Commentary: A British Perspective on the Use of Restraint and Seclusion in Correctional Mental Health Care

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Policy and practice in the safe management of disturbed and violent behavior as applied in USA and UK correctional facilities is examined in this article. Certain differences emerge and are discussed, particularly relating to physical restraint. The paucity of evidence to support particular interventions is highlighted through a review of a UK systematic analysis of world literature on best practice.

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American colleagues may be reassured to know that clinicians in the United Kingdom also struggle with the safe management of disturbed or violent behavior in health care settings. The short-term management of violent and disturbed behavior (including use of seclusion and restraint) has been recently extensively examined by the National Institute for Health and Clinical Excellence (NICE).[1] NICE is the most authoritative body in the United Kingdom that produces clinical guidelines. Although not binding on clinicians, deviation from their guidance has to be justified on sound evidence. The NICE review involved and reported a systematic search and evaluation of the world's literature on short-term management of disturbed or violent behavior in inpatient psychiatric settings. The review concluded with authoritative guidelines on best clinical practice, separately published in short form.[2]

Terminology differs between the United States and the United Kingdom. The generic term prison is used for all correctional establishments in the United Kingdom and will be used in this commentary to refer to both prisons and jails as understood in the United States.

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Prison Health Care in the United Kingdom

Including all forms of imprisonment, the prison population in the United States in June 2006 stood at 2.2 million, whereas that in the United Kingdom was 81,000. These statistics translate to rates of 750 per 100,000 in the United States and 148 per 100,000 in England and Wales, a fivefold difference between jurisdictions.[3] The prison population in England and Wales is rising rapidly, however, with no discernible upper limit, due to changing attitudes toward crime and punishment, particularly the increasing use of indeterminate sentences for public protection (life sentences based on actuarial assessment of future risk). Policy and health care in prisons were radically reformed in the late 1990s.[4] Health care in prisons has since been the responsibility of the National Health Service (NHS), with health care in prisons commissioned, staffed, and funded by the NHS separate from the correctional system. Public policy on health care provision for prisoners states that those who require any prolonged period of inpatient care should be transferred out of prisons to a health facility within the NHS. There is a network of medium- and high-security forensic psychiatric facilities wholly within the NHS to meet this need (currently standing at around 3,000 places), with additional capacity within local psychiatric facilities. When transferred from prison to a health facility, a

mentally disordered prisoner is no longer subject to prison rules, security, or care.

Seclusion and Restraint in the Prisons of England and Wales

Mental health practice within prisons is governed by the principle of equivalence,[4] of which the stated aim is "to give prisoners access to the same quality and range of health care services as the general public receives from the National Health Service."[4] There are areas within British prisons that are designated as health care centers, which house inmates who present with disturbed or violent behavior. Employing the principle of equivalence, because these are not staffed, designed, or managed according to NHS standards, they are not considered hospitals equivalent to hospital facilities in community NHS practice. Health care staff are not responsible (unless dually trained) for the security/custody function within health care units. When restraint and seclusion are used, they are applied by prison correctional staff according to the standards and procedures of the prison.

English law does not allow for involuntary administration of medication to a prisoner who will not give consent to treatment. The administration of medication for restraint is considered unethical in U.K. clinical practice. This prohibition means that medication is not available as an alternative to seclusion or restraint in prison-based health care. For a minority of patients who may lack legal capacity, treatment under common law may be allowed.[5]

As in the United States, British prisons have high numbers of inmates with psychiatric morbidity. There is considerable public concern about the management of psychiatric disorder and particular concern about high rates of suicides in prisons. The NHS secure unit program does provide for diversion from prison to health care, but these facilities are limited in number, with length of stay measured in years, which means that prisons are left with a considerable number of disturbed, disordered, and potentially violent prisoner patients. There are about 750 transfers from prison to NHS inpatient units each year from a population of 81,000 in prison (with about 160,000 turnover per year). There is current debate about how best to tackle the extraordinary morbidity within prisons, with some advocates arguing for greatly expanded NHS hospital facilities and others calling for "hybrid" hospital-type facilities within prisons that could operate to a standard equivalent to those of their counterparts in the community.

The result of the debate is that the NICE guidance on short-term management of disturbed or violent behavior, which governs practice in community NHS hospitals, does not apply to health care facilities in prisons in England and Wales. This regulation is in contrast to the guidance published for U.S. correctional facilities. As an English observer of the U.S. system, I have concerns that the principle of equivalence may not be strictly adhered to in U.S. prisons. There is a risk in correctional facilities that compromises will be made on facilities, staffing, or training. In the United Kingdom, we would consider such a compromise to be such a risk that it would preclude the adoption of NHS standards for seclusion or restraint for prison health care unless there was a guarantee that the health care facilities in prisons were, indeed, strictly equivalent to community NHS hospitals in staffing, training, availability of treatments, and standards of facilities. Such equivalence is currently not the case. We see risks in having facilities that share health care and correctional staff employ different guidance for seclusion and restraint.

Notwithstanding this difference, in the rest of this commentary, I will make comparisons between the British NICE guidelines and the Center for Medicare and Medicaid Service rules for the use of seclusion and restraint, which I understand form the basis for the American Psychiatric Association "Resource Document on the Use of Restraint and Seclusion in Correctional Mental Health Care."[6]

A Note on Evidence

A strength of the National Institute for Clinical Excellence clinical guideline procedure is the systematic approach that is employed in assessing the strength of clinical evidence for practice. The assessment is done by means of classifying evidence on a four-point scale, depending on whether the evidence comes from case reports/expert opinion or from systematic meta-analyses or randomized controlled trials. On this basis, NICE rates the evidence for clinical guidance on the short-term management of disturbed or violent behavior as arising primarily from case report and expert opinion (lowest level of evidence). Their findings are cause for concern, in that

they can find only limited evidence for most interventions that we use. For example, in relation to physical interventions or seclusion, NICE guidelines state that "there is insufficient evidence to determine the effectiveness and safety of either physical interventions or seclusion for the short term management of disturbed/violent behavior in psychiatric inpatient settings."[2] Given the frequency and often catastrophic effects of violence in psychiatric settings, this is a sobering finding indeed. It means that practice in different jurisdictions may be determined more by cultural norms and physician opinion than by sound empirical evidence of effectiveness or safety.

The Structure of NICE Guidance

NICE guidance[2] is based on an algorithm that starts with prediction, then prevention, and finally interventions for continued management. Prediction includes risk assessment and searching. Prevention involves de-escalation techniques, observation, and other staff interventions. Prevention also includes the design, staffing, and physical construction of units, which can affect the baseline level of disturbance and violence in a psychiatric setting. As with the APA guidance, considerable emphasis is placed on training in accredited interventions and continuous retraining and rehearsal of accepted techniques. In what follows, I will concentrate mainly on the third limb—that is, the interventions for continuing management.

The NICE guidance[2] divides the interventions for continuing management into three types:

> Rapid tranquilization (the use of medication to calm or lightly sedate the patient to reduce the risk to self or others);
>
> Seclusion (defined in almost identical terms as that in the U.S. guidance);
>
> Physical intervention (which essentially involves manual holding and not physical restraints. Manual holding is defined as a skilled hands-on method of physical restraint, the purpose of which is to immobilize safely the individual concerned).

The guidance emphasizes that rapid tranquilization, physical intervention, and seclusion should only be considered once de-escalation and other preventive strategies have failed.

The guidance advocates using patients' advance directives to guide interventions. Patients are encouraged, when well, to engage in discussion on their preferences for different interventions should they become disturbed or violent and require intervention. Within the NICE guidance there is a preference for the use of rapid tranquilization before seclusion or physical intervention. It is by no means clear, however, that patients prefer the forced administration of medication over the use of seclusion or physical intervention. The increasing use of such advance directives is likely to alter clinical practice in the United Kingdom.

Some Differences

U.K. guidance is similar in most respects to policy in the United States. Several important differences stand out to this author.

The first is in the employment of physical interventions. In the United Kingdom, the physical interventions used in the short-term management of disturbed or violent behavior are essentially manual holding rather than mechanical devices. The use of mechanical restraint of any form in U.K. health care is almost unknown and is confined to particular specialist interventions in high-security settings. Thus, in the very detailed guidance provided by NICE, a U.S. reader may be intrigued to find that there are no guidelines given to clinical practice for the use of mechanical restraints, as in practice they are not used. Indeed, in U.K. prisons, mechanical restraints are rarely used; manual holding or seclusion is used most often to contain disturbed or violent behavior. The systematic review carried out by NICE concludes that there is no systematic evidence that gives preference to one means of physical intervention over another, which must mean that the difference between practice in the United Kingdom and the United States is determined by custom and practice or culture rather than by high-quality clinical evidence. The absence of use of mechanical restraint in U.K practice results in prolonged manual holding being employed, with its own ethics-related, technical, and safety considerations. In certain situations, it may also compromise the safe use of seclusion where patients may be at risk of injuring themselves in a confined space. A comparative study between U.S. and U.K. practices in managing disturbed or violent behavior would be an interesting exercise.

U.K clinicians would be startled to find that U.S. guidance on seclusion and restraint allows drugs to be used as a restraint. Such use of medication in the United Kingdom would be considered unethical and does not appear in NICE guidance. It would be interesting, however, to compare patients in the U.S. who receive medication for restraint with patients in the U.K. who receive rapid tranquilization. In practice, it may be that the U.S. approach is more honest in identifying the purpose of medicating patients in certain emergency situations.

Risk, Sudden Death, and Interventions

Several cases involving sudden death during physical intervention (manual holding) have heavily influenced clinical practice in the United Kingdom. One particular case has led to widespread debate about the safety of interventions in U.K. practice: that of the death of David Bennett.[7] Mr. Bennett died after being manually restrained for over half an hour in the prone position. The intervention was criticized by the inquiry team. What emerged from the inquiry was a sensitizing of staff to the idea that all methods of short-term management of disturbed or violent behavior have significant risks. Thus, the use of rapid tranquilization can, in certain situations, lead to sudden death due to cardiac arrhythmias. Prolonged manual interventions have been associated with death, with special concern that manual physical intervention in the prone position is particularly risky. This history led to the David Bennett inquiry team's recommendation that when manual physical restraint is employed, it should last for no more than three minutes. The systematic review carried out by NICE concluded that in the absence of controlled trials or other controlled studies, no recommendation could be made about the effectiveness, benefit, or harmfulness of seclusion or restraint. The review team did not find convincing evidence that restraint in the prone position results in effects likely to cause death, and thus sudden death in such circumstances must be influenced by other factors. The guidance does not, therefore, recommend any limit to time in manual restraint.

The NICE guidance[1,2] contains standards relating to availability of cardiopulmonary resuscitation in clinical settings in which rapid tranquilization, seclusion, or physical restraint interventions are used. The standard states that an emergency crash bag should be available within three minutes in health care settings where these interventions might be used. Staff involved in administering or prescribing rapid tranquilization should be competent in immediate life support (opening the airway, cardiopulmonary resuscitation, and use of defibrillators). For seclusion or physical interventions, staff is required to be trained in basic life support. It is unclear to this author whether U.S. guidance similarly sets such standards for health care staff in facilities managing violent or disturbed behavior.

Conclusions

There is much to be gained by having clinicians in the United States and the United Kingdom understand their respective guidance on the management of imminent violence in health care settings. There is much similarity between guidance in both countries and intriguing differences in practice, governed not by a sound evidence base but more by apparent culture or custom/practice. The NICE guidance document is particularly useful, in that it systematically reviews the world literature. Nevertheless, because of the paucity of high-quality evidence, the guidance necessarily relies on expert opinion. Both countries, correctly in my view, employ a principle of equivalence in relation to health care facilities in prisons. This principle leads to a conclusion within the APA document that standards used in health care facilities in the United States should be used within prison health care settings, while in the United Kingdom, an opposite conclusion is reached—namely, that in the absence of equivalent hospital facilities in prisons, health care standards for seclusion and restraint carry too great a risk to be routinely adopted in prison health care facilities. In the United Kingdom, the provision of health care in prisons is undergoing radical review, and the future shape of health care in U.K. prisons remains uncertain.

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