Restraint Reduction Network

Involuntary Transport

Resource pack for health and social care staff, ambulance crews, people who are detained and their families

This resource was coproduced by people with lived experience of restrictive practices and professionals. This is part of a set of information about **involuntary transport** for health staff, ambulance crews, people who are detained and their families. There is a:

- **Talking heads video** focussing on people's lived experiences and the effects of the restrictions encountered.
- **Single page summary sheet/poster** which defines what involuntary transport is, summarises the issues and gives a list of key points that are important to keep in mind.
- **'What to do' resource pack** which gives examples of common restrictive practices and their effect; guidance on individual advanced directives; guidance on supporting people's sensory needs; information on self-regulation and co-regulation; and a 'myth buster'.

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Introduction

Involuntary transport is when a person is moved from one venue to another against their will. Under the right conditions, this process can be a supportive and safe experience. It can also be traumatic, leaving a legacy of harm for all involved.

This resource pack is designed to support people to understand, plan, carry out, and evaluate involuntary transport. The resources were coproduced by people with lived experience, sensory integration experts, occupational therapists, speech and language therapists, mental health nurses, social workers, and psychologists. We hope they support safe, calm and secure involuntary transport.

When and why is involuntary transport likely to be used?

People are likely to be transported in vehicles against their will when they are detained under a piece of legislation (such as the Mental Health Act or Mental Capacity Act):

- If they need a safe place, assessment, or admission to an institution (e.g., from home to a place of safety or psychiatric inpatient unit).
- If they need transfer between institutional/ congregate settings.
- In response to being absent without leave (when a person leaves hospital outside of the agreed leave or does not return at the agreed time).
- For the purpose of escorted leave (when a person leaves the ward accompanied by a member or members of the hospital staff).

Involuntary transport and the co-occurring use of restrictive practices

During involuntary transport, different types of restrictive practices might be used.

Some people may experience minimal restrictions, such as when they are transported in a taxi, with only the legislation acting to compel the move. When the trip is planned together, the person might actually find it enjoyable, or at least not stressful – such as when they have the appropriate staff support, packed their own things, and can access entertainment while travelling.

Some people mention using a lot of restraints, which, even if used in a way that respects rights, can make things worse by creating a feeling of being trapped (a 'pressure cooker' effect), exacerbating powerlessness, indignity, distress, and trauma.

People's lived experience examples:

I was in this small cage.

The cage squeaked loudly when we went over bumps.

My daughter died because she wasn't wearing a seatbelt. She was put in this cage without a seatbelt and driven for hours.

I was fed and watered through a hatch.

Mechanical restraint...

People's lived experience examples:

- I was sat in the back, in this cage, all tied up like a hostage.
- The cuffs were too tight. My wrist got broken.
- It's hard to sit with your legs strapped. I got cramp.
- I was sandwiched between two staff with this big body vest/belt holding me to the seat so I couldn't move.

Physical restraint...

People's lived experience examples:

- I was covered in bruises.
- They carried me like a battering ram, then restrained me to get me in the van.
- They held me for hours and hours all the way.

People's lived experience examples:

I'd be sedated the whole trip, barely able to sit up.

Staff would inject me before every transfer, regardless of whether I needed it.

People's lived experience examples:

The ambulance was sat on the tarmac of the hospital as staff were lost... I fed my son sweets through the cage to keep him calm .

They told me not to follow the vehicle with my son in it because I wouldn't keep up.

They transferred me bollock naked.

I felt like an animal... my urine on the floor soaked into my socks.

I didn't know where I was going... where my stuff was.

They took me from my house, my safe place... I haven't felt safe at home again.

They got my son into the van using wine and holiday brochures, pretending he was going on holiday.

Surveillance...

People's lived experience examples:

CCTV was watching me wet myself.

Staff kidnapped me in the night from my bed. They then didn't tell me where I was going... they turned on the body cam and prosecute me like I'm supposed to not be upset about what happened.

The only thing more degrading than the transport, is having it filmed.

Blanket restrictions...

People's lived experience examples:

It didn't matter whether I was calm or kicking off, they'd transfer me in a cage anyway, often in the middle of the night or without any warning .

They had staff watching me through this hatch and they still filmed me.

I wasn't even stressed, and they injected and cuffed me anyway... just in case.

People's lived experience examples:

My son is an inpatient so they told me they have to transfer him in a cage.

I had to fight to sit in the back and stroke my brother's hair because they said he was dangerous.

They always use handcuffs and sedatives, even if I'm calm.

I was told I couldn't sit with my son because it's a mental health transfer.

Advanced directive for involuntary transport – guidance for staff and family

It can be helpful for people to fill out an advanced directive. This will help the person think about what might be helpful or unhelpful if/when they need to be transported. It will also help staff (those working in health care settings and transport crews) to know how best to support the person.

When supporting someone to fill out an advanced directive, staff might explore these things.

Does the person understand why the transport might be necessary?	☐ Would a social story explaining the need for medical treatment in another location help them understand? ☐ Would spending time with a family member who can explain why they are moving help them feel safer? ☐ Does the person need an accessible explanation of the legal framework being used to hold/transport them and their right to appeal?
Does the person have things that will help them to self-regulate/feel safe on the journey?	☐ Consider what has been (un)helpful on previous transfers. ☐ Does the person have favourite music that could be played on the journey? ☐ What sensory/fidget items, activities, word games, or other personal interests might help? ☐ Would scripts for staff help provide the answers the person expects when they ask a question, e.g., if the person repetitively asks the same questions when anxious and expects a certain answer?

Does the person know where they are going and what to expect?	☐ Has the person been given enough time to process the information and their related feelings about the transfer? Often people are given little warning and this can make them feel distressed, overwhelmed and powerless. ☐ Has the person been shown pictures of the setting they are going to so they know what their bedroom and outdoor space will look like? ☐ Does the person know what they will have access to when they arrive, e.g., a TV or their favourite things? ☐ Has the person seen pictures/been given names of the staff who will welcome them when they arrive and who will care for them? ☐ Is it possible to do a virtual tour of the hospital or virtually meet a staff member who will be caring for them? ☐ Will it be helpful having a map of the route that will be driven, e.g., following a GPS?
Who is best placed to help the person during the transport?	☐ Is it possible for a family member/friend to travel with the person? ☐ Can staff, who the person has a trusting relationship with, accompany them on the journey? ☐ How can people sit with the person? Engage with them? Reassure them?
How can a person safely access the transport in the least traumatic way?	☐ Consider what events/experiences could be triggering. ☐ How will the person enter and exit the vehicle, e.g., clear thoroughfares for the person to walk? Would protective holds help the person feel safer? ☐ If the person needs the toilet on the journey, how can they access this? ☐ Could someone ensure they use the toilet before they leave? ☐ Can a stop be scheduled on the way?

Even if an urgent move is required, many elements of the above advanced directive planning can still be followed, e.g., a brief social story written, internet search for images of the setting the person is going to, family on speaker phone in advance/ during the journey.

Contingency planning if the person becomes very distressed.

If the person is too anxious or overwhelmed to understand the information given.	☐ Can staff follow a clear script to reinforce a consistent message, e.g., "we are going to the new hospital that is closer to your home" . ☐ Can the person be distracted by doing something they enjoy. e.g., music, games, conversation about their areas of interest?
If the person is becoming so distressed that they are seeking to harm themselves or others.	☐ Can the person follow clear verbal instructions to remain in their seat? ☐ If not, explore the person's preferences for least restrictive options, e.g., does the person prefer a 'safety seatbelt' so they can travel in the minibus with staff/ family rather than being isolated or handcuffed? ☐ If further safety measures are required, e.g., sitting in an isolation area, how can the person be made comfortable, e.g., personal items? ☐ Where can staff be located so that the person can engage with staff and receive reassurance? ☐ Does the person prefer a problem-solving approach, someone just to sit with their feelings when they are distressed, or something else?

My transport – advanced directive for people using health and social care transport

This advanced directive tells staff what you want to happen if you are going to be transported against your will.

You would only be transported against your will if you are very unwell, and people think you need extra help and support in another place like a hospital.

You are the most important person when choosing what you want.

You do not have to make this plan if you don't want to.

You can change your plan whenever you want to.

People can help you to make this plan, or you can do it alone.

You can share the plan with whoever you want.

An advanced directive, with your permission, can be shared with your ambulance crew, who will then be able to understand your needs better and try their best to facilitate your wishes.

Whilst they may not be able to guarantee all your requirements, it is their duty to try and respect your wishes if it is safe to do so and they are able.

The following resources can be used to support conversations with people ahead of transport taking place.

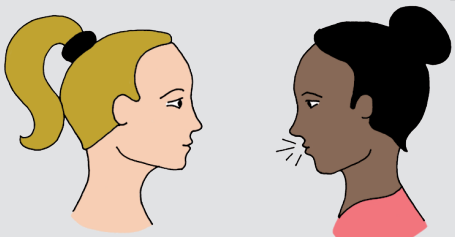
Name: Date:

Planning my move

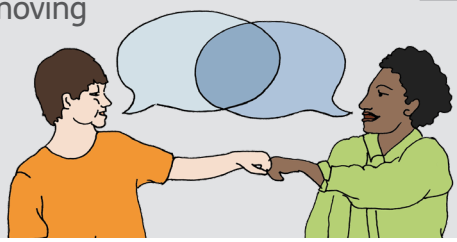
I want staff to:

Give me time to prepare

Explain why I need to go



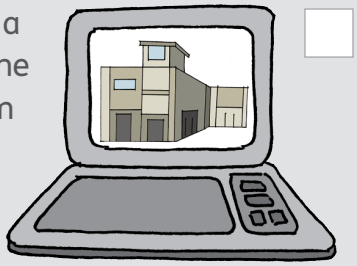
Involve me in decisions about moving



Show me pictures of the place I am going to

Tell me the names of the staff at the place I am going to

Show me a video of the place I am going to



Name: Date:

Planning my move (continued)

I want staff to:

Tell me what facilities are at the place I am going to ☐

Plan who is going to secure my room or my home ☐

Plan who is going to care for my dependents (children or pets) ☐

I would prefer to move in the

morning ☐ afternoon ☐ evening ☐

I would prefer to have someone pack my bag ☐

I would prefer to pack my own bag ☐

Please add anything else you want to request ☐

Please add anything else you want to request ☐

Name: Date:

On the journey

I want:

Family travelling with me ☐

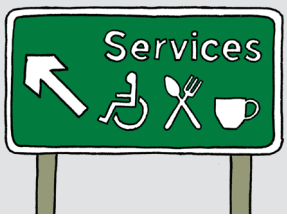
Staff that I know travelling with me ☐

Staff/family sitting next to me ☐

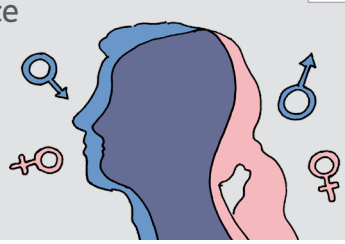
To sit alone ☐

To follow the journey on GPS/sat nav ☐

To know when and where we will stop ☐



To request a gender preference for the crew ☐



If we can't stop for the toilet on the journey because I am too distressed I want staff to: ☐

Name: Date:

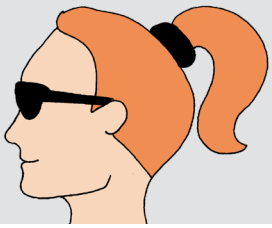
On the journey (continued)

Things that might help me on the journey:

Ear defenders ☐

(Weighted) blanket ☐

Sunglasses ☐



Using my tablet/ phone ☐

Pillow ☐

Smoking/ vaping ☐

Things to hold: ☐

I like to hold:

Music: ☐

The music I like:

People talking to me and reassuring me: ☐

I like talking about:

My favourite snacks are:

My favourite drinks are:

My favourite sensory equipment is:

Name: Date:

Getting in and out of the vehicle

I would like people to:

Create a space for me to walk

☐

Let me get in and out of the vehicle myself

☐

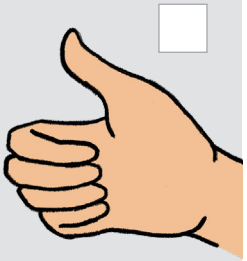
Support me using safeholds

☐

Please add anything else you want to request

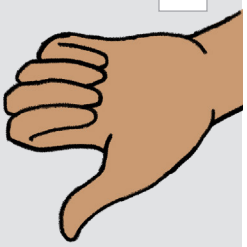
☐

When I am distressed, it is helpful for staff to say these things:



☐

I do not like it when staff say these things:



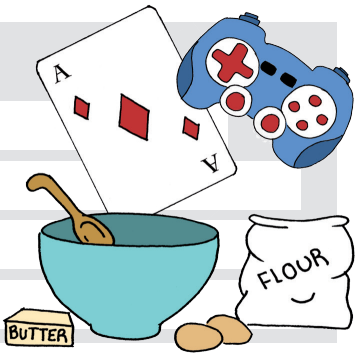
☐

Name: Date:

Getting in and out of the vehicle (continued)

Other things to think about:

My favourite things to do are:



It is helpful when people talk to me about things I like

Yes ☐

No ☐

Please add anything else you want to request ☐

If I am too distressed to sit in the same space as people during the journey, I want these things to happen:

Other things to think about (for example: pets; things I am allowed to take to the new location; any particular emergency service that might be triggering):

Supporting people's sensory needs during involuntary transport

People experience the world in unique ways and have different thresholds for how much sensory information they need to feel calm and alert. Some people have a high threshold for the sensory input they need. This means that they don't easily get enough of this information from the environment and therefore look for different ways to achieve the sensation from somewhere. For example, if they have a high threshold for deep pressure touch (tactile) they will try to get the sensation of being squeezed and pressed by whatever means possible in their environment. Some people have low thresholds for certain sensory stimulus. This means they only need a very small amount of it before it starts to overwhelm them. When these people experience too much, their nervous system becomes triggered into a stress response and their emotions become dysregulated. They may then start to react in distressed ways that services find difficult to manage.

To offer the most effective support, practitioners need to understand how to tailor sensory experiences appropriately for people during involuntary transport. It can be helpful to think about the person's sensory needs and what helps them feel safe, regulated, and supported in environments. This will help hospital staff (prior and after the transfer) and practitioners (doing the transfer) avoid overwhelming sensory experiences for the person. Conversely, it enables them to provide more of whatever the person requires to remain calm and alert.

If possible, a sensory profile or sensory processing measure questionnaire can be used. This will help to determine patterns of sensory processing differences. Ideally this will be done with the person, but if this is not possible, someone that knows them very well should complete it, e.g., a family member/carer.

The more control people have over their environment, the more emotionally regulated they are likely to be. When planning involuntary transport or supporting a person to write an advanced directive, consider the following:

	Considerations	
	Low threshold	**High threshold**
Sight 	☐ Turn light down in the vehicle. ☐ Offer sunglasses. ☐ Allow a peaked cap to be worn. ☐ Consider positioning in the vehicle – the person may prefer to be seated between staff or by a window to reduce being overwhelmed by the external view. ☐ Consider reducing direct eye contact with person.	☐ Put internal lights on in the vehicle. ☐ Ask if they'd like to use an iPad or electronic device. ☐ Use light based sensory equipment, e.g., glitter tube, light up stress balls.
Hearing 	☐ Turn music off. ☐ Ear defenders/noise cancelling headphones. ☐ Try to keep voices low and soft, offering minimal verbal discussion.	☐ Play music. ☐ Engage in conversation. ☐ Offer iPad or electronic device.
Smell 	☐ Allow windows to be opened. ☐ Staff to be mindful of their personal care – avoid using strong aftershaves/perfumes.	☐ Use scents the person likes. ☐ Use preferred essential oils in vehicle air vents. ☐ Offer to open windows when driving through odorous environments – past farms/factories etc.

	Considerations	
	Low threshold	**High threshold**
Taste 	☐ Offer sweets, drinks and snacks (if appropriate).	
Touch 	☐ Sit away from staff to reduce physical contact. ☐ Remove unnecessary clothing/restraints. ☐ Use weighted items, e.g., lap pad or weighted toy/ equipment. ☐ Staff should avoid unexpected touch and offer explanation and warning when touch is necessary.	☐ Sit between staff to increase physical contact. ☐ Use weighted blanket/lap pad or weighted toy. ☐ Offer plastic spikey ball etc. ☐ Offer massage device, e.g., rolling ball. ☐ Support with appropriate caring, compassionate touch (e.g., could be given by a family member). ☐ Make use of seat belt. ☐ Ask whether open windows are helpful – to feel wind on skin.
Balance (vestibular) 	☐ Consider travel sickness medication/strategies for long journeys. ☐ Advise non medication options like looking outside to the horizon and not down into the vehicle when it is in motion.	☐ Stop for sensory breaks (if possible), especially on longer journeys. ☐ Offer more support if posture appears poor – encourage forward leaning (propping upper body using arms or hands).

	Considerations	
	Low threshold	**High threshold**
Body awareness (proprioception) 	☐ Offer the use of fidget spinners and other touch-related toys that don't require squeezing or big muscle work.	☐ Offer squeezy/stress balls. ☐ Offer chewy sweets or purpose-made chew toys for oral motor work. ☐ Suggest pulling a thera-band between hands.
Interoception (the ability to be aware of internal sensations) 	☐ Ensure the person has gone to the toilet before the journey starts. ☐ Provide regular opportunities for food/water. ☐ Ensure any restraints are applied correctly, e.g., handcuffs are not too tight. ☐ Consider the temperature. Some people may overheat or feel very cold depending on the ways their body manages stress or changes in environment etc. Ice packs, ice cream, cold drinks, could help. Blankets or warm drinks/food alternatively. ☐ Look for visible body signs that the person may not be registering. People with poor interoception can often not recognise they're hot even when they are perspiring, or that they are about to vomit even though they are pale, clammy and begin swallowing saliva a lot.	

Sensory resource written by Hannah McNulty and Alexis Quinn

Providing supportive transport – a psychological resource for mental health staff and transport crews

Neuroception is the process by which the nervous system evaluates risk without requiring awareness.

(Porges, S (2017) p.19)

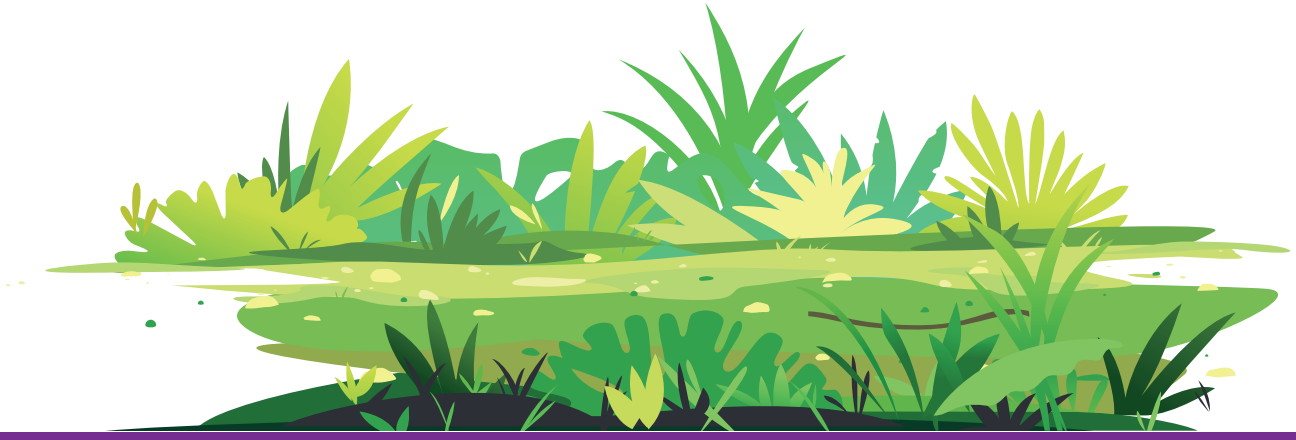
Porges, S (2017) The pocket guide to the Polyvagal Theory: the transformative power of feeling safe. WW Norton and Company.

People can sense danger in the environment

Many people who are transported involuntarily will have trauma histories. They will be primed to pick up cues from the environment that something 'wrong' or 'dangerous' might be happening. They might find it difficult to trust that people around them are safe and will care for them. Some people told us they sensed **"something was going to happen"** before they knew they were being moved. While being transported people said that they had a **"bad feeling"** or that **"staff didn't like [them]"** and this made them feel fear and panic.

Understanding neuroception can help staff realise that people will scan for cues of danger and safety in the environment, without being aware that they are doing so (subconsciously). When people pick up cues of danger in their bodies, they respond automatically.

Think about a time you have walked along a path and seen a snake, only later to realise it was a stick. Your body will have reacted with fear without thinking.



People who have been transported against their will describe the following:

- Stress flooding their brains and bodies.
- Feeling helplessness, anxiety, and anger.
- Entering a fight/flight/freeze/flop mode.
- Difficulty managing fear, resulting in action orientated coping, e.g., lashing out.
- Sensory overload and seeking/avoiding sensations on the journey.
- Feeling confused and/or disorientated.
- Increasing their feelings of paranoia, symptoms of mania or anxiety.
- Making those who are cognitively impaired feeling more confused and less orientated.

Safety starts with staff/crew

Sometimes there is an unrealistic expectation that those being transported can regulate their experience and make effective decisions even though they are often unwell, distressed and/or in fight, flight, or freeze modes.

> Even if someone appears physically SAFE, it doesn't mean they FEEL SAFE. A person's need for emotional and psychological safety must be recognised and supported.

As humans, we are all hard wired to survive. When we feel safe, our brains can reason, problem solve, and empathise with others. However, when we feel unsafe, our brain switches into survival mode. In this mode, it is hard to think or rationalise, because our brain is primed for managing immediate danger. We are programmed to respond by 'fighting' off danger, 'fleeing' from danger or 'freezing' (e.g., disengagement).

When someone is not wanting or expecting to be transported, they can become very fearful of the event and feel unsafe. It is likely they will enter their fight, flight or freeze modes. The use of restrictive practice will likely increase a person's fear, as the restriction might feel threatening, and it will prevent the person's ability to 'flee'. As such, it follows that they are more likely to 'fight'.

For people to come out of their threat/survival mode, they need to feel safe and soothed. We often need another person to help us achieve this. When we can't feel calm ourselves, we need someone else to lend us their calm presence first (co-regulation). We need that person to stay calm for us and not absorb our stress (emotional self-regulation).

Self-regulation

It is important that staff/crews notice, reflect and manage their own feelings.

It is OK for staff/crews to have a range of feelings themselves (e.g., nervous, sad, frustrated).

It is not OK for staff/crews to not be aware of their feelings or consider how they influence interactions with the person in the transport.

If staff/crews can't regulate themselves, they too enter their own fight, flight or freeze modes and become more reactive and less thoughtful or empathetic.

Crews and companies need to consider what support and training is required to manage their own emotional wellbeing.

> Staff/crews can be part of the problem or part of the solution!

Co-regulation

As humans, we seek and get much of our safety and comfort from relationships. This is a survival instinct – there is strength in numbers.

If the person being transported is very distressed, it is especially important that staff/crews remain calm. No-one can put out a fire with fire!

When staff/crews remain calm and gentle, they can lend the person their calm presence, acting as a mirror to soothe. Co-regulation helps staff/crews to be warm and responsive to the person, enabling them to express and modulate their thoughts, feelings, and behaviour. This can bring comfort and safety to everyone.

Think about your experiences on a plane when there is turbulence. You don't know what is going to happen.

- You feel scared.
- If the cabin crew are calm and connect with you, it helps you to stay calm.
- Think about your body language and how to help a person feel safe (be like the cabin crew).

Self-regulation involves balancing your own emotions.

Co-regulation supports the emotions of those in the transport, helping to manage hopes and fear.

Staff/crew self-regulation can support co-regulation.

Co-regulation helps others to self-regulate.

It can be helpful for the staff/crew member to recognise, know, and respond to their emotions by:

1. **Being aware of their own feelings as they approach the person (and accept these feelings).** Ask:

> How do I feel in my body and how do these feelings impact me?

2. **Recognising any emotions and behaviours.** Ask:

> How do different wards/pick-ups/ people make me react? When do I feel more/less in control? What happens within me when things don't go to plan?

3. **Recognising thoughts and beliefs about crew/staff members' behaviours when things are stressful.** Ask:

> What do I find more/less supportive? How do I react? What makes me feel comfortable/uncomfortable?

4. **Recognising any thoughts/beliefs about the different types of people they transport:** Ask:

> Do I have any judgements/stereotypes/ beliefs/fears?

5. **Practicing self-awareness.** Ask:

> What makes me feel safe/unsafe? How do I react to different mental health staff/situations/restraint? What is my reaction when someone is aggressive/quiet/fearful/ demanding?

6. **Practicing self-soothing strategies in response to feelings.** Ask:

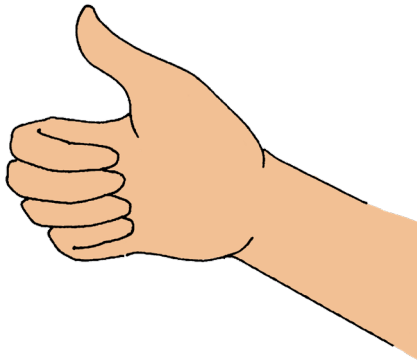
> How do I feel about breathing exercises, visualisations etc.?

7. **Responding compassionately when feeling overwhelmed.** Ask:

> What self-talk do I use? Is it compassionate?

To support co-regulation, staff/crew might do the following:

- Stay in the moment, e.g., not focussing on the setting, the person's risk history etc.
- Keep your tone of voice calm.
- Validate yourself and other staff (through facial gesture, mirroring and presence)... this is scary for you too.
- When we are scared our muscles get tense, our breathing gets quicker so:
  - slow down your breathing
  - focus on the exhale (calms the body), and
  - bring shoulders down, shake arms to release tension.
- Use 'I' statements instead of 'you' statements to reduce defensiveness. Focus on how you feel or felt instead of trying to put those emotions onto the person.
- Practice active listening. Focus fully on what the person is saying, trying to understand their perspective.
- Reduce triggers and stressors by planning ahead.
- Focus on the emotions you and others may be feeling, not behaviour.



What staff/crew can do:

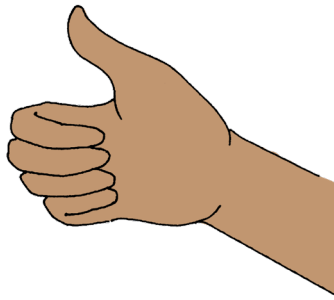
- Read the person's advanced directive or pen sketch (see pg. 15) to know/understand what the person likes/doesn't like and how to provide support.
- Let the person know that you are there to provide support and that they are safe.
- Acknowledge and validate the person's distress.
- Notice how quickly they are breathing.
- Slow your breathing down – sometimes it helps to breath as fast as them, then gradually slow down your breathing.
- Use nonverbal cues of safety and connection.
- Let people know what is happening – the unknown is scary. Tell them:
  - where they are going;
  - how long the journey is;
  - the time they are likely to get there;
  - if/when they will have toilet breaks.
- Reply calmly to repetitive questions, e.g., "how long till we get there?". The person may not be able to process or remember what you said or they may seek comfort in hearing the same response over and over.
- Chat with your colleague about the things the person likes – give them the opportunity to join the conversation.
- Constantly observe to see if their breathing slows, their muscles relax, if they want to interact with you. Note: this may not be verbal. This will let you know if the person's thinking brain has come back online.
  - You may then be able to ask them a direct question about what they like or what they need.
  - They may like to follow the journey on a sat nav, talk to their family etc.

The benefits of co-regulation include:

- ☺ feeling in control due to increased self-awareness;
- ☺ being able to express and respond to emotion;
- ☺ being able to self-soothe;
- ☺ increasing problem solving capacity.

Using your nonverbal cues to help a person feel safe and connected/coregulate

Potentially helpful things to say:



I'm with you.

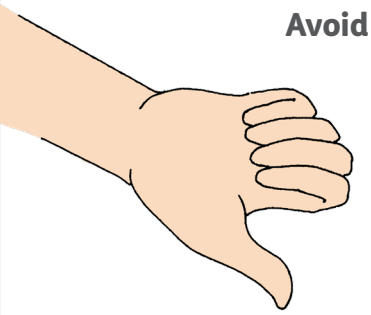
I see and hear you.

We'll do this together.

You're safe.

If they are too scared, they may not hear the words. But they may sense in your tone of voice and attempts at connection, your care and compassion.

Avoid saying:



You'll be OK.

Calm down.

It's for your own good.

What do you expect if you act like that.

This won't take long.

(or any judgement-laden comments)

Avoid:

- ☹ Asking direct questions. They can be seen as a demand and make people feel more anxious.
- ☹ Making value judgements about the person's behaviour. Remember they are scared.

Questions for staff teams to ask when planning to support psychological safety:

- Who is travelling with the person that knows them well?
- Which parent and/or close friend is travelling with the person? If they are not, why not?
- What belongings can the person use on the journey that mean something to them. e.g., a mobile phone, photo, sensory item, stuffed animal?
- If the person is too scared to hold their belongings when they first get in the vehicle, when can they have them?
- In what ways can staff portray safety, e.g., with their tone of voice and body language, so that the person can become calm enough to notice the object(s)/people they like?
- As the person's thinking brain comes online, how will staff provide the person with a sense of control, e.g., asking, “what song would you like to listen to”?
- How will staff use the person's personal profile to connect with the person?
- How will the staff team organise for important people and things to be at the destination when they arrive and how will this be communicated to the person?

Restraint Reduction Network

Involuntary Transport: Least restrictive culture

Managing stress can feel unpredictable.
Unpredictability can activate our fight, flight or freeze response.
This can make it difficult to think and reason.

Person being transported

I am being moved to an unfamiliar place against my will

Staff/ambulance crew

I must move this person to somewhere they wouldn't choose to go

UNCONSCIOUS THOUGHT PROCESSES IN SURVIVAL MODE

- Flight mode: "I am afraid. I need to get away from here"
- Fight mode: "I feel trapped. I must act out to stay safe"
- Freeze mode: "I'm overwhelmed and feel stuck. If I disengage they will leave me alone"

Restrictive practice more likely to occur

AMBULANCE CREW IN SURVIVAL MODE

- Flight mode: WHAT IF... the person runs away when I'm meant to be caring for them...
- Fight mode: WHAT IF... the person harms themselves or hurts me...
- Freeze mode: WHAT IF... I don't feel able to manage the uncertainty...

THE ROAD TO LEAST RESTRICTIVE PRACTICE

- Compassionate leadership
- Choosing crew with the right value base
- Collect data on restrictive practice and the person's satisfaction
- Workforce development, including supervision
- Post conveyance (debriefing) support and learning

Created by Dr Laura Lovatt

Edited by Alexis Quinn on behalf of the Restraint Reduction Network

Power is not a finite resource

Everyone feels they have control, a sense of mastery and inner strength

PERSON HAS CHOICE AND CONTROL

- I know what is happening, where I am going and who I will be with
- I have time to plan, discuss and process what is happening
- I have built a relationship with staff/crew

Co-regulation

Collaborative compassionate least restrictive practice

LEAST RESTRICTIVE PRACTICE

- I know something about the person and how to support them
- I feel empathy for the person and know how to listen and respond
- This journey has been coproduced and I feel confident to provide bespoke support

Safety is created through building trusting relationships, not through control and restraint

Name: Date:

My moving plan

I am moving to:

It looks like this:

Add a photo

My room looks like this:

Add a photo

Name: Date:

My moving plan (continued)

I am moving to:

I will go in a vehicle like this:

Add a photo

I am going there because:

These people will go with me:

I will go at this time:

I will sit in this position:

Name: Date:

Moving plan for ambulance/transport crew

Reasonable sensory and communication adjustments needed to support NAME to move.

Moving can be a difficult and traumatic experience for anyone. The following things will be needed to support NAME .

The care team will provide items required, but it is useful for you to understand things that might help the experience be more therapeutic and less traumatising for the person.

Communication and relationships

Please introduce yourself to the person using first names	☐ Yes	☐ No

☐ Please wear uniforms	☐ Please do not wear uniforms

NAME enjoys talking about:

Avoid:

Preparation of vehicle

Position the person will sit in:

Sensory aspects to be mindful of:

Touch	
Light	
Sound/music	
Temperature	

Items to be taken in the vehicle (the team will provide items)

E.g., food, drinks

Restrictions

☐ Cage	☐ Cuffs	☐ Belts	
☐ Holds		☐ Seats	☐ Harness

Least restrictive rationale:

The following things might increase the person's distress:

E.g., traffic jams; not being able to stop to use the toilet

How to respond:

Involuntary transport myth buster

MYTH	FACT
Restraint during transport (e.g., a caged environment) is necessary for mental health transfers.	Involuntary transport should be a planned, proportionate way to reduce foreseeable risks that are unable to be mitigated by other means. Otherwise, it's illegal.
The more secure/ restrictive, the safer the move.	The more restraint is used, the more distressed a person is likely to become. Restraint carries risks of injury, harm and death. Creating relational safety, using an advanced directive, and coproducing a plan, can reduce risk.
The gender of those doing the transfer does not matter.	Due to people's preferences, physicality and past traumatic experiences, gender considerations are important when staffing transport.
Not telling a person about the transfer until the last minute can be helpful as the person will be distressed for less time.	Not informing people about a transfer creates additional stress resulting in action-orientated coping, e.g., lashing out. It reduces predictability, trust in staff, and can disrupt future caring relationships. The abrupt breach of safety in the physical and relational environment can become a trauma of its own.
Deceiving a person about where and when they are moving can reduce distress.	Deceit creates trauma. It can also be difficult for autistic people, people with a learning disability, and those with traumatic histories, to process and understand. Deceit increases unpredictability, reducing chances of developing and sustaining cooperative relationships. The legacy of this harm can be lifelong.
Rewarding someone with something they like on arrival is a good way to manage behaviour, e.g., telling someone they can smoke once they finish the journey.	Rewards can create demand anxiety. They can also communicate that only certain ways of being are acceptable and that distress is unacceptable. This instils conditionality and limits people's self-expression.

MYTH	FACT
It is better not to stop for toilet/comfort breaks as to do so is invariably risky.	Planning is important to ensure people are treated with dignity. Inhumane and degrading treatment is never acceptable.
There is no need to provide food, snacks and drinks as the journey will take place between mealtimes.	Food, snacks and drinks on long journeys are necessary. People might also manage their sensory needs by ingesting more/less (as a response to stress).
Packing a person's belongings for them without their input is ok.	Packing a person's belongings without their consent might feel invasive, abusive and retraumatising.
Getting feedback about the application of the mechanical restraint is not important, so long as the person is secure.	Checking restraints are applied correctly, e.g., not too tight, is important. Staff can do this by observing their application themselves and/or asking the person how they experience the restraint. This might change throughout the journey and so repeated checking might be important.
Delays when a person is in secure transport are ok, they are detained anyway.	Being stuck in a vehicle can feel unbearable, increase panic, distress, and action-orientated coping.
There is no need to find out about a person's sensory, communication, history, or past trauma. The person needs to be moved securely regardless.	Research into a person's uniqueness can help make the transfer a positive experience, rather than a traumatic one for all involved. For some people, planning and addressing sensory and communication needs will be the only way to avoid equality and human rights breaches.
The more crew members on board, the better.	More crew members can constitute psychological restraint [See RRN psychological restraint resources]. The level of restriction applied to a person must be legitimate and proportionate, otherwise it is likely illegal.
If there is a lack of available transport, it's ok to use a secure vehicle. It'll make it safer.	The level of restriction applied to a person must be legitimate and proportionate, otherwise it is likely illegal.

Evaluation: my experience of being in transport

We want people to feel supported and safe when they are being transported. Please take a few minutes to tell us if you felt supported and safe.

1. Was the vehicle comfortable?

- ☐ Yes
- ☐ No

If no, why did it not feel comfortable?

2. Did the vehicle feel safe?

- ☐ Yes
- ☐ No

If no, can you say why it did not feel safe?

3. Were the staff kind to you on the journey?

- ☐ Yes, they were kind
- ☐ No, they were not kind
- ☐ They were neither kind nor unkind

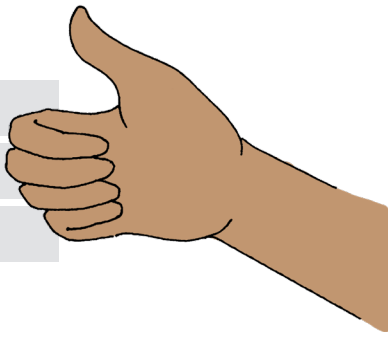
4. Did you know where you were going?

- ☐ Yes
- ☐ No

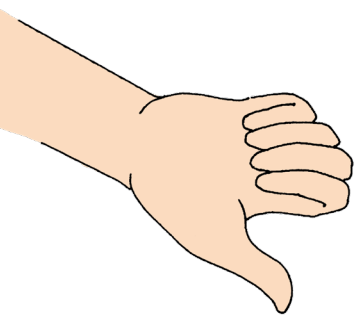
5. Did you have things that helped you to feel supported and safe during the journey?

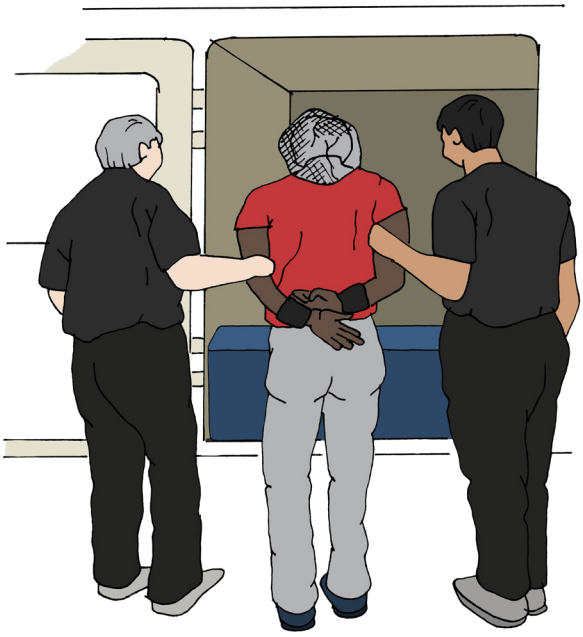
- ☐ Yes
- ☐ No
- ☐ I was asked, but I didn't want anything.

6. What went well on the journey?



7. What could have been better?





Conclusions and recommendations

When the Mental Health Act Code of Practice was implemented, it was recognised and recommended that specialist mental health ambulances were available. Prior to this, police would often assist and transport people in police cars and vans. We have since recognised that those requiring involuntary transport are often at a very difficult and vulnerable point in their lives. They therefore need to be supported by specialist health care professionals rehearsed in respect, dignity and compassion, who use vehicles designed for care. A significant culture change is required to move away from the use of power to more collaborative means of engagement.

Restraint reduction

For a journey to be successful, people need to feel safe and secure. This reduces risks. Connection, trust, and compassionate supports are paramount. Large crew sizes, unfamiliar faces, restraint equipment, security-style uniforms, caged vehicles, will likely cause people to feel scared and intimidated, rather than safe. This escalates risk and the probability of harm. There is a strong evidence-base that shows that the more restriction is used, the greater the risk of physical and psychological harm to all.

Blanket use of, or over-reliance on, restrictive practice is therefore both risky and harmful. It gets in the way of building trusting relationships and the offering of compassion, dignity, and care.

Risk is dynamic, so any use of mechanical restraint should be able to be titrated up and down to mirror the change of a person's risk status. It could be argued it is not easy to modify the levels of restriction in a caged vehicle, so these should only be considered for use in rare circumstances.

Restrictive practice shouldn't be used to manage the transport company's (understandable) worries about potential risk.

> It is unlawful to use more restriction than is absolutely necessary.

Breaking the news

Often, there can be the misconception that it is better not to tell someone they are moving before the transport arrives, for fear it will upset and dysregulate them.

But it is a justified response for people to be anxious, upset or angry when they have to go somewhere against their will.

Telling people at the point that transport arrives can be a shock. Such a shock can then make the situation feel overwhelming and out of control. It doesn't give people enough time to process, ask questions, plan, and feel agency or control.

This can make the person more distressed and risks the transfer feeling like a negative experience.

We therefore must allow people time to process the information and acknowledge their feelings around it.

Involving those who know the person best

Often journeys are booked and funded for one way. This limitation can make it complicated for a relative, friend or trusted staff member to escort the person in the ambulance, as there is often no plan for how the carer can return home. If this could be thought about and organised before the transfer takes place, more journeys could be facilitated with trusted people on board.

Different wards have differing visiting hours and policies around visitors. If this could be researched and discussed by the referrer, this would help make the transition smoother for the person and their family. Planning around leave and breaks (e.g., toilet, cigarette), is also useful.

Data collection and accountability

There is little guidance on data collection that supports improvements in the quality of involuntary transport. The collection, analysis, and publication of data on the use of restrictive practices during transport is important because it increases accountability and can help inform and improve practice.

The reduction or elimination of restrictive practice should be one measure of quality. Other measures are equally important, particularly those that relate to a person's direct, qualitative experience.

The evaluations of people who have been transported should be made available [see pg. 44 for an evaluation form], with the person's consent and with attention to privacy.