The Use of Restraint in Mental Health In-patient Environments

In the early 1980's the use of control and restraint as a means to managing violence and aggression within mental health was introduced to the Special Hospitals following an investigation in to the death of a patient at Broadmoor hospital (Ritchie 1985). Control and restraint was initially developed by the prison service as a way to deal with violent episodes, and since then has cascaded in to the health service with adaptations made to meet the needs in forensic mental health services and named C and R General Services. However After initially being regulated by the prison service this ended in the late 1980's opening the flood gates for different variations of the original control and restraint to be taught. Within mental health settings this now forms part of the mandatory training for all NHS front line staff.

The use of restraint in mental health in-patient environments continues to be one of both interest and concern. The use of restraint must be kept to a minimum and applied as safely as possible. Paterson et al (1992) comments that the NHS fails to provide consistency in physical intervention. Current guidance and outcomes of recent inquiries such as the Blofeld Inquiry (2004) ensures that this subject remains in the spotlight. NICE (2005) defines physical intervention as a skilled, hands on intervention used to prevent individuals from harming themselves or others. The term skilled implies that after training staff are competent and safe to apply taught restraint maneuvers although as there is no formal evaluation process the term skilled should be used very loosely. Current training continues to be mainly based on the old control and restraint and not on patient safety. The National Institute for Health and Care Excellence (NICE 2015) estimate that there are over 700 trainers are now in circulation teaching their own version of the historically sanctioned control and restraint training program. The Department of Health (2005) did recommend that a national training system in violence reduction training be implemented as a matter of urgency although this has yet to surface allowing trainers to carry on regardless. Even with the most stringent prevention plans in place it is not possible to prevent all episodes of violence and as NICE (2005) explains predicting violence is not always possible. Therefore staff should be trained to deal with and manage aggressive and violent behavior when all other primary and secondary measures have failed. Wright (1999) concurs with this concluding that it should be acknowledged that physical intervention training is necessary in the absence of any alternative. Reasons for the use of why restraint is used vary between staff and patients. Patients view restraint as a punishment and often experience pain during restraint and feel it is not as a last resort. Whereas staff reported restraint was always used when all other options had failed. Physical intervention can reignite previous traumatic experiences for patients (Bonner et al 2002) and create anger amongst staff.

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If staff fails to acknowledge and manage their feelings there is a risk that physical intervention could be abused.

The guidance on the short term management of violence in mental health care given by NICE in 2005 fails to address the issues surrounding the efficacy of physical intervention or offers any suggestions of what is effective and safe. Paterson and Leadbetter (2004) argue that literature does support that some restraint positions pose a significantly higher risk than others. Inquiries into restraint related deaths has highlighted restraint positions which increase the risk of injury or death in particular the prone position. Miller (2005) makes distinctions between prone restraint and forced prone restraint where weight is applied to the body. Undoubtedly the latter carries the greatest risk although Leadbetter and Paterson (2005) comment that safely applying prone restraint is reliant on skilled competent staff. Prone restraint is not the only position that has raised questions regarding its safe use. Whilst seated restraint is identified as one of the safest forms of physical intervention, bending someone over at the waist whilst seated increases the risk of injury/death particularly in those with a body mass index of above 25 due to reduced lung function. Research studies that have attempted to measure the impact that certain restraint positions have on the human body, although these are fraught with limitations due to legal, moral and ethical concerns such as the exclusion of participants with a body mass index of below 35 existing health problems and/or drug use. Probably the most infamous inquiry was after the death of David Bennett in 1998 at a medium secure unit. Evidence does suggest that although David died in the prone position, weight was applied to his torso.

The Blofeld Inquiry (2004) concluded that David's heart stopped whilst being restrained in the prone position by at least three staff. This inquiry went on to recommend that a three minute time limit should be applied when using prone restraint. This however has never been implemented. Paterson and Leadbetter (2004) argue that this is unrealistic as it suggests that either the patient has calmed down within three minutes or a spare member of staff would be present to inform the restraining staff when they have reached the time limit.

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