Royal College of Nursing consultation

Draft guidance on the minimisation of and alternatives to restrictive practices in health and adult social care, and special schools
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Preface

In 2011, BBC’s Panorama programme exposed an appalling catalogue of abuse at Winterbourne View, a private hospital for adults with learning disabilities and challenging behaviour. The programme rightly provoked outrage from service user groups, families, professionals and the wider community. Eleven staff were subsequently charged with criminal offences, with six receiving custodial sentences.

In his foreword to Transforming Care: A national response to Winterbourne View, Norman Lamb, Minster of State for Care and Support, wrote that “…as much as Winterbourne View fills us with sorrow and anger, it should also fire us up to pursue real change and improvement in the future.” Importantly, the report states that, whenever young people and adults with learning disabilities and challenging behaviour need specialist support, the default position should be that this support is provided in the person’s home through specialist community teams and services that use the best evidence on good practice.

Transforming Care listed a wide-ranging series of actions that need to be achieved for this objective to be realised. This guidance is one of a series of publications that will appear over the next year. The collective aim of which is to help deliver the quality of services that must be provided if further Winterbournes are to be avoided.

While triggered by concerns about a very specific service user group, these concerns are unfortunately not unique to that group. Though the needs of people with learning disabilities and behavioural challenges were at the forefront of the work described here, the principles and recommendations in this report are therefore applicable across all health and adult social care services, regardless of setting, and health staff working in children’s services. It also applies to educational staff working in special schools.

A catalogue of systemic failures was evident at Winterbourne, but the misuse of restraint and other physical interventions was central to much of the abusive practice seen. This report is a direct response to that abuse, and brings together the best contemporary evidence on the use of restrictive practices. In doing so, it sets the standard that services must reach in this difficult, but unfortunately sometimes necessary, element of care.
Key principles
This guidance is founded on a number of key principles. They underpin the need to make substantial reductions in the use of restrictive practices and to ensure that when, as a last resort they have to be used, it is in the least damaging manner:

- People’s human rights must be protected and honoured at all times.
- Understanding people’s behaviour allows their unique and individual needs to be identified and quality of life enhanced.
- Involvement and participation of service users, their families, carers and advocates is essential.
- People must be treated with compassion, dignity and kindness.
- Health and social care services must keep people safe and free from harm.
- Positive relationships between the people who deliver services and those they serve must be protected and preserved.

Key recommendations
This guidance requires service providers and commissioners to take action. The key actions are set out below.

It is inherent to the nature of some services that they support people whose needs and histories mean that it can reasonably be predicted that they may present with behaviours that place themselves and/or others at risk of harm. Examples of such services might include acute psychiatric settings (including secure services), residential units specialising in working with people who present with challenging behaviour, residential special schools for children with severe learning difficulties and challenging behaviour etc.

In such services:
1. Individuals who use services must have Behaviour Support Plans which include primary and secondary strategies which aim to prevent the use of restrictive practices.
2. Behaviour Support Plans must be put together in partnership with users of services and the people who know the person best.
3. Behaviour Support Plans must include details of individualised, bespoke proactive strategies, as well as reactive management strategies which possibly include restrictive practices. These must take account of service users’ unique circumstances.
4. Behaviour Support Plans should include broader consideration of the support/training needs of the person’s wider circle of support. This should include the needs of family members.
5. Wherever restrictive practices are included in a Behaviour Support Plan, it must be clear that:
   a. there must be a necessity to act in order to avoid harm to the person
   b. the nature of restrictive practices must be proportionate to the potential harm to the person
   c. the practice must be the least restrictive option that will meet the need
   d. any restriction should be imposed for no longer than absolutely necessary
   e. what is done, why and with what consequences must be recorded in an open and transparent manner.
6. In the event that a person using a service presents with an unpredicted behaviour that places themselves or others at risk, an unplanned restrictive practice may have to be used. The Behaviour Support Plan should subsequently be promptly updated to include contingencies in case of any recurrence as well as any necessary amendments to primary and secondary preventative strategies.
7. Services must ensure that reviews of Behaviour Support Plans are included within their internal audit programmes, it is good practice for audit processes to include ‘experts by experience’.
8. Commissioners of such services and placements must ensure that service providers have access to the knowledge and skills required to develop and deliver Behaviour Support Plans.
9. The Care Quality Commission (CQC) must seek assurances during service visits and reviews that people who are subjected to restrictive practices are supported by Behaviour Support Plans.

Restrictive practices sometimes need to be used in situations where service users, their histories and needs are not fully understood and therefore the manner of their application cannot be planned in advance. Examples might include a newly admitted service user who has had no previous contact with services, an emergency department where an altercation develops or a primary health care setting where a person aggressively resists an intervention. The following recommendations...
apply to all such settings, as well as those where Behaviour Support Plans are used:

10. All services need to have local policies that minimise the use of restrictive practices, as well as to ensuring that when they are used it is in a safe and ethically acceptable manner.

11. For the purposes of consistency, all policies should use the terminology contained in this document, in accordance with the definitions provided.

12. Services where staff are trained in the delivery of restrictive practices must have an overarching multi-component strategy to minimise their use.

13. Services must provide an annually updated, accessible document which summarises the use of restrictive practices in the service, outlines their training strategy, techniques used and reasons why. This must be available to users of services and their family carers.

14. Services providers must publish data on the use of each form of restrictive practice and plans for their reduction within their annual quality accounts, or equivalent document reporting on the quality and safety of their services.

15. Executive boards (or equivalent) should at least annually, review the incidences of restrictive practices, agree the training strategy and plans for reduction of restrictive practices, and monitor progress made.

16. Decisions as to what restrictive practice should be used in a given situation and for a specific individual, should take account of any underlying physical health conditions that increase the risk of harm resulting.

17. With regards to physical restraint:

   a. Floor holds (prone or supine) should be avoided and must not arise from the direct and intentional action by staff to forcibly control an individual on the floor as a means of coercion.

   b. Physical interventions and breakaway techniques must not involve the deliberate application of pain by staff, or as a result of the use of holds whereby movement by an individual will in itself induce pain.

   c. Physical restraint that impacts on an individual’s physiology by means of airway, breathing or circulation must be avoided.

   d. There should be no deliberate use of techniques whereby an individual is allowed to fall, unsupported, to the floor.

   e. An individual’s physical condition must be monitored closely throughout any period of restraint in order to minimise the potential of harm or injury.

   f. A member of the care team must monitor the individual’s airway at all times, if they raise concerns, restraint must stop immediately.

   g. Support staff should continue to monitor the individual for signs of immediate emotional/physical distress for a period of time (up to two hours) following the application of restraint.

   h. Support staff should communicate with the service users throughout any period of restraint in order to continually attempt to de-escalate the situation.

18. Whenever restrictive practices have been used the staff involved and the service user, their families and carers (if appropriate and available), should be invited to take part in a supportive debriefing and post incident review process.

19. In order to deliver the recommendations of this guidance all health and social care staff will require training, this must include:

   a. A focus on skills in crisis management, including alternatives to restrictive practices.

   b. Promoting attitudinal change among staff.

   c. Implementation of new models of care including Positive Behavioural Support.

Introduction

1. In 2012 the Department of Health published *Transforming Care: A national response to Winterbourne View Hospital*. This outlined key actions in response to the abuse and illegal practices witnessed at Winterbourne View Hospital as well as concerns that emerged from the subsequent Care Quality Commission (CQC) inspection of nearly 150 learning disability in-patient services. CQC inspections found evidence of uncertainty among providers regarding the use of restrictive physical interventions, with some services having an over-reliance on the use of ‘restraint’ rather than more proactive approaches such as positive behavioural support (PBS).

2. Failure of services to apply PBS, places people who present with challenging behaviours at heightened risk of detrimental responses such as:
a. exclusion from local services
b. people being moved to ‘out of area placements’
c. restricted access to meaningful daytime activities, employment, education or home support
d. exposure to seclusion, restrictive physical interventions, locked environments and in some cases abuse
e. hazardous clinical approaches such as inappropriate prescribing of medication, punitive responses to behaviour and management regimes that are so restrictive as to significantly impair an individual's quality of life; and
f. direct or indirect harm.

3. PBS is fundamentally about improving quality of life as well as meeting needs and reducing distress; it recognises that people engage in challenging behaviours because they have unmet needs, are exposed to environments and interactions which they find challenging and often have a generally impoverished quality of life. Much of the time, people’s behaviours represent a desperate attempt to meet their own otherwise unmet needs.

4. In response to growing concerns about physical interventions across all care sectors, the coalition Government committed the Department of Health (DH) to work with the CQC and external partners to review how providers record and monitor the use of restrictive interventions and to publish guidance on PBS with the aim of ensuring that physical interventions are only ever used as a last resort.

5. This new document replaces the 2002 DH and Department for Education and Skills guidance on the use of restrictive physical interventions in special schools, social and health care settings for people with learning disabilities and/or autistic spectrum conditions. It provides a road map by which to reduce inappropriate reliance on unnecessary and restrictive reactive management approaches through the delivery of PBS and organisational Restrictive Practice Reduction Programmes. Its scope is broader than the document it replaces in that it applies to:
   • all adult health and social care settings
   • all health staff working with children and young people
   • educational staff working in special schools; and
   • all service user groups regardless of health conditions and support needs.

The guidance is not intended to cover children’s social care settings or mainstream schools. It should be read in conjunction with Use of Reasonable Force. Advice for head teachers, staff and governing bodies which provides guidance for mainstream schools.

Aims of guidance

6. Commissioned by the Department of Health (DH), this guidance has been developed by the Royal College of Nursing (RCN) with the support of an expert reference group, and in liaison with a number of bodies who are working on aligned and corresponding guidance, notably; the Care Quality Commission (CQC), the National Institute for Clinical Excellence (NICE), NHS Protect, Skills for Care, and Skills for Health.

7. This guidance aims to:
   • reassure service users and their families that services are well informed regarding good practice and are delivered through a partnership approach, in which the person’s best interests are paramount at all times
   • provide guidance on the use of organisational models of restrictive practice reduction and Positive Behavioural Support (PBS) in order to bring about lasting reductions in the use of restrictive practices
   • ensure that when, as a demonstrable last resort, such interventions are required, that they are used in a transparent, legally valid and ethically stringent manner
   • assist health and social care staff, across a range of settings by promoting best practice principles; and
   • prevent the misuse and misapplication of restrictive practices.

Who should read this guidance?

8. This guidance applies across all adult health and social care settings, health care provision for children and young people and special schools. It has important implications for all such services and to all staff, practitioners, families and carers who support people who are either exposed to restrictive interventions, or are at risk of being so. It is of particular significance for individuals working with people with autistic spectrum conditions, learning disability, mental health conditions, dementia and / or personality disorder, but it is not limited to individuals with these conditions.
It is fully applicable to the care and support delivered by health and social care staff outside of traditional care settings, including in people's own homes, in the community, in prisons and police cells.

9. The guidance requires important actions to be taken by:
   - commissioners of health and social care services
   - directors of adult social services
   - directors of children's services
   - directors of nursing
   - service managers, governance leads and executive quality leads in health and social care services, across both statutory and third sectors
   - staff of all disciplines and degrees of seniority working in health and social care services
   - chairs (and members) of local safeguarding adults boards and safeguarding children boards
   - enforcement and inspection staff
   - those who provide training staff on the use of physical interventions
   - those who provide training in PBS
   - lecturers and teaching staff who deliver professional training to health and social care staff; and
   - academic and research staff.

10. The guidance will also be of interest to:
    - family carers and parents of people receiving services
    - people who use services
    - independent advocates and organisations
    - legal advocates; and
    - security staff working in health and social care settings.

This guidance does not specifically cover the police working in health and social care settings, although it may be of interest. It is good practice for health and social care providers, who may need to call on the police for support, to work together to promote de-escalation and support crisis management, in line with the forthcoming Crisis Care Concordat, which is currently in preparation by the DH. It is important to note that if the police are invited onto health and social care premises the lead health or social care worker is still responsible for handling the situation.

People in police custody, prison, young offender institutions, high secure hospitals and restricted patients

11. This guidance also applies to health and adult social care staff working in non-health settings such as police cells, immigration removal centres and prisons. It does not however apply to staff from other professions eg the police, prison officers or security staff.

12. It is important to note that health care centres in prisons or youth detention accommodation come under their own respective rules and regulations and control and order of young people in healthcare centres is ultimately the responsibility of the governor/director, or person in charge of the establishment.

13. It is not expected that health and social care staff would use formal restraint techniques on prisoners or detained patients under their care. It is however accepted that there may be occasions when staff working in healthcare centres in prisons or youth detention accommodation and in high secure hospitals may need to resort to personal protection methods as a last resort when they cannot get away and where they would be acting in self-defence. Further guidance on what is appropriate for restricted patients is included in the Mental Health Act (1983) Code of Practice.

14. Health and adult social care staff should have a clear local protocol about when the police are called in to support with handling a crisis situation and that when they are called in the health and social care staff retain the duty of care for the person. The police are proposing improved training to deal with such situations. It is expected that the local protocol will set out that the police will only be called as a last resort and therefore the police will use the appropriate methods for the situation.
Whole service approaches to minimising restrictive practices

15. Recovery based approaches have been successfully embedded into many modern mental health services although have much broader applicability across health and social care services for people with other presenting needs. They are founded on the principle that recovery is possible for all people i.e that everyone can achieve satisfying and fulfilling lives, in accordance with their own preferences, goals and aims, through the processes of empowerment and self-determination and unconditional engagement within wider communities and society more generally. Recovery means working in partnership with service users to improve both their clinical and social outcomes. Recovery models are entirely consistent with other contemporary philosophies such as those that drive learning disability services and which are inherent to PBS; the promotion of human rights based approaches, enhancing personal independence, promoting and honouring choices and increasing social inclusion. International literature on seclusion and restraint reduction is also clear that the recovery approach both demands a reduction in the use of restrictive interventions carried out against a person’s wishes and that it is in turn an essential component in achieving such outcomes.

16. A number of recent studies have shown that it is possible to achieve significant reductions in the rate of restrictive practices through an organisational commitment to changing the approach to aggression violence management. A thorough knowledge review conducted by the Irish Mental Health Commission in 2012 explored a broad range of such models and found nine consistent components of programmes to reduce the use of restrictive practices:

• Government level support.
• Policy and regulation changes.
• Service user, family and advocate involvement.
• Leadership.
• Training and education.

• Staffing changes.
• Using data to monitor restraint episodes.
• Review procedures and debriefing.
• Medication.

17. The Safewards model has also shown impressive reductions in incidents of conflict in acute mental health setting; consequently the use of physical restraint, seclusion and rapid tranquillisation also reduced. The model includes a range of approaches by which routines and environments can be modified, flashpoints avoided, de-escalation achieved and alternatives to restrictive interventions consolidated into practice.

18. Despite originating from the field of learning disabilities, PBS has demonstrated a wider applicability and its introduction in a systematic, organisation wide context is an important mechanism by which to deliver many of the key elements associated with restrictive practice reduction models:

• The provision of effective leadership;
• The involvement of service users, their families and advocates;
• The development of capable environments and effective programmatic structures;
• The provision of clear crisis management strategies;
• Attention to mediator variables and training;
• Learning from critical incidents and
• Data-driven quality assurance.

19. All health and social care services where staff are trained in the delivery of restrictive practices must have an overarching multi component strategy for restrictive practice reduction/minimisation based on models such as those identified above. These should be informed through quarterly reporting and must be reviewed at executive board level or equivalent, at least annually.

20. Where on the basis of history and assessed needs, it can predicted that service users are likely to present with behaviours that might lead to the application of restrictive practices, reactive management strategies must be incorporated into the context of an overarching Behaviour Support Plan. This should also contain a range of proactive strategies, in keeping with the principles of PBS.
Positive behavioural support

21. PBS has recently been defined as:
*A multicomponent framework
a) for developing an understanding of the challenging behaviour displayed by an individual, based on an assessment of the social and physical environment and broader context within which it occurs,
b) with the inclusion of stakeholder perspectives and involvement and
c) using this understanding to develop, implement and evaluate the effectiveness of a personalised and enduring system of support
d) that enhances quality of life outcomes for the focal person and other stakeholders*.

22. PBS is an approach which incorporates the safe use of reactive strategies (possibly including restrictive practices) alongside a broad array of targeted, proactive primary and secondary preventative approaches. The sole purpose of any reactive strategy is considered to be nothing more than to make a situation safe and return a person to a state where they can resume engagement in their regular lifestyle. A considerable evidence base has emerged over recent decades, which shows the clear benefits of PBS as a strategy in terms of enhancing the quality of life of service users and also reducing challenging behaviours.

Understanding behaviour in order to meet needs and enhance quality of life

23. PBS aims to enhance a person’s quality of life, ensure that otherwise unmet needs are better met and to reduce the impact of their challenging behaviour. This is achieved by applying a number of concurrent and complementary strategies:
- Using person centred, values based, approaches to ensure the person is living the best life they possibly can. This involves assisting a person to develop personal relationships, improve their health, to be more active in their community and to develop personally. When done properly, person centred planning processes ensure that those who support service users get to know them as individuals.
- Skilled assessment in order to understand probable reasons why a person presents behaviours of concern; what predicts their occurrence and what factors maintain and sustain them (this is area of assessment is often referred to as a functional assessment). This requires consideration of a range of contextual factors including personal constitutional factors, mental and physical health, communication skills and the person’s ability to influence the world around them. Patterns of behaviour provide important data, skilled analysis of which enables key areas of unmet need to be elucidated.
- The use of written Behaviour Support Plans which have been informed by a robust assessment in order to ensure a consistent and shared proactive approach to meeting the person’s needs, that challenging environments are remediated, that quality of life is enhanced and that wherever possible people are supported to develop alternative approaches by which they can better meet their own needs. These are sometimes referred to as primary preventative strategies.
- The Behaviour Support Plan also details the responses such as de-escalation techniques, to be used by carers/supporters when a person starts to become anxious, aroused or distressed. These are often referred to as secondary preventative strategies and aim to promote relaxation and avert any further escalation or crisis.
- The Behaviour Support Plan also details those reactive strategies to be used when the person’s agitation further escalates to the point where behaviours are presented which place either themselves or others at significant risk of harm. These may include the use of restrictive practices.

24. NHS Protect Guidance Meeting Needs and Reducing Distress – Guidance on the prevention and management of clinically related challenging behaviour in NHS Settings provides a comprehensive review of wide ranging strategies and contextual factors which are essential for the delivery of high quality, compassionate, personalised care to service users who present with challenging behaviour. Its guiding principles clearly have broader applicability outside of the NHS for all social and health care providers.
25. **Forthcoming NICE guidance** (due for publication in 2015) on challenging behaviour and learning disabilities will provide a comprehensive review of the evidence base and principles for delivering lasting behavioural change. It will clearly articulate those assessment and intervention strategies that have the greatest efficacy and efficiency. This will have direct implications for the practices used within health care services (both hospital and community based) but will also identify key principles which have equal relevance across social care provision.

**Ethical foundations of PBS**

26. In the face of conclusive evidence in support of the use of PBS, it is not acceptable for any service user to be repeatedly exposed to restrictive practices in the absence of robust and regularly reviewed, individualised Behaviour Support Plans.

27. Given that restrictive practices should only ever be used as a last resort, individualised support plans detailing both primary and secondary preventative strategies should be put in place for service users presenting with challenging behaviours.

28. Effective delivery of PBS requires a collaborative partnership between service providers, families and service users. All approaches including those around audit and quality assurance should be fully inclusive.

29. As is the case for any form of care and support planning, Behaviour Support Plans should ordinarily only be implemented with the consent of service users. If service users are assessed to lack the capacity in accordance with the provisions of the Mental Capacity Act (2005) and associated Code of Practice, this should be fully documented and best interests decision making processes used to determine the appropriate content of a Behaviour Support Plan.

30. Where Behaviour Support Plans are delivered to a service user who is detained under the Mental Health Act (1983), as a component part of a broader treatment plan for mental disorder (within the meaning of section 1 of the Act), this should clearly be recorded as such within the person’s notes.

**Ensuring high quality behaviour support**

31. Positive and well-designed Behaviour Support Plans can significantly enhance service users’ quality of life and bring about considerable reductions of behaviours that otherwise, all too often, lead to the use of restrictive practices. Conversely, badly designed or poorly implemented Behaviour Support Plans can give rise to hazardous adverse effects. These can include traumatisation of service users and exacerbation of behavioural presentations. Service providers need to undertake robust training needs analyses in order to ensure that they develop and sustain the necessary knowledge and skills to deliver effective Behaviour Support Plans.

32. Any commissioner who funds placements for people who are known to present with challenging behaviours must assure themselves that the service has the necessary competencies to provide effective support. This must include ensuring that the person has access to the range of specialist skills necessary to formulate effective Behaviour Support Plans; these may be found either in-house, or may be available on a consultative or peripatetic basis. The Challenging Behaviour National Strategy Group has produced a range of publications to help commissioners to know what is required.

33. Commissioners of specialist community based services must assure themselves that, in accordance with the needs of the local population, there is adequate provision of specialist services within any locality to provide the skilled assessments that are needed to develop effective Behaviour Support Plans. This will likely mean commissioning specialist peripatetic or consultative, community based support teams.

34. During service visits and reviews (including regulatory inspections of service quality), the CQC will seek to assure themselves that people who are exposed to restrictive practices have access to high quality Behaviour Support Plans, designed, implemented and reviewed by staff with the necessary skills.

35. Wherever restrictive interventions are used, reviews of the quality of design and application of Behaviour Support Plans should be included within service providers’ internal audit programmes (including the use of experts...
by experience). These audits should inform broader organisational ‘restrictive practice reduction strategies’.

The role of de-escalation strategies

36. De-escalation has been defined as:

The gradual resolution of a potentially violent and/or aggressive situation through the use of verbal and physical expressions of empathy, alliance and non-confrontational limit setting that is based on respect.

37. De-escalation refers to a range of psychosocial approaches and skills that are employed as secondary preventative strategies where a person begins to show signs of agitation and arousal that are believed to be predictive of an impending episode of high risk behaviours. Most de-escalation strategies are verbal in nature, they inherently avoid confrontation and may, on occasions, include prompts to service users to move to a low stimulus, private, relaxing area designated for this purpose (there is no compulsion to go to or to remain in such areas and low stimulus areas are in no way analogous to seclusion).

38. De-escalation strategies should be individualised and seek to promote relaxation. Approaches typically involve establishing rapport and the need for mutual cooperation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting into alternate pleasurable activities and being sensitive to non-verbal communication. Each of these strategies aligns naturally to PBS. In other instances manipulation of the sensory environment may help to promote calming.

39. The sole purpose of de-escalation is to defuse and render the situation safe. It is not appropriate to forensically interrogate or debate the legitimacy of the reasons that a person has become upset or agitated. Placing demands on people, telling them to stop or telling them that restricted approaches will be used if they do not desist are seldom helpful; verbal exchanges, appropriate to the person’s level of understanding, which acknowledge people’s state of distress and upset are far more constructive.

Breakaway techniques

40. Breakaway techniques comprise a range of physical skills by which a person can disengage from another person’s grip/grasp. In accordance with current NICE guidance, breakaway training is currently routinely delivered to health and social care staff and is regularly refreshed. The forthcoming NICE guidance (scheduled for publication in 2015) is likely to provide further clarity as to what should be taught, to whom and how.

41. Current NICE guidance states that ‘the deliberate application of pain has no therapeutic value and can only be justified for the immediate rescue of staff, service users and others’. In some instances breakaway techniques have historically included the use of brief painful stimuli in order to distract people and thereby render escape from a grip easier. Techniques using the application of pain should no longer be used, and this should be made clear in local policies.

A human rights based approach

42. The use of restrictive practices must be lawful. For providers to whom this guidance applies who are subject to the Human Rights Act (1998), lawfulness will necessarily include compliance with the European Convention on Human Rights (ECHR).

43. The use of restrictive practices must not breach a person’s rights under the ECHR, particularly:

- Article 5: right to liberty
- Article 3: prohibition on inhuman and degrading treatment; and
- Article 8: right to private life.

44. Article 5 is triggered when there is a deprivation of liberty. Restrictive practices restrict a person’s liberty, but may not necessarily be of a degree or intensity amounting to a deprivation of liberty. The difference between deprivation of and restrictions upon liberty is one of degree or intensity, and not one of nature or substance. Whether or not there is a deprivation of liberty turns on the individual circumstances of each case. The interpretation of ‘deprivation of liberty’ is evolving through judgments made by the European Court of Human Rights and UK courts.

45. Article 5(1) of the ECHR guarantees that a person may only be deprived of their liberty in certain circumstances, which include the
lawful detention of a person of ‘unsound mind’, and only if the deprivation of liberty has been authorised by a procedure prescribed in law. Article 5(4) requires that a detained person must be able to challenge the lawfulness of that detention before a court or tribunal.

46. A person can be lawfully detained for the purposes of Article 5 if:
• they are compulsorily detained under the Mental Health Act 1983; or
• if the person lacks capacity to consent to their admission or treatment, and will be kept in a hospital or care home, the deprivation of liberty has been authorised by the Mental Capacity Act 2005 under an authorisation given under Schedule A1 to that Act, or a Court of Protection order.

47. Article 3 of the ECHR prohibits inhuman or degrading treatment. The ill-treatment must reach a certain level of severity to fall within the scope of Article 3 – this level depends on all the circumstances of the case, such as the duration of the practice, its effects and the patient’s particular characteristics. The use of forcible measures in respect of a detained hospital patient, which are not medically necessary, could amount to ill-treatment that breaches Article 3.

48. Practices that might fall within Article 3 include: automatic handcuffing of service users; the imposition of restrictive practices that are not justified by a patient’s history or current assessment; forcible measures that are not a medical necessity; or treatment that humiliates the person or arouses feelings of fear, anguish or inferiority.

49. Article 8 of the ECHR provides the right to respect for private and family life. Restrictive practices that do not meet the minimum level of severity for Article 3 may nevertheless breach a person’s article 8 rights if they have a sufficiently adverse effect on the person’s moral and physical integrity.

The lawful application of restrictive practices

50. It is essential that organisations and practitioners who impose restrictions on those in their care have a legal basis for doing so.

51. The application of restrictive practices could breach the European Convention on Human Rights. Applying a restrictive practice without consent, or lawful authority or excuse, could make individuals and their employers liable to civil and criminal actions for assault, battery, breach of contract, negligence, false imprisonment, ill treatment or neglect.

52. Statutory and common law defences may apply to the application of restrictive physical interventions. Reasonable force may be used for the purposes of self-defence, the defence of others, prevention of crime, lawful arrest or to protect property.

53. In order to be ‘reasonable’ in the circumstances, the force involved should be both necessary and proportionate. Force should only be used as a last resort.

54. These justifications and defences should not be relied on for the long-term planned use of restrictive physical interventions in respect of an individual.

55. The law in respect of issues relevant to restrictive practices, such as consent, capacity and deprivation of liberty, continues to evolve and services should therefore review and update their local policies on an ongoing basis in light of legal developments.

Selected relevant legislation

56. The legislative regimes mentioned below will be relevant when considering the lawful application of restrictive practices.

The Mental Health Act (1983)

57. The Mental Health Act (1983) (MHA) provides authority to lawfully detain and assess and treat individuals in hospital for mental disorder, whether or not they have capacity to consent to their admission or that treatment.

58. Any restrictive practice used must be necessary to protect the person or others.

59. The use of restrictive practices to treat a physical condition unrelated to the person’s mental disorder cannot be justified by their detention under the MHA. If the detained person has the capacity to consent to or refuse a restrictive practice, the restriction must be justifiable on the general grounds mentioned above. However, if the detained patient lacks the capacity to consent to or refuse a restrictive practice:
• and that practice does not amount to a deprivation of liberty, then section 5 of the Mental Capacity Act 2005 (MCA) may offer some protection from liability (except for
negligence), if the conditions in section 6 of the MCA are met; or

- if that practice amounts to a deprivation of liberty, then such a deprivation of liberty would need to be authorised by the inherent jurisdiction of the High Court. This is because a person who is actually detained under the MHA is ineligible to be deprived of their liberty by the MCA.17,30

60. The MHA Code of Practice is clear that the purposes of applying restrictive interventions (where lesser interventions such as de-escalation have proved ineffective) are to:

- take immediate control of a dangerous situation
- end or reduce significantly the danger to the service user or others; and
- contain or limit the person’s freedom for no longer than is necessary.

61. The five key guiding principles established within the MHA Code are:

- **Purpose** principle – the Act must be used to minimise the undesirable effects of mental disorder by maximizing their safety and wellbeing (mental and physical) of patients, promoting recovery and protecting others from harm.

- **Least restrictive** principle – people taking action without a patient’s consent must attempt to keep to a minimum the restrictions they impose on the patient’s liberty.

- **Respect** principle – people taking decisions under the Act must recognize and respect each patient including their race, religion, culture, gender, age, sexual orientation and any disability.

- **Participation** principle – patients must be involved in their care as much as is practicable. The person’s family and other carers should be involved unless the service user does not want them to be (or there are other specific reasons as outlined in the Act).

- **Effectiveness, efficiency and equity** principle – this refers to the most appropriate use of resources to meet the needs of patients.

62. Service users who lack capacity to consent to admission or treatment, who do not meet the criteria for detention under the MHA, but who need to be deprived of their liberty in a hospital or care home, must be deprived of their liberty in accordance with the MCA17.

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**The Mental Capacity Act (2005)**

63. Services will be considering the MCA, the Code of Practice: Mental Capacity Act 200518 and the supplementary Deprivation of Liberty Safeguards Code of Practice27 in relation to services users who may lack capacity.

64. The MCA provides a legislative framework for decision-making for people aged 16 and over who lack the capacity to make specific decisions. A person is assumed to have capacity unless it is established they do not. Sections 1-3 will need to be considered in determining whether a person lacks capacity.

65. Section 5 provides protection from civil and criminal liability (except for negligence) if care and support staff undertake acts in connection with the care and treatment of people who lack capacity to consent if that act is in the person’s best interests.

66. Certain acts of restraint (ie restrictions on liberty not amounting to a deprivation of liberty) will be protected under section 5 if the conditions in section 6 are met. In relation to the physical interventions described in this guidance:

- The person proposing to apply the physical intervention must reasonably believe the service user lacks capacity to consent to the intervention, and that the intervention is in the service user’s best interests. A service user’s best interests must be assessed in accordance with section 4 of the MCA; and

- The person applying the physical intervention must reasonably believe that it is necessary in order to prevent harm to the service user; and

- The physical intervention is a proportionate response to:
  - The likelihood of the service user suffering harm, and
  - The seriousness of that harm.

67. The conditions in section 6 require that the intervention be necessary to prevent harm to the service user, not others. Interventions for the protection of others would need to be justified by reference to other statutory or common law powers or defences.

68. If proposed interventions are likely to amount to a deprivation of the service user’s liberty, this must first be lawfully authorised by detention under the MHA (see above) or authorisation by the MCA (see below).
69. Table 1 (below) provides examples of restrictive practices which should be taken into account when considering whether, in all the circumstances of the case, there is likely to be a deprivation of liberty that will need to be authorised under the MHA or MCA.

Table 1

<table>
<thead>
<tr>
<th>Examples of restrictive practices to be considered in determining whether or not there is a deprivation of liberty that requires authorisation</th>
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<tbody>
<tr>
<td>Restriction of movement:</td>
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<tr>
<td>• Using disproportionate physical intervention techniques.</td>
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<tr>
<td>• Tying limbs to chairs and beds.</td>
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<tr>
<td>• Arm splints.</td>
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<tr>
<td>• Strategic placing of furniture.</td>
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<tr>
<td>• Use of chairs or commodes with trays/tables.</td>
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<tr>
<td>• Tip back, or low bean bag type chairs.</td>
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<tr>
<td>• Mattresses on floors to prevent people getting up.</td>
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<td>• Harnesses.</td>
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<tr>
<td>Environmental restriction of circulation:</td>
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<tr>
<td>• Seclusion rooms.</td>
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<td>• Long term segregation.</td>
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<tr>
<td>Psychotropic medication</td>
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<td>• Excessive sedation.</td>
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</table>

Deprivation of Liberty Safeguards (DoLS)

70. To comply with Article 5(1) of the European Convention on Human Rights, a person can only be deprived of their liberty, without their consent, in accordance with a prescribed legal procedure. The Deprivation of Liberty Safeguards (DoLS) were incorporated in the MCA to ensure there is a legal procedure for authorising deprivations of liberty in hospitals and care homes for adults who lack capacity to consent to admission or treatment.

71. ‘Deprivation of liberty’ is given the same meaning in the MCA as in Article 5 of the European Convention on Human Rights. A deprivation of liberty is based on facts in every case. It is a question of degree of intensity. There is a distinction between a restriction of liberty and a deprivation of liberty. The DoLS apply where there is, or is likely to be, a deprivation of liberty (and therefore where Article 5 is relevant), not merely restrictions on liberty.

72. DoLS is the framework of procedural safeguards in the MCA comprising:
   • section 4A: a person may be deprived of their liberty under the MCA if this is authorised by an order of the Court of Protection or a DoL authorisation under Schedule A1
   • section 4B: while the Court of Protection is being asked to consider whether the deprivation of the person’s liberty under section 4A is authorised, there is authorisation of deprivation of liberty necessary to give the person life-sustaining treatment or prevent a serious deterioration in their condition
   • Schedule A1: the qualifying requirements and process for DoL authorisations to be put in place, and subsequently reviewed; and
   • Schedule 1A: the circumstances where the MCA (whether by an order of the Court of Protection or a DoL authorisation) cannot be used to deprive a person of their liberty.

73. Hospitals and care homes apply to their respective local authorities for DoL authorisations. The local authority is responsible for obtaining the assessments of whether the person meets the six qualifying requirements for a DoL authorisation.

74. A local authority can give a DoL authorisation subject to conditions. The local authority must review the DoL authorisation if asked. The local authority may terminate the DoL authorisation, vary conditions or change the reasons recorded for why the person meets the qualifying requirements for a DoL authorisation.

75. The Court of Protection’s jurisdiction is set out in the MCA. The court has the power to make orders in respect of people who lack mental capacity concerning a wide range of matters including their personal welfare and their financial affairs. The court can, as part of an order concerning a person’s welfare, authorise their deprivation of liberty. This can be in any setting (not just hospitals and care homes, which DoL authorisations can cover). However, the court may not make an order depriving a person of their liberty if the person is ineligible to be deprived of their liberty by the MCA under Schedule 1A.
Unacceptable de facto detention

76. In January 2013 the CQC highlighted concerns about cultures that persist where control and containment are prioritised over treatment and support, in this kind of service, users have been locked in, told that they would be detained if they attempted to leave, exposed to rigid and institutional ‘blanket rules’ (such as those around access to meals, opportunities to smoke, being allowed access or leave bedrooms only at specific times of day), not made aware of their liberties and the choices open to them and exposed to other unwarranted and unnecessary restrictions. They reported that during 20 per cent of inspections service users who were not subject to formal detention under the MHA were therefore being subjected to de facto detention of this nature.

77. This type of de facto detention is ethically unacceptable and can amount to an unlawful deprivation of liberty, which would be a violation of a service user’s human rights. Any service operating such regimes will be in clear breach of CQC requirements and may risk prosecution. Professionals of any discipline who are complicit in implementing such practices risk being removed from their respective professional registers and potential prosecution. All professionals have a duty to challenge such practices.

78. Executive Boards (or equivalent) of all NHS or local authority funded services have a responsibility to develop open and safe cultures through which all workers can execute their duty of care to speak up if they have concerns.

79. This guidance promotes the lawful and ethical use of restrictive practices alongside governance driven strategies to reduce organisational reliance upon them through the delivery of values based, person centred PBS.

Types of restrictive practices

80. The following taxonomy of restrictive practices, along with definitions, are intended to establish a common vocabulary for discussing restrictive practices. Subsequent sections consider their safe and ethical application.
81. Restrictive practices
Restrictive practices refer to ‘the implementation of any practice or practices that restrict an individual’s movement, liberty and/or freedom to act independently without coercion or consequence. Restrictive practices can take a number of forms which are defined below.

81.1. Restraint
The use of force, or the threat to use force, to make someone do something that they are resisting, or restrict a person’s freedom of movement, whether they are resisting or not.

- Restrictive physical interventions
  The use of force to control a person’s behaviour and can be employed using bodily contact or mechanical devises.

81.1.1. Physical restraint
Any direct physical contact, with or without resistance, where the intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

81.1.2. Clinical holding (sometimes known as therapeutic holding)
The use of physical holds to assist or support a person to receive medical care or treatment in situations where their behaviour may otherwise limit the ability to meet the person’s clinical needs, or where the person’s behaviour may present a safety risk to themselves, members of the care team or other accompanying persons.

81.1.3. Mechanical restraint
The use of a device to prevent, restrict or subdue movement of a person’s body, or part of the body, for the primary purpose of behavioural control.

- Chemical restraint
  The use of medication to control or subdue a person’s behaviour, be it regularly administered or ‘prescribed as required’ and where it is not prescribed by a registered medical practitioner for treating a formally identified physical or mental illness.

81.1.1. Forced medication
The administration of intramuscular medication by force or by definite psychological pressure, i.e. announcing intramuscular medication if medication is not taken orally at once.

81.1.2. Rapid tranquillisation
All medication given in the short-term management of disturbed/violent behaviour should be considered as part of rapid tranquillisation (including PRN medication taken from an agreed rapid tranquillisation protocol).

- Psychosocial restraint
  Psychosocial restraint is the use of coercive social or material sanctions, or verbal threat of those sanctions, in an attempt to moderate a person’s behaviour.

81.2. Seclusion
Seclusion refers to the confinement of a person alone, as an immediate response to severely disturbed behaviour, at any hour of the day or night, in an area from which the person’s egress is actively prevented through the deliberate actions of another person, or consequences thereof.

81.3. Long term segregation
Long term segregation refers to a situation where in order to control a sustained high risk of serious harm to others, which is an almost constant feature of their presentation, a service users is not allowed to mix freely with other people within the service.

Who is at risk of being exposed to restrictive practices?

82. Evidence suggests that variations in the use of restrictive practices are largely influenced by environmental, interpersonal and contextual factors. Unclear policy and guidelines, overcrowding, poor care environments, low or inflexible staff numbers, inexperienced staff, poor staff retention, poor information sharing and acuteness of service users’ presentations have all been implicated. Central to the restrictive practice reduction models outlined above and recommended within this guidance, is the need to deliver services in therapeutic environments and in accordance with the key principles contained in this document. Person centred, value based care which focuses on recovery and aims to enhance quality of life should be the experience of all service users, regardless of the challenges they may present.
83. There is a growing evidence base that suggests that some individuals are more at risk of being physically restrained than others, whether because of bio-physiological, interpersonal, situational or attitudinal factors. These groups include those with serious mental illness or learning disabilities, those from black and minority ethnic communities, those with a high body mass index; men age 30-40 years and young people (under the age of 20)\textsuperscript{32,33}.

84. Furthermore, variation in the use of restrictive interventions between different geographical districts has been reported and is likely to be due to a number of factors including: inconsistencies in seclusion and restraint practice; geographical variations in the prevalence and acuteness of mental health presentation; differences in eligibility criteria with services in some areas treating more acute service users; care environment design factors, such as the availability of intensive care and low-stimulus facilities; staff numbers, experience and training; the use of sedating psychotropic medication; the frequent or prolonged seclusion/restraint of one service user, distorting figures over a 12-month period; and cultural differences across services\textsuperscript{34,35}.

85. While the prime focus of this guidance is on reducing the need for and use of restrictive practices, it is recognised that where a person’s behaviour places themselves or others at imminent risk of significant harm and de-escalation strategies have not prevented a crisis, a restrictive practice may be necessary as a proportionate and reasonable response to the risk posed. The choice of intervention will be informed by the service user’s preference (if known), any particular risks associated with their general health (again if known) and an appraisal of the immediate environment.

86. Where a person lacks capacity to consent to the contents of a Behaviour Support Plan and it is proposed to include restrictive practices in the plan, there should be a ‘best interests’ meeting held involving the people who know the individual best to determine which restrictive practice(s) should be used, if necessary.

87. Service users require bespoke, planned responses in order that they are effectively supported at times of extreme agitation. It is clear that interventions that may be ‘least detrimental’ for one person may not be so for another. Planning to deliver ‘least intrusive’ restrictive practices therefore requires a values-based, person-centred approach that considers the person as an individual.

88. There is considerable concern and controversy surrounding the potential harm to individuals caused by the use of restraint in health and social care settings. Restrictive practices have caused serious trauma, both physical and psychological, and even death in some instances\textsuperscript{36}.

89. There is a range of medical theories as to why people may be at risk of dying under restraint. Six of thirty-eight deaths in custody reviewed by Duxbury et al\textsuperscript{37} were found to involve people with pre-existing conditions that may have increased the risk of cardiac arrest eg ischaemic heart disease, diabetes and four people suffered from epilepsy. Asphyxia appeared to have been implicated in at least twenty-six deaths with concerns being noted around struggles/physical stressors prior to restraint, the number of staff involved and, in particular, the length of time of the restraint and position of the individual. It is of note that increased physical ill health is characteristic of the service user populations that this guidance is aimed at.

90. All restrictive interventions can pose risks, both physical and emotional, to individuals. These risks vary in nature from technique to technique and are multifactorial in origin; it is important that the risks associated with individual practices are understood by those who use them. In many instances rigorous practice can establish effective safeguards in order to minimise risks.

91. More open and transparent recording of incidents will help organisations better understand local risks and learn from them through thorough review processes.

92. Restrictive practices must always be used for the shortest time possible. Individuals should be immediately released from restrictions when they no longer present a danger to themselves or others and they should be subsequently observed for a period (at least two hours) in order to monitor and provide appropriate support in the event of any signs of emotional or physical distress.

93. Details of the circumstances around the use of any restrictive practice in health and social care settings should be scrutinised and reviewed by service managers at an early opportunity, in order that they can assure themselves that the
intervention was appropriate and warranted. These measures would tend to indicate the service is transparent and accountable. Where service managers consider that restrictive practices were not appropriate or warranted they should consider their response carefully. In all instances a safeguarding referral is appropriate in order to ensure external scrutiny and the provision of adequate measures to ensure that service users are protected from further abuses. Otherwise a full investigation of the circumstances may lead to a review of corporate training strategies, local policy review, disciplinary investigation and/or police action.

94. Services’ records of the use of restrictive practices should be reviewed at least annually at board level or equivalent.

PROPORTIONATE RESPONSES

Proportionality is a core principle that underpins the Human Rights Act, it is centrally concerned with establishing a fair balance between the general interests of the community and the protection of an individual’s fundamental rights. Case law has established a four-pronged test of proportionality:

1. Does the measure in question pursue a sufficiently important objective?
2. Is the proposed measure rationally connected with that objective?
3. Are the means adopted no more than necessary to achieve that objective?
4. Does the measure achieve a fair balance between the interest(s) of the individual and the wider community?

This test provides a structured approach to assist in choosing between various options connected with the care and treatment of an individual who has been assessed as lacking the capacity to make their own decisions. This inherently means that the least restrictive or ‘least drastic’ option of a series of interventions needs to be employed in order to achieve a legitimate aim.

Restrictive physical interventions

95. Restrictive physical interventions should be avoided if at all possible but where they are used, staff should seek to communicate with the service user in order to continually attempt to de-escalate the situation and cease the period of restraint as soon as possible.

96. Individual risk factors, if known, which suggest a service user is at heightened risk of physical and/or emotional trauma must be taken into account when applying restrictive physical interventions. This would include for instance, recognising that for a person with a history of traumatic sexual/physical abuse, any physical contact may carry an additional risk of causing added emotional trauma, or for a person known to have muscular-skeletal problems such as a curvature of the spine, some positions/holds may carry and additional risk of traumatic injury.

97. Restrictive physical interventions should only be used by staff who have been fully trained to do so. Any staff member who uses restrictive interventions should be supported and the impact on them explored within post incident debriefings and supervision.

Physical restraint

98. Restrictive practices and in particular physical restraint (as defined above), do not do not include any other form of physical contact which may be considered as appropriate in terms of supporting people in their everyday life eg providing physical prompts to support an individual to dress or undertake a daily living task; offering an individual physical contact as a means of socially appropriate interaction, comfort or support.

99. All forms of restrictive physical intervention, including physical restraint, should be avoided wherever possible. The use of physical restraint on the floor is of particular concern given the number of adverse outcomes that have arisen in these circumstances. Services must have a programme to bring about the circumstances where planned restraint in a face down (prone) position is no longer necessary; this will best be achieved through the adoption of Restrictive Practice Reduction Programmes and the delivery of care pathways which incorporate PBS. Prone restraint should only be used in exceptional circumstances such as where an
individual naturally falls forwards to the floor and for some unusual reason, it is considered too hazardous to turn them; or where someone needs administration of an intramuscular injection and the only safe injection site is the gluteal muscle.

100. Staff must never cause deliberate pain to a service user in an attempt to force compliance with their instructions. The use of pain inducing techniques cannot be justified in settings the primary purpose of which is the provision of care and support. Such techniques were previously routinely taught within physical intervention courses and so employers need to be mindful that this guidance will be replacing previously received inconsistent instruction. In order to provide absolute clarity to support staff, local polices must therefore be explicit that such methods are no longer acceptable.

101. In circumstances where physical restraint is required to maintain the safety of the individual or others, the following recommendations are made:

1. Floor holds (prone or supine) should be avoided wherever possible. In any event where this occurs, such methods of restraint should be a response to the dynamic nature of risk and must not arise from the direct and intentional action by staff to forcibly control the individual on the floor as a means of coercion.

2. If prone restraint is ever undertaken, staff (and those responsible for training them) must take account of the differing risks associated with various prone holding techniques and use the safest available method.

3. Physical restraint and/or breakaway techniques must not involve deliberate pain induction by staff or due to the use of holds whereby movement by the individual will in itself induce pain.

4. There should be no deliberate use of techniques whereby a person is allowed to fall, unsupported, to the floor.

5. Physical restraint that restricts an individual’s airway or breathing in any way must be avoided. For example the mouth and / or nose must never be covered and techniques should not incur pressure to the neck region, rib cage or abdomen.

6. One of the support staff must monitor the service user’s airway and physical condition throughout the duration of any restraint in order to minimise the potential of individual harm or injury, if they raise concerns restraint should stop immediately.

7. Observations that include vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/discolouration) should be conducted and recorded, and staff should be trained so that they are competent to interpret these vital signs.

8. A member of staff should assume responsibility for communicating with the service user throughout any period of restraint in order to continually attempt to de-escalate the situation.

9. Support staff should continue to monitor the individual for signs of emotional/physical distress for a period of time (up to two hours) following the application of restraint.

10. The police or security should not be used as an alternative to the management of behaviour that challenges. The police should only be called if all other efforts have been unsuccessful to manage a crisis situation. When the police attend an urgent situation on health or social care premises it is essential that care and support professionals continue to coordinate a collaborative response. In particular, the use of tasers, pepper sprays and CS gas are not appropriate in health and social care settings.

102. Staff undertaking restraint must be mindful of the potential for these interventions to cause significant emotional and physical trauma and, if used as part of a Behaviour Support Plan, plans should seek to offset any such risks. Effective post incident debriefing of service users may help to understand a service user’s perspective as to how a situation arose. It is good practice to support service users, if they have the capacity to do so, to record their wishes and feelings about how they can best be supported during periods of heightened distress or agitation. Knowledge of service user background through personalised assessment is crucial.

103. Staff should only use methods of physical restraint for which they have received training; the only exception to this is where it is imperative to use other techniques to avoid greater, imminent harm than the harm which may result to the individual from intervention. Training records must record precisely what techniques a member of staff has received training in.
104. Where physical restraint has been used as an emergency response to an unforeseen hazardous behaviour, this should be followed by:

- updating of risk assessments
- a plan for intervention the context of PBS in case of any recurrence
- analysis of the factors that led to the unanticipated behaviour. This may examine factors associated with the service user and the environmental and social context within which the behaviour occurred, it should also consider whether there were unidentified aspects of the person’s assessment which failed to elicit an adequate profile of risks in the first instance. This review process should inform an ongoing iterative process of systems improvement.

105. In settings where staff are trained in restraint techniques, they should also be trained in basic life support and have access to resuscitation equipment.

**Clinical holding**

106. Clinical holding is concerned with the application of safe restrictive physical interventions in order to deliver essential care and treatment to people who are unable or unwilling to comply due to a lack of mental capacity. Staff involved in the essential care and treatment must act in the best interests of the service user in order to maintain the patient’s health, safety, and welfare. In some instances stopping or not carrying out a procedure could negatively affect a person’s welfare, health, or medical condition. The use of clinical holding should be proportionate to the aims of the procedure to be carried out.

107. Clinical holding typically involves proactively holding a part of the body to which a procedure is being carried out such as holding an arm from which blood is being taken to prevent reflexive withdrawal and consequently unnecessary pain/distress or injury to the service user. On other occasions clinical holding may be necessary to restrict free movement which might otherwise interfere with or prevent the safe and necessary implementation of care of treatment.

108. Where an adult with capacity to consent to a specific procedure does not consent, clinical holding cannot be used.

109. Where it is thought that a service user may lack capacity to consent to a specific procedure, the Mental Capacity Act applies.

110. Staff should endeavour to support the person to make their own decisions wherever possible, this includes explaining the proposed procedures in an accessible and easily understandable way. They should support the person to ask questions and to weigh up the decision to be made. Only if this fails should staff then carry out a formal assessment of capacity in relation to the specific intervention that is being proposed. If the person is found to lack capacity, the subsequent best interests decision must consider the views of the person, their wishes and feelings, their history of restraint and of care, and the views if their family or friends.

FIVE STATUTORY PRINCIPLES OF THE MENTAL CAPACITY

1. A person must be assumed to have capacity unless it is proved otherwise.
2. A person must not be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because she/he makes an unwise decision.
4. An act done, or decision made for, or on behalf of a person who lacks capacity, must be done in their best interests.
5. Before an act is done, or a decision made, consideration must be given to whether the same outcome can be achieved in a less restrictive way.

111. Clinical holding should only be considered where a risk assessment determines that a service user’s assessment, care or treatment cannot be carried out effectively and/or safely due to the behaviour likely to be presented by a service user.

112. When considering whether clinical holding is warranted a number of questions will need to be explored:

- Can known environmental triggers be removed prior to the delivery of care/treatment?
- Can augmentative therapeutic approaches be employed which promote relaxation eg relaxation techniques, music therapy etc?
- Can desensitisation be used to reduce a service user’s anxious response to care and treatment procedures?
- Can supported communication approaches/
health education strategies be employed to maximise opportunities for care?

- Precisely who will do what? Consideration should be given as to who is the most appropriate person to implement holds and what skills they will need to do so. This will require discussion with the practitioners who will be carrying out the care or treatment, the service user and/or their family carers and advocates.

113. Clinical holding should be clearly recorded in a service user's care plan. Where it is used for a one off in order to facilitate a medical procedure its use should subsequently be fully reviewed.

114. Where clinical holding is considered to be necessary as part of a routine care plan eg to deliver or sustain routine support with personal care, its use should be expressly indicated along with the legal justification for its application. Such care plans should be subject to regular review.

### Mechanical restraint

115. Devices used under exceptional circumstances, following full risk assessment and in accordance with agreed care plans, to mechanically restrain include harnesses, straps, belts, handcuffs and any other equipment that restricts a person's movements and which cannot be easily be removed by the service user. Each is likely to carry specific risks in terms of both hazards to physical and emotional wellbeing; careful risk controls are required as well as clear legal and ethical justifications.

116. The definition of mechanical restraint does not encompass devices recommended by a medical practitioner or therapist for therapeutic purposes (such as an orthotic appliance prescribed by a physiotherapist to control an ankle joint when deformity or instability is present), or the wearing of a seatbelt, required by law, to transport a person safely. An appliance is a mechanical restraint when its primary purpose is to control behaviour, rather than to meet a therapeutic need or legal requirement. If a device is primarily used for therapeutic purposes as described above but is secondarily used for behavioural control then it must be considered to be a form of mechanical restraint and would need consideration in line with this guidance.

117. The routine use of mechanical restraint to manage extreme violence directed towards others should be exceptional and it is therefore envisaged that it should seldom be applied in this context outside of high secure settings. Mechanical restraints should never be a first line means of managing disturbed behaviour.

118. It is recognised that following rigorous assessment there maybe exceptional circumstances where mechanical restraints need to be routinely used to limit self-injurious behaviour of extremely high frequency and intensity39. This contingency is most notably encountered with small numbers of service users who have severe cognitive impairments, where devices such as arm splints or cushioned helmets may be required to safeguard a person from the hazardous consequences of their behaviour.

119. Wherever used, mechanical restraint should be a planned contingency identified within a broad ranging, robust Behaviour Support Plan, which aims to bring about the circumstances where continued use of mechanical restraint will no longer be required. Where prolonged mechanical restraint is used, the risk of associated forced immobilisation giving rise to additional physical health problems should be specifically considered and risks mitigated, so far as possible, through the provisions within the plan.

120. Behaviour Support Plans which include the use of mechanical restraint should be developed, monitored and reviewed through multidisciplinary team processes, which include consultation with at least, direct health or social care staff, the service user and/or their family carer or advocates, psychiatry and psychology personnel, as well as any medical practitioner with specialist knowledge regarding the specific physical health hazards associated with any proposed mechanical device.

### Chemical restraint

121. Chemical restraint refers to the use of medication to calm/lightly sedate a service user, thereby ensuring their safety and/or that of others. Reductions in agitation and aggression should provide opportunity for medical evaluation to take place and allow comprehension and responses to spoken message throughout the period of intervention34.

122. Wherever psychotropic medication is routinely prescribed in order to aid the management of challenging behaviour in people with learning disabilities (and in the absence of a clear psychiatric diagnosis), the safeguards...
and recommendations in the University of Birmingham’s 2006 Guide\textsuperscript{16} should be followed. The good practice principles in this guidance clearly have wider applicability to other service users groups who are similarly liable to be subjected to chemical restraint for the purpose of behavioural control rather than treatment of an identified underlying mental health condition. Key recommendations of note include:

- The prescriber should ensure that appropriate clinical assessments, including physical state examinations have been carried out. Consultation should take account of the communication needs of the person.
- An appropriate formulation and treatment plan should be drawn up prior to instigating prescribing. In addition to involvement of other appropriate professionals there should be full engagement with service users and their families. The formulation and treatment plan should be shared with all parties.
- The treatment plan should be part of a broader care plan that takes a person centred approach.
- Where a medication is prescribed outside of its licensed indication, the service user and/or their family or carers should be told about the type and quality of evidence available to demonstrate its effectiveness.
- The service user and/or their family or carers should be told of any common and serious adverse events associated with the treatment and advised of what action to take if a serious adverse event takes place.
- Full account should be taken of the person’s capacity to consent to the specific treatment. If the person is assessed as not having capacity, appropriate best interests decision making procedures must be followed and full account taken of any advance decisions recorded at a time where the person is presumed to have had capacity.
- There should be an objective approach to the measurement of outcomes in order to determine the effectiveness of the medication. The method and timing of the assessment of treatment outcome should be determined from the outset along with follow up arrangements for periodic review.

Where chemical restraint is used in the context of rapid tranquillisation, it should be used only for a service user who is highly aroused, agitated, overactive, aggressive or making serious threats or gestures towards others or is being destructive to their surroundings, when other therapeutic interventions have failed to contain the behaviour. Chemical restraint should only ever be delivered in accordance with acknowledged, evidence based best practice guidelines\textsuperscript{24,41,42}, which include details of physical observations and monitoring as well as the nature of pharmacological agent and routes of administration in the case of forced medication.

The use of medication to manage acutely disturbed behaviour is a very short term strategy designed solely to reduce immediate risk; this is distinct from treating any underlying mental illness. The term ‘rapid tranquillisation’ does not only refer to or imply the use of intra muscular injections; oral medication should always be offered first.

Where chemical restraint is used as part of a person’s care or treatment, it should be undertaken in accordance with the provisions of the MCA (2005)\textsuperscript{19} or MHA ( 1983)\textsuperscript{20} to the extent to which each Act applies to the person.

### Psychosocial restraint

Psychosocial restraints have traditionally been concerned with trying to manipulate behaviours through the alteration of their consequences. Such approaches can be viewed as punitive and typically fail to address the underlying needs that drive behaviours. They have included practices such as the programmed withholding of access to valued items or activities in response to specific behaviours, increasing supervision, or implementing limits or boundaries beyond normally accepted community practices. The use of such ‘response cost’ programmes whereby a person is effectively fined ie denied access to preferred items, ignored or barred from preferred activities as a punitive consequence of presenting a behaviour of concern are ethically unacceptable, have the potential to provoke dangerous behavioural escalations and should be avoided.

This is in contrast to formal programmes designed to educate a person about the natural consequences of their actions and to assist them to make reasoned decisions or choices about appropriate behaviour. Such programmes should only be used with service users who are felt to have capacity to be able to learn to make such choices and as such are likely to have little place in the care and support of people with significant cognitive impairments.
The use of verbal interactions and threats of social or tangible sanctions, which might reasonably be construed by a service user as intimidating and which rely on fear to moderate a person’s behaviour are examples of abuse and cannot be countenanced.

In some instances, psychosocial restraint can be construed as including environmental modifications or restrictions which aim to manage risks for example, locking a cupboard or room where food is kept in the case of a person prone to hazardous binge eating, or denying access mobile phone where it is believed that someone may make threatening phone calls to another person.

Where, exceptionally, psychosocial restraints are used they must be subject to the same rigor of practice as any other restrictive practice. Any such programme should only be delivered under the supervision of an appropriately qualified professional, such as a clinical psychologist or another professional with a qualification in behaviour therapies (or equivalent) and within the broader context of a Behaviour Support Plan.

Service providers need to be alert to the possibility of psychosocial restraints being introduced either in a clandestine manner by staff, or unwittingly. Services which have cultures that are founded on recovery models and the principles of PBS and where staff have access to high quality training are unlikely to develop such practices.

Seclusion

The definition of seclusion put forward in this guidance is broader and more inclusive than that contained within the MHA Code of Practice which clearly specifies that seclusion is undertaken in a dedicated room. Concerns have been raised over a number of years that some services may have operated restrictive practices that, despite not meeting the precise definition in the Code of Practice, were tantamount to seclusion and were being implemented in the absence of a clear legal basis and without affording many of the safeguards required by chapter 15 of the MHA Code of Practice.

Where such containment practices have fallen outside of the precise Code of Practice definition, they may not have been regarded as seclusion by service providers and therefore may not have been reported as seclusion episodes. In 2006 the Mental Health Act Commission (now part of the CQC) identified a range of euphemisms that they had encountered during visits to services. These included:

- Removal from the environment.
- Single person wards.
- Therapeutic isolation.
- Enforced segregation.
- Open-door seclusion.
- Restriction of movement.
- De-stimulation room.
- Removal to a calming room.
- De-escalation room.
- Place in a quiet room.

If a service user is contained in any way that meets the definition provided herein, they have effectively been secluded regardless of any local term that services may wish to use, or the conditions of the immediate environment. Seclusion is a significant restriction of a person’s liberty and in the absence of adequate safeguards is evidence of serious neglect of duty of care and likely abuse. Seclusion must only be undertaken in accordance the definition and legal safeguards established via the MHA and associated Code of Practices, any other form of seclusion is likely to amount to an unauthorised DoL; an infringement of a person’s human rights and cannot be countenanced.

The safeguards outlined in the MHA Code of Practices include local policy and procedural frameworks to ensure that seclusion is only used as a last resort, for the shortest time possible and not as part of a treatment programme. Procedures need to provide clarity as to who can initiate seclusion, how ongoing seclusion is to be reviewed, how service users should be monitored and have their ongoing needs met, arrangements for recording and reporting and the nature of the physical environment where seclusion can take place.

The decision to use seclusion (or equivalent practices to seclusion defined differently) is a clinical one and should only be taken after other options have been excluded. The decision to seclude someone should be taken by a clinical team not a single practitioner working in isolation. All services who routinely seclude service users should have a corporate strategy for its reduction, which must be monitored at executive board level (or equivalent). Seclusion policies should be compliant with existing NICE guidance and will need to be updated and revised upon the scheduled publication of renewed NICE guidance in 2015. They must also
be compliant with the requirements of Chapter 15 of the MHA Code of Practices. Seclusion should only ever be used for a minimum of time. Where there is a risk of suicide, the use of one-to-one care and observation should be considered as an alternative.

137. Care plans for people in seclusion must identify: emotional and physical risks and how they are to be minimised, the timing and frequency of medical examination/review, details of bedding and clothing to be provided, details as to how the person’s hygiene and toilet arrangements will be met and details as to how the person’s nutritional needs are to be met. Care plans should also make provision for continuous observation of the service user.

138. Seclusion should only be undertaken in environments, which meet the requirements set out in the MHA (1983) Code of Practices. This Code is currently being revised and therefore local policies and seclusion arrangements will need to be reviewed and updated upon publication of the new Code.

139. People who are not detained under the MHA should only be secluded under the most exceptional of circumstances. In order to ensure that their rights are safeguarded, if an informal patient is secluded, they should promptly be assessed to determine whether formal detention for assessment or treatment of a mental disorder is warranted under the MHA.

140. Care plans should not prescribe seclusion under specific circumstances but should outline the circumstances under which this might need to be considered.

141. Local policies will be required to outline precisely how a person should be transferred into a seclusion area and how staff can safely exit the room. It is acknowledged that a person who is highly disturbed and presenting an acute risk to others is highly unlikely to simply walk into a seclusion facility and therefore some other restrictive practice, such as physical restraint, may need to be used in order to transfer the person.

Longer term segregation

142. Service users who are not detained under the MHA should never be subject to longer term segregation.

143. It is important to recognise that in some services longer term segregation may be in use. There are a very small number of individuals who are not responsive to short-term management of their aggression and violence; they present a sustained high risk of serious harm to others which is an almost constant feature of their presentation and is not subject to amelioration by a short period of seclusion in combination with any other form of treatment. Exceptionally in such cases, there may be times when a clinical judgement is made that, if an individual were allowed to mix freely in the service, other people would continuously be open to the potential of serious injury or harm.

144. In contrast to seclusion, longer term segregation is not an emergency response to an acute incident, rather it is a planned restriction introduced in response to a chronic presentation of violence and aggression and which is used to create the optimal situation in which to provide care and treatment and promote recovery. Segregation in itself has no therapeutic value; service users should not be isolated from contact with staff or deprived of access to therapeutic interventions. Long term segregation cannot be accepted as a lifestyle and treatment plans must aim to reduce and eliminate its continued use.

145. Longer term segregation should always be undertaken in a manner consistent with the MHA (1983) Code of Practices, which includes having a robust local policy for its use.

Post incident reviews

146. Organisations have a responsibility to ensure post incident learning takes place and that those involved or witness to the use of restrictive interventions have access to post incident debriefing.

147. Following an incident in which a restrictive practice is employed, both staff and service users should be given separate opportunities to talk about what happened in a calm and safe environment. For some service users with cognitive and/or communication impairments their engagement in the process may require significant modification of usual methods.
of discourse, this might include the use of simplified language or visual imagery. For others, it is recognised that their involvement may not be possible. Discussions should only take place when those involved have recovered their composure. People who use services should in no way be compelled to participate in post incident reviews. Service users should be informed of their right to be supported or represented by an independent advocate (such as their Independent Mental Health Advocate or Independent Mental Capacity Advocate), family member or another representative (such as the donee of their lasting power of attorney, or their deputy, under the MCA (2005)\(^{27}\)).

148. The aims of post incident reviews are to:

- evaluate the physical and emotional impact on all individuals involved (including witnesses)
- identify the need for (and provide) counselling or support for the people involved for any trauma that might have resulted
- assist service users and staff in identifying what led to the incident and what could have been done differently
- determine whether alternatives, including lesser restrictive practices, were considered
- determine whether service barriers or constraints will make it difficult to avoid the same course of actions in future; and
- recommend changes to the services’ philosophy, policies, care environment, treatment approaches, staff education and training.

149. Immediate or post incident reviews for both staff and service users should focus on acknowledging the emotional responses to the event, promoting relaxation and feelings of safety, facilitating a return to normal patterns of activity, ensuring that all appropriate parties have been informed of the event, that necessary documentation has been attended to and beginning to consider whether there is a specific need for emotional support in response to any trauma that has been suffered.

150. Many restraint reduction models also advocate the use of a more review process, typically the next day. This may take the form of a facilitated group discussion which aims to establish what were the warning signs of an impending crisis, what de-escalation strategies were user, how effective were they and what could be done differently in future? Staff will usually be prompted to explore the emotional impact of the incident upon them. Discussions with service users be with someone not involved in the incident, in a blame free context and within 48 hours of the incident. From service users we want to understand how we failed to understand what they needed, what upset them the most, did we do anything that was helpful, what did we get wrong and how could we do better next time? We also want to establish whether we could have done anything to make the restrictive practice less helpful.

151. In response to post incident reviews, the care team in conjunction with the service user and/or their families and advocates should consider whether Behaviour Support Plans or other aspects of care need to be revised. Any organisational factors such as the need for policy reviews, environmental modifications, staffing reviews or training needs must to be formally reported to service managers via robust governance arrangements.

Protecting employees and others in the working environment

152. The routine use of physical interventions within a service provider organisation is clearly an activity which places both staff and service users at risk of physical and/or psychological harm. Organisations where such techniques are used have responsibilities to have in place mechanisms by which to minimise the risk of any such harm.

153. The Health and Safety at Work Act (1974)\(^{45}\) (HSWA) establishes that employers have a duty to ensure so far as is reasonably practicable, the health, safety and welfare at work of their employees and the health and safety of others that maybe affected by the employers undertaking. Within the Act and other more specific health and safety legislation there are certain requirements that employers need to comply with to protect employees and others. These include:

- The need to assess the risks to employees and others (including reasonably foreseeable violence), decide on the significance of these risks, how the risks can be prevented or controlled and implement these arrangements to reduce the risk: The Management of Health and Safety at Work Regulations 1999\(^{46}\).
The need to provide adequate information, instruction, training and supervision to ensure the health and safety of the employees. This would include the risks that arise from both violence and aggression, as well as those linked to the use of restrictive practices and restraint: HSWA and The Management of Health and Safety at Work Regulations 1999.\(^6\)

The need to monitor and review the arrangements implemented to reduce risks to ensure they are effective: The Management of Health and Safety at Work Regulations 1999.\(^6\)

It is only through effective governance arrangements that excessive use of restriction can be minimised and safety for all maintained. In order to adequately meet their responsibilities, all provider organisations across health and social care must:

- ensure that the hazardous nature of violence and aggression encountered in their service is acknowledged within corporate risk registers
- ensure that the hazardous nature of the restrictive practices used in their services is acknowledged within their corporate risk registers
- ensure that corporate risk registers provide details of a number of key controls adopted to minimise these risks:
  - There must be an overarching, evidence based Restrictive Practice Reduction Strategy based on the principles of: effective leadership, data informed practice, workforce development, the use of specific restraint reduction tools, service user empowerment and a commitment to effective models of debrief.
  - There must be details of the provision of training in PBS to staff. Staff with differing degrees of specialism will require varied levels of associated competence ie the competencies required to deliver an effective Behaviour Support Plan are qualitatively and quantitatively different than those required by a specialist practitioner who undertakes functional behavioural assessments and devises Positive Behavioural Support Plans.
  - Provisions by which care provider organisations assure themselves of the quality of training provided to their staff in relation to physical interventions and proactive approaches including PBS.
- The nature and range of training in relation to de-escalation techniques must be specified.
- The precise nature of physical intervention and breakaway techniques taught to staff must be acknowledged. This should be informed by training providers issuing care provider organisations with specific risk profiles for each and every technique that is taught, these should specify nature and likelihood of any potential for harm. Organisational polices will embed practices to reduce the risk of serious harm where physical interventions are used.
- Provider organisations must utilise a process whereby there is board level (or equivalent) authorisation and approval of the specific physical interventions to be taught to their staff and utilised in practice.
- Ensure that risk registers are be reviewed on on-going basis but as a minimum there must be evidence of at least annual, full, evidence based review of control measures leading to revision and update of corporate action plans.
- Make available all corporate risk registers and evidence of associated review for inspection by the regulators (CQC and Monitor).

Corporate accountability

In response to Transforming Care: a national response to Winterbourne View Hospital and the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry,\(^4\) the coalition Government committed to work with the Care Quality Commission to deliver a system which will ensure that there are robust mechanisms to hold corporate and NHS boards to account for failings in care. Key areas of focus include the ability to hold individual board members to account, revising CQC registration requirements to include fundamental standards that will allow CQC to prosecute providers without having to issue prior warning notices and establishing a duty of candour which obliges services to be open and honest with service users and their families about things that go wrong.
156. The legal and ethical case for organisations sanctioning the application of restrictive practices within a workforce is founded, regardless of legal jurisdiction, on a number of overarching principles:

- Restrictive practices must never be used to punish or to purposefully inflict pain, suffering or humiliation.
- There must be a necessity to act in order to avoid harm to the person or others.
- The nature of techniques used to restrict must be proportionate to the risk being controlled.
- Any action taken to restrict a person’s freedom of movement must be the least restrictive option that will meet the need.
- Any restriction should be imposed for no longer than absolutely necessary.
- What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.
- There is widespread acknowledgement that Physical Interventions should only ever be used as a last resort.
- Service users, carers and advocate involvement is essential when reviewing plans for restrictive practices.
- Restrictive practice policies must be reviewed at board level at least annually.

157. Organisations have clear responsibilities under health and safety legislation (and in accordance with their corporate duty of care) for ensuring the delivery of effective proactive ways of working ie understanding and addressing the primary causes of violence and aggression (preventing trouble before it happens) and for instating organisation wide, evidence based Restrictive Practice Reduction Programmes and PBS. In essence if restrictive practices are to be used as a last resort, then providers must ensure that their organisations employ lesser restrictive resorts by which to avoid violent and aggressive incident in the first place. Honouring these responsibilities will be subject to CQC monitoring and any negligence or failures may result in formal action being taken against providers.

158. The notion of ‘last resort’ needs to be taken very seriously by organisations, not least in view of the new arrangements to enforce corporate accountability for quality and safety. It is clear that care providers must ensure that those who work for them can competently use a range of strategies in order to safely respond in the face of violence and aggression. To minimise the risk that employees respond with disproportionate force or impose excessive restrictions, staff will require access to a wide range of care measures; these will include expertise in the use of de-escalation strategies and pain free breakaway techniques. Preventative strategies must always be the starting point in any organisation however and inherent in this is the need to take stock and understand the nature of the challenges staff, service users and carers face. Local evaluation and audit is key.

159. Effective governance frameworks are founded on transparency and accountability, accordingly all service where restrictive practices are used must:

- provide an annually updated, accessible document on restrictive practices in the service which outlines the training strategy, techniques used (how often) and reasons why, as well as strategies for bringing about reductions in the use of restrictive practices
- include data indicating the use of each forms of restrictive practice within their annual quality accounts (or equivalent publications)
- all service provider organisations who use restrictive practices should have an identified executive director who takes a lead responsibility for delivering programmes of restrictive practice reduction and PBS. Service users and the families should be informed who this is
- ensure the organisation’s board or equivalent must review the use of restrictive practices, and review and implement a plan to reduce the use of restrictive practices and report this to their commissioner(s).

Delivering safe, effective, quality services

160. In relation to the use of restrictive practices care pathways must be founded on the following core principles:

- Practitioners must undertake systematic, evidence based assessments to determine the nature and range of any behaviours likely to be presented by service users which may compromise their personal safety or the safety of others.
• Personal safety assessments, completed for each individual must also identify any unique service user specific physical and emotional vulnerabilities which mean they are at heightened risk of experiencing harm if exposed to particular restrictive practices.

• Care plans must ensure that the hazardous nature of any specific restrictive practice is balanced against individual’s unique strengths and vulnerabilities in order that interventions are only used on the basis the person is unable to keep themselves safe or is a risk to others.

• There must be clarity regarding the lawfulness of the planned use of restrictive practices.

• Care plans which advocate the use of restrictive practices must be prepared as a constituent part of a broader Behaviour Support Plan.

• All Behaviour Support Plans must also include individualised de-escalation strategies and arrangements for post incident de-briefing of staff and service users.

• Wherever possible Behaviour Support Plans should be completed and follow the person on their care pathway – ensuring that services ‘know and understand’ the person’s unique story, including their own preferences for support when in a highly distressed or agitated state.

Recording and reporting

161. The principle aim of this guidance is to reduce services’ reliance on restrictive practices. There is strong evidence that real reductions can be achieved through effective training and the wide scale adoption of Restraint Reduction Programmes (including the use of PBS) however clear and accurate recording of the use of restrictive practices will be needed in order that services’ progress can be evaluated. If services are going to allow restrictive practices to be used then their senior managers must understand the extent of their application and this needs to be founded on accurate and transparent data:

• Services must monitor the incidence of the restrictive practices defined in this guidance. Data informed practice is a key factor in reducing reliance on restrictive practices.

• All services must maintain a register of Behaviour Support Plans which include the planned use of restrictive practices as defined herein. This should allow numbers of each individual form of restrictive practice to be delineated as well as numbers of service users who are subjected to multiple combinations of restrictive practice.

• This register should be available for scrutiny during regulatory inspections and should any such care plan be found during an inspection that is not included within the register could be seen as strong evidence of a lapse of governance.

• Similarly should inspectors find evidence that a service user is subjected to the recurrent use of unplanned restrictive practices in the absence of a clear Behaviour Support Plan, then this would be construed as indicative of poor quality of practice.

• Any service user with a Behaviour Support Plan advocating the use of restrictive practices should have clear proactive strategies including details of primary and secondary preventative strategies.

• Following any occasion where a restrictive practice is used, whether planned or unplanned, a full record should be made. This should be recorded as soon as practicable (and always within 24 hours of the incident). The record should allow aggregated data to be reviewed and should indicate:

  • the names of the staff and service users involved
  • the reason for using the specific type of restrictive practice (rather than an alternative less restrictive strategy)
  • the type of intervention employed
  • the date and the duration of the intervention
  • whether the service user or anyone else experienced injury or distress; and
  • if they did, what action was taken.

162. To help protect the interests of service users who are exposed to restrictive practices it is good practice to involve the individual concerned, and wherever possible, family carers, advocates and other relevant representatives (e.g. the attorney or deputy for a person who lacks capacity) in planning, monitoring and reviewing how and when they are used.
Responsible commissioning

163. Health and social care service commissioners have a responsibility to ensure that services meet the needs of individuals, their families and carers. This includes ensuring that commissioned services can deliver high quality support to people who have complex and at times challenging needs.

164. In order to honour these obligations commissioners will need to ensure that placements are only made and sustained on the basis of a full understanding of a person’s needs and any associated risks. They will also be required to assure themselves, on an ongoing basis, of the competence of provider organisations to meet users’ needs. This will mean interrogating the available proactive therapeutic approaches as well as organisational strategies to maintain appropriate competencies across the workforce. Special attention should be paid to the ability of the service to deliver PBS and to the availability of high quality assessments and support in order to develop such plans.

165. Commissioners should also assure themselves that mechanisms are in place to ensure that physical interventions are delivered in as safe a manner as possible and are only ever applied as a last resort. Commissioners should not place people in services which use Restrictive Practices unless there are readily available robust, regularly reviewed, organisational Restrictive Practice Reduction Programmes.

166. In reviewing placements, commissioners must review all data regarding the application of restrictive practices for their service users.

Staff training and development

167. Staff who are expected to use restrictive practices will require specialised training. The precise nature and extent of intervention techniques, as well as frequency of refresher training will depend upon the characteristics of the people who may require a physical intervention, the behaviours they present and the responsibilities of individual members of staff. Corporate training strategies should be explicit in learning outcomes relating to:

- the experience of service users
- trauma informed care
- core skills in building therapeutic relationships
- the principles of PBS
- legal and ethical issues
- risks associated with restrictive practices
- staff thoughts and feelings on being exposed to disturbed behaviour
- the use of safety planning tools and advance decisions
- alternatives to restrictive practices
- effective use of de-escalation techniques
- training in the risks of restrictive interventions and how these risks can be minimised, especially relating to physical restriction where there may be the likelihood of adverse events including pain, injury or respiratory or cardiovascular compromise
- the use of breakaway technique by which to disengage from grabs and techniques to protect against punches and kicks
- safe implementation of restrictive physical interventions; and
- post incident debriefing and support for staff and service users.

168. Workforce development is a core and essential strategy within the organisational change models described earlier in this guide. The Irish Mental Health Commission reviewed such approaches and identified three focal areas for staff training and development:

- Promoting attitudinal change among staff.
- Skills in crisis management, including alternatives to seclusion and restraint.
- The implementation of new models of care.

169. Effective training and workforce development will be necessary if safe practice is to be promoted and the use of restrictive practices in services is truly to be lessened. It is vital that service users are supported by staff who have access to high quality training in order to develop the knowledge and skills necessary to deliver PBS and Restrictive Practice Reduction Programmes. Staff also need to be equipped with effective skills so that when, as a last resort, restrictive practices have to be used physical and emotional trauma are minimised.
Training for attitudinal change

170. Research suggests that without substantial attitudinal changes among staff, it is unlikely that reductions in the use of restrictive practices can be achieved. Typically, certain key traditionally held views about the perceived value of restrictive practices, which are erroneously based on misinformation and inaccurate assumptions, need to be challenged, these include perceptions that:

- restrictive practices keep people safe
- restrictive practices are only used when absolutely necessary
- staff know how to recognise and de-escalate potentially violent situations
- restrictive practices are based on empirical knowledge; and
- restrictive practices are used without bias and only in response to objective behaviours.

171. Front line staff who largely decide whether or not seclusion or restraint are used, should be the focus of training initiatives. Boards who authorise the use of restrictive practices in their organisations should undertake both the training in the use of PBS and physical interventions themselves, to ensure they are fully aware of the techniques their staff are being trained in. It is also important that new entrants to health and social care professions who work with people with learning disabilities and mental health problems are robustly educated in relation to these issues.

New models of care

172. Delivering effective models of PBS will require many services to instigate wide ranging programmes of staff development:

- All support staff who support people with who are at risk of exposure to restrictive interventions should receive in-house training in the principles of PBS which is refreshed at least annually.
- In order to ensure an appropriate balance between positive and reactive approaches is embedded within organisations, at least twice as much training time should be spent focusing on PBS as on restrictive practices.
- Any organisation or practitioner that develops and implements Behaviour Support Plans must be able to provide assurances of their competence to do so. All staff with a specialist role (which may be peripatetic or consultant) in respect of assessing or advising on the use of PBS should have completed, or be undergoing, externally-validated training in PBS which includes both practice and theory-based assessment at National Qualifications Framework Level 5 or above. This training must include functional assessment of behaviours of concern.
- All staff involved in the development or implementation of PBS strategies must receive supervision from an individual with more extensive PBS training and / or experience.

173. New models of care in which staff have been trained to good effect include the development of high-therapy, low-conflict care environments and collaborative problem-solving. Trauma informed care is a model of care that recognises that many service users have been negatively affected by traumatic life events, has also been identified as pivotal to reducing restrictive practices.

174. These training models should be embedded into undergraduate professional training programmes but should also be delivered in-service in support of organisation wide Restraint Reduction Models.

Crisis management

175. The delivery of training on the management of violent and aggressive episodes of behaviour is a complex area. Instruction methods around restrictive practices, particularly physical restraint, vary as do the precise nature of techniques taught.

176. Some providers continue to teach methods, which involve pain inducing techniques, some offer refresher training via video or eLearning. Many training providers deliver train the trainer models with successive generations often continuing to train further trainers in a pyramidal network. There is no current requirement for trainers to have any demonstrable knowledge and skills in teaching.

177. There is no regulatory body that oversees the nature and quality of physical interventions training or indeed agreed national standards, though some oversight of theoretical content was provided by the National Health Service Counter Fraud and Security Management Service in their training curriculum, which set out ten mandatory learning outcomes in its publication Promoting Safer and Therapeutic Services.
178. There is no register of training providers and so it is not possible to say with certainty how many training providers there are. There are currently no universally accepted standards although both the British Institute of Learning Disabilities (BILD) and the Institute of Conflict Management (ICM) offer voluntary quality accreditation schemes. Over the last decade BILD have produced an extensive range of publications and guides in relation to PBS and physical interventions (many, though far from all have been referenced in this guidance).

179. The population exposed to restrictive practices is heterogeneous and diverse, ranging from the elderly in care homes to detained patients in secure hospital settings therefore it is highly unlikely that a one size training option can be made to fit all. Restrictive practices are also used across a vast array of health, social care and educational settings, which include both statutory and third sector providers. Current NICE guidelines identify potential core components of training in the use of physical interventions, although this guidance is aimed only at psychiatric in-patient services and emergency departments. The forthcoming NICE guidance will explore the evidence based relating to a far broader range of settings.

180. Skills for Care in conjunction with Skills for Health are in the process of drafting guidance to support service providers to understand their training obligations towards both staff and service users, as well as how to assure themselves that they are procuring training of high quality. This guidance will ensure that services focus on the application of restrictive practices within an overarching Positive Behavioural Support framework and will clearly articulate expectations around compliance with standards.

**Local policies frameworks**

181. Organisations that provide care and support to people who are at risk of being exposed to restrictive practices will require clear organisational policies which reflect current legislation, case law and evidence of best practice.

182. Policies should outline the organisational approach to restraint/seclusion reduction, including training strategies. This section of the policy must also include arrangements for the provision of high quality Behavioural Support Plans for people who are likely to present behaviours that may require the use of restrictive practices. Employers and managers are responsible for ensuring that staff receive training, including updates and refresher courses, appropriate to their role and responsibilities within the service.

183. Policies must include guidance to employees on the safe application of restrictive practices, as a demonstrable last resort either as part of a Behaviour Support Plan or as an emergency measure where behaviours cannot be predicted. There must also be guidance on how the hazards associated with restrictive practices will be minimised eg first aid procedures to be employed and those responsible for implementation in the event of an injury or physical distress arising as a result of a physical intervention.

184. Clear recording and reporting arrangements will need to be explicit along with the mechanism by which this data will inform ongoing review of a Restrictive Practice Reduction Programme.

185. The policy is expected to explain how service users, their families and advocates participate in planning, monitoring and reviewing the use of restrictive physical interventions and in determining the effectiveness of Restrictive Practice Reduction Programmes. This will include providing accessible updates and publishing key data within quality accounts or equivalent report.

186. Children and young people should always be kept as fully informed as possible, just as an adult would be, and should receive clear and detailed information concerning their care and treatment, explained in a way they can understand and in a format that is appropriate to their age. This is similarly the case for people with learning disabilities, autistic spectrum conditions, sensory impairments, specific communication difficulties and for whom English is not their first language.

**Conclusions**

187. Users of health and special care services who present with behaviour that is perceived as challenging have a higher risk of being subjected to restrictive practices. This is known to occur across the full range of statutory and third sector, health and social care services. Many of the associated techniques place service users, and to a lesser degree, staff and those who provide support, at risk of suffering physical and/or emotional harm. In some instances service user deaths have resulted.
188. Restrictive practices should only ever be employed for the shortest time possible, out of necessity and as a last resort, and never to deliberately inflict pain, punish or humiliate.

189. It can be difficult for service providers to navigate the complexities of sourcing high quality training in relation to the safe application of restrictive practices and understanding what specific techniques their staff should be trained in, however this guidance sits alongside additional and forthcoming guidelines which aim to provide greater clarity. It is essential that as services move forwards with this important agenda, they ensure that they are able to proceed on the basis of accurate data, accordingly all services will need to commit to gathering data on the extent of the use of restrictive practices.

190. There is robust evidence base that shows that much can be done in order to reduce services’ reliance on restrictive practices. PBS can lead to enhancements in quality of life and associated reductions in behaviours that frequently are followed by restrictive practices. Originating from mental health services, and receiving international acclaim, restrictive practice reduction programmes can both reduce the incidence of violence and aggression and ensure that less detrimental alternatives are used as an alternative to restrictive practices. These two approaches are entirely consistent and their integrated application needs to occur across all services.

191. Services need to demonstrate the routine and wide scale use of high quality PBS as part of a strategic and multi-component approach to restrictive practice reduction. Such approaches must be consolidated into practice through rigorous governance structures.
Annexe A: Sharing your concerns as an individual service user, carer or staff member

- All services should adopt the measures described in the guidance to make sure restrictive practices are only used where absolutely necessary and in as safe a manner as possible.
- Services will need to make considerable changes to the ways in which work and that this may take time. In the meantime, service users’ rights should be protected.
- Where this is not happening, you should share your concerns.
- It may be helpful to keep a diary, a list or a log of events and incidents that worry you.
- You can raise your concerns in the following ways:
  - Raise your concerns informally with people you trust within the service.
  - Use the service’s formal complaints process.
  - All health and social care services have complaints policies and these should be made available to service users and their families, carers and advocates.
  - Staff members should use the staff complaints process.
  - NHS organisations have Patient Advice and Liaison Services (PALS) officers who are able to offer confidential advice, support and information.
  - Since April 2013, local authorities have had a responsibility to organise independent advocacy for people who are making or thinking of making a complaint about NHS care or treatment. PALS officers, complaints managers or local authorities can provide information about how this service can be accessed.
  - All local authorities have children and adult safeguarding teams. Contact details can usually be found either on local authority websites or by ringing them directly. If people are being abuse, safeguarding teams have a responsibility to take action.
- Service commissioners, including social workers and care managers could be alerted to concerns. Under this guidance they have clear responsibilities to monitor quality of the placement that they arrange for service users.
- The Health Service Ombudsman or the CQC could be contacted and have powers to investigate.
- You may wish to share your concerns with local councillors or MPs.
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