate term to use any more.' However, staff in mental healthcare settings need to transform not just how they talk about the prevention of violence in services for people with mental health problems. They need to see a number of key actions with regard to the social policy agenda.

First, explicit government commitment to the principles of restraint reduction across mental health services is needed. Nothing else will have the same potential to reduce injuries to staff and service users. Its widespread adoption in the United States and, more recently, the Republic of Ireland, illustrates the continued failure by the UK to take action on this area.

Second, mental healthcare staff need to see the introduction of a scheme of regulation for trainers

and training programmes recommended by the inquiry into the death of David Bennett (Blofeld 2003), rather than it simply be seen as a topic for discussion. The learning disability sector, via the British Institute of Learning Disability (BILD), has developed an accreditation scheme, but this remains voluntary. It is now long past time for government via the NHSSMS, the National Mental Health Development Unit or the National Patient Safety Agency to either develop its own mandatory

scheme or to adopt the BILD scheme, making it mandatory for all NHS training that incorporates physical intervention.

C&R should be treated in the same way as other physical interventions. For example, over-the-counter analgesics, such as paracetamol, would only be given by a nurse under certain circumstances and in line with clearly defined standards and regulations.

Accreditation scheme

Standards would ensure quality during the process of developing the management of violence interventions, in addition to setting the criteria by which the safety, effectiveness, and contraindications of the intervention were determined. Regulations would govern the circumstances under which the intervention might be used, in addition to setting the standards of prescription, the recording of use, and the monitoring of subsequent outcomes (Health Service Executive 2008). Given the potentially fatal consequences of poorly designed or applied physical interventions, the absence of effective regulation is a scandal.

An accreditation scheme would facilitate the creation of a national database of injuries during restraint, enabling staff to establish the relative risks of different models of physical interventions and make decisions regarding what form of physical interventions will be used based on systematically collated evidence, rather than 'expert' opinion. The more commonly used models may not be the safest for either service users or staff (Hart 2008).

Finally, this unregulated experiment has harmed not only service users – many staff too have been injured during training, often having to struggle for years to obtain compensation. A formal investigation into the serious injuries sustained during C&R training is required, and a no-fault compensation scheme that would allow compensation to be awarded without delay to practitioners injured during training. It is important to recognise that there are victims of the previous ways of working, not just among service users but also among staff.

A radical agenda and a further step change is needed if we want to realise the new era represented by initiatives such as the Promoting Safe and Therapeutic Services training programmes and create an approach to violence prevention in service for people with mental health problems in the UK that is fit for the new century.

New ways of thinking and working and relating to those who use our services are required, ones that John Connolly, the illustrious physician in charge of the Middlesex County Asylum in the 1840s, who advocated non-restraint, would be proud. He cautioned a visitor to his asylum, where he had successfully eliminated almost all forms of restraint that he would succeed only if he were in earnest. As mental health professionals, we could not be more so.

What next

Implications for practice

- Stop using the term control and restraint.
- Ensure you have accessed the Promoting Safe and Therapeutic Services training programme (or an equivalent).
- Be aware of the ever present possibility of corruption in your service.
- Start thinking seriously about how your service could use restraint less.

Further reading

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Brodie Paterson, senior lecturer, department of nursing and midwifery, University of Stirling
Co-authors:
Patrick Bradley, teaching fellow
Maggie Robertson and Sandy McComish, senior teaching fellow, Department of Nursing and Midwifery, University of Stirling
Steve Kay, senior clinical nurse, Broadmoor Hospital, Berkshire
Gary Greenwald, clinical nurse lead, Regional Forensic Psychiatric Services, Norvic Clinic, Norwich
Terry Heenan, head of management of violence and aggression, Partnerships in Care, Borehamwood, Hertfordshire
Trudii Isherwood, training and assessment facilitator, Norfolk and Waveney Mental Health NHS Foundation Trust
Mark Kidder, network leader managing aggression and violence, South West Yorkshire Partnership NHS Foundation Trust
Anita Lewin, clinical nurse specialist, The Reservation, Sleaford, Lincolnshire
Alan Maughan, violence reduction lead, Rampton Hospital, Nottinghamshire
Gail Miller, associate director, Risk Management, West London and Broadmoor NHS Trust
Paul Yates, training manager/ clinical lead, Promoting Safer and Therapeutic Services Training, Kent and Medway NHS and Social Care Partnership Trust
Kevin McKenna, lecturer, Dundalk Institute of Technology, Dundalk.
Ted Foulger, prevention and management of violence and aggression manage, North Warwickshire Primary Care Trust

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