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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)

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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 that 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.

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). While 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

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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 outlined 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 and 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. While 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 databases. 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, Rollin, & Darmoni, 2013), was also searched. Additionally, hand searching was employed as referenced articles can often identify research for further exploration (Taylor, Dempster, & Donnelly, 2003).

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