Restraint Reduction Network

NHS
Sheffield Health and Social Care
NHS Foundation Trust

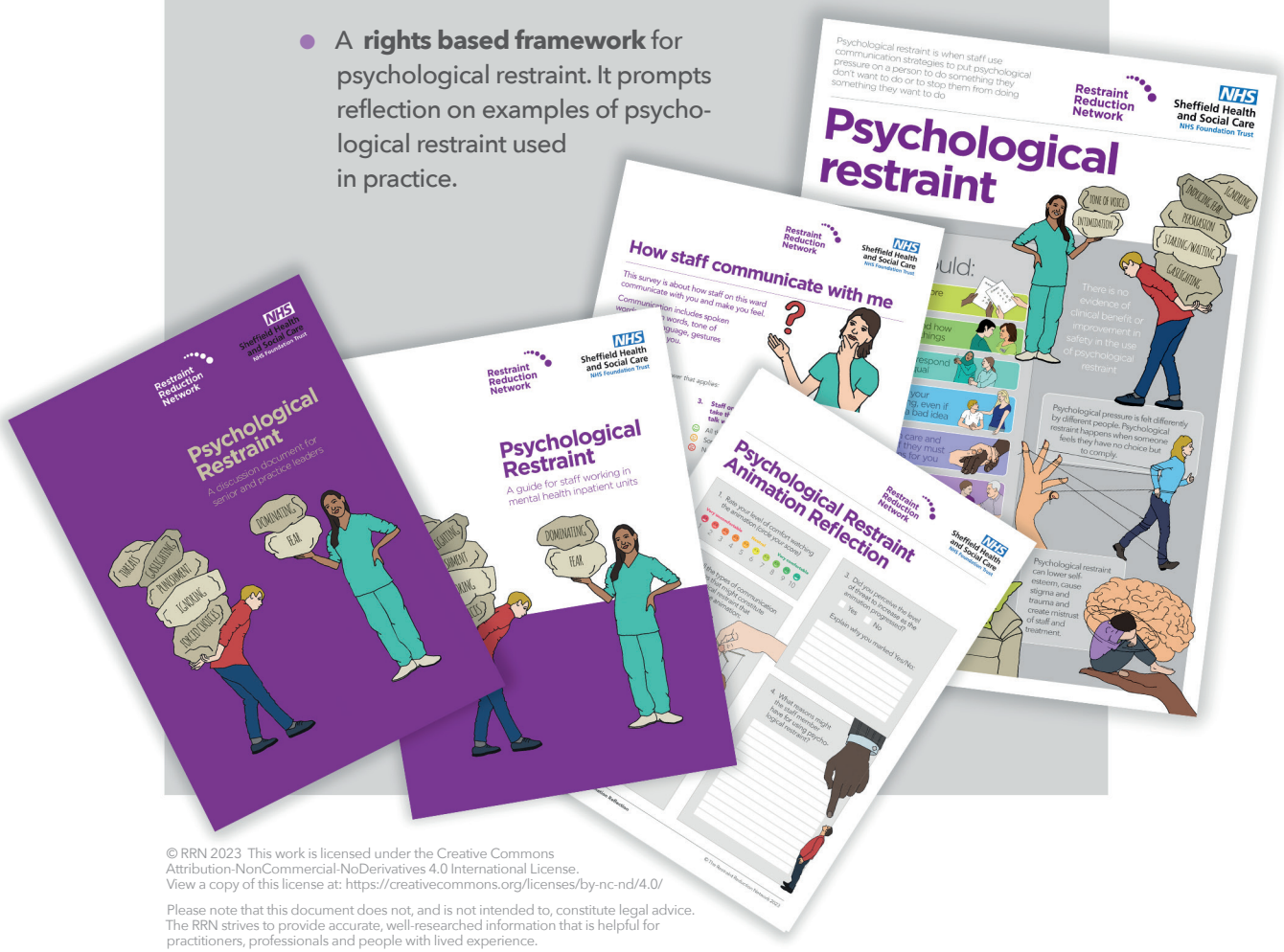
Psychological Restraint

A discussion document for senior and practice leaders

This is part of a set of information about **Psychological Restraint**.

There is:

- A poster which summarises how staff should care for people.
- A booklet called, **'Psychological Restraint: a discussion document for senior and practice leaders'**. It aims to promote reflection on the use of communications and interactions in mental health services.
- A summary called, **'Psychological Restraint: a guide for staff working in mental health inpatient units'**. It has some key points that you should know about the way that people in mental health inpatient units should be cared for.
- An evaluation form called, **'How staff communicate with me'**. These resources can help people to assess how staff on the ward communicate with them and how this makes them feel.
- An animation and '**Psychological Restraint Animation Reflection**' which can help educate people on the use of psychological restraint in inpatient settings.
- A **rights based framework** for psychological restraint. It prompts reflection on examples of psychological restraint used in practice.



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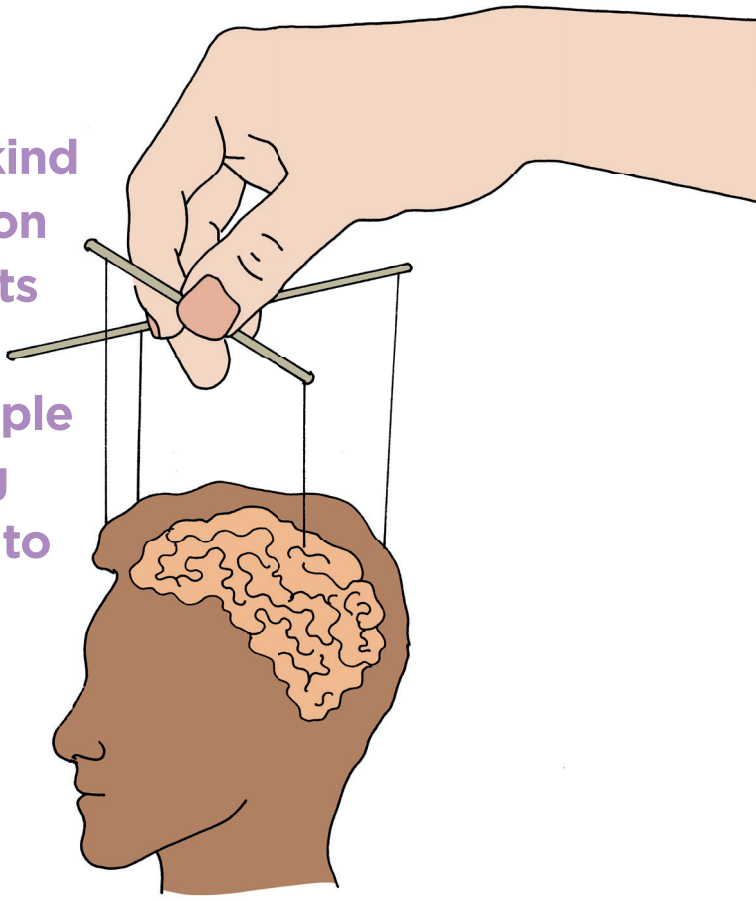
What is psychological restraint?

Psychological restraint is any kind of communication strategy that puts psychological pressure on people to do something they don't want to do or stop them from doing something they do.



Communication strategies include verbal (written and oral communication), non-verbal (facial expressions, hand gestures, eye contact, hugs, smiles, a head nod which indicates agreement).

There is now greater awareness and monitoring of the restrictive practices (e.g., physical, mechanical and chemical restraint) that are sometimes used in inpatient mental health hospitals to influence and control people. However, the use of psychological restraint has received far less attention, despite its frequent use.

(Potthoff et al., 2022)

Staff in mental health settings can see pressuring people to comply with their treatment and/or influence their behaviour as integral to their care.

(Andersson et al., 2020)

This document aims to promote reflection on the use of communications and interactions in mental health services that encourage people to do things they otherwise don't want to do, or to discourage them from doing the things they want to do.

Research has found that staff often use psychological restraint unknowingly.

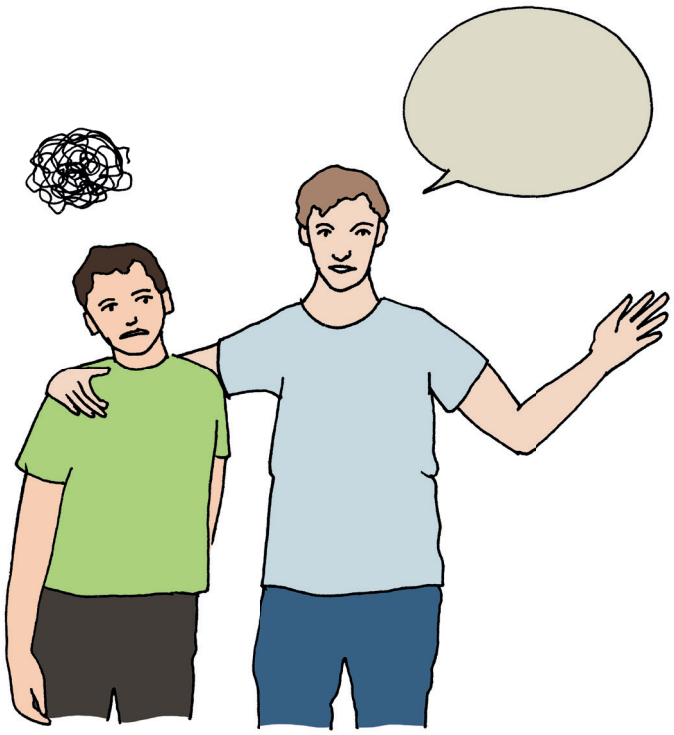
(Gooding et al., 2020;
Valenti et al., 2015;
Elmer et al., 2018)

Many consider psychological restraint a least restrictive alternative to other types of restraint, as it avoids the use of physical force.

(Potthoff et al., 2022)

This lack of awareness means that it is unlikely to be reported, used reflectively, and constitute least restrictive practice.

(Elmer et al., 2017;
Jaeger et al., 2014;
Schori et al., 2018)



A lack of awareness makes it difficult to reduce the use of psychological restraint, so it can go on unchecked and unsupported.

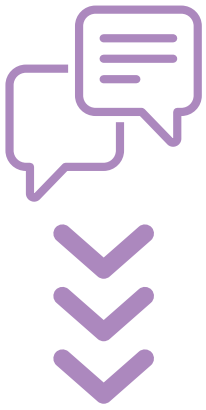
Where such communications and interactions are deliberate, they may be part of a clinically sanctioned treatment or intervention plan, in which case their hazardous nature should be recognised and wherever possible, risks should be mitigated. There should also be a clear evidence base in support of their use and they should be implemented and overseen by practitioners with the right knowledge and skills. Finally, these approaches are sometimes used deliberately, outside of agreed clinical plans, which may amount to abuse.

The Restraint Reduction Network (RRN) has written this discussion document to help senior and practice leaders in inpatient settings identify when psychological restraint is happening, understand its impact, and take steps to reduce its use.

What does psychological restraint look like?

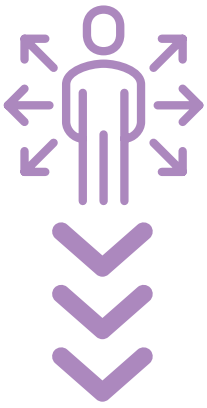
When describing experiences of psychological restraint, people in services told the RRN about the different ways that they were pressured to do something against their will. They identified the following types of pressure.

Verbal pressure



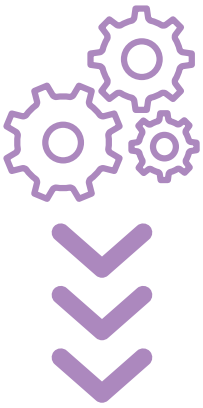
This happens when staff try to force people to change their behaviours and attitudes, using spoken or written words.

Non-verbal pressure



This happens when staff try to force people to change their behaviours and attitudes using their tone of voice, body language and/or other cues (e.g., facial expressions).

Systemic pressure



This happens when staff harness the power of the institutional structure and/or system to change people's behaviours and attitudes.

Verbal pressure examples

Strategy	Description	Lived experience example
Persuasion	Instruction, explanation, focussing on one detail, verbal reinforcement and support, including encouragement and interpretation to change a person's ideas and behaviour.	*"Staff would tell me something over and over and encourage me when I wasn't sure. I just did what they said because I knew that's what they wanted."*
If/then negotiation	Placing conditions on something a patient wants to do, giving the person an illusion of choice or autonomy.	*"They* [staff] *would say, 'if you want to do X* [e.g., smoke, go for a walk, speak to your parents] *then you need to do Y first'* [behave in a certain way, take medication, have a shower]*."*
Cultural restraint	Trying to change a person's behaviour to align with dominant cultural norms.	*"I wasn't allowed to eat unhealthy food or have takeaways."* *"They made me feel bad for smoking."* *"They wanted me to make eye contact and stop stimming, and stuff like that."* *"They made me feel praying was stupid."* *"They use their jargon to frame my behaviour and frustration as being part of my illness, when it's not."*
Actual or perceived threats	Using verbal (or non-verbal) threats to enforce compliance. Not giving alternative options removes a person's agency.	*"The nurse said to me, 'if you don't do what I'm asking you in the next five minutes, I'll stop your leave.'"*
Inducing fear	Giving detailed information about negative consequences of non-compliance, causing such fear that the person complies.	*"Staff would tell me about all the psychiatric symptoms I'd get if I didn't have the injection. It was really scary that it seemed better to have the injection. I didn't want to get worse."*
Using expert language	Using specialist language to convey expertise and influence people's decision-making.	*"They would tell me all these big words that I didn't understand. It was confusing and also made me think that I didn't know as much as them, so I thought I'd better do it* [whatever staff said]*."*

Non-verbal pressure examples

Strategy	Description	Lived experience example
Waiting and/ or using gestures or facial expressions	Waiting for long periods, looking at the person intensely until they do what they have been asked.	*"I'd tell the nurse I didn't want the medication, but they would wait and wait, staring at me and keep coming to me with it until I took it."*
Multiple staff presence	Sending a high number of staff to attend to a person, to create fear and gain compliance.	*"Loads of them [staff] would come… they all just stood there and I knew they would restrain me if I didn't do what they said."*
Omitting information	Staff deliberately not telling people important information so that they comply.	*"The nurses often wouldn't tell me things, like the side effects of the drugs or if my mum had called, to get me to take the drugs or do things."*
Blanking, ignoring and delaying	Staff not explicitly denying a request, but stopping it from happening.	*"Patient knocking at window to staff office with no response, or asking at start of day and repeatedly told will be looked into but never done."*

Systemic pressure examples

Strategy	Description	Lived experience example
Using status	Using role as a staff member to influence people's decision-making.	*"They* [staff] *use this medical language so it's hard to disagree with them, because they justify what they are doing to be in my best interest. I don't even bother to argue."* *"I am the nurse and you are the patient. Do what you are told."*
Institutional power and 'othering'	This happens when the culture of an organisation and the staff working there treat people as if they are second class citizens. This then impacts on the person's ability to be autonomous and challenge decisions about their care.	*"I had to eat off the floor with my hands when I was in seclusion. They wouldn't even give me a table or a knife and fork."*

When does communication become restraint?

Equality Act 2010

Using communication-friendly strategies can be helpful for many people. It is important for staff to help people to understand information and communicate their thoughts, wants and needs. By law (Equality Act, 2010 (EA)), staff must make reasonable adjustments for a person's communication differences, for example if they have a disability (e.g., learning disability), are neurodivergent (e.g., autistic) or if English is not their first language. However, staff should ensure that any strategies they use are person-centred (i.e., those that are identified as helpful by the person, their family, their carers and/or speech and language therapists).

Mental Capacity Act 2005

There may also be occasions when staff need to adjust the way in which they behave and/or communicate if it has been decided to be in someone's best interests, according to the Mental Capacity Act, 2005 (MCA). For example, only offering two choices to someone if this is helpful in reducing their anxiety, or using humour to ease a stressful situation. However, staff should only adapt their behaviour and communication to benefit the person, and not to put pressure on a person to benefit themselves (e.g., to make their job easier).

> Staff should be empathetic, curious and sensitive to people's histories, preferences and concerns, and take steps to address these.

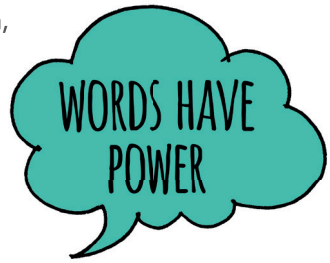
Using any psychological pressure is morally problematic. This is because it can compromise the voluntariness of people's consent; applying pressure means a person is not giving their consent voluntarily (Potthoff et al., 2022). It can also treat people unfairly, perhaps contravening the EA.

A communication strategy should be considered a restraint when a person feels they have no option but to comply with staff/the institution. This situation differs for every person, depending on many individual factors (e.g., communication differences, sensory needs, concerns and preferences, personal history, reactions to medication). Different communication strategies put different levels of pressure on people and are experienced differently by different people. Staff therefore need to be person-centred and trauma-informed in the care and support they provide. For example, a person might be especially susceptible to certain types of psychological pressure, depending on what has happened to them in the past (e.g., fear of a certain medication, the time of the day or around different staff member genders).

Power and psychological restraint

Many people in hospital have fluctuating capacity and varying support needs. People's autonomy can be compromised if they lack capacity or are doing something dangerous. Staff also have power in their role, professional expertise and laws (e.g., the Mental Health Act (MHA) and the MCA) supporting them to make decisions in a person's best interests. Restrictive practices that compromise autonomy can sometimes be necessary and lifesaving.

Nevertheless, any treatment or intervention should be collaborative as far as reasonably possible. Each stakeholder (e.g., the person, their families and staff caring for them) should contribute their knowledge and understanding. For example, the person (and where appropriate their family and/or carers) knows themselves best, and any information they provide will help staff to adapt approaches and achieve better outcomes.



What is meant by power?

Power can be defined as people's ability to influence outcomes (Boonstra, 2016). People's ability to act can be limited and/or enabled by their dependence on staff and institutional structures. Staff, because of their superior position and status, have greater potential to directly influence people's ability to act. This is a serious responsibility. It is therefore important for staff to reflect regularly on how they use their power when working with people.

The power that staff members have can be summarised in the following four ways.

1. '**Power over**'. This happens where staff see power as a finite resource in a win/lose relationship. They think that having power means they must take it from a person, use it to dominate and prevent the person from having it back. 'Power over' is associated with restraint, domination, control and abuse.

2. '**Power with**'. This is about building collective strength through mutual support, solidarity and collaboration. It happens when staff recognise people's own expertise and lived experience, seeing them as equals.

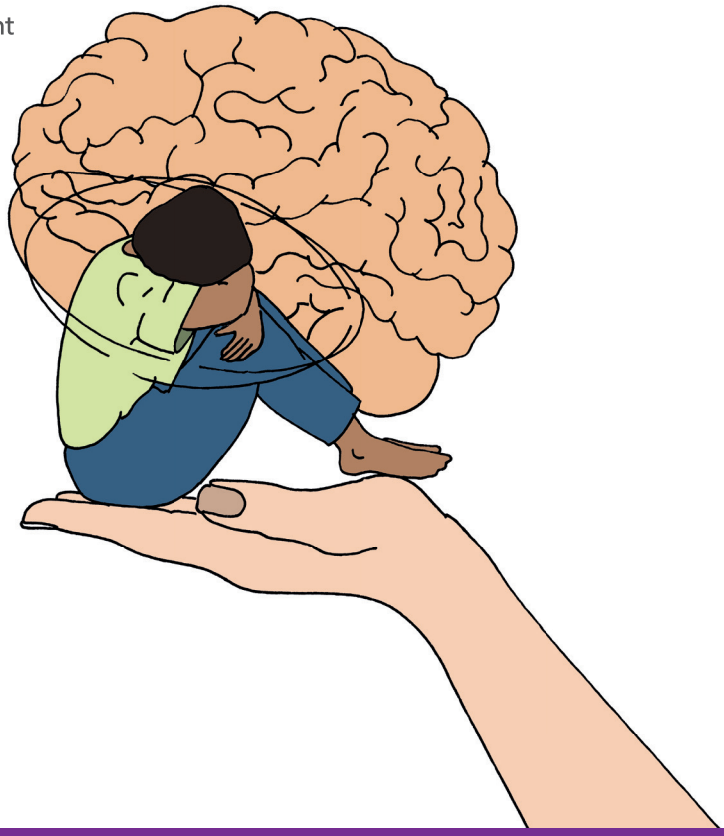
3. '**Power from within**'. This happens when staff build strong relationships with the people they support and harness the environment for good, helping them increase their self-worth and self-knowledge. When people grow their knowledge and worth, it gives them the 'power to' act. For example, by putting in place support the person needs to help their decision-making.

4. '**Power to**'. This refers to people's ability to act and shape what they do (Boonstra, 2016). This is when people are most independent and self-determined, and perhaps ready for discharge. Staff should take every opportunity to give people choice and control in their care, treatment and in the things they do so that they can act and do.

Staff should aim to create relationships within hospital that encourage 'power with', 'power from within' and 'power to'. These forms of power are more equitable as they affirm people's capacity to be self-determined. Staff might also experience better outcomes for the person, use fewer restrictive practices and incur less iatrogenic harm.

The impact of using 'power over'

As previously discussed, psychological restraint happens when a person feels that they have no choice but to comply. Different people have different thresholds for when communication strategies turn into a level of pressure that becomes psychological restraint. For example, people from marginalised communities (e.g., Black Asian Minority Ethnic (BAME), autistic and learning disability) are likely to have experienced considerable systemic and interpersonal trauma. This trauma might be a major traumatic incident, such as an assault, or smaller and cumulative traumatic experiences (micro-trauma), such as those that can happen in interpersonal relationships or when services fail to make reasonable adjustments for a person's disability.



Staff may also not be aware that their communication is being experienced as traumatising. For example, even when they are working hard to include people and coproduce care, staff might guide a person to what they believe will be a good solution. The person might experience this as encouraging them to take control of their treatment, so long as they only follow the ideas of the staff.

The cumulative effect of such trauma is that people's sense of self, their self-worth and self-esteem are eroded. People are then more susceptible to mental health difficulties (e.g., anxiety and depression), experience a lower frustration tolerance on the unit, disaffection with treatment/ staff, and hyperarousal that results in dysregulation and an increase in restrictive practice.

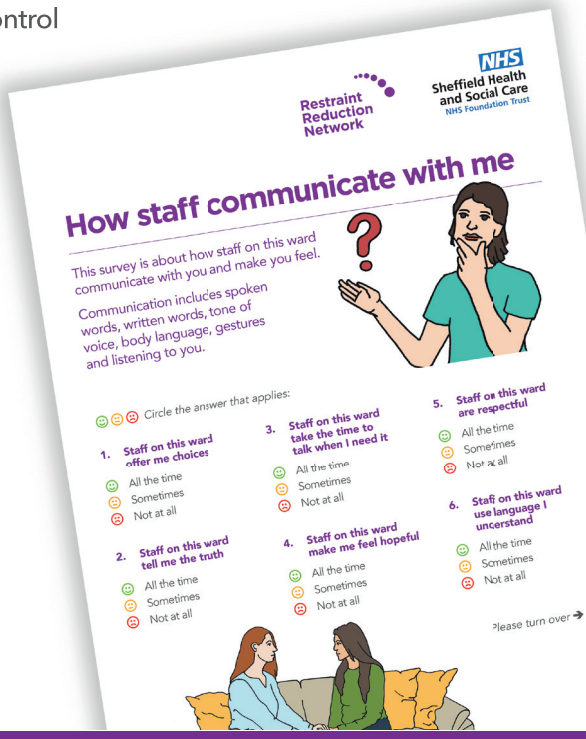
For example, professionals may unconsciously (or consciously) have an undermining way of relating to the people they care for (e.g., making derogatory comments, bullying or gaslighting) that goes unchallenged by the colleagues and the person themselves, often because they don't want to avoid conflict and maintain allegiance with other staff.

(Crastnopol, 2015)

How leaders can help

It can be upsetting for staff to realise something they have said or done has caused someone distress. Senior and practice leaders should try to normalise these feelings and create a reflective culture that moves away from shame and blame, towards accountability and meaningful change. They can achieve this through the following.

- Review and revise policies to ensure that they give people as much freedom, choice and control as possible, as well as instilling transparent communication, trust building and reflective practice.
- Frame staff practice as being 'in service' of the people they care for in a mutually collaborative process. This will promote cultures that ooze 'power from within' rather than 'power over'.
- Measure and act on data collected about relational working (See "How staff communicate with me" survey).
- Share helpful strategies (see below) with staff through practice leadership.


Restraint Reduction Network

NHS Sheffield Health and Social Care NHS Foundation Trust

How staff communicate with me

This survey is about how staff on this ward communicate with you and make you feel.

Communication includes spoken words, written words, tone of voice, body language, gestures and listening to you.

Circle the answer that applies:

1. Staff on this ward offer me choices
2. Staff on this ward tell me the truth
3. Staff on this ward take the time to talk when I need it
4. Staff on this ward make me feel hopeful
5. Staff on this ward are respectful
6. Staff on this ward use language I understand

All the time / Sometimes / Not at all

Please turn over

Be powerful against using 'power over' people

This means actively taking steps to watch out for coercive interaction and exercising a determination to work with mutuality. You might be especially mindful of how you interact with the people you care for. Try to put yourself in their situation and think how you might respond in their shoes. Take time to reflect on your behaviour and the language you use. Is there anything you could do differently to give people more choice and control?

Remember that power is infinite and does not diminish when shared

Instead, shared power gives more opportunities, greater choice, more control and better outcomes for staff, as well as the people they support.

Welcome and listen to feedback from the people you care for

Support one another when feedback from people and their families in the service is unexpected or difficult to hear and use it as a chance to reflect and change.

Say what you mean and mean what you say

Being transparent in what you say (e.g., not making false promises, being honest about what you can and can't do) is especially important when supporting a person who is experiencing high levels of anxiety or fear. This builds mutual trust and leads to better outcomes for the person as well as the staff supporting them.

Connect with people to learn about their histories and experiences

Take time to understand what they have experienced and are still experiencing. This will help you understand how best to care for them, identify any additional support they might need and help avoid any potential triggers for re-traumatisation. It also helps to establish good communication and trust.

Why do staff use psychological restraint?

Health professionals are charged with providing people with, as well as communicating information about, their care and treatment. In general healthcare, applying psychological pressure to manipulate people's decision-making is considered bad practice. Instead, it is thought that people should be free to choose and act on their preferences, unless there is an overriding reason they should not.

In contrast, there is an unspoken assumption in mental health units that coercive practices are usually justified, because inpatients have limited autonomy and/or lack capacity.

(O'Brien, 2003)

In addition, staff can find themselves using psychological restraint because of systemic factors and the demands of their role (e.g., time constraints, staff shortages, work overload and negative workplace cultures).

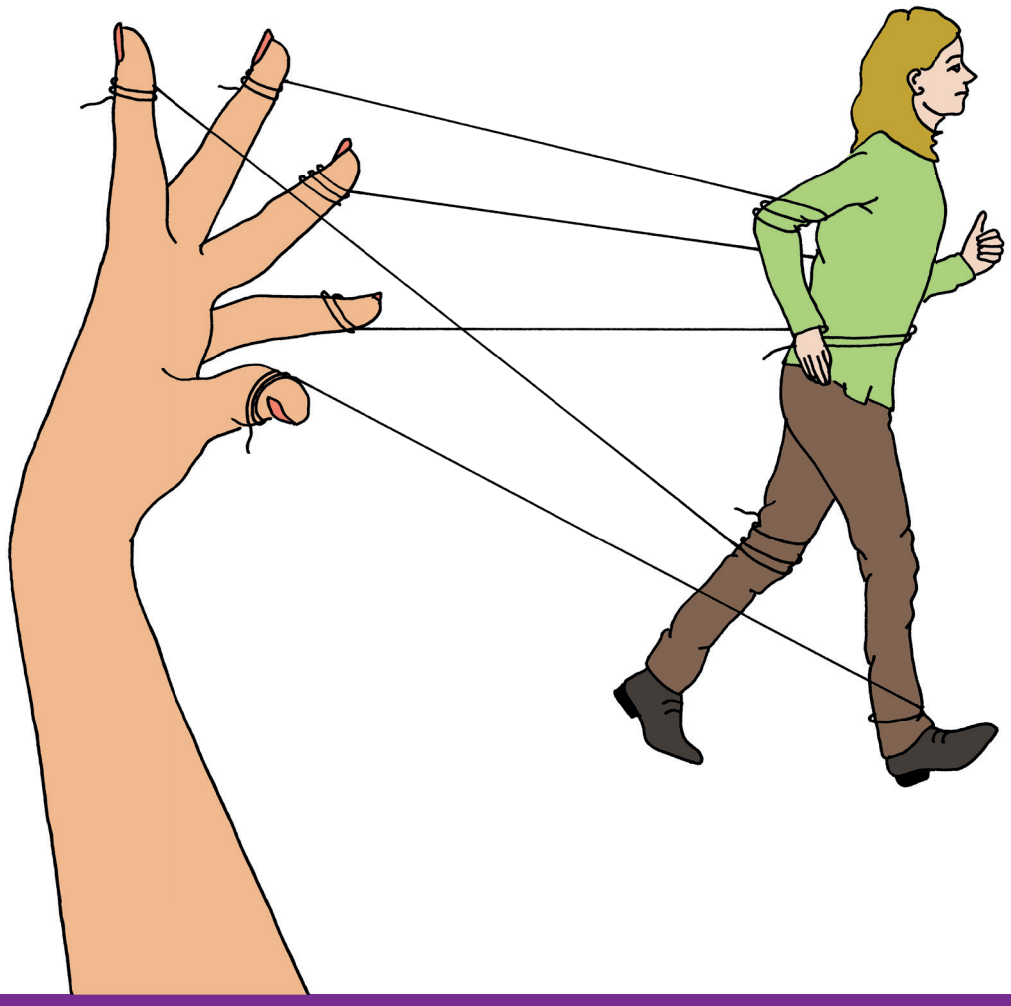
(Delgado, 2022)

Nevertheless, many staff members find using psychological restraint ethically problematic and want to work in less coercive ways.

(Potthoff et al., 2022)

Reasons staff use psychological restraint include the following:

- **For a person's 'own good'**. Staff might believe that the person is not able to make their own choices or that they need a certain type of help that they will not consent to.
- **To improve a person's adherence to treatment**.
- **To ensure a person follows instructions**, routines and ward cultures (e.g., using psychological restraint to carry out a doctor's instructions).
- **For convenience**, so that people are easier to work with (e.g., getting people to eat or take tablets only at designated times).
- **To allow staff to feel they have control** of a difficult situation, or to cope with work demands (e.g., getting someone to agree to something, such as not going on leave, to make things easier, save time or improve the stability on the ward).
- **To avoid using other types of restrictive practices** (e.g., staff might try to persuade or threaten a person to avoid using physical, chemical or environmental restraint).



Impact on therapeutic relationships and treatment effectiveness

Evidence shows that psychological restraint can cause the following harms:

- **Undermines trust between the person and staff** (Glenister, 1997)
- **Results in the person having poor therapeutic and treatment outcomes** (Wallsten et al., 2006; Kallert et al., 2013)
- **Causes the person to mistrust their care and treatment, avoid taking care of their health and disengage from services** (Swartz et al., 2003)
- **Damages the person's self-esteem, causing them emotional harm, and leaving them feeling less than a full person** (O'Brien, 2003)
- **Gives rise to trauma** (Paksarian et al., 2014)
- **Leads to the person deviating from treatment** (Jaeger et al., 2014)
- **Results in further involuntary treatment** (Sashidharan et al., 2019)
- **Coercive stigma of services** (Valenti et al., 2015)

There is little evidence that shows the use of psychological restraint results in clinical (therapeutic outcomes, recovery, discharge) or social benefit (reconnection, trust, ability to make decisions)

(Sailas and Fenton, 2000;
Wright, 2003)

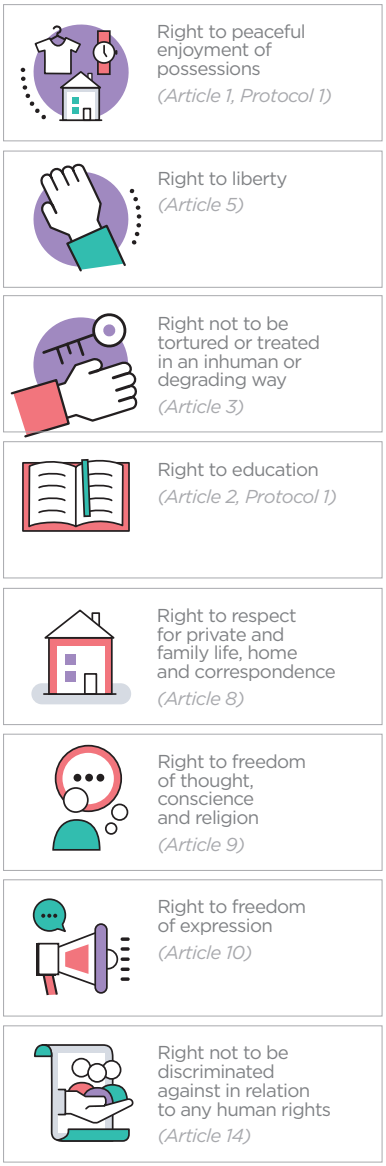
or improvements in patient safety

(Luciano et al., 2014;
McLaughlin et al., 2016;
D'Lima et al., 2017)

In contrast, respecting people's views and avoiding putting psychological pressure on them has many positive benefits. Supporting people to make their own decisions helps them to develop their self-esteem, to improve their decision-making, and become more autonomous. The therapeutic relationship between staff and people may foster these benefits, which are also supported by mental health nursing standards.

Psychological restraint and human rights

Any organisation that provides public services (e.g., hospital or government department), and the professionals working within it, must protect and respect people's human rights under the Human Rights Act, 1998 (HRA). This means **staff must intervene if a person's human rights are at risk**. It also means that **staff must respect people's autonomy to make their own decisions** and live their life as they wish.



Some rights are **absolute** (e.g., the right to life, and freedom from inhumane and degrading treatment). This means they should never be restricted.

Others are known as **qualified** rights (e.g., the right to liberty, and the respect for family and private life). This means that they can only be restricted if:

- **there is a legal reason** (e.g., if a person has been deprived of their liberty under section 5 of the MHA or subject to Deprivation of Liberty Safeguards (DoLS) under the MCA)
- **there is a legitimate reason** (i.e., to protect a person from harming themselves or others)
- **it is proportionate** (i.e., any restriction should be the least restrictive option, imposed for the shortest possible time and subject to regular review)

For more information about psychological restraint, please see the Restraint Reduction Network's *Rights based framework for psychological restraint*. You can also find out more about the HRA in relation to mental health here: https://bit.ly/3jSM9i9

Is psychological restraint ever justifiable?

As previously discussed, psychological restraint can cause significant harm to a person, clearly conflicting with their care and treatment. It is therefore important for senior leaders and staff to ask themselves what would cause the least harm and be of the most benefit to a person. For example, even if a person does not have capacity to consent to their treatment, staff could cause unnecessary harm by pressuring the person about other aspects of their care or daily life choices.

> If the harm done to the person is greater than the benefits provided by a psychological restraint, the restraint is unjustified.

Under the MCA, staff must respect a person's choices – even if staff consider them to be foolish (unless there is a significant risk of harm). If the person has been found to lack capacity, the benefit from applying psychological pressure must clearly outweigh any harm that is caused from doing so.

As with many human rights issues, outright and obvious breaches are easier to identify than those that occur inadvertently. Harassment, put-downs, mockery, threats, provocation, bullying, gaslighting, name-calling, gossiping about patients and manipulation are all obvious examples of unjustified and disproportionate use of force. However, as previously discussed, not only can staff presume the use of psychological restraint is acceptable, it can also be harder for them to identify. Miscommunication and misinterpretations can also occur, which can inadvertently cause further harm and potential human rights breaches. Staff should be mindful of this possibility and ensure they use clear and literally accurate language.

> Under the MCA, any decisions made on behalf of a person who lacks capacity must be in their best interests. People making decisions on a person's behalf must demonstrate it has a positive aim and that there is no other way to achieve the aim in a way that preserves the person's liberty.

As previously mentioned, a person's qualified human rights can only be limited if there is a lawful, justified and proportionate reason to do so. Staff should be aware that, not only are these rarely met, but these conditions also apply to the use of psychological restraint.

Mental health services exist to help people get to a place they want to be in their lives and to help people realise their goals and decisions autonomously. They are not there to punish, discipline behaviour or impose choices.

How staff can avoid using psychological restraint

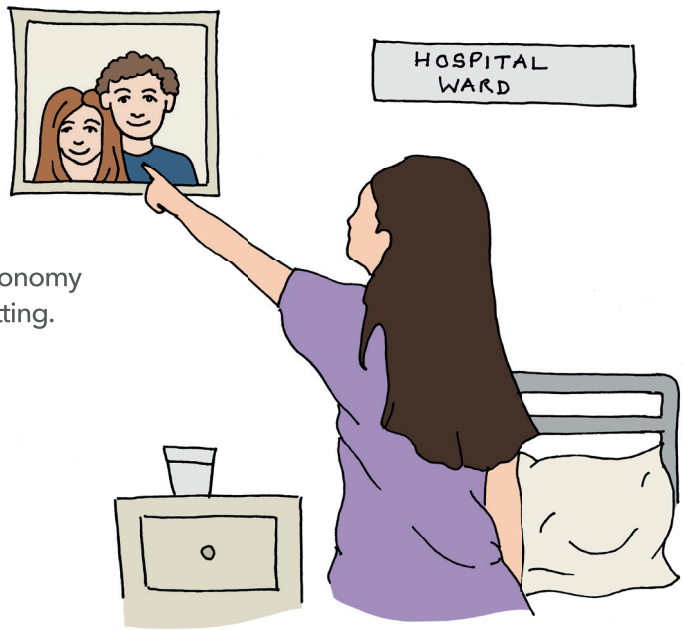
1. Building relationships

It is important for people to experience real and positive relationships with the professionals who support them. Staff should not only take time to listen to what a person is saying, but also try to understand the message and emotions behind it. Staff should learn about a person's history, hopes, concerns, likes, and dislikes. They should spend time observing and asking the person about their triggers so these can be avoided. It can be helpful for staff to think about what safety and security look like for the person they are supporting, and to try to put these conditions in place.

Staff should also be careful about the language they use. What they say to people should be affirming and asset-based. Staff should take time to learn a person's strengths and qualities, create opportunities for these to be demonstrated and built upon, praising people for their achievements. Staff conversations, and the clinical records they keep, should reflect the person's uniqueness as a human being, not as a patient or a disorder.

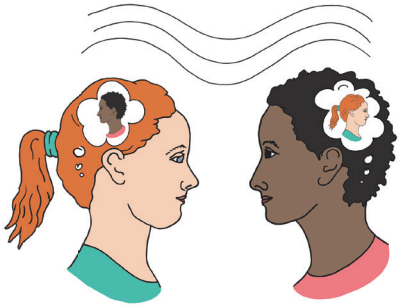
2. Exploring choices and options

Being non-directive, by talking about and exploring choices, can help people understand their options. It also helps staff to communicate realistic treatment expectations (e.g., what the treatment is and how it will be given). This helps to create transparency and trust and gives people a chance to exercise their autonomy within the confines of the hospital setting.



3. Listening, empathising and responding

Staff should try to understand how the person is feeling and why this might be. They should show the person that they are listening, and respond to their hopes and worries (e.g., with their verbal and body language). This will help to improve the person's wellbeing and treatment satisfaction.



4. Treating the person's perspective as equal

Inevitably, staff hold more power in hospitals because of their role and expertise. As previously discussed, staff should avoid using 'power over' in their communication and interactions with the person, promoting 'power with' and 'power from within'. They should try to create mutuality by avoiding making assumptions or generalisations about people that are based on their status in hospital. This will ensure the person's individuality and agency are acknowledged, and they are fully understood in the context of their life experience.

5. Supporting the person's decision-making

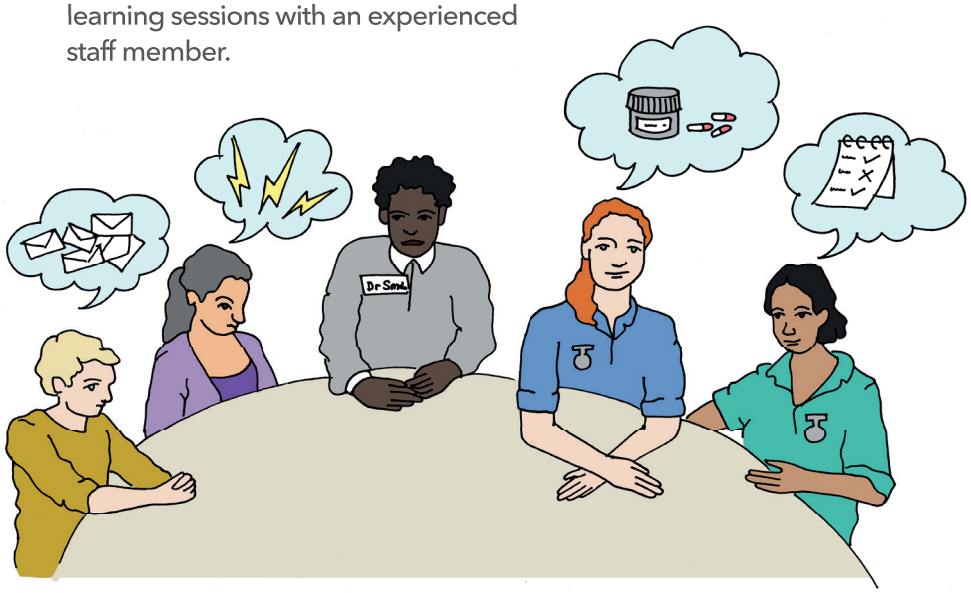
As previously mentioned, a person has the right to make their own decisions (even if staff consider them unwise), unless there are legitimate and legal reasons to prevent this. Wherever possible, staff should take a consequential approach, supporting a person to understand the consequences of their decisions.

6. Offering post-incident support and learning

If psychological restraint is used, or if distress escalates into an incident, it is important that people reconnect within the safety of a relationship. Any use of force should be followed by post-incident support and learning, with a staff member who the person experiences as unequivocally on their side, to reduce further distress and possible trauma. Staff should follow the RRN's *Post-Incident Debriefing Guidance*.

7. Finding spaces to communicate with staff

It is important that senior and practice leaders create time and space for staff to discuss psychological restraint, and to reflect on how this might link to staff bias and assumptions. For example, this could be in mentoring sessions with a practice leader or during post-incident learning sessions with an experienced staff member.



Using a "How staff communicate with me" survey

Leadership and staff need to know how effective their relationships are with the people they care for and whether or not psychological restraint is a problem on their ward. The "How staff communicate with me" survey is a tool that can evaluate the quality of the relationship between staff and people they support. It provides staff with direct feedback on how they work with people and if they feel they have agency or are being coerced.

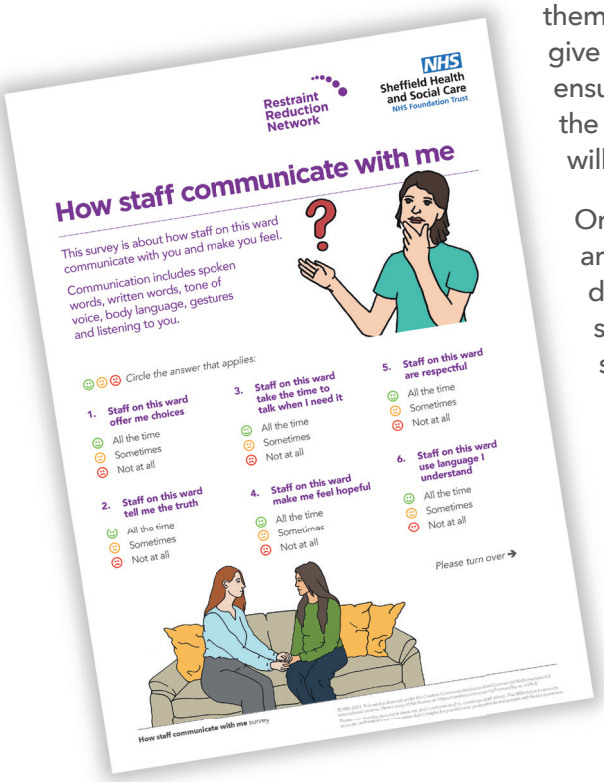
Using data is a core strategy in reducing restrictive practices.

(Huckshorn, 2004)

Before the survey is carried out, senior leaders should work with practice leaders and staff to find out how and why psychological restraint is being used on the ward and the function it serves. Senior leaders should develop a clear mission to reduce its use. Practice leaders should model effective ways to interact and communicate that respect people's autonomy.

People need to feel safe to complete the survey. Staff might consider handing the survey out to everyone on the ward, allowing people to place them in a box anonymously. Staff should also give people pre-survey and after-survey care to ensure the person understands the purpose of the survey, why data is being gathered, how it will be used and how it will benefit them.

Once data is collected, senior leaders should analyse the results and meet with staff to discuss findings in an encouraging and solution-focussed way. Senior leaders should support staff with any difficulties they may be experiencing and encourage, praise, and reward them for their efforts. Practice leaders should offer to work one-on-one with staff to nurture their ability to prioritise people's autonomy.


Restraint Reduction Network

Sheffield Health and Social Care NHS Foundation Trust

How staff communicate with me

This survey is about how staff on this ward communicate with you and make you feel.

Communication includes spoken words, written words, tone of voice, body language, gestures and listening to you.

Circle the answer that applies:

1. Staff on this ward offer me choices
   All the time / Sometimes / Not at all
2. Staff on this ward tell me the truth
   All the time / Sometimes / Not at all
3. Staff on this ward take the time to talk when I need it
   All the time / Sometimes / Not at all
4. Staff on this ward make me feel hopeful
   All the time / Sometimes / Not at all
5. Staff on this ward are respectful
   All the time / Sometimes / Not at all
6. Staff on this ward use language I understand
   All the time / Sometimes / Not at all

Please turn over

How staff communicate with me survey

Conclusion

Psychological restraint can conflict with rights-respecting practice. It undermines a person's autonomy and the effectiveness of their care and support. The arguments presented in this discussion document indicate that there needs to be further debate on whether or not psychological restraint is ever permissible in mental health care.

Avoiding the use of psychological restraint can increase trust, build stronger therapeutic relationships, and improve treatment adherence.

(Sheenan and Burns, 2007)

Rather than assuming that psychological restraint is justified by 'good intentions', the RRN recommends that mental health hospitals uncover its use and function in sustaining the service's culture. Staff must understand that any psychological restraint intervention must be legitimate, legal, and proportionate, involving a process of justification that establishes why it is necessary and how it will be applied in the least restrictive way possible.

Next steps might include a rights-based, inclusive approach based on collaborative discussions and reflections with staff and people with lived experience. This might assist in moving towards agreed strategies and approaches that ensure people are protected against the most hazardous effects of communications and interactions that aim to restrict people's freedoms, be they unwitting or deliberate.

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