Restraint in mental health services

What the guidance says

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Acknowledgements

We are very grateful to our advisory group, people who shared their experience and insights in focus groups or through questionnaires, and campaigners and their colleagues who shared their stories. They include: Niki Glazier, Henderson E. Goring, Dorothy Gould, Carolyn Green, Naomi Good, Gary Molloy, Hannah Moore, Kim Parker, Sarah Rae, Sarah Yiannoullou, Derby Mental Health Action Group, Healthy Minds (Calderdale), Maat Probe Group (Sheffield), People's Network (Hackney), Viewpoint (Hertfordshire).

This report provides information about restraint and other restrictive interventions in mental health services. It goes with the companion guide *Restraint in mental health services: Influencing change in your area*, which sets out how you can get involved in shaping your services and campaigning locally.

Wales

This report focuses more on England because it builds on Mind's campaigning in England; one of its aims is to spread awareness of Department of Health guidance. However, much of the information applies in Wales as well and we have included Wales-specific data and references.

This guide's companion document, *Restraint in mental health services: Influencing change in your area*, is for people in England and Wales.

For more information about restraint campaigning in Wales please contact Rhiannon Hedge at r.hedge@mind.org.uk

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This information was written and produced by Mind's Policy & Campaigns team in partnership with the National Survivor User Network.

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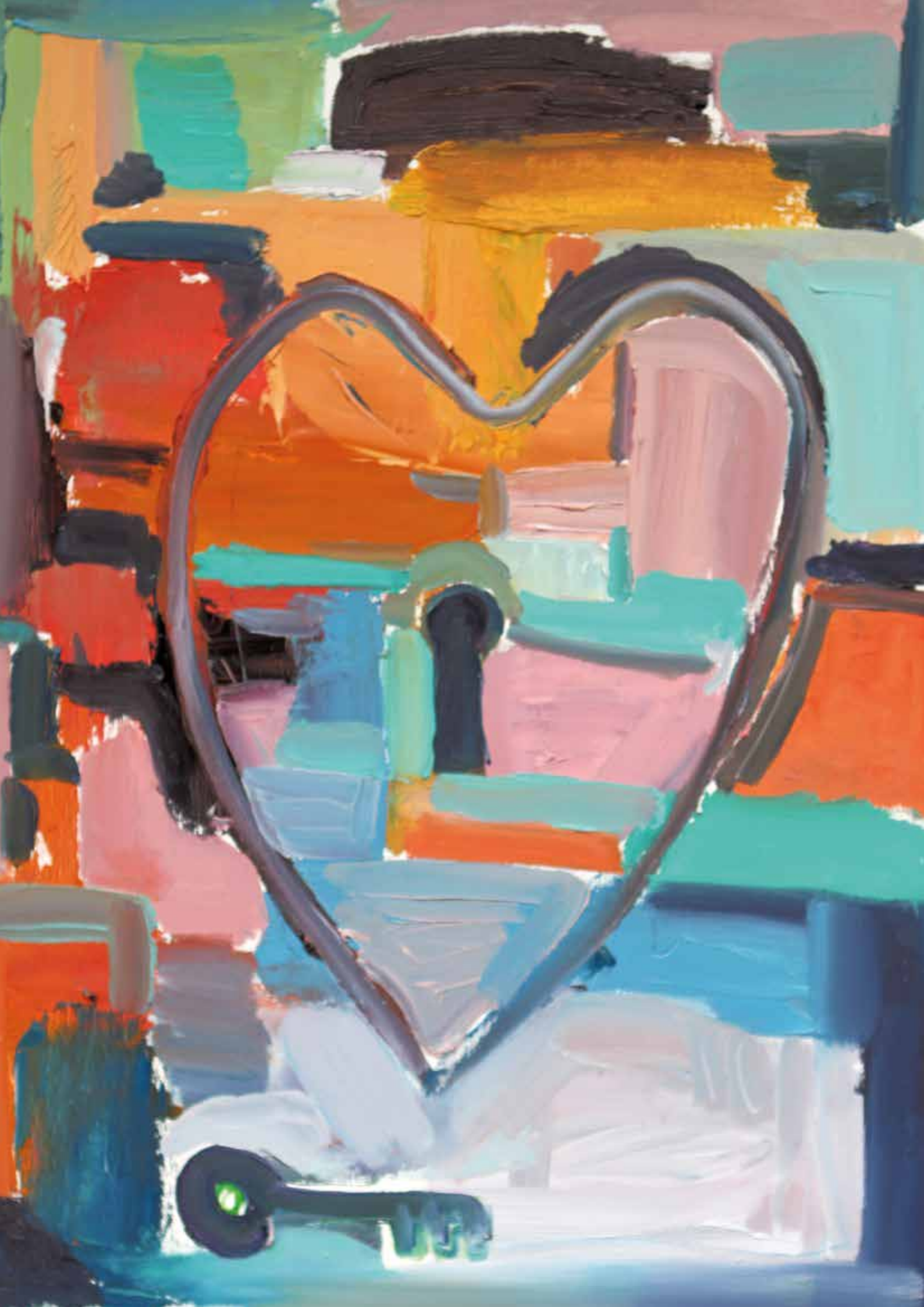


Foreword

National Survivor User Network

Being physically restrained by staff as a patient on a psychiatric ward is not only humiliating and distressing, it can also be dangerous – even life-threatening. In 2011–12 there were almost 1,000 incidents of physical injury reported after restraint had been used.[1] But the emotional damage is costly, traumatising and can last a lifetime.

Restraint is not just about physically restraining people. It includes the use of medication to subdue patients, and the use of seclusion to confine and isolate someone on the ward. Abusive restraint can, however, take more subtle forms than these restrictive interventions. People tell of being subject to controlling behaviour and psychological manipulation on wards with a coercive culture. Common experiences are being unnecessarily prevented from going outside, accessing the internet or making a phone call. All of these acts potentially violate an individual's human rights. Often coming on top of the loss of liberty, they can be profoundly psychologically damaging.

Recognising the overuse and abuse of restraint, the Department of Health published guidance for health and social care providers in 2014.[2] It called upon them to reduce the use of all forms of restraint and restriction, and to eliminate the dangerous practice of face down restraint. We do not know, however, how much this guidance is being acted upon on the ground. Even the CQC acknowledges, with many trusts failing to submit the necessary data, the extent of the misuse of restraint nationally cannot be reliably assessed.[3] The CQC are now paying closer attention to restraint, and providers' practice affects their ratings and sometimes leads to enforcement action.[4]

This guide is intended to empower people to challenge how restraint is used in their local mental health services and to hold NHS professionals to account. NSUN exists to promote and support the rights of people – ensuring we have a voice, and are able to challenge damaging practices. Working together, we can end the abuse of restraint in our mental health services, a practice which has no place in modern, civilised society.

Sarah Yiannoullou and Naomi Good
National Survivor User Network

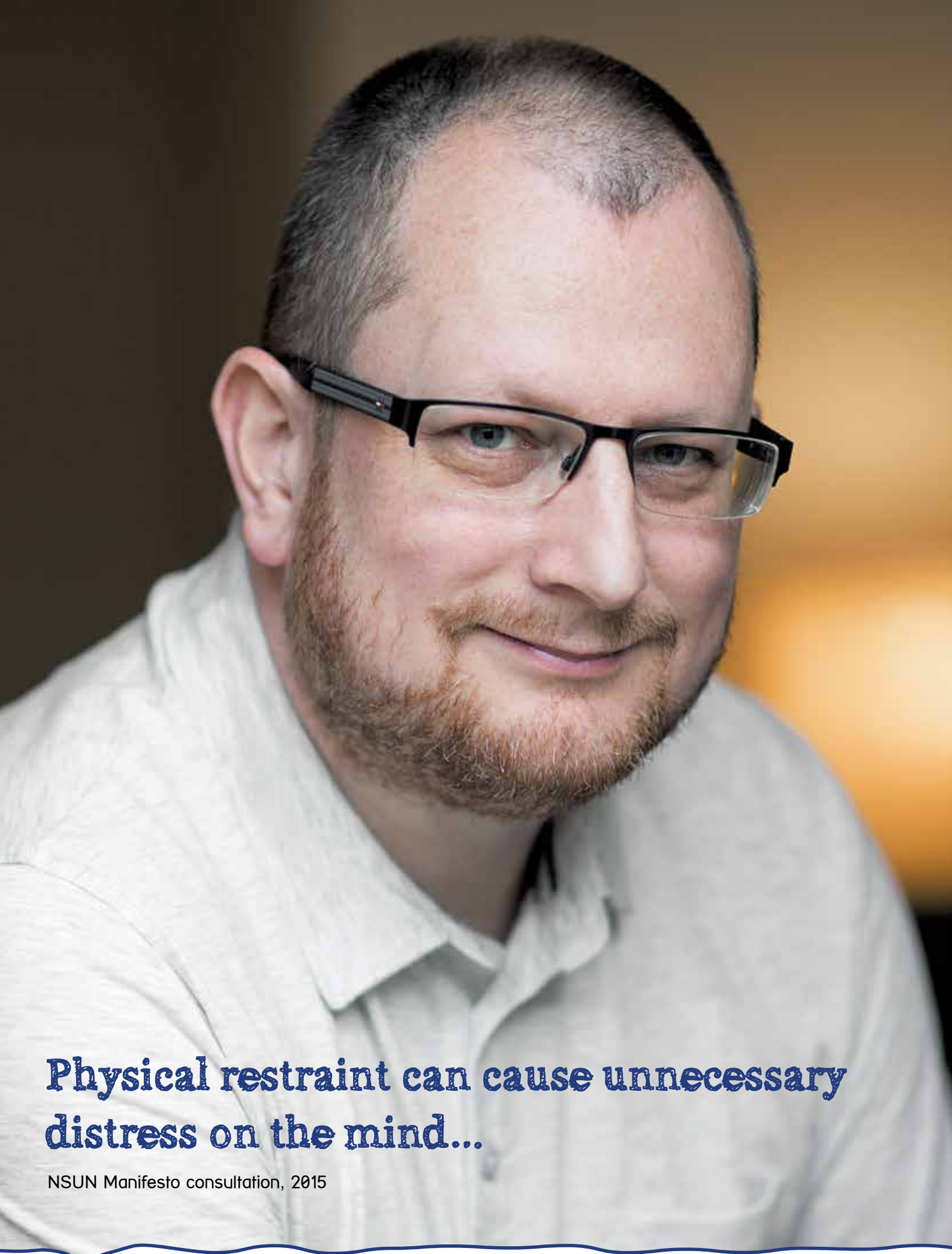
About the artwork

Having spent 10 years in and out of hospital through the nineties with bipolar disorder, I would experience being restrained on many occasions. From these experiences, there seemed to be a lack of empathy and compassion around the use of restraint.

My painting 'Harmonia' is about the importance of empathy and compassion around restraint and how both of these aspects should be at the forefront of discussions around restraint as we move forward.

We hear so much about mindfulness these days. 'Harmonia' is about heartfulness – connecting with the heart to develop and maintain wellbeing, and to aid healing and recovery.

Gary Molloy
Artist & advisory group member



Physical restraint can cause unnecessary distress on the mind...

NSUN Manifesto consultation, 2015

Introduction

Mind's view on face down (prone) restraint

When we launched our campaign in 2013 we called for an end to face down restraint. Reactions to this highlighted different views about the risks of different physical holds and what might be necessary in some circumstances. We still want to see an end to this practice and to other restraint techniques that are hazardous or cause fear or pain.

We think the main way to do this is to make wards calmer and safer places, where staff and patients know each other better, where there is a determination not to rely on force, and using the kinds of good practice described in this guide. Where wards become better places to be, evidence shows that frustration and agitation are reduced along with the need for restraint. Then, if physical intervention cannot be avoided, it should be done without holding people down if at all possible.

What this report is for

Together with *Restraint in mental health services: Influencing change in your area*, this report is a resource for people who want to change the practice of restraint in mental health services and end reliance on force, particularly on adult mental health wards. It is mainly aimed at people who use mental health services, carers, advocates and campaigners.

This report provides information about restraint, people's experiences, official guidance, good practice and campaigners' stories.

Restraint in mental health services: Influencing change in your area provides practical information about how you can influence practice.

If you need to complain or report abuse and want to find out more, please see *Restraint in mental health services: Influencing change in your area* or contact Mind's legal line on 0300 466 6463 or at legal@mind.org.uk

What we aim to achieve

We want to spread good practice and end reliance on force. Both Mind and NSUN have campaigned for people using mental health services to be treated fairly, positively and with respect. Mind's 2013 campaign about the use of physical restraint helped lead to new national guidance in England, *Positive and Proactive Care*. Now we hope that more people will get involved in shaping policies and improving practice.

What is restraint?

Overview

Restraint can mean different things to different people. Different terms all have slightly different meanings.

Restrictive practice

'Restrictive practice' has been explained as making someone do something they don't want to do or stopping someone doing something they want to do.[5] It can include stopping people from going outside or from using the internet or phone. The Mental Health Act Code of Practice says these restrictions should not be imposed as blanket rules (where they apply to everyone on a ward regardless), but only if they are necessary because of a specific individual risk.

Restrictive interventions

'Restrictive interventions' include observation, seclusion, manual restraint, mechanical restraint and chemical restraint which may include rapid tranquillisation (see box across page). These are all deliberate acts that restrict someone's movement or freedom so as to take control of a dangerous situation or to end or reduce danger to the person concerned or others.[6] Acts like these all have the potential to violate the person's human rights.

Restraint

We are using 'restraint' as shorthand for all the restrictive interventions listed in the box across the page.There are other practices on this spectrum which people experience as restrictions or restraint: **psychological coercion and manipulation**, and withdrawal of care, resources and/or information. They are not 'interventions' because they are not methods that that staff are expected or allowed to use, but can occur where there is a coercive or controlling ward culture.

Type of restraint	Definitions and explanations taken from official sources*
Physical restraint Holding – also called manual restraint	Any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person. (Positive and proactive care and Mental Health Act Code of Practice)
Mechanical restraint Handcuffs or other equipment. Used in high secure hospital or when people are moving between secure hospitals	The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control. (Positive and Proactive Care and Mental Health Act Code of Practice)
Chemical restraint Medication	The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour. This does not include where it is prescribed for the treatment of a formally identified physical or mental illness. (Positive and proactive care)
	Rapid tranquillisation is the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. (Code of Practice)
	The Code of Practice says it may include oral medication or injections; NICE says it refers to an injection given if oral medication is not possible or appropriate and urgent sedation with medication is needed. Both are clear that oral medication should always be considered first.
	Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed. (NICE)
Seclusion	The supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. (Mental Health Act Code of Practice)

Taken from:

Mental Health Act 1983: Code of Practice

Positive and proactive care: reducing the need for restrictive interventions (Department of Health guidance)

Violence and aggression: short-term management in mental health, health and community settings (NICE guidance)

The purpose of restraint

Healthcare staff do a challenging job and have to intervene where a person is a risk to themselves or others. However, restraint should only be used as a last resort, when prevention and de-escalation have not worked. It should be done in a way that avoids pain and reduces fear and distress, with continuing efforts to de-escalate.

People expect staff to act where there is risk of harm – to be proactive in preventing difficult situations arising and to use their skills to de-escalate situations that do arise. Even when physical intervention is used, people have said it was okay when it was appropriate and done well, and in these cases could make you feel secure and cared for, or stop you hurting yourself. However we have also heard about a lot of restraint that was unnecessary and traumatising.

The context of restraint

The culture and environment of wards can create the situations where restraint is used. 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. Over-crowding, blanket or arbitrary rules and restrictions, and not being able to go out, all add to the pressure.

Reducing the use of restraint starts with getting the quality of care right.

One time I kicked a door, a couple of members of staff talked me down... They were reassuring and they explained that they weren't going to restrain me or isolate me. They asked me what the matter was.

The scale of use of restraint

In England

During the month of August 2015, in England, there were 9600 uses of restraint reported across all mental health trusts and 15 independent mental health service providers. This includes physical and mechanical restraint and rapid tranquillisation. Of all these, 16.5 per cent (1,591) were prone/face down restraint.[7]

Physical restraint was used most frequently in child and adolescent mental health services, acute wards in learning disability services and psychiatric intensive care. Face down or prone restraint was used most frequently in child and adolescent forensic mental health services and psychiatric intensive care.

There were also 1,671 incidents of seclusion. People were most likely to have been secluded in child and adolescent forensic mental health services, psychiatric intensive care and medium secure learning disability services.

This and further data is expected to be published on gov.uk and linked from the Positive and Safe Champions web page on england.nhs.uk

In Wales

There were 382 recorded uses of face down restraint in Wales 2014–15. The figures for Betsi Cadwaladr and Cwm Taf were similar to the previous year, but in Aneurin Bevan there were more than five times as many uses reported as the year before. Hywel Dda's figures quadrupled over a three year period from 10 in 2010 to 41 in 2013. They've also almost quadrupled over the last two years. Cardiff and Vale health board stopped using face down restraint ten years ago, Abertawe Bro Morgannwg do not record the types of restraint used, and Powys does not have in-patient mental health services.[8]

Board	No. of cases
Aneurin Bevan Health Board	150
Betsi Cadwaladr Health Board	64
Cwm Taf Health Board	15
Hywel Dda Health Board	153

It takes one person to talk to you. It takes four people to restrain you.

Experiences of restraint

Poor communication

People told us that they did not fully understand what would happen when they were admitted to hospital, or if they said no to medication, or left the ward. Non-verbal communication is also powerful; an aggressive stance can strike fear into the heart and make things worse. Good communication and empathy are vital to help allay fears and avoid misunderstandings.

Avoidable escalation

When the rapid response staff act energetically or aggressively instead of behaving calmly, it can make the situation worse. People told us that the nurse or police team who are called to respond to a situation on a ward will "do what they have come to do" even if the person has calmed down.

Provocation and bullying

We heard examples of harassment and verbal put downs, threats and provocation, bullying behaviour and manipulation where people felt they were being forced to be a certain way, or being wound up. This is far from the empathy that characterises some practice and that we want to see everywhere. Restraint was described as punishment for infringement of arbitrary rules. Threats included sectioning, restraint, forced medication and tasers. Psychological threats included withdrawing leave or visits, that is, without a good reason.

Making assumptions about people

Assumptions based on people's personal characteristics, physical appearance or past history can have a negative influence on staff actions and the use of restraint. For example staff can over-anticipate and assume that someone will become aggressive or need medication based on a previous incident; this doesn't recognise that people change and recover.

[My dad] said he could calm me; they weren't having any of it and dragged me off. It didn't need to escalate.

The 'big, bad black man syndrome'... you're more likely to be heavily medicated or physically restrained. You expect it.

Ethnicity and culture

Assumptions can also be made based stereotypes or misunderstandings. Well-documented cultural stereotypes and misunderstandings persist in practice.

Gender

Both women and men may be re-traumatised by restraint that parallels past physical or sexual abuse. The gender of staff involved in restraint may be relevant and make this more likely to occur, or be worse if it does. Staff expectations of, and responses to, behaviour may differ for men and women too.

Aftercare

It is important that emotional support or other aftercare is offered following times when you have been upset or angry. People told us that activities can be helpful distractions, such as art therapy, relaxation, chess, drama, gym.

Post-incident review and debrief

Very few of the people we spoke to had been offered the opportunity to be debriefed. Where people had been approached after an incident it was not always at the right time or done in the right way – before the person was ready to talk, or in a way that felt like a telling off or character assassination.

Complaints

People told us they did not know how to complain, did not expect to get anywhere with a complaint or were afraid of the repercussions when they were still in the hospital or might need to use the service again. Advocacy is clearly important to assist people to complain.

What do people want to change?

These are things people said helped them or that they wanted to see happen. They may help your thinking about positive changes that could be made in your local services.

Information and support

- Mutual support from other patients
- Staff talking to you, being open and supportive
- Support from advocates and advisers
- Rights information, Mental Health Act Code of practice on wards
- A patients' survival guide with tips

Staffing, training and attitudes

- Staff selection, training and assessment to include compassion and person-centredness
- Peer workers involved in de-escalation
- Training by service users
- Promoting empathy and compassion, where staff imagine how it feels to be on the receiving end of restraint and choose the least restrictive option.

Environments and culture

- Culture of rights and positive attitude
- Acceptance of individual cultures and beliefs
- Sensitivity to people's gender, ethnicity, age, sexual orientations, physical health conditions/ physical, learning and sensory disabilities
- More choice of treatments and activities, occupational therapy and alternatives to medication and medical model approaches

Organisational responsiveness

- Management and leadership focus on prevention
- Involving patients in service design and delivery
- Including patient perspectives in incident reports/records

What does the guidance say?

The guidance available

These guidance documents set out how staff and organisations should treat you and how you should be involved. Details of where you can access this guidance can be found in the 'Where can I find out more?' section at the back of this guide.

Positive and Proactive care: reducing the need for restrictive interventions

This Department of Health guidance was published in 2014. It aims to promote the development of therapeutic environments and minimise all forms of restrictive practices so they are only used as a last resort. It applies across all adult health and social care in England and there is a two year programme called *Positive and Safe* to put it into practice.

Mental Health Act Code of Practice

The Code of Practice is statutory guidance for professionals in how they carry out their functions under the Mental Health Act 1983, the Act under which you can be sectioned and detained in hospital for mental health treatment. It was revised in 2015 and includes an updated chapter, *Safe and therapeutic responses to disturbed behaviour*.

NICE guideline on managing violence

The National Institute for Health and Care Excellence (NICE) published updated guidance in 2015 on *Violence and aggression: short-term management in mental health, health and community settings.* This says how staff should work with you and how different interventions should be used if necessary.

Care Quality Commission fundamental standards

These are standards below which care must never fall. They include procedures and processes to prevent service users from being abused, which includes unnecessary or disproportionate restraint of different kinds.

In Wales

For guidance in Wales please see the *Mental Health Act 1983: Code of Practice for Wales* (2008), which is being revised in 2015/16; the Welsh Government's *Framework for restrictive physical intervention policy and practice* (2005); and NHS Wales *All Wales Violence and Aggression Training Passport and Information Scheme* which sets a common standard for staff training in Wales. The NICE guideline also applies in Wales.

Key points from the guidance

Physical restraint and other restrictive interventions must only be used as a last resort when there is a real possibility of harm if no action is taken. The action must be proportionate to the risk of harm and its seriousness, and the least restrictive thing staff can do. It must be imposed for no longer than is absolutely necessary. It must never be used to punish, hurt or humiliate.

Physical (manual) restraint

Staff should avoid, if at all possible, holding you down on the floor or any other surface.[9] Most importantly, you must not be held in any way that makes it hard for you to see, hear, speak or breathe, or that affects your blood circulation. This means that the person holding you shouldn't press on your rib cage, neck or abdomen, or cover your eyes, ears, nose or mouth. You should be held for as short a time as possible; NICE says this should not usually be for more than 10 minutes. But any restraint must always be ended as soon as possible. One of the staff members involved in the restraint should keep communicating with you from before the restraint and during it, continually trying to de-escalate the situation.

Mechanical restraint

Mechanical restraint should only happen in high-secure settings in exceptional circumstances. It should only as a last resort to manage extreme violence directed at other people or to limit self-injurious behaviour of extremely high frequency or intensity. The Mental Health Act Code of Practice sets out how mechanical restraint should be authorised, recorded, reviewed and ended.

Chemical restraint

The decision to use medication, and which medication to use, should take your views (including any advance statements or decisions), your previous experience of the medication, and any physical problems you have in to account. Before giving an injection, staff should consider offering a tablet instead.

Seclusion

This should only be used if you are detained under the Mental Health Act, unless it is an emergency. In that case it should be used for the shortest time possible while the emergency is being managed and an assessment for detention should be undertaken. There are procedures in the Mental Health Act Code of Practice on seclusion including how it is reviewed and ended.

How staff should work with you

You should be treated with compassion, dignity and kindness. Your human rights and personal characteristics – gender, ethnicity, age, sexuality, disability, or religion and beliefs – should be respected. You must not be discriminated against because of these characteristics, and services should be actively shaped to suit these. You have

a right to follow religious and cultural practices while in hospital.

Ward environments and culture

NICE says your ward should be as pleasant and comfortable as possible. It should be easy to find your way around and doors shouldn't be locked unless necessary. You should be able to have some privacy, go outside and take physical exercise. You should be able to access psychological therapies (if suitable) and leisure activities such as a film or reading club. Wards should not be oppressive or enforce blanket restrictions.

Care planning and decision-making

- Anyone who could be at risk of being restrained in a health or care service should have an individualised support plan (sometimes called behaviour support plans).
- Your care team should learn what triggers these feelings for you and try to avoid setting off these triggers. They should also encourage you to get to know your own triggers and ways that you can control them.
- Your care plan should include how to prevent incidents arising, how to de-escalate or calm things down, and how to respond safely if incidents do still occur.
- You can include your wishes about particular medications, what staff can do to help you calm down or, if you need to be held, how to make this less distressing.[10] [11]

Post incident reviews

- Following restraint you should always have the opportunity to give the organisation your perspective on what happened.
- This is so the organisation understands from your point of view what you needed, what upset you most, what staff did that helped or was wrong and how things could be better next time.
- NICE says that, in addition to being debriefed, there should also be a formal external post-incident review led by a service user experience monitoring unit or equivalent. This should be done as soon as possible and no later than 72 hours after the incident.

Organisational responsibility and accountability

Health and care organisations should have:

- Strategy for reducing restraint (see examples on page 20)
- Clear organisational policies on restrictive interventions, clear and accurate recording of their use and a published accessible report that is updated annually
- A board level, or equivalent, person with lead responsibility for increasing individualised support planning and reducing restrictive interventions. The board, or equivalent, should approve the interventions that are used by staff.

Involvement

People who use services, families and carers must be involved in planning, reviewing and evaluating all aspects of care and support. As well as your individual care this includes involvement in:

- Producing policies on restrictive interventions
- Planning, monitoring and reviewing the use of restrictive interventions and in determining the effectiveness of restrictive intervention reduction programmes
- Training and staff development.

What good practice initiatives are there?

Around the country there are good practice initiatives where organisations are working to minimise restraint, uphold people's rights, facilitate recovery and make wards calmer, safer places to be. They mostly prioritise service user involvement and we think this is essential to creating change. Details of these organisations can be found in the 'Where can I find out more?' section at the back of this guide.

4Pi National Involvement Standards

Meaningful involvement is important because it can transform individual lives, improve services and build resilience within communities. The National Involvement Partnership project, led by NSUN and made up of mental health service users and carers, has developed national standards for involvement.

Motivated by the motto 'Nothing about us without us', their aim was to 'hard wire' the service user and carer voice and experience into the planning, delivery and evaluation of health and social care services. The framework is based on principles, purpose, presence, process and impact (4Pi) and is simply a means to enable services, organisations and individuals to think about how to make involvement work well.

Involvement for Influence: the 4Pi Standards for Involvement (NSUN, 2014) is available from nsun.org.uk or through calling 020 7820 8982

No Force First

No Force First aims to change ward cultures from containment to recovery and ultimately create coercion free environments. This approach, which also originated in the US, is being adopted by some mental health trusts that are part of ImROC (Implementing Recovery through Organisational Change, a joint initiative by the Centre for Mental Health and NHS Confederation).

Positive and Safe Champions Network

A Department of Health led network to promote good practice and implementation of guidance. There are resources from other initiatives on their pages on NHS England's website.

PROMISE

PROMISE (PROactive Management of Intergrated Services and Environments) is a Cambridge-based initiative between staff and service users that is working towards eliminating reliance on force in mental health services globally. It was sparked by a conversation between an expert by experience and professional, and you can read Sarah's account on page 26.

RESPECT

A training approach supervised by Lincolnshire social enterprise NAViGO Health and Social Care. It is based on supportive de-escalation, empowerment and physical interventions that do not cause pain or panic. A service user group in Sheffield (see page 22) campaigned for it locally as their preferred alternative to control and restraint.

Restraint Reduction Network™

Restraint Reduction Network brings together and supports organisations that wish to make meaningful changes to the services and support they offer, so that coercive or restrictive practices are minimised, and the misuse and abuse of restraint is prevented. Working towards restraint-free services.

REsTRAIN YOURSELF

A UK adaptation of Six Core Strategies©, an approach developed in the US. Run by Advancing Quality Alliance (AQuA), it is being trialled in eight mental health trusts in the north west of England. It is based on evidence that a lot of use of seclusion and restraint can be prevented if issues like ward design, staff numbers, poor communication and negative behaviour by staff are addressed

Safewards

A model for making wards safer for everyone, which includes evidence-based tools and resources such as advice for staff on how to talk in ways that foster collaboration rather than confrontation, how to talk someone down, and what calming equipment it is good to keep on wards (such as scented pillows, blankets, music, massage balls and ear plugs).

Campaigners' stories

Maat Probe Group's campaign in Sheffield

This account is based on a group discussion with Maat Probe Group members and additional input from Kim Parker, a senior nurse in Sheffield Health and Social Care Trust.

A successful campaign

Maat Probe Group, who are service users based at Sheffield African Caribbean Mental Health Association, successfully campaigned to change restraint practice in Sheffield. Inspired by a speech about how to make change, they got a grant to investigate African Caribbean people's experiences of mental health services. Their 2009 report *Can you handle the truth* showed how much worse people's experience was of inpatient compared to community care, and that a lot of people had experienced aggressive restraint.

The group set out to find a better alternative to control and restraint. They researched different training programmes for de-escalation and minimising trauma and chose the Grimsby Model, RESPECT. This is based on a philosophy of support and empowerment and teaches prevention, de-escalation and physical interventions that do not cause pain or panic. They lobbied Sheffield Health and Social Care NHS Foundation Trust (SHSC) to adopt it and by 2013 it was being fully implemented.

Now the group have evaluated the impact of RESPECT in Sheffield, by interviewing people who had been inpatients both before and after its implementation. They found that 75 per cent of people thought things had changed for the better. Seventy-seven per cent had not seen the old style control and restraint being used while 23 per cent had.

Speaking for the Trust, Kim Parker told us that they learned a lot as they went along. They have done a significant amount of work to reduce seclusion and, while improved reporting means that more assaults on staff have been recorded, the severity of assaults has not increased. Communication and relationships between staff and patients are better. One change, popular with patients and staff, was the creation of 'green rooms' – therapeutic, safe spaces for de-escalation – and 'green bags' filled with portable items which enable staff to create a calming, relaxing space wherever the patient may be.

Challenges

Introducing change was a slow process. The group found it frustrating when nothing seemed to be happening despite lots of meetings and discussions. Kim told us that when they were approached by Maat Probe they were keen to look at their practices and see what they could do differently, but it took time to get right. They started with a thorough review before making any changes to practice, which in itself took 18 months.

Maat Probe Group members said that at first staff thought that the Respect approach was 'too gentle'; both frontline staff and trainers thought they would be more at risk if they didn't use physical restraint. However staff have since reported that Respect has positively changed their practice and perception. In fact one

challenge for the Trust is how to keep staff's skills in physical intervention up-to-date when they use them so much less.

Another problem of success was that the group got national recognition - becoming famous and frequently cited as good practice – but not direct action or support. Burn out and disillusionment is a real concern when trying to change practice within a large system.

What helped

So what helped the group's success? First, they used a creative approach to get people together and sharing their stories, by holding a BBQ with music. It was fun, but it was still research, and using a research methodology provided credibility – their evidence couldn't be so easily dismissed as 'anecdotal'. But it was sharing those personal stories with frontline staff and trainers that made a powerful impact and helped communicate what worked. And the fact that the group had found a model – Respect – that embodied what they wanted to achieve, meant they had a compelling solution that they believed in.

Support from within the group, the grants programme, the service user group in Grimsby who helped develop the model, and Sheffield African Caribbean Mental Health Association all enabled the group to achieve what it has today – individually and together.

Maat Probe members recommend persistence, perseverance and keeping the common goal in mind.

Next steps

The group is now working to get Respect used nationally, to secure further funding for their group, and to have their findings and recommendations taken forward in Sheffield and in national policy. They are working towards helping the police to improve their good practice with service users.

Maat Probe

'The group chose its name from our ancient Egyptian heritage. As an African Caribbean service user group we found trying to campaign for better practice in services can be a discouraging experience. The group was told in the early days by someone "be careful not to bite the hand feeds you". As a group part of our development we watch videos and read Afro-centric perspective on combatting and understanding racism. We do this to keep us strong so that we can be unapologetic when we work to change the continuing poor experience many of us have experienced going back many decades. We have drawn strength from our culture and heritage to campaign for best practice ultimately for all mental health service users. Truth and justice are universal human needs.'

Campaigning on the use of seclusion and restraint in Derby

Niki Glazier tells the story of Derby Mental Health Action Group's campaign and Carolyn Green shares a view from the Trust.

Being heard

Back in 2011 we became aware of some very harrowing experiences that our members had gone through as a result of being secluded. Such was its impact on us that we knew this voice of experience had to be heard and our role was to make sure it was heard in the right places. We approached the General Manager of our local mental health trust who we knew to be sympathetic to the experience of our members. A meeting was set up with him, being careful to ensure support for those sharing their very personal experiences of seclusion.

We discovered that this was fortuitous timing as the trust had just recently commissioned an internal survey of nurse practice and patient experience in relation to seclusion and restraint. This work had confirmed their increasingly uneasy feelings about seclusion, concluding that in some instances, at least, it probably was or should have been avoidable. They were keen to explore a better way forward.

Being able to listen first hand to the patient experience – how it had felt to be in their shoes before, during and after the experience of seclusion – clearly impacted the General Manager greatly. It drew a line in the sand and from that point onward we saw a resolve at the most senior level to tackle the use (and potential abuse) of seclusion.

Involvement in monitoring and review

The trust established a Seclusion Project Group which we and another Derbyshire service receiver group attended regularly. It was a long journey with many obstacles and hindrances but our continued presence helped to urge them on and reassured us that progress was being made. Through that group we were able to monitor the numbers of seclusion in significant detail – gender, age, ethnicity, point of hospital stay, triggers to seclusion incidents etc. We were able to ask questions about how lessons were being learnt and applied from the reviewing of seclusion incidents especially from the patient perspective. It was certainly clear that in some cases an earlier therapeutic intervention may well have prevented the situation escalating into restraint and seclusion. All of this information was vital for the trust to work out new initiatives in patient care.

Winning hearts and minds

We were also commissioned by our healthcare trust to produce a DVD of our members' experiences of seclusion. This was filmed and produced by two of our members who then interviewed others about their experiences. It resulted in a very powerful tool which will be used in future staff training both as a reminder of the damaging effects of seclusion and to reinforce the commitment to work in more proactive and therapeutic ways. This is

something we would highly recommend in winning hearts and minds.

A key factor in enabling progress was getting the ward staff themselves on side, reassuring them that the trust at the most senior level would support them as they adjusted to the closure of seclusion rooms. We found that the importance of this can easily be underestimated. Ensuring that a cohesive message of support was sent all the way through from senior and middle management was vital.

Practical progress

Seclusion rooms were gradually re-furbished to provide de-escalation/relaxation areas and new policies were developed around safety and care.

Another crucial step forward was for the Trust to host a presentation to staff of The Safewards Project (safewards.net) led by Len Bowers and subsequently to embrace the Department of Health's Positive and Proactive Care initiatives. They are just about to publish their own Safe and Positive Policy which sets out very clearly the need for change and acknowledges that the driving force has been the shared experiences of their customers. Service receiver groups such as ourselves have been invited to sit on their Safe and Positive Steering Group whose role will be to ensure that all the necessary initiatives and changes are driven forward.

At the point in time at which I write this piece our local trust has closed all its seclusion rooms apart from two remaining rooms on the Enhanced Care Ward. For the time being it has been felt necessary to retain these seclusion rooms for use in only the most extreme circumstances. However we have seen a very considerable drop in the use of seclusion overall. As the Safe & Positive policy rolls out who knows where it can take us in the future.

Thanks to people sharing painful experiences

We, in Derbyshire, continue to face enormous challenges caused by funding deficits and the effects of the plethora of legal highs available on our streets. We will not deny that the journey so far has been very slow and frustrating at times but we have crossed an important line in relation to seclusion. That has only been possible because some extremely brave people have shared their own very painful experiences including past life traumas which had been re-triggered by the use of seclusion and restraint. Our admiration and grateful thanks goes to them.

Niki Glazier, Co-ordinator,
Mental Health Action Group (Derbyshire)
Affiliated to Derbyshire Mind

Working to get it right

As a nurse and a health professional when I hear that seclusion is in use I have very mixed reactions. Restrictive practices, both restraint and seclusion, do not sit comfortably with many staff who work in mental health. I often think that at a point in the future we will look back at our care provision and be ashamed; I am sometimes now, I am continually very torn. How can it be therapeutic to place a person in a locked room on their own? I am not alone in these thoughts in my organisation. We want to dramatically reduce the use of seclusion and restrictive practices. One day I hope we will get to a place that seclusion is not used and that everyone who leaves our wards and bed-less services says 'you got it

right'. We are not there yet. But one day I hope we will be. I believe where this is a will there is way. We have the will; we have to keep making our way. It's hard and we have had bumps in the road in reducing restrictive practices, we will have more, but we will dust ourselves off and keep going. We would not have come so far without our colleagues and our services are fundamentally better with their expertise. My admiration and grateful thanks goes to Mental Health Action Group and to those individuals who are helping us to get it right.

Carolyn Green, Director of Nursing and Patient Experience, Derbyshire Healthcare Foundation Trust

PROMISE: (PROactive Management of Intergrated Servives and Environments) – Spark to a Flame

Sarah Rae describes what she did to instigate change in her Trust and how the initiative she jointly leads is developing locally and globally.

Force is incompatible with a vision of recovery. This belief forms the foundation of PROMISE, a new initiative aiming to eliminate reliance on force in mental health services. Begun in Cambridge, it is now a global alliance between Cambridge, Yale, Prague, Brisbane and Cape Town. And it all started from a conversation, a conversation between an expert by experience (myself) and a professional (Dr Manaan Kar Ray).

Reading Mind's 2013 campaign report about physical restraint made me wonder what my local NHS trust was doing to reduce restraint. So I approached Manaan (who is a Clinical Director within Cambridgeshire and Peterborough NHS Foundation Trust) to find out.

Until then, I'd only know Manaan from a distance, but I knew he was a keen proponent of recovery and that shifting the balance of power between patients and professionals was close to his heart. By the end of our meeting we were discussing a possible research bid to explore staff and patient experiences of physical restraint, and their suggestions for reducing restraint and promoting proactive care.

In the coming months Manaan and I established a working group, secured funding and co-authored a story 'Navigating Rocky Waters' to capture the imagination of the workforce. We involved frontline staff and service users in steering the project, which taps into the innovation that exists within staff but is rarely called on. This has enabled us to list over 200 initiatives over the last year, which we are turning into a PROMISE toolkit. They include:

- Tea and toast evening reflection group for staff and patients to talk about their day and get rid of any frustrations before going to bed.
- Open Door is a shared agreement between the assessment unit and patients with severe

personality disorder which allows them to request a 2 night admission when needed.

- Comfort in a box where people are supported to make their own box of things they personally find comforting and soothing
- 'No' audit where staff reflect whenever they say no to a patient, to see if they can reframe and find a way to say yes.

The fact that the PROMISE project is co-led by a psychiatrist and someone with lived experience has had a tremendous impact on staff and management. It has enabled us to influence policy and practice in a way that I could never have done as a lone campaigner. Looking back I feel it is important to put thought into who to approach. The person not only needs to have influence over services but also must have a passion for the kind of change you want to make. In my case I was pushing at an open door.

My advice to anyone who is thinking about approaching an organisation is to do their homework first and then give it a go because you never know what might transpire and every patient can be a catalyst for change.

Where can I find out more?

Mental health organisations

Mind

mind.org.uk
020 8519 2122

Mind Infoline - 0300 123 3393, text 86463
9am to 6pm, Monday to Friday except bank holidays

Mind Legal Line - 0300 466 6463
9am to 6pm, Monday to Friday except bank holidays

National Survivor User Network (NSUN)

nsun.org.uk
020 7820 8982

Guidance in England

Positive and proactive care: reducing the need for restrictive interventions

Department of Health, 2014

gov.uk

Department of Health, Richmond House, London SW1A 2NS

Mental Health Act 1983: Code of Practice

Department of Health, 2015, The Stationery Office

Available at: gov.uk

Order from the TSO on 0870 600 5522

A positive and proactive workforce: A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health

Skills for Care, Skills for Health and Department of Health, 2014

skillsforcare.org.uk

Skills for Care 0113 245 1716

Skills for Health 0117 922 1155

Briefing on *Positive and proactive care: reducing the need for restrictive intervention*

Mental Health Network NHS Confederation with the Care Quality Commission, 2014

nhsconfed.org

NHS Confederation 0870 444 5841

Safeguarding service users from abuse and improper treatment

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 13

Care Quality Commission Fundamental Standards

Available at: cqc.org.uk

Meeting needs and reducing distress: management of clinically related challenging behaviour in NHS settings

NHS Protect, 2014

Guidance, information and training resources

nhsprotect.nhs.uk/reducingdistress

Guidance in Wales

Framework for restrictive physical intervention policy and practice

Welsh Assembly Government, 2005

gov.wales

All Wales Violence and Aggression Training Passport and Information Scheme

NHS Wales, 2004

wales.nhs.uk

Mental Health Act 1983: Code of Practice for Wales

Welsh Assembly Government, 2008

wales.nhs.uk

Copies from mentalhealthandvulnerablegroups@wales.gsi.gov.uk

Currently being revised.

Enquiries about these publications:

0300 0603300 (English), 0300 0604400 (Welsh).

Guidance in England and Wales

Violence and aggression: short-term management in mental health, health and community settings (NICE guideline NG10)

National Institute for Health and Care Excellence, 2015

nice.org.uk

NICE 0300 323 0140

Good practice initiatives

4Pi National Involvement Standards

National Survivor User Network (NSUN)

020 7820 8982

nsun.org.uk

No Force First

ImROC

c/o Mental Health Network NHS Confederation

020 7799 8702

imroc.org

Positive and Safe champions network

england.nhs.uk

PROMISE

www.promise.global

07519 735137

RESPECT Training Solutions

NAViGO

respecttrainingsolutions.co.uk

01472 583030

NAV.RespectTraining@nhs.net

Restraint Reduction Network™

restraintreductionnetwork.org

0161 929 9777

REsTRAIN YOURSELF

Advancing Quality Alliance (AQuA)

aquanw.nhs.uk

AQuA@srft.nhs.uk

0161 206 8938

Safewards

The Section of Mental Health Nursing,
PO Box 30, David Goldberg Building,
Institute of Psychiatry, De Crespigny Park,
Denmark Hill, London SE5 8AF

safewards.net

Endnotes

1. *Mental health crisis care: physical restraint in crisis*, Mind 2013

2. *Positive and proactive care*, Department of Health 2014

3. *Monitoring the Mental Health Act in 2013/14*, Care Quality Commission 2015

4. *Monitoring the Mental Health Act in 2014/15*, Care Quality Commission 2015

5. Skills for Care and Skills for Health (2014) *A positive and proactive workforce*

6. Based on the definition in the Mental Health Act Code of Practice

7. Department of Health communication about this NHS Benchmarking Network data, 2015

8. Taken from responses to a Freedom of Information request by Mind Cymru.

9. *Positive and proactive care* says that prone restraint (face down on your front) should not be used deliberately. The Mental Health Act Code of Practice and NICE both strongly advise against it, but allow it.

10. Read about people's experiences of the Care Programme Approach in Gould, D. (2012) *Service Users' Experiences of Recovery Under the 2008 Care Programme Approach*, London: National Survivor User Network and Mental Health Foundation nsun.org.uk/about-us/our-work/cpa-and-recovery/

11. You can plan for future care through advance decisions and advance statements – mind.org.uk/information-support/legal-rights/mental-capacity-act-2005/advance-decisions/#nine

Please let us know whether you have used this report and if you found it helpful.

For enquiries about this publication or feedback, please contact our Policy and Campaigns team:

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This information was written and produced by Mind's Policy & Campaigns team in partnership with the National Survivor User Network

To be reviewed in 2019

mind
for better mental health