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Restraint and Seclusion in Services for People with Mental Health Problems and Learning Disabilities: A Literature Review

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Abstract

This paper reviews the literature pertaining to the practice and experience of restraint and seclusion in inpatient psychiatric settings. These are physical practices typically used by nursing staff in order to manage violence within such services. The available quantitative literature demonstrates the variability in the prevalence of the practices and attitudes towards them. Qualitative research has focussed on the experience of the practices and the different but largely negative impacts they have. Many of these qualitative studies produce interesting and valuable findings; however the literature does not account for the role that language may play in constructing the experience and meaning of the practices for those involved. This and other limitations in the research are described and direction for further research indicated.

Keywords Restraint, seclusion, literature review, mental health, learning disability

Introduction

Restraint and seclusion are practices that are used in mental health services in the National Health Service (NHS) and in the independent health sector. They are physical interventions that staff use to protect patients, other people and themselves from harm. The *Mental Health Act Code of Practice* (Department of Health and Welsh Office 1999) and *Violence: the short term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments* (National Institute for Clinical Excellence 2005) guide staff in the appropriate application of the interventions. Such practices have a controversial history, and a number of inquiries have highlighted cases of misuse and malpractice (Ritchie 1985; Blom-Cooper et al. 1992; Prins et al. 1993). The most recent of these is the inquiry into the death of David Bennett at the Norvic Clinic (a medium secure unit in Norfolk) (Blofeld 2003). These practices can provoke strong emotional responses from all concerned and there can be a temptation to avoid discussion of them. This is reflected in the amount of research that has been conducted in this area; secure services and those for people with learning disabilities have received even less attention.

This paper reviews literature in a number of areas, highlighting key findings and questions that remain to be addressed. Papers were selected because they described restraint and seclusion as they happen in psychiatric services for working age adults in the UK. Additional papers were sought that provided a context within which these practices could be understood; however, policy frameworks, services for children or older adults, services that do not use any type of physical intervention and practices in other countries were not the focus of the review. The first sections of this paper

deal with matters of definition within the subject area. This is followed by a review of papers selected as they were concerned with incidence of restraint and seclusion in a range of psychiatric services. The latter sections deal with papers selected because they examined the perspectives and experience of those involved in the practices of restraint and seclusion; researchers generally used qualitative methods to investigate these areas. Papers were selected that were concerned with both mental health services and learning disability services, and with both secure settings and non secure settings.

Restraint and Seclusion

Restraint

Restraint involves measures intended to restrict a patient's bodily movements (Sailas & Fenton 2001). Alty & Mason (1994) distinguish between chemical (pharmacological) restraint and physical restraint, and state that along with seclusion and transfer these constitute the typical responses to violence from people who are psychiatric patients throughout the world (ibid. p.7). In practice chemical and physical restraint often coincide; in their study of 2180 recorded 'violent incidents' in a medium secure unit Gudjonsson et al. (2000) found that 67% of incidents involved physical restraint; of those involving restraint 44% also involved (chemical) sedation/restraint (54% of those secluded also received tranquilizing medication).

Restraint as it is practised in NHS psychiatric services (including secure services) typically involves a minimum of three people taking hold of a patient using wrist and arm holds where necessary; *Control and Restraint* guidelines indicate that one person should control and protect the patient's head and neck/airway, with one person on each arm (Wright 1999). Additional people can immobilise the patient's legs. The person can be restrained whilst standing, or whilst seated, or whilst on a bed or on the floor and the restraint would continue until the person had calmed and no longer posed a substantial threat of violence. The Royal College of Psychiatrists (RCP) produced guidelines on the management of imminent violence in which they make many recommendations including that staff may 'use secure grips, minimise pain [and] maintain dignity' (RCP 1998, p.61).

Seclusion

Seclusion is the 'placement and retention of an inpatient in a bare room in order to contain a clinical situation' (Sailas & Fenton 2001, p.1.). Alty & Mason (1994) emphasise that seclusion is an emergency measure to contain a situation and one which removes all social contact, thereby distinguishing it from 'time-out' and restraint respectively. They also state that seclusion involves force, a locked door (locked by someone other than the patient) and is 'theoretically' an appropriate term only with regard to the treatment of people with mental illness.

The assertion that seclusion is a practice to be used in emergency situations is supported by the Mental Health Act Code of Practice (Department of Health and Welsh Office 1999) in that it states that

'seclusion is not a treatment technique and should not feature as part of any treatment programme' (ibid. p.96). However, the original Statute Law (Mental Health Act 1983) stated that seclusion *was* a 'medical treatment'. Alty & Mason (1994) contended that seclusion is a practice found within institutions, rather than in community settings (p.130). Royal College of Psychiatrists guidelines emphasise that seclusion should only be used when violence is uncontrolled by other means and they recommend specific observation and review procedures (RCP 1998).

The use of restraint and seclusion

Large variations have been found in the use of seclusion and restraint (Way & Banks 1990); Alty & Mason (1994) cite figures showing between 2% and 66% of psychiatric inpatients experience one or both practices, and the characteristics of people who are restrained or secluded differ widely between studies (Swett 1994; Walsh & Randall 1995). Measuring in terms of number of incidents rather than number of people, Gudjonsson et al. (2000) found that seclusion was the outcome of 4% of violent incidents; Shepherd & Lavender (1999) had a comparable figure of 1.6%. Way & Banks (1990) suggested that there was a 'facility effect' with the culture of the institution being the biggest factor in the use of these practices. Differences in practices of recording, legislative frameworks, interpretation of guidelines, type of institution and demographics of a patient population (e.g. age, forensic or psychiatric history, length of stay) may account for some of the variation in reported incidence and confound attempts to compare quantitative data.

Rates of seclusion and restraint have been reported to be stable over time despite changes in the political climate and size of institutions (Crenshaw & Cain 1997; Salib et al. 1998). A survey of 117 psychiatrists in high and medium security hospitals found that half had initiated seclusion in the previous year, similarly half believed that it constituted a 'form of treatment', a third contested claims that it could be a 'therapeutic practice' and less than 10% objected to its use altogether (Exworthy et al. 2001). In a later survey of high and medium secure units (39 units from a possible 46 responded) 27 (69% of respondents) stated that they had used seclusion at least once in the past year (Cormac et al. 2005). Incidences such as these reinforce the need to understand the nature and persistence of these practices.

Over 80% of the respondents in the study by Exworthy et al. (2001) stated that they would authorise the use of seclusion following *threats* of violence, with the remainder maintaining that it should only follow *actual* violence. Shepherd & Lavender (1999) investigated a series of 130 incidents of aggression and found that attribution of cause was likely to be external (situational or interpersonal) rather than internal (dispositional or mental illness related) and that physical intervention was more likely to be used than verbal intervention, though they identified problems with under reporting of 'minor' incidents. Attribution of cause raises many interesting questions particularly regarding assumptions about 'internal' states and the problems of treating understandable and justifiable anger against oppressive institutions as pathology (Masson 1990). Irwin (2006) provides a very clear rationale for greater emphasis on self awareness on the part of staff when attempting to manage aggression and violence.

Sailas & Fenton (2001) reviewed the available literature with regard to the evidence of the effectiveness of restraint and seclusion. They found no controlled studies that evaluated the value of these practices. However they did find studies that used qualitative methods that reported 'serious adverse effects' (these studies are discussed further below). They called for the development of alternative means of dealing with target behaviours and the evaluation of these in randomised and controlled studies. However, such quantitative studies explore little more than how often these common practices occur, and tell us little of the meaning and experience of the methods.

Variation in methods and terminology

The methods used for physically restraining a person are commonly referred to as Control and Restraint (C&R). These methods were developed by the Prison Service Physical Education Department in the early 1980s following criticism of previous practices that resulted in high levels of injury and damage to relationships. Based on martial arts techniques, in particular Jujitsu (Lewis 2002), they were introduced to Health and Social Services settings from the mid 1980s onwards (Wright 1999). They became very widely used (Gournay et al. 1998) and, though broadly similar, there are still differences in implementation between services. Winship (2006) provides a fascinating history of the development of the use of mechanical and physical restraint from the 15th century to the present day.

Techniques are reviewed locally and nationally following significant injuries or fatalities (Blofeld 2003). C&R was formally recommended for use in statutory psychiatric facilities by the Department of Health and Social Security (DHSS 1988), when they also criticised the unplanned, unsafe and punitive methods previously in use. More recently there has been a move to 're-brand' C&R as 'care and responsibility' rather than 'control and restraint' (McDougall 1996) though this was not accompanied by a shift in practice. Management of Aggression and Violence Techniques is a more contemporary term used somewhat confusingly for some diffusion and self defence techniques, as well as for the taught physical practices which aim to be less aversive and better tailored to particular situations and as another term for the original C&R methods. In an innovative study Ryan & Bowers (2005) reported observations of coercive practices that, whilst not constituting restraint or seclusion in a formal sense, shared some of their function; examples included 'blocking and guiding' a patient's movement and 'show of force' where staff would position themselves around a patient without contact with them. These informal techniques were used to manage 'low level' disturbances but are neither explicitly taught, monitored nor evaluated and have received very little attention in the literature.

In the UK 20 years ago the term 'physical restraint' would have been considered to have included clothing and mechanical devices (e.g. strait jackets, handcuffs and belts). These do still exist and can still be used, but only in exceptional circumstances and then only with stringent regulation (Fennell 1996). The term 'physical restraints' is still used in North America and elsewhere to describe such measures.

Power and Psychiatric Practice

The roles and nature of mental health professions and institutions have been subject to criticism for many years; some of this criticism follows particular inquiries (see above). What follows is a summary of the wider sociological and philosophical critique of power and regulation in the mental health system.

Post-structuralist accounts of 'the professions' identify what Foucault (cited in Alty & Mason 1984) describes as 'discursive practices' (i.e. particular technologies, procedures and linguistic styles) which act as mechanisms of social subjugation through control over knowledge. 'Foucault gave the example of psychiatry regulating morality, rationality and the work ethic in bourgeois society' (Morrall 1998: 12-13). Institutions act as powerful repositories of such discursive practices.

In his seminal sociological study *Asylums*, Goffman (1961) described how hospitals develop hierarchies of dominance. His influential work depicted the depersonalising nature of the 'total institution' a whole societal system of social control, power surveillance and punishment. Writing from a right wing, libertarian perspective Szasz (1994) portrayed the practice of psychiatry as a measure of social control.

There have been examples of the application of these critical ideas to specific situations. In a fascinating study Whittington & Balsamo (1998) used micro analysis of exchanges between nurses and patients in forensic settings following Foucault's conceptualisation of power and control in these services. Exchanges and the fluctuations in power were situated in the structures of authority and power that were the institution's, and reflected a need for control (from either party) and fear at its loss.

The main professions at work in psychiatric institutions are those of medicine and nursing; the latter are vastly more numerous; however typically they have much less power than the former. Morrall (1998) questions 'whether mental health nurses have control over their clinical practice or whether their work is susceptible to the dominance and hegemony of other mental health professionals (i.e. medicine)' (ibid., p.43). He argued that mental health nursing is inextricably bound up with psychiatry and its social control function.

> 'In the final analysis, the psychiatric nurse's role is at best apologist for the more obvious omnipotent features of psychiatry and the state. The primordial function of the psychiatric nurse in society is revealed as one of social control, however, when she or he engages the powers and directives of the law to force the non compliant to take medication [or] apply physical restraints on 'aggressive' in-patients' (Morrall 1998, p.121).

The Experience of Restraint and Seclusion

There have been studies that looked at the experience of restraint and/or seclusion by patients and by staff. A variety of qualitative methods are used to analyse the accounts of experience and practice that have been

gathered through survey, observation and interview; those that pertain to staff will be addressed first.

Staff experience

Marangos-Frost & Wells (2000) conducted an ethnographic study of the thoughts and feelings of 6 nurses who had been involved in restraint where they faced the dilemma of whether to restrain or not. They were interested in the decision making process, believing that they were based less on rational information gathering processes than on 'internalised morals, values and emotions which constitute normative-affective factors' (p.364). They identified four themes that played a part in the decision to restrain; these concerned the threat of harm, the availability of alternatives, conflicting roles and the context of the ward environment. The retrospective nature of the study, asking what thoughts and feelings occurred at the moment of the decision (an emotive time), ran the risk of eliciting what the participants thought they should have been considering. They also identified the potential power of the culture, structure and philosophy of the institution in decision making but did not investigate or explain how this could happen.

In a study conducted in regional secure units Lee et al. (2003) surveyed staff and found views on physical restraint that were different from those of patients and they called for more psychological interventions. 269 nursing staff completed questionnaires and 96% of these believed that there had been a *positive* outcome to the incidents in which they had most recently been involved. In spite of this, in a thematic analysis of 'qualitative responses', a third of participants identified a number of concerns. Participants described the damage that had been done both bodily and to relationships, regretting the demeaning and physically painful experience that patients endured. They also complained of a 'deck them first' attitude where physical restraint would be used too quickly. Though their findings are intriguing the process of analysis was not described so one is not able to see how the themes arose. It was outside the remit of their study but further examination of these attitudes and the factors that perpetuated their influence would have been valuable.

Morrison (1990a) gathered data through participant observation and interviews with staff and patients (analysed using grounded theory methodology) on a psychiatric ward. Her description centred on the culture, a 'tradition of toughness', in psychiatric settings that was dominated by 'control', with much of the discourse about patients being concerned with a lack of/being out of/gaining control. She found that staff were socialised into the need for physical restraint and seclusion as the means for ensuring control; staff who favoured or tried 'verbal therapeutic interventions' would be isolated and unsupported by their colleagues. Themes of restriction, surveillance and control were also central to a content analysis of mental health nurses' perceptions of their work by Hall (2004) with some participants believing such functions made a positive contribution to care, and others certain that they disrupted or precluded engagement in nurse patient relationships.

Staff and Patient Experience

Themes of control were central to Hinsby & Baker's (2004) grounded theory analysis of staff and patients' accounts of violence in a medium secure unit. They discussed paternalism, segregation, autonomy (for patients and staff) and the construction of identities all of which were related to elements of control. The authors allude to discursive constructions that could allow a different analysis of the language used to construct this 'control' but do not expand on this in their paper.

Alty & Mason (1994) looked at patients' views regarding physical intervention (that included seclusion) and found that nurses did not describe the experience as being as traumatic as patients do. However, Bonner et al. (2002) reported that physical intervention can be traumatic for all those who are involved. They interviewed staff and patients following incidents of physical restraint and found that both groups talked of re-experiencing trauma (previous violence or sexual trauma). The report of their content analysis does not give detail, and their treatment of data did not seem even handed as the fear and embarrassment expressed by patients was altered (perhaps minimised) by a belief that 'in some cases these emotions were exacerbated by paranoid ideas about the ward staff' (p.468). The same was not expressed with regard to staff accounts.

Patient experience

Wynn (2004) interviewed psychiatric inpatients about their experiences of restraint and his qualitative (grounded theory) analysis identified a negative impact on staff patient relationships and a need for debriefing after incidents. His participants talked of how restraint was used as a means of demonstrating power and regaining control, though they gave varying accounts of whether this was legitimate or not. In Wynn (2004) and in Gallop et al. (1999) people who had experienced abuse previously (typically but not exclusively women) re-experienced that trauma during restraint. This echoed the findings of Bonner et al. (2002) though Gallop et al. (1999) portrayed this as a crystallisation of a more general devaluing and dehumanising experience of hospitalisation.

There have been many calls for more 'collaborative' and 'psychological' methods of dealing with violence in psychiatric settings. Taxis (2002) reported perhaps the most marked success, with a reduction of 94% in incidents involving restraint and seclusion at a psychiatric unit in Texas, USA. This was achieved through consensus building, education, environmental and administrative alterations over a 42 month period, though the detail is scant and the explanation for the change is limited. Interestingly Taxis notes the parallel process of empowered staff (more freedom to direct the course and nature of their work) being more open to empowering patients through the use of less controlling and more collaborative, reflective interventions. Unfortunately the process by which this change in culture (rather than just practice) happened and how it could be maintained are not elucidated.

Some of those interventions described by Taxis (2002) fall within common descriptions of 'anger management' techniques, cognitive and behavioural strategies that 'teach' ways of thinking about and responding to situations

that provoke anger. Lewis (2002) produced a case study and critique of restraint in light of 'anger management' interventions. Despite the jargon of the 'treatment' that the man in the case study received, Lewis made valuable points regarding the need to explore 'the client's experience of oppression, invasion, privacy and criticism' (ibid. p.61) and the therapeutic nature of being able to express anger. He suggested that there should be a move away from ideologies that treat disturbing behaviour as being maladaptive, but as with calls for 'cultural changes' elsewhere the process is not described. Language is central to change or perpetuation of social conditions and analysis of such discourses could elucidate those processes.

It is generally accepted that restraint should be used as little as possible (e.g. Royal College of Psychiatrists 1998); it is hoped that advances in the understanding of the phenomenon will aid this reduction.

Secure Services

Secure services perform several (sometimes conflicting) functions; providing therapy and rehabilitation, protecting the general public, managing 'risk' and conducting assessments for court purposes; 'Nurses attempt to fulfil an impossibly hybrid role, with the apparently mutually exclusive tasks of therapy and security competing with each other' (Burrow 1998: 183). The 'security' comes from physical measures, (locks, high fences, fixed furniture in some areas, unbreakable windows, etc) restrictions on potentially hazardous activities (e.g. use of sharp knives in food preparation) and potentially high levels of observation and supervision through staff to patient ratios. Staff within these services are given training in the use of restraint and seclusion (and other strategies for 'aggression management' such as de-escalation).

Secure services for people with learning disabilities

People with learning disabilities have been found to be at greater risk of developing mental health problems than the general population (Dosen & Day 2001). High rates of physical violence have been found in populations with learning disabilities in community settings (Allen 2000) and forensic settings (McMillan et al. 2004). Psychiatric services for this population are provided by both generic (adult mental health) and specialised (people with learning disabilities) settings, though the latter are typically considered more appropriate and positive from the perspective of users and carers (Longo & Scior 2004).

Though people with learning disabilities are overrepresented in secure service settings, there is a dearth of research regarding practice in services and the experience of the same (Hodgins & Muller-Isberner 2000). As a result of this there is an over reliance on pharmacological treatment to 'control the behaviour of the mentally retarded' (ibid. p.159). Busch & Shore (2000) found that people with 'mental retardation' were more likely to experience restraint and seclusion than many other patient groups. However research on this subject with this population is limited.

Restraint and seclusion for people with learning disabilities

Stirling & McHugh (1997) provided a critique of control and restraint techniques in the management of violence for people with learning disabilities. They accused services of inappropriate focus on psychiatric practice rather than those for people with learning disabilities. They stated that they are reactive practices with no theoretical framework for professional use, and criticised the pain and discomfort inherent in these techniques and proposed a 'non-aversive' therapeutic holding approach. In their examination of different types of training for physical intervention Murphy et al. (2003) identified the need for studies of effectiveness, claiming there was no clear leader and that inconsistencies in type and level of training compounded the problem.

It has been suggested that the 'management' of people with learning disabilities in forensic settings would be very much the same as for mentally disordered offenders in general; 'however, some of the techniques used may have to be adapted to take into account cognitive and physical abilities' (Turnbull 2000: 86), though these are not expanded to give any detail. He also comments that as training is dictated by local (rather than national) policy 'this has lead to a wide variety of methods being taught, from the use of wrist locks in some establishments to the alternative, more dignified wrist holds in others' (Turnbull 2000: 87).

More recently, working with the Department of Health, the British Institute for Learning Disabilities (BILD) has published *Guidance on Restrictive Physical Interventions for People with Learning Disability and Autistic Spectrum Disorder, in Health, Education and Social Care Settings* (Department of Health 2002). As statutory guidance this required relevant services to have specific policies and procedures in place, and staff to have 'approved training', in order to deal with 'behavioural episodes'. Documents such as this also gave credence to particular terms of reference in relation to behaviour and the need to intervene to restrict it, though the power of 'guidance' in this regard has not been investigated.

Three qualitative research studies investigated restraint and seclusion with people with learning disabilities. As with the qualitative studies outlined above the focus was on investigating experience using grounded theory or phenomenological approaches. Fish & Culshaw (2005) interviewed staff and patients in a secure service for people with learning disabilities. Their findings echo those found elsewhere in that both parties spoke of their experiences as being traumatic and having longer term negative consequences; however the groups differed in their opinion as to whether or not physical interventions were a 'last resort'. Hawkins et al. (2005) also interviewed staff and clients (in community settings) about their experience of restraint. They used grounded theory methods to analyse the accounts of diverse experience; they found themes that included emotional upheaval on the part of the staff (such as worry about 'getting it right') and confusion and pain on the part of the clients (even though the techniques used were stated to be 'non-pain compliance approach to physical intervention'). They recommended measures to debrief clients and help them understand why the restraint happened and, for staff, a need for skills in self regulation and self awareness. Sequiera & Halstead (2001) interviewed five women with learning disabilities about their experience of the emergency procedures (which also included rapid tranquilisation with sedative medication). The

women gave accounts of their emotional experience of pain anger and resentment that were rich, and suitable for qualitative analysis. There are very few studies that are based on the discourse of people with learning disabilities; in this regard these three studies provide encouragement.

Further research

The quantitative research reviewed above demonstrates the prevalence of the practices of restraint and seclusion in a number of psychiatric settings. The qualitative studies use phenomenological and grounded theory methodologies to describe the experience and impact of the practices; these are overwhelmingly negative for both staff and patients. There are a number of parallel lines of enquiry that could be addressed that look at experience in different settings for specific populations and services. However it seems unlikely that this will answer questions concerned with understanding how this unsatisfactory situation is maintained and what opportunities there might be for change.

Several studies commented on the culture within institutions and how restraint and seclusion become part of institutional practices, and several reported the language and terminology used within these settings to describe action and attitude; however, this language has not been investigated systematically. If institutions are powerful repositories of discursive practices (Alty & Mason 1984; Morrall 1998) then the Foucauldian analysis they advocate, the attention to the power of language and its effects, will aid the understanding of how this situation is perpetuated. It is perhaps naïve to expect that one day there will be no need for physical intervention to deal with violence in inpatient settings; yet it is hoped that better understanding of interactions of power, language and culture will encourage a move in this direction.

References

Allen, D. 2000. Recent research on physical aggression in persons with intellectual disability: An overview. Journal of Intellectual and Developmental Disability. 25 (1): 41-57.

Alty, A. & Mason, T. 1994. Seclusion and Mental Health: a break with the past. London: Chapman Hall.

Blofeld, J. 2003. Independent Inquiry into the death of David Bennett. Cambridge: Norfolk, Suffolk and Cambridgeshire Strategic Health Authority.

Blom-Cooper, L., Brown, M., Dolan, R. & Murphy, E. 1992. Report of the Committee of Inquiry into Complaints about Ashworth Hospital. London: HMSO.

Bonner, G., Lowe, T., Rawcliffe, D. & Wellman, N. 2002. Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. Journal of Psychiatric and Mental Health Nursing. 9: 465-473.

Burrow, S. 1998. Therapy versus security: Reconciling healing and damnation. In: Mason, T. & Mercer, D. *Critical Perspectives in Forensic Care: Inside Out*. London: Macmillan.

Busch, A., B. & Shore, M., F. 2000. 'Seclusion and restraint: A review of recent literature'. Harvard Review of Psychiatry. 8: 261-270.

Cormac, I., Russell, I. & Ferriter, M. 2005. Review of seclusion policies in high secure hospitals and medium secure units in England, Scotland and Wales. Journal of Psychiatric and Mental Health Nursing. 12: 380-382.

Crenshaw, W. B., Cain, K. A. & Francis, P. S. 1997. An updated national survey on seclusion and restraint. Psychiatric Services. 48 (3): 395-7.

Department of Health and Social Security 1988. Violence to Staff: Report of the NHS Advisory Committee on violence to staff. London: HMSO.

Department of Health and the Welsh Office 1999. Code of Practice of the Mental Health Act 1983. London: HMSO.

Department of Health 2002. Guidance on Restrictive Physical Interventions for People with Learning Disability and Autistic Spectrum Disorder, in Health, Education and Social Care Settings. London: Department of Health Publications.

Dosen, A. & Day, K. (Eds.) 2001. Treating Mental Illness in Children and Adults with Mental Retardation. Washington, DC: American Psychiatric Press.

Exworthy, T., Mohan, D., Hindley, N. & Basson, J. 2001. Seclusion: punitive or protective. Journal of Forensic Psychiatry. 12 (2): 423-33.

Fennell, P. 1996. Treatment without Consent: Law, psychiatry and the treatment of mentally disordered people since 1845. London: Routledge.

Fish, R. & Culshaw, E. 2005. The last resort?: Staff and client perspectives on physical intervention. Journal of Intellectual Disabilities. 9(2): 93-107.

Gallop, R., McCay, E., Guha, M. & Khan, P. 1999. The experience of hospitalisation and restraint of women who have a history of childhood sexual abuse. Health Care for Women International. 20: 401-416.

Goffman, E. 1961. Asylums. Harmondsworth: Penguin.

Gournay, K., Ward, M., Thornicroft, G. & Wright, S. 1998. Crisis in the capital: Inpatient care in inner London. Mental Health Practice. 1: 10-18.

Gudjonsson, G., Rabe-Hesketh, S. & Wilson, C. 2000. Violent incidents on a medium secure unit: the target of assaults and the management of incidents. Journal of Forensic Psychiatry, 11 (1), 105-118.

Hall, J. E. 2004. Restriction and control: The perceptions of metal health nurses in a UK acute inpatient setting. Issues in Mental Health Nursing. 25: 539-552.

Hawkins, S; Allen, D. & Jenkins, R. 2005. The use of physical interventions with people with intellectual disabilities and challenging behaviour – the experiences of service users and staff members. Journal of Applied Research in Intellectual Disabilities. 18: 19-34.

Hinsby, K. & Baker, M. 2004. Patient and nurse accounts of violent incidents in a medium secure unit. Journal of Psychiatric and Mental Health Nursing. 11: 341-347.

Hodgins, S. & Muller-Isberner, R. 2000. Violence, Crime and Mentally Disordered Offenders. Chichester: Wiley.

Irwin, A. 2006. The nurse's role in the management of aggression. Journal of Psychiatric and Mental Health Nursing. 13: 309-318.

Lee, S., Gray, R., Gournay, K., Wright, S., Parr, A. –M. & Sayer, J. 2003. Views of nursing staff on the use of physical restraint. Journal of Psychiatric and Mental Health Nursing. 10: 425-430.

Lewis, D. M. 2002. Responding to a violent incident: physical restraint or anger management as therapeutic interventions. Journal of Psychiatric and Mental Health Nursing. 9: 57-63.

Longo, S. & Scior, K. 2004. In-patient psychiatric care for individuals with intellectual disabilities: The service users' and carers' perspectives. Journal of Mental Health. 13(2): 211-221.

McDougall, T. 1996. Physical Restraint: A review of the literature. Psychiatric Care. 3: 132-137.

McMillan, D., Hastings, R. & Coldwell, J. 2004. Clinical and actuarial prediction of physical violence in a forensic intellectual disability hospital. Journal of Applied Research in Intellectual Disabilities. 17: 255-265.

Marangos-Frost, S. & Wells, D. 2000. Psychiatric nurses' thoughts and feelings about restraint use: a decision dilemma. Journal of Advanced Nursing. 31 (2): 362-369.

Masson, J. 1990. Against Therapy. London: Fontana.

Mental Health Act 1983. c.20. London: HMSO (Statute).

Morrall, P. 1998. Mental Health Nursing and Social Control. London: Whurr.

Morrison, E. F. 1990a. The tradition of toughness: A study of non-professional nursing care in psychiatric setting. Image: Journal of Nursing Scholarship. 22 (1): 32-38.

Murphy, G., Kelly-Pike, A., McGill, P., Jones, S. & Byatt, J 2003. Physical Interventions with people with learning disabilities: staff training and policy frameworks. Journal of Applied Research in Intellectual Disability. 16: 115-125.

National Institute for Clinical Excellence 2005. Violence: the short term management of disturbed/violent behaviour in inpatient psychiatric settings and emergency departments. London: NICE.

Prins, H., Backer-Holst, T., Francis, E. & Keitch, I. 1993. Report of the Committee of Enquiry into the Death in Broadmoor Hospital of Orville Blackwood and a Review of the Deaths of Two Other Afro-Caribbean Patients: 'Big Black and Dangerous'. London: SHSA.

Ritchie, S. 1985. Report to the Secretary of State for Social Services concerning the death of Mr. Michael Martin. London: SHSA.

Royal College of Psychiatrists 1998. Management of Imminent Violence: Occasional Paper OP41. London: Royal College of Psychiatrists.

Ryan, C. J. & Bowers, L. 2005. Coercive manoeuvres in a psychiatric intensive care unit. Journal of Psychiatric and Mental Health Nursing. 12:695-702.

Sailas, E. & Fenton, M. 2001. Seclusion and restraint for people with severe mental illnesses (Cochrane Review). In: the Cochrane Library, Issue 1, 2004. Chichester, UK: John Wiley & Sons Ltd.

Salib, E., Ahmed, A.G. & Cope, M. 1998. Practice of seclusion: A five year retrospective review in North Cheshire. Medicine, Science and the Law. 38 (4): 321-327.

Sequiera, H. & Halstead, S. 2001. "Is it meant to hurt, is it?": Management of violence in women with developmental disabilities. Violence Against Women. 7 (4): 462-476.

Shepherd, M, & Lavender, T. 1999. Putting aggression into context: An investigation into contextual factors influencing the rate of aggressive incidents in a psychiatric hospital. Journal of Mental Health. 8 (2): 159-170.

Stirling, C. & McHugh, A. 1997. Natural therapeutic holding: a non-aversive alternative to the use of control and restraint in the management of violence for people with learning disabilities. Journal of Advanced Nursing. 26: 304-311.

Swett, C. 1994. Inpatient seclusion: Description and causes. Bulletin of the American Academy of Psychiatry and Law, 22, 421-430.

Szasz, T. 1994. Cruel Compassion: Psychiatric control of society's unwanted. Chichester: Wiley.

Taxis, J. C. 2002. Ethics and praxis: Alternative strategies to physical restraint and seclusion in a psychiatric setting. Issues in Mental Health Nursing. 23: 157-170.

Turnbull, A. 2000. Working with learning disabled offenders. In Chris Chaloner & Michael Coffey (Eds.) Forensic Mental Health Nursing: Current Approaches. Oxford: Blackwell Science.

Walsh, E. & Randall, B. 1995. Seclusion and restraint: What do we need to know? Journal of Child and Adolescent Psychiatric Nursing. 5 (4): 28-40.

Way, B. B. & Banks, S. M. 1990. Use of seclusion and restraint in public psychiatric hospitals: Patient characteristics and facility effects. Hospital and Community Psychiatry. 41 (1): 257-261.

Whittington, R. & Balsamo, D. 1998. Violence: Fear and power. In T. Mason & D. Mercer: Critical perspectives in forensic care: inside out. London: Macmillan.

Winship, G. 2006. Further thoughts on the process of restraint. Journal of Psychiatric and Mental Health Nursing. 13: 55-60.

Wright, S. 1999. Physical restraint in the management of violence and aggression in in-patient settings: A review of issues. Journal of Mental Health. 8 (5): 459-472.

Wynn, R 2004. Psychiatric inpatients' experiences with restraint. The Journal of Forensic Psychiatry and Psychology. 15 (1): 124-144.