



# Mental health crisis care: physical restraint in crisis

A report on physical restraint in hospital settings  
in England

June 2013

[mind.org.uk/crisiscare](http://mind.org.uk/crisiscare)



**It was horrific... I had some bad experiences of being restrained face down with my face pushed into a pillow. I can't begin to describe how scary it was, not being able to signal, communicate, breathe or speak.**

**Anything you do to try to communicate, they put more pressure on you. The more you try to signal, the worse it is.\***

\* All the quotes in this report are from people who have either experienced or witnessed physical restraint. Many are taken from interviews conducted between February and April 2013.

# Executive summary

This report sets out Mind's findings on the use and impact of physical restraint in mental healthcare settings in England. Our research found huge levels of variation across the country in the use of physical restraint, and highlighted the psychological and physical injuries caused as a direct result of being physically restrained.

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.

In 1998, David 'Rocky' Bennett died at a medium secure mental health unit. An independent inquiry found that he died as a direct result of prolonged face down physical restraint and the amount of force used by members of staff during the incident. The inquiry made specific recommendations about the use of physical restraint, especially in regards to face down or prone position restraint.

Shockingly, since Rocky Bennett's death there have been at least 13 restraint-related deaths of people detained under the Mental Health Act 1983<sup>1</sup>. Eight of these occurred in a single year (2011). More than 15 years since Rocky Bennett's death, we are still no closer to implementing the lessons learned from his death and people are still dying as a result of physical restraint.

It is unacceptable that successive governments have neglected to take action, failed to establish national standards for the use of physical restraint in England and to introduce accredited training for healthcare staff.

Physical restraint can be frightening and hugely disempowering for anyone, let alone someone in a highly distressed state. It should only be used as a last resort.

Face down physical restraint is a life threatening form of physical restraint because of the severe impact it can have on breathing. It is a disproportionate and dangerous response to someone's behaviour when they are in a mental health crisis. Face down physical restraint has no place in healthcare settings and there must be an immediate end to its use.

## Our key findings are<sup>2</sup>:

- The huge variation in the use of physical restraint across England is unacceptable. In a single year, one trust reported 38 incidents while another reported over 3,000 incidents.
- Last year there were almost 1,000 incidents of physical injury following restraint.
- Face down restraint, which means pinning someone face down on the floor, is dangerous and can be life-threatening. It can feel like you're being suffocated and can cause even more distress. Last year alone it was used over 3,000 times. Yet some trusts have put an end to face down restraint altogether.

## Our key recommendations are:

- For Government to introduce an end to face down physical restraint in all healthcare settings urgently. Include the use of face down physical restraint in the list of 'never events'.
- For Government to establish national standards for the use of physical restraint and accredited training for healthcare staff in England. The principles of this training should be respect-based and endorsed by people who have experienced physical restraint.

# Foreword

There is a fundamental contradiction at the heart of mental health, between care and control. While mental health services in general are driven by the commitment to help and support people who are distressed or in crisis, many aspects of our work involve containment and control of people who are considered a risk to themselves or others as a result of their mental health problems. This poses a significant challenge to clinical staff and those managing and regulating mental health care. We have a huge responsibility to ensure that the power invested in us as clinicians is not abused and there are checks and balances in place to prevent harm and ill treatment of people who are at the sharp end of coercive psychiatric care.

Sadly, it would seem many people using mental health services continue to experience not only harm but serious injury and even death as a direct result of psychiatric interventions. This is most obvious in relation to the use of physical restraint in mental health care. In most of medicine, any procedure or intervention that carries with it a significant risk of harm to the patient will be subject to strict controls, supervision and explicit guidelines on their use and careful surveillance of such practice. However, as this report by Mind shows, this is far from the case when it comes to the use of physical restraint. It would appear that there is a huge variation across England in the use of physical restraint, the procedure is too often associated with physical or psychological harm to the victims of restraint and, currently, there are no national standards or accredited training for healthcare staff in England on its use. Mind's report, rightly, calls attention to these deficiencies. It argues for the need to change the culture and environment of healthcare settings which can often trigger behaviours that may lead to restraint and for support and accredited training for staff in the use of restraint, underpinned by respect for service users and involving those who have been at the wrong end of restraint procedures.

What this report also highlights is the lack of any progress in regulating and minimising the use of physical restraints in psychiatric settings.

It is now 10 years since the publication of the Independent Inquiry into the death of David Bennett and 20 years since the inquiry into the death of Orville Blackwood, Michael Martin and Joseph Watts at Broadmoor Hospital. These inquiries drew similar conclusions about the use of physical restraint and made similar recommendations. The Bennett inquiry was unequivocal in its recommendations about "face down" or prone physical restraint, identifying this procedure as carrying a significant risk of death to the person being restrained. Yet this and other recommendations made by the Bennett Inquiry and previous reports have still not been implemented. This is a major failure on the part of successive governments and the NHS. As data from the Independent Advisory Panel on Deaths in Custody shows, people continue to die in our psychiatric units as a result of being subject to physical restraint. It is totally unacceptable that the lessons learnt as a result of the tragic deaths of Orville Blackwood, Michael Martin, Joseph Watts and David Bennett continue to be ignored and people using mental health services still remain at high risk of injury and even death as result of the use of physical restraint.

Given the grave psychological and physical risks associated with physical restraint, there is a compelling and urgent need for a common set of guidelines and national standards on the use of physical restraint in all settings, including mental health care.

**Dr S P Sashidharan**

Consultant psychiatrist and panel member of the independent inquiry into the death of David "Rocky" Bennett

# What we wanted to know about physical restraint

Following a year long independent inquiry in 2010/2011<sup>3</sup>, we sent Freedom of Information (FOI) requests to all 54 mental health trusts in England asking how they use physical restraint in their trust, the impact of physical restraint and the procedures and training in place which govern the use of physical restraint.

We received responses from 51 trusts<sup>4</sup>. Three trusts failed to reply. Of those that replied, one declined our request citing cost and time and one said they could provide no data due to the way their data system captured information.

We did not approach independent providers. Further research is needed to identify the experience of people in these settings.

Our findings show a staggering variation in the use of physical restraint in mental health trusts in England. It is used far too often in some parts of the country.

Some mental health trusts have successfully managed to end the use of face down physical restraint completely and others reported low numbers of physical restraint. However, other trusts continue to have a shameful overreliance on physical restraint and use face down physical restraint too readily in their response to managing a crisis situation.

On a mental health ward the experience of being controlled and physically restrained can be traumatic and result in a loss of dignity and respect, or even death in some cases. When people's lives come crashing down and they are at their most vulnerable, they need help immediately not further harm. People in hospital for mental healthcare should feel confident that physical restraint should only be used competently, safely and only as a last resort with minimum force<sup>5</sup>.

# Background

When someone is having a mental health crisis, they may become frustrated, frightened and extremely distressed. Even when they seem aggressive and threatening, or refuse treatment, they still desperately need help and compassion.

Healthcare staff do a challenging job and physical interventions are often used to manage a person's behaviour if they are deemed to be at risk to themselves or others. However, physical restraint should only be used as a last resort when there's no other way of stopping someone from doing themselves or others immediate harm.

According to both the Care Quality Commission's *Count me in* census<sup>6</sup> and the *Mental Health Minimum Dataset*<sup>7</sup>, physical restraint is 'the physical restraint of a patient by one or more members of staff in response to aggressive behaviour or resistance to treatment'. The fifth and final *Count Me In* census, carried out in 2010, found that about 12 per cent of patients had experienced one or more episodes of physical restraint<sup>6</sup>.

Currently in England, there is no national framework to govern the use of physical restraint and current training used by mental health trusts remains variable and unaccredited. This lack of standardised policy contrasts with Wales which has a nationwide All Wales NHS Violence and Aggression Training Passport and Information Scheme. In Wales, staff are taught to use face-to-face safe-holding when a hands-on intervention is required. Although some physical restraint training approaches in England emphasise the importance of safety, dignity and respect, our research has shown that use of such training is not standard practice for all mental health trusts.

Urgent action is needed to ensure that the care delivered by healthcare professionals is built on humane values and embodies the principles of dignity and respect where the person's choices are paramount.

## Mental Health Act and the use of physical restraint

If a person is detained under the Mental Health Act 1983 and is a hospitalised inpatient then staff are entitled to exercise a degree of control over that person, for example preventing that person from leaving the hospital or requiring them to leave a public area of the hospital. Force may be used to achieve this if it is necessary, but it must be reasonable and proportionate.

Physical restraint is not defined in the Mental Health Act but the key guidance on use of restraint and detained patients is in the Code of Practice to the Act. Chapter 15 of the Code of Practice, *Safe and Therapeutic Responses to Disturbed Behaviour*,<sup>8</sup> explains that restraint is a response of last resort and requires that:

- All hospitals should have a policy on the recognition and prevention of disturbed or violent behaviour as well as risk assessment and management including the use of de-escalation techniques, enhanced observation, physical intervention, rapid tranquilisation and seclusion. (15.6)
- Physical restraint, rapid tranquilisation, seclusion and observation should only be used where de-escalation has proved insufficient and never as punishment. (15.8)
- Professionals should not categorise behaviour as disturbed without taking account of the context. (15.13)
- Individual care plans are fundamental to management of disturbed behaviour. In addition, problems may be minimised by promoting the therapeutic culture of the ward, and identifying and managing problem areas. (15.16)
- Hospitals' policies on the management of disturbed behaviour should include clear written policies on the use of restraint and physical interventions, and all staff should be aware of the policies which should allow for post-incident review. (15.21)



# Recent developments in policy and practice

A number of recent initiatives have highlighted the issue of physical restraint.

## Mid Staffordshire

The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry<sup>9</sup> highlighted significant problems of inhuman and degrading treatment across the NHS that are particularly pertinent to mental health. Some services were found to be using force and coercion where people were not involved in deciding about the care and treatment they received. The report made it clear that the quality of care in the NHS must be delivered based on dignity and respect.

## Winterbourne View

The Department of Health's final report into the horrific abuse encountered by many at Winterbourne View<sup>10</sup>, an independent provider of services for people with learning difficulties, highlighted the extremely high number of physical restraints regularly being used on inpatients. The numbers of recorded incidents was so high that the Care Quality Commission concluded it would be impossible to justify the necessity of physical intervention for every incident.

The report made strong recommendations for clear guidance around preventing and managing challenging behaviour. It emphasised that physical restraint must only be used as a last resort, where the safety of the person would otherwise be at risk, and never to punish or humiliate.

In our own call for evidence for this report, people told us they felt they were treated "worse than a criminal" and had been pinned to the floor by members of staff with very little or no communication.

Following the Winterbourne View investigation, the Care Quality Commission produced a briefing on restrictive practices in mental health and learning disability settings<sup>11</sup>. It explored a programme of unannounced inspections of

services alongside evidence from visits to people detained under the Mental Health Act. Although the briefing identified the use of different types of restrictive practices which are still prevalent, such as seclusion/segregation techniques, there was also evidence of the use of physical restraint varying in frequency and intensity with some inspection reports highlighting how common the practice was in some areas.

## Independent Advisory Panel on Deaths in Custody

In 2008 the then government set up the Independent Advisory Panel on Deaths in Custody<sup>12</sup> to help shape government policy in this area through the provision of independent advice and expertise to the Ministerial Board on Deaths in Custody. The remit of the panel covers deaths occurring in various settings including of people detained under the Mental Health Act in hospital. The panel have been hearing from families who have been affected by the death of a relative within state custody and liaising with practitioners from both the health and legal profession. They are developing common principles on the use of physical restraint, to apply to all sectors, expected to be released later in 2013.

## Metropolitan Police Service

The Metropolitan Police Service set up an Independent Commission on Mental Health and Policing looking into how it responds to people with mental health problems<sup>13</sup>. The review carried out an examination of cases from the last five years where someone with a mental health condition had either died or been seriously injured following contact with the police. The Commission's report found the tactics and behaviour used by the Metropolitan Police Service to physically restrain people with mental health problems the most disturbing of their findings and it examined several cases which involved prolonged physical restraint by the police.



The Commission's report recommends that the Metropolitan Police Service develop policy and training for police officers on physical restraint which is developed in partnership with people with mental health problems<sup>14</sup>.

## National Institute for Health and Care Excellence (NICE)

The 'Violence' guidelines produced by the National Institute for Health and Care Excellence (NICE) are set to be replaced in 2015 by an updated version entitled 'The short-term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments'. The new guidelines will include the views of people who have experienced the use of physical intervention and seclusion, as well as other aspects of restraint such as rapid tranquilisation.

## Royal College of Nursing

Earlier in 2013, the Royal College of Nursing held its annual congress where members overwhelmingly voted to lobby UK governments to review, accredit and then regulate national guidelines of approved models of physical restraint in healthcare<sup>15</sup>. Nurses spoke out about poor practice they had witnessed and the critical need for establishing appropriate guidelines.

## Implementing Recovery through Organisational Change (ImROC)

In the meantime, some health settings are making progress to reduce the use of physical restraint. The Implementing Recovery through Organisational Change (ImROC) programme is run by the Centre for Mental Health and the NHS Confederation<sup>16</sup>. The aim of ImROC is to encourage organisations to be recovery-oriented and to improve the quality of the service they provide to support people more effectively. Organisational culture and the quality of interactions is core to the approach and some mental health trusts participating in ImROC are successfully working towards zero use of physical restraint.

All these initiatives are welcome, but there urgently needs to be definitive national standards and accredited training to bring all these practices together and address the huge variations in physical restraint we found across England.

# Race equality

There has been slow progress to date on changing the stark inequalities in the acute sector of mental healthcare for people from some Black and minority ethnic (BME) communities, and they continue to be over-represented in hospital and as detained patients<sup>17</sup>. While the *Count Me In* census did not show ethnic differences in the use of physical restraint, this issue has a strong resonance in Black communities because people from these communities are disproportionately treated in inpatient and secure settings, and because of recent cases of deaths of young Black men in police custody<sup>18</sup>. INQUEST identified that 'in 2008, BME deaths accounted for 32 per cent of all deaths in police custody<sup>19</sup>'.

The report produced by the Independent Commission on Mental Health and Policing found various 'failures in the system, misjudgements of

errors in the system' and a degree of 'discrimination' towards people with mental health problems. It also found 'evidence of... a small number of alleged racist incidents<sup>20</sup>'. The findings demonstrate that issues of racism continue to be prevalent within the Metropolitan Police Service, and that it is likely that these views will have an impact on how some officers, including frontline officers and custody officers, respond to people from BME communities.

There was also strong criticism in our own crisis care inquiry of how Black men are treated. They are disproportionately diagnosed with schizophrenia, treated with suspicion and assumed to be violent and dangerous by staff due to misplaced perceptions and cultural stereotypes<sup>3</sup>.

## Case study: Maat Probe Group

During our 2010/2011 crisis care inquiry and call for evidence, we heard about aggressive treatment and physical injuries towards people with mental health problems in inpatient wards. We heard about physical restraint from the Sheffield based African Caribbean service user group Maat Probe, several individuals who responded to the call for evidence, the Centre for Mental Health and the Care Quality Commission.

When the Maat Probe Group carried out a monitoring exercise in 2009 to investigate Black people's experiences of mental health services, they found that 46 per cent of the people they interviewed had been restrained by mental health staff. Of these, 79 per cent felt it was aggressive and 34 per cent had been physically injured. People talked about being pinned to the floor, having a knee on the back of the neck and feeling violated.

Members of Maat Probe Group told us about the importance of communication between staff and people in crisis in preventing and dealing with difficult situations – for example, to listen and respond to people's fears about medication. The group also felt there needed to be better understanding and awareness among staff about people's cultural backgrounds and ethnicity.

As a result, the Maat Probe Group's top priority was for an alternative to conventional methods of control and physical restraint to be used in resolving difficult situations on the ward – methods taught in programmes such as RESPECT, SCIP or Studio III Training. The group have successfully lobbied for the mental health trust in Sheffield to adopt RESPECT Training and are currently evaluating its impact to date (see page 23).

The death of Rocky Bennett prompted an inquiry in 2004 which found that Rocky died as a direct result of force used during physical restraint by five nurses, and that his death would not have occurred if there had been approved guidelines in place<sup>21</sup>. The inquiry also prompted the Delivering Race Equality programme<sup>22</sup> and encouraged the Department of Health to work on the management of violence that was intended to result in definitive guidance and accredited training.

Unfortunately definitive national standards for physical restraint and accredited training are still to be established and implemented, even though these recommendations were made almost ten years ago. This means each mental health trust in England and each independent hospital uses its own training scheme.

Physical restraint is linked with death, and people with mental health problems continue to experience excessive force, physical injury and psychological harm in psychiatric settings. Continuing to leave the practice of physical restraint unchecked and open to variation in England, and failing to put an end to the use of face down physical restraint is unacceptable.

# Face down physical restraint

**Prone restraint is an area that we know from cases around the world is a position in which people appear to die suddenly when they are restrained for long periods. And that I think is a matter of fact.<sup>23</sup>**

Dr Nat Cary, Consultant Home Office Forensic Pathologist, in evidence to the David Bennett inquiry (2004)

Face down physical restraint means pinning and holding someone face down for a period of time. It is particularly dangerous and life threatening because of the impact it can have on a person's breathing. Along with other forms of physical restraint, it can also be dehumanising and distressing and should have no place in a healthcare setting where people go to recover.

Face down physical restraint was identified as a contributing factor in the death of Rocky Bennett.

The medical experts who gave evidence at the inquiry all agreed that the single most important cause of death was the prolonged period (20 to 30 minutes) of prone restraint carried out by nurses<sup>24</sup>. Despite specific recommendations made in the 2004 inquiry about the use of face down physical restraint, there is still an over-reliance on this practice when managing a mental health crisis in healthcare settings. The Care Quality Commission's latest Mental Health Act Monitoring Report 2010/11 refers to concerns about the recent deaths of three detained patients during restraint in the prone position, where lack of training was identified at inquest as a contributory factor<sup>25</sup>.

We have found through our research that some trusts have put an end to face down physical restraint altogether. They use other forms of physical restraint, developed jointly with people with mental health problems, which promote respect-based principles. These alternatives show that it is entirely possible for staff to manage challenging behaviour effectively without the need for the life threatening and dangerous use of face down physical restraint.

# What mental health trusts told us about physical restraint

**Restraint is used too quickly and services need to understand why someone is behaving in that way. To come at someone who's already in a bad way makes it so much worse and causes even more distress.**

On-duty psychiatrist

We know healthcare staff do a challenging job and sometimes need to make difficult decisions very quickly. However, in situations where staff feel there is a threat to the safety of the patient in distress or the people around them, de-escalation alternatives to physical restraint should be considered first. If none of the de-escalation alternatives are effective, only then should physical restraint be carried out. It should only be used as the last resort, when there is no other way of stopping someone from doing themselves or others immediate harm.

Through our FOI requests we asked for a range of data for the year 2011–2012 from all 54 mental health trusts in England about:

- how they use physical restraint
- the impact of physical restraint
- the current procedures and training which underpinned the trust's physical restraint policy<sup>26</sup>.

We asked for the information to be broken down by both gender and ethnicity.

We received very low responses for ethnicity. A large number of trusts did not provide data on gender and ethnicity citing that they did not capture this information or that it would be too costly to collect. This is highly worrying given the disproportionate numbers of people from BME communities using secondary mental health services and being detained in custody. The failure to record the ethnicity of people being physically restrained could be masking the true extent of inequalities faced by people from BME communities.

Overall, responses showed stark variations in how the practice of physical restraint is used throughout England, and recording of the impact caused due to physical restraint also varied from trust to trust.

# Use of physical restraint

## Incidents of restraint

Total number of incidents of physical restraint by one or more members of staff	
Number of respondents	47 (87 per cent of all trusts)
Total	39,883
Range	Highest 3,346; lowest 38
Median	455 <sup>27</sup>

...[during physical restraint] the six of them then started talking about what they were going to do for their Christmas holidays... they were talking about these matters while pinning down a 20-year-old terrified woman.

These figures show the huge variation in how physical restraint is used in NHS mental health settings. The range displays the highest and lowest reported figures received from the trusts which replied to this question. The range varied enormously from 38 incidents of physical restraint in one trust to over 3,000 in another. This level of variation is appalling, even if each trust may use different definitions of restraint in their records. Nor is it clear from the data whether all physical restraints are effectively recorded.

What is clear from the information, even allowing for potential poor reporting, is that it is possible to deliver a mental health service with minimal use of physical restraint. It is unacceptable that some trusts are reporting hundreds or thousands of incidents a year.

## Number of patients restrained

Total number of patients who experienced physical restraint by one or more members of staff	
Number of respondents	39 (72 per cent of all trusts)
Total	19,044
Range	Highest 3,133; lowest 38
Median	247

They hold them, release them after five minutes, take a 30 minute break and then hold them again. It's again and again... they're too quick to use restraint

Ward Psychiatrist

Again we found a huge variation in the total number of people who experienced physical restraint by one or more members of staff. Worryingly this data suggests that some people may be being restrained repeatedly.

## Face down restraint

Total number of incidents of face down physical restraint by one or more members of staff	
Number of respondents	27 (50 per cent of all trusts)
Total	3,439
Range	Highest 923; lowest 0 (in 4 Mental Health Trusts)
Median	65

**It was like a rugby scrum... They got on top of me and held my face down to the floor... with my arms behind my back. There was someone on every limb... it stayed with me.**

Data from the numbers of incidents of face down physical restraint revealed that at least 3,439 incidents of face down physical restraint occurred in England during 2011-2012; over half of the face down physical restraints occurred in just two trusts. These extremely high figures suggest that face down physical restraint is occurring at least nine times a day on average – and this is just within the 50 per cent of trusts who sent us data.

One trust reported 923 incidents of face down physical restraint in one year which is highly concerning, especially as we also know from our findings that some trusts have worked hard to eliminate face down holds and consequently reported zero prone position restraints.

## Restraint and medication

Total number of incidents where physical restraint was used to administer medication	
Number of respondents	31 (57 per cent of all trusts)
Total	4,300
Range	Highest 592; lowest 1
Median	74

**Four of them held me down onto the bed and gave me an injection. I kept saying that I didn't want it and that I wanted a female nurse. No one listened to me... The younger staff members are the worst. They're new and excited by their training and get carried away with it.**

Information received for numbers of incidents where physical restraint was used to administer medication, was another area where the figures were exceptionally high. Over 4,000 recorded incidents of physical restraint were reported for medication purposes with a mid-range of 74 incidents in 2011–2012. Some trusts explained their reasons for using physical restraint to administer medication, such as to calm an inpatient who had become highly distressed through the use of rapid tranquilisation. But we heard in our crisis care inquiry that some staff don't try to understand why someone is refusing medication and are using physical restraint too quickly.



## Police involvement

Total number of incidents where police were involved in physically restraining a patient	
Number of respondents	27 (50 per cent of all trusts)
Total	361
Range	Highest 100; lowest 0 (in 3 Mental Health Trusts)
Median	8

**It made me feel like a criminal like I had done something wrong, not that I was just ill and needed to get better. That's all it is.**

Of half the responses received for incidents where police were called to physically restrain someone in a healthcare setting, there was significant variation in the numbers of recorded incidents. One trust alone in 2011-2012 reported 100 incidents whereas three trusts reported not having to call the police at all. Given this variation in the need to call the police, it raises the question of how necessary or appropriate it is to call law enforcement into health settings.

One person responding to our crisis care inquiry, who witnessed physical restraint on a ward, described what happened when staff were unable to de-escalate a situation and police were called in, "storming the car-park, alarming visitors and patients". They heard staff making accusations to someone in crisis (which did nothing to defuse things) and police mocking the situation.

# Impact of physical restraint

## Physical injury

Total number of incidents of physical injury following physical restraint	
Number of respondents	34 (62 per cent of all trusts)
Total	949
Range	Highest 200; lowest 0 (in 5 Mental Health Trusts)
Median	7

**It hurt a lot of the time as well. Being 20 and quite petite resulted in me quite often being left with bruises after being restrained.**

We found that, while no deaths during the period of 2011–2012 were reported to us, in the 75 per cent of the trusts which answered questions about physical injury as a direct result of restraint, the recorded incidents of physical harm varied from zero to 200.

Interestingly, one trust commented that they were unable to determine if the injuries sustained were due to a prior incident or if they were caused by the physical restraint itself. One way to eliminate

this uncertainty is to ensure that every person who has experienced physical restraint has the opportunity to write an account of the episode of physical restraint and this is filed in their notes, as required in the Mental Health Act Code of Practice. The Care Quality Commission's *Monitoring the Mental Health Act in 2010/2011* report stated that although many services find this requirement challenging, compliance with the Code's guidance would mark a positive cultural shift for many hospitals and they will continue to promote it through their visits<sup>28</sup>.

Earlier this year Mind and the Sheffield based African Caribbean mental health Maat Probe Group – who also gave evidence to our *Listening to experience* inquiry – jointly hosted a workshop to explore people's experiences of physical restraint in mental healthcare settings. The Maat Probe Group had successfully influenced their mental health trust to focus on more therapeutic holds and de-escalation techniques which start from a position of respect for the person with mental health problems. We also heard from people who described the physical injuries they had received as a direct result of being physically restrained, such as a 'Chinese burn' (gripping and twisting one's skin in opposite directions so as to cause a burning sensation) or having their fingers bent backwards. These forms of physical injuries have no place in mental healthcare and cannot be justified as safe or respectful.

## Psychological harm

Total number of incidents of psychological harm following physical restraint	
Number of respondents	14 (25 per cent of all trusts)
Total	96
Range	Highest 74; lowest 0 (in 11 Mental Health Trusts)
Median	0

**I've suffered physical abuse when I was younger and being held down where someone forces their weight on you is triggering for me... it's the last thing that's going to make me conform; I don't want them touching me.**

The lowest response rate, just 25 percent, to our FOI requests was to the question on psychological harm caused as a result of being physically restrained. Many of the trusts were unable to provide this information because it was either captured in an individual's medical records and extracting this information would be costly, or because psychological trauma is not routinely

recorded. Others suggested that psychological trauma was open to different interpretation and not easily identifiable. One trust went as far as to say that "it would not be possible to record this information as it would be difficult (impossible) to clarify that a patient's psychological presentation was linked solely to their restraint and not to their underlying mental health issues."

From our call for evidence, we also heard about staff belittling people when they were being physically restrained and continuing with their conversations and ignoring the person being physically restrained. Many respondents to our inquiry told us again and again how humiliating, distressing and disempowering physical restraint can be and this can only have a negative impact on recovery. Some told us of long term psychological impact from an episode of physical restraint.

While we understand that it would be difficult to fully attribute psychological harm to the incident of physical restraint, especially if the person is not given the opportunity to report their experience, some trusts do record psychological harm.

However, physical restraint doesn't have to be negative, and we did hear from one or two people about how physical restraint could be done well and positively. They told us about being listened to during physical restraint and being held in a safe way which didn't fully restrict their movement or cause pain.

# Complaints about physical restraint

Total number of complaints received following physical restraint	
Number of respondents	37 (68 per cent of all trusts)
Total	111
Range	Highest 21; lowest 0 (in 10 Mental Health Trusts)
Median	2

**What's the point of complaining? They don't believe you and you know you'll see them [staff] again the next day. It's not worth it.**

Given the many negative experiences of physical restraint we heard about through our crisis care inquiry and call for evidence, it might be expected that numbers of complaints would be relatively high. However the responses we received

indicated very few recorded complaints were lodged about physical restraint in the year 2011–2012. Sadly these low numbers are unsurprising and fit with other research we have conducted.

Through our engagement of people with mental health problems, Mind knows that there is a huge issue of underreporting of safety incidents and poor treatment among people with mental health problems. The power imbalance between people in crisis and staff is a significant deterrent to raising a complaint. People may not have confidence to complain or think they will not be listened to, so believe it is not worth bothering. They may also lack the confidence or ability to complain because their mental health problem makes it difficult for them to engage in the complaints process. For these reasons, the low figures for physical restraint complaints are likely to reflect under-reporting of abuse or inappropriate treatment rather than an absence of a need to complain about the service people have experienced.

## Case study: Rosemary's story

Rosemary was 55 at the time of her inpatient experience in a mental health hospital. This is her account of what happened to her.

It was a bright day and the doors to the hospital garden were open so Rosemary went outside. Two women were out there smoking and asked Rosemary to go back inside. Because Rosemary had not had the opportunity to go outdoors for a while she went ahead and sat on the bench. The two women, who were in fact duty nurses, went inside coming back a little later with other staff.

All the members of staff approached Rosemary and began to try to remove her physically from the bench. They managed to pull Rosemary off and went on to pin her on the floor in full physical restraint, face down. She had one nurse on each arm plus one sitting on her legs. They then started to inflict pain, one giving her a Chinese burn and twisting her fingers.

Rosemary was told to get up but couldn't, as they were holding her arms and wouldn't let go.

Eventually she got to her knees and then to her feet. She had been face down on a muddy path and her face was covered in mud and dirt. She asked for someone to wipe her face before she was taken back inside, but her request was ignored. Rosemary was then taken back on to the open ward in front of everyone, with one nurse walking backwards in front of her, one behind, and one holding each of her arms. People on the ward had also been able to witness the physical restraint through the window.

Soon after leaving hospital, Rosemary developed post traumatic stress disorder (PTSD) as a result of the incident and ten years later still has flashbacks. As a result of this experience, Rosemary has tried three times to take her own life and has been admitted into hospital.

Rosemary now receives treatment for her PTSD and is making progress in her recovery.

## Case study: Lucy's story

This is Lucy's account of what happened to her.

Between the ages of 16 and 17, Lucy was in an inpatient unit where staff were allowed to physically restrain people. From Lucy's experience, the times when she had witnessed and experienced physical restraint, it was only used as the last resort. Lucy felt that even though she had experienced a history of violence perpetrated by others,

physical restraint used as a last resort made her feel safer and more secure in moments where she was unable to control her behaviour in a crisis. When physical restraint had been used on Lucy, it helped her feel grounded because it was carried out in a gentle and respectful way, she felt it was entirely appropriate. It made Lucy feel like somebody was there to help.

# Our analysis of physical restraint

**I went into this job to care for people and make them better and ideally you wouldn't restrain anybody. But it happens quite often. At what point do people intervene? When there's fear, people do drastic things and act less controlled.**

Staff nurse

Physical restraint is often a response by healthcare staff to behaviour which is perceived as challenging and potentially disruptive or violent. When people are highly distressed and in a mental health crisis, their behaviour may appear erratic and violent which can lead to staff initiating a form of intervention to either protect the inpatient, others or themselves.

The way someone behaves in a situation or in a crisis can be a response to various factors, and not just a manifestation of someone's diagnosed mental health problem. The culture and environment of wards can act as a trigger for

challenging behaviour. If people are not listened to or given the opportunity to have a say in their care, have nothing to do or no-one to talk to, tensions can rise and people may become frustrated and distressed.

Problems with inpatient environments – often overcrowded, noisy, unsafe and with limited therapeutic input – have been identified over the last 10 years or more<sup>29</sup>. We heard of people being locked in their rooms without access to outdoor space or even something as simple as a request for a cup of tea being turned down. These limiting conditions and rules placed upon people's everyday movements, especially when they are at their most unwell and vulnerable, can have severe adverse effects on their mental health and can be a trigger for challenging behaviour.

The aim of inpatient wards should be to provide a therapeutic and safe environment which aids the person's recovery by providing care which encompasses the person's choices and their needs. Physical interventions and other restrictive practices such as seclusion, should be severely limited and used only when other techniques such as de-escalation have been exhausted.

# The importance of communication

**I was manhandled. They didn't explain anything to me but just threw me on the floor and another person stood over to watch. There was no explanation or communication the whole time.**

During our crisis care inquiry and call for evidence from people who had experienced being physically restrained, there was a recurring theme of little or no communication with them to find out how to remedy or de-escalate a situation. People told us about being disregarded and given no choice or information before, during or after physical restraint. We heard from someone who asked staff to take extra care if they were to be physically restrained because their existing self-harm abrasions were still very painful and should be carefully avoided. This request was ignored.

Often this lack of communication follows a more general failure to engage with people and to create relationships where the person is able to trust and work with staff on an ongoing basis and where staff in return understand each person's needs and behaviour.

Effectively creating a joint care plan between staff and the person, or identifying things that might increase or decrease distress, anxiety or trigger challenging behaviour in a person can help manage future crises.

In order to understand each person's actions, staff should be encouraged to actively listen and respond to someone's needs through continually referring to their care plan, not only their mental health diagnosis.

We heard at our workshop with the Maat Probe Group that people feel their race and ethnicity can define how they are treated by professionals. Staff can assume that someone's behaviour is threatening or challenging when in fact their cultural background can mean they are often more animated or speak in louder tones. This is not aggressive behaviour and staff may feel less intimidated if they are more culturally aware.

Treating people with dignity and respect, listening to them and trying to understand their frustrations or refusals, providing activities, therapies and access to outdoor space will help their recovery and prevent challenging situations.

**Some of the psychiatric nurses are gems. They go the extra mile and try and look out for you.**



# Evidence of training and good practice

Training in the prevention, de-escalation and management of challenging behaviour must be based on humane values and people should be treated according to the choices they have previously identified through joint care plans and advanced directives.

To truly understand and therefore positively support someone in immediate crisis, there should be an explicit acknowledgement that individuals know what they need for their own recovery. People should have more say over what happens at a time when they may not be able to exercise choice directly.

Current Royal College of Nursing guidance states that physical restraint should only be used as a last resort and not solely to reduce workload. In most circumstances, physical restraint can be avoided by positive changes to the provision of care and support and an individual's choice should be acknowledged and included in a care plan and risk assessment<sup>30</sup>. Cultural awareness training and in-depth learning techniques should be pursued so staff and providers understand the context of a person's actions.

## Case study: RESPECT Training Solutions

RESPECT Training Solutions is based in North Lincolnshire and aims to provide a holistic and ethical approach to physical interventions in mental health settings. Their training has been created with direct involvement from people who have experienced physical restraint and carer involvement, emphasises support rather than control and seeks cooperation where possible.

This person-centred training is based around prevention and designed to help staff empower people. The principles of RESPECT are based on:

- No use of facedown holds
- Avoidance of labelling people
- Care rather than simply control
- Developing healthy environments
- Awareness and avoidance of abuse
- Recognising differences between threat and violence/de-escalating
- Presenting a realistic view/reducing fear in staff

Sheffield Health and Social Care Foundation Trust have employed RESPECT Training Solutions techniques in their practice since the Maat Probe Group worked with the Trust to promote awareness and prevention methods to physical restraint.

Sheffield Health and Social Care Foundation Trust use prevention methods to minimise incidents of aggression and violence, such as creating an environment of dignity and allowing a collaborative approach with people with mental health problems.

They emphasise the need for use of physical restraint to be honestly and openly acknowledged, and that all incidents should be recorded. Where this is not the case, the use of physical restraint is deemed inappropriate and regarded as abuse. Underlying issues or circumstances that may lead to aggressive behaviour are taken into account to de-escalate situations. Staff are provided with an understanding of the cultural and diverse needs of people through training, and promoting awareness of physical and psychological harm to people and staff as a result of using physical restraint.

## Case study: West London Mental Health NHS Trust

As an ImROC pilot site (see page 9), the Trust has made improvements through embedding recovery principles into routine clinical practice including the provision of a Wellness Recovery Action Plan (WRAP) for everyone. There is now an expectation that the individual is able to discuss their WRAP in all care programme approach meetings. This Trust no longer uses face down physical restraint.

The Trust has appointed advisors to support resolution of high risk incidents using only the necessary amount of physical intervention. The main focus is on exhausting all routes of de-escalation before more restrictive but still proportionate approaches are considered.

By being aware of the emotional and physical environment, other underlying causes of aggression are also taken into account.

When physical restraint is deemed necessary, staff are required to be sensitive to the person and consider any physical, sensory or communication impairment, gender, race and ethnicity, religious and cultural beliefs. The focus is on the intervention being proportionate and on ceasing physical restraint as soon as it is safe to do so. The person is then encouraged to discuss the incident and their crisis care plan is updated accordingly.

## Case study: Hertfordshire Partnership NHS Foundation Trust

The Trust uses the RESPECT Training Solutions model and principles and is currently developing a conflict reduction strategy which it hopes will further reduce incidents where physical restraint is used. The Trust has also launched its own RESPECT campaign which focuses on managing appropriate behaviour and making improvements to the care environment, especially regarding the dignity

of staff, service users and carers. This includes a new self assessment framework for dignity and equality that is being trialled across their learning disability services before being fully rolled out across the Trust. One of the key aims of their RESPECT campaign is to create services and workplaces where the potential for abuse is significantly minimised.

# Our recommendations

Crisis and acute mental health services are a crucial part of healthcare. They provide support and treatment for people when they are most unwell and vulnerable. How people are treated in these circumstances makes a huge impact on their recovery and willingness to seek help should they need it again.

Our findings have shown that physical restraint is used far too often in some parts of the country and the practice varies significantly. Some mental health trusts use respect based and de-escalation techniques, yet other trusts still use the dangerous and life threatening technique of face down physical restraint.

Over the years, unnecessary and avoidable deaths, such as Rocky Bennett's, have occurred because of excessive physical restraint but lessons have not been learned. Repeated calls for reappraising the use of physical restraint, introducing accredited training and bringing an end to face down physical restraint continue to be ignored by decision-makers.

We believe that the use of control and physical restraint needs urgent reappraisal and that the use of face down physical restraint should be ended. We are calling for established national standards on the use of physical restraint and accredited training for healthcare staff in England. The traditional practice of face down holds should be ended immediately as it is a dangerous and life-threatening response to managing someone's behaviour when they are in a mental health crisis.

The recommendations made below are long overdue and the need to urgently reform the practice of physical restraint is as crucial as it has ever been.

## Recommendations for Government and NHS England

- For Government to introduce an end to face down physical restraint in all healthcare settings urgently. Include the use of face down physical restraint in the list of 'never events'.
- For Government to establish national standards for the use of physical restraint and accredited training for healthcare staff in England. The principles of this training should be respect-based and endorsed by people who have experienced physical restraint.
- For NHS England to introduce standardised data capture methods to ensure every mental health trust is collecting the same accessible data on physical restraint. This data should be published regularly and show:
  - the frequency of physical restraint for each person
  - the frequency of physical restraint to administer medication
  - incidents where physical restraint has been used resulting in physical and/or psychological harm
  - where a person makes a complaint directly relating to physically restraint.

All the above must be captured according to gender and ethnicity breakdown.

## Recommendations for Clinical Commissioning Groups

- Set clear standards in your commissioning contracts which promote respect-based training in physical restraint and an end to face down restraint.
- Require providers to report on how staff will be trained and supported to use de-escalation and alternatives to physical restraint, that the methods used are safe and that physical restraint incidents are reported and feed into ongoing data collection.

- Monitor the use and impact of physical restraint in your area and include this data in regular performance reviews to monitor and interrogate provider practice.
- Ensure providers have sufficient policies in place to monitor and improve the environment and culture of wards to minimise the need for physical restraint.

## Recommendations for providers

- Urgently end the use of face down physical restraint
- Commit to working without coercion and train your staff in de-escalation techniques and respectful alternatives to physical restraint to help them manage challenging situations and support the recovery of people in crisis
- Provide ongoing cultural and ethnicity training for staff which is regularly reviewed and updated
- Ensure staff are using joint care plans to discuss and record possible responses to challenging behaviour
- Ensure that people who have been subjected to a physical intervention are given the opportunity to write their account of the episode as soon as possible and this is then recorded in their file
- Board members - ensure that your governance arrangements are sufficiently robust to satisfy you that staff are well trained and supported to use de-escalation and alternatives to physical restraint, that the methods used are safe and that physical restraint incidents are reported and feed into ongoing organisational learning
- Review the environment and culture of wards to ensure:
  - more therapeutic environments
  - people are treated with dignity and respect
  - people's needs are listened to
  - people's culture and ethnicity are respected
  - outdoor access and therapeutic activities are provided which help recovery and prevent challenging situations.

## Recommendations for staff

- Urgently end the use of face down physical restraint
- Commit to working without coercion and ensure that physical restraint is only ever used as a last resort and only when all other methods of de-escalation have been tried
- Where you do have to intervene, use alternatives like face-to-face safe-holding, talk to and reassure people throughout and give people an opportunity to record their experiences afterwards
- Listen to and understand people's needs and cultural background to help you prevent and respond to difficult situations. Your ability to be warm and compassionate can reduce distress and uncover the reasons behind their behaviour, preventing the need to intervene physically
- Use your communication skills to effectively understand people and build relationships where both staff and the person understand what care is needed
- Involve people in planning their care and respect their choices. Jointly agree how to respond to challenging behaviour through joint crisis plans which set out the triggering situations for the person and how they would like to be treated in a crisis.

# Methodology

Mind commissioned an independent panel to carry out an inquiry into acute and crisis mental healthcare in 2010/2011. We ran a call for evidence, held hearings and visited a range of services and used this information throughout this report. The research was published in our *Listening to experience* report<sup>3</sup>, including people's experiences of being physically restrained in mental healthcare settings.

## Freedom of Information requests

In February 2013, we sent FOI requests to all 54 mental health trusts in England. We wanted to find out how they use physical restraint, the impact of physical restraint, and trusts' procedures and training which govern the use of physical restraint. We asked for all questions to be answered with a breakdown by gender and ethnicity.

As of 10 May 2013, we received a response, or partial response, to our requests from 51 trusts. Three trusts failed to reply at all. Of the rest, one declined our request citing cost and time and one said they could provide no data due to the way their data system captured information.

Our largest response rate to one question was 87 per cent per cent (47/54) and the lowest response was 24 per cent (13/54). The majority of trusts answered at least one question with data and/or policies and where trusts didn't give full replies they cited cost or data capturing issues. The largest single reason for not providing data for use or impact of physical restraint was because the data was captured in the individual's care records and could not be extracted. Many trusts also did not collect gender and/or ethnicity data in an accessible way but recorded only in individual care records. As a result, our data set is not complete and we cannot provide a full picture for every mental health trust in England.

We are reporting raw numbers and have not adjusted for general or patient population size. However we do not believe the high figures for some trusts and significant variation between trusts can be explained purely by differences in population. Even if differences are partly due to variable reporting practices, this in itself is unacceptable.

In relation to face down physical restraint, some trusts have completely ended face down physical restraint and use alternative methods to this practice, so high numbers of face down physical restraint in other trusts cannot be due solely to population size.

We have used the median number in these calculations as not all trusts answered all the questions and it is less subject to outliers.

## Mental health and physical restraint Freedom of Information request questions

### 1. Use of physical restraint

For the year 2011–12, please provide information on the following, providing a breakdown by ethnicity and gender for each item where possible:

- a) the total number of incidents of physical restraint by one or more members of staff
- b) the total number of patients who experienced physical restraint by one or more members of staff
- c) the total number of incidents of face down physical restraint by one or more members of staff
- d) the total number of incidents where physical restraint was used to administer medication
- e) the total number of incidents where police were involved in physically restraining a patient.

## 2. Impact of physical restraint

For the year 2011–12, please provide information on:

- a) the total number of incidents of physical restraint which resulted in the patients'
  - (i) physical injury, (ii) psychological harm, (iii) death
- b) the total number of complaints relating to physical restraint (from a person, or representative on behalf of a person who was subject to physical restraint).

## 3. Procedures and training

Please give details of:

your physical restraint policy, including details of training and risk assessment of training packages and techniques taught

- a) any policies and practices you use to prevent the need for physical restraint
- b) any examples of good practice in using alternatives to control and physical restraint
- c) what process is used to report, review and reflect on incidents of physical restraint and allow the person who has been restrained to record their own account of the incident.

## Call for evidence

We revisited previous evidence given to our original inquiry panel and findings from the original *Listening to experience* report.

In addition, we used our online social media channels to seek responses from people with mental health problems who had experienced any form of physical restraint. We also asked the National Survivor User Network (NSUN) to publicise the call for evidence in their membership bulletin.

We interviewed people who had experienced or witnessed physical restraint, and staff members and other professionals who also witnessed physical restraint on wards.

In the interviews, we asked:

- What experiences have you had of being restrained or witnessing physical restraint?
- What was the reason for you being restrained?
- What happened and how did it make you feel at the time?
- Did staff talk to you before they restrained you to find out what was wrong?
- How did you feel afterwards?
- Were you given a chance to write an account of what happened as part of the reporting of the physical restraint?
- Were you offered any other support after being restrained?



# Endnotes

1. Independent Advisory Panel on Deaths in Custody (2012), *Statistical Analysis of all recorded deaths of individuals detained in state custody between 1 January 2000 and 31 December 2011*
2. Freedom of Information Act request 2013
3. Mind (2011), *Listening to experience: An independent inquiry into acute and crisis mental healthcare*
4. Based on responses to Freedom of Information request received by 10 May 2013
5. National Institute of Clinical Excellence (2011), *Service user experience in adult mental health: Improving the experience of care for people using adult mental health services*. NICE Clinical Guidance 136, Quality standard 14
6. Care Quality Commission (2011), *Count me in 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*
7. The NHS Information Centre for Health and Social Care, Mental Health Minimum Dataset (MHMDS). The MHMDS reports information on people in contact with specialist secondary mental health services.
8. Department of Health (2008), *Code of Practice: Mental Health Act 1983, Chapter 15 Safe and therapeutic responses to disturbed behaviour*
9. The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013), *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, Chaired by Robert Francis QC
10. Department of Health (2012), *Transforming care: A national response to Winterbourne View Hospital: Final Report*
11. Care Quality Commission (2012), *Briefing: Restrictive practices in mental health and learning disabilities settings*
12. Independent Advisory Panel on Deaths in Custody, set up in 2008 by the Ministerial Council on Deaths in Custody, chaired by Lord Toby Harris
13. Metropolitan Police Service (2012), *Independent review into MPS and its contact with people with mental health problems including death or injury as a result of police contact*. Chaired by Lord Victor Adebowale
14. Independent Commission on Mental Health and Policing Report (2013)
15. Royal College of Nursing Congress and Exhibition 21–25 April 2013, Agenda item 10 <http://www.rcn.org.uk/newsevents/congress/2013/agenda/10-regulating-and-accrediting-physical-restraint> [accessed 9 May 2013]
16. Implementing Recovery Through Organisational Change (2011), Joint initiative from Centre for Mental Health and the NHS <http://www.imroc.org/>
17. Bhui K. et al (2003), *Ethnic variations in pathways to and use of specialist mental health services in the UK: systematic review*
18. Care Quality Commission (2011), *Count me in 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*
19. Inquest (2012) *Inquest submission to the Home affairs Committee Inquiry on the Independent Police Complaints Commission*
20. Independent Commission on Mental Health and Policing Report (2013)
21. INQUEST (2004), *Briefing: The restraint related death of David 'Rocky' Bennett*
22. Delivering Race Equality in Mental Health Care (2005), *An action plan for reform inside and outside services: The Government's response to the independent inquiry into the death of David Bennett*



23. Independent Inquiry into the Death of David Bennett (2003), An independent inquiry set up by HSG(94)27, Dr Cary Expert witnesses: Consultant Forensic Pathologist

24. INQUEST (2004), Briefing: The restraint related death of David 'Rocky' Bennett

25. Care Quality Commission (2011), *Monitoring the Mental Health Act in 2010/11: The Care Quality Commission's annual report on the exercise of its functions in keeping under review the operation of the Mental Health Act 1983*

26. See methodology for further details

27. We have used the median number in these calculations as not all trusts answered all the questions and using the mean average would not give a true reflection of the data. See methodology for further details

28. Care Quality Commission (2011), *Monitoring the Mental Health Act in 2010/11: The Care Quality Commission's annual report on the exercise of its functions in keeping under review the operation of the Mental Health Act 1983*

29. Department of Health (2002), *Mental Health Policy Implementation Guide: Adult Acute Inpatient Care Provision*; Care Quality Commission (2011), *The state of healthcare and adult social care in England: An overview of key themes in care in 2009/10*

30. Royal College of Nursing (2008), *Let's talk about restraint: rights, risks and responsibilities*



For more information on our campaign and how we can work together for excellent crisis care, contact:

**Vicki Ensor**

t: 020 8215 2223

e: [crisiscare@mind.org.uk](mailto:crisiscare@mind.org.uk)

Mind, 15–19 Broadway, Stratford,  
London E15 4BQ

[mind.org.uk/crisiscare](https://mind.org.uk/crisiscare)

Registered charity number 219830.

Registered company in England number 424348.

