

Towards Safer Services

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Publisher's foreword

The Restraint Reduction Network (RRN) is delighted to publish this edition of Towards Safer Services. This will give services and organisations a quality assurance framework within which to plan and implement restraint reduction. These standards have been developed by a group of professionals and experts in the field.

These standards complement the [RRN Training Standards](#) (Ridley and Leitch, 2019) and the [Mental Health Units \(Use of Force\) Act 2018 Statutory Guidance](#) (DoH, 2021) and provide a framework that organisations can use to develop strategy and steer their mission to reduce the use of unnecessary restrictive practices.

It will also support organisations and providers of training in restrictive interventions to work together on organisational restraint reduction plans.

The RRN is committed to developing accessible versions of these standards so that people with lived experience of services and families are clear about the standards they can expect from organisations who say they are committed to restraint reduction.

Version 2 of the RRN Training standards will be developed in 2022/2023 following the publication of an evaluation by Manchester Metropolitan University.

The authors of Towards Safer Services are committed to work with people with lived experience of restrictive practices to review and update the next version of these organisational standards.

Version 2 of Towards Safer Services will be published in 2023.

Plain language summary

This document is called Towards Safer Services. It sets standards on how to restrain people less. The advice is for workers in places that might restrain people. Those are places like hospitals, schools, and some sorts of housing. Each part is written for a different sort of worker in those places.

1. The first sort we call Directors, who are in charge.
2. The second are workers that care for people, like teachers, nurses, or care workers.
3. The third are people who teach restraint. Everyone should work together to reduce restraint.

Directors

They need a strategy to restrain people less. Making a good plan for reducing restraint can be hard.

Directors must listen to people to reduce restraint. They must make systems that work at different levels of the place, like at classroom, ward or home level, department level, and everywhere.

Directors must decide where to spend money. They need good information. One of the best ways is to ask people who have been restrained, or their family or carers.

Those people should join meetings and help decide things. The rules of meetings should let them help.

Directors must know who is being restrained in their own places and why. Restraint reduction is a good use of money.

Directors of organisations that are good at reducing restraint should help other places. Directors must never feel happy when restraint increases in other places.

Directors must avoid some common mistakes. For example, plans should not just be promises. Plans must be based on facts. Plans should do more than ban things.

Good communication is everything. This means speech therapy, sign language, advocates, and so on, for people that need it.

Workers who look after people

These workers must see the person who might be restrained as the most important person.

Workers have to care about reducing restraint. Workers have to make sure they are trained. They need to know how to get help when they need it. They must tell the truth when things go wrong.

Workers should write good care plans and do that with the person. Care plans can

have 'interventions'. Interventions are the things we do to care for people and keep them safe. The first interventions are good everyday care. This might be how the person looks after themselves, is treated, learns, or works. These day-to-day things reduce restraint too, so they are 'interventions'.

The second part of the care plan is for when the person feels unhappy or unwell, especially if that means they might do unsafe things. There must be a good plan for these difficult times. That might mean more help, more treatment or care. This second part can avoid restraint, it is very important.

The third part of the care plan explains how the person might be restrained, or have other things, like medication they might not want at the time. These are 'tertiary' or third, interventions. Even though we don't want to do them we have to plan for them. Safety should come first.

Workers doing restraint need to know why restraint is dangerous. They must know how to avoid and deal with injuries and traumas. They must care for the person's feelings safely. People should have as much say in restraint as possible, including during it.

Plans must say what happens after restraint. Workers and the person restrained need to talk again. They need to check they are all safe.

People in charge should check these very important care plans. The care plans should be written in clear language. People who are restrained may need help with communication and this must be paid for.

People who teach restraint

The last part of Towards Safer Services is for people who teach restraint. It goes with the other standards that the Restraint Reduction Network have provided. This plain language summary does not explain them more.

Executive summary

This document outlines minimum standards for restraint reduction plans* in mental health and learning disability services and is designed to advise care and education settings that may implement restraint. It offers a framework to support providers to reduce their use of restrictive practices. In restraint reduction, the general principles are well established, but it is implementation that is the challenge.

Restrictive practices are often a response to behaviours described variously as 'behaviours of concern', 'challenging behaviour', or 'behaviours which challenge'. Such behaviour occasionally includes willful acts that cause or have the potential to cause harm. However, the behaviour is often a symptom of distress or frustration and a response to the environment or situation that the person finds themselves in. If the legal framework is observed, these minimum standards acknowledge that, in accordance with the Mental Health Act Code of Practice, interventions to prevent a greater harm, such as a breach of human rights, are sometimes necessary.

The content is in line with the legislative requirements outlined for mental health services in the Mental Health Act Code of Practice (Department of Health, 2015) and other relevant legislation, such as the Human Rights Act 1998 (HRA). It is informed by evidence-based best practice where possible. These minimum standards were developed in consultation with expert practitioners and experts by experience. They bring together recommendations from the publications listed in the selected bibliography. They aim to protect human rights and maximise the safety and welfare of the people who receive services and the staff who work in them.

The compliance statements contained in this document provide a structure that may inform both internal quality assurance and external regulation. Due to their systematic nature, the statements vary in their scope and so we have given a thematic summary at the start of some sections, similar to the style of the foundational 2004 NIMHE document.

The standards are applicable to all providers of mental health and learning disability services including independent health and social care providers. They will, by extension, be of interest to any health, care or education service or sector where there are risks associated with behaviour and restriction.

* *The Restraint Reduction Network also provides a template restraint reduction plan for members based on six core strategies. See Appendix 2.*

Foreword

Health, social care, and education providers should not accept as inevitable the occurrence of violence, behaviours of concern, which may harm others, nor the restrictive interventions used to manage them, which may also lead to harm.

Organisations must aspire to eradicate the causes of these behaviours, the behaviours themselves, and the restrictive interventions used to manage them. To do so providers must use a proactive organisational approach to monitor where and when behaviours of concern occur and work to understand the causes of that behaviour.

They should then use this understanding to prevent or mitigate the occurrence of the behaviour. Similarly, providers should monitor where and when restrictive interventions are used and use their increased understanding of the causes of disturbed behaviour to develop strategies to reduce their use.

Such an approach will help deliver a service that is safe and rights-respecting for people who receive the services, staff, and the wider community. Providers will work in collaboration with people who receive services, their family and carers, and other stakeholders to achieve this goal.

All countries experience violence, but its context – the circumstances in which it occurs, its nature and society's attitude towards it – varies greatly from one setting to another. Wherever prevention programmes are planned, the context of violence must be understood in order to tailor the intervention to the targeted population. (World Health Organisation, 2002)

Restrictive interventions are deliberate acts by providers that restrict a person's movement, liberty and/or freedom to act independently in order to take immediate control of a dangerous situation. They are used when where there is a real possibility of harm to the person or others if no action is undertaken and used so that the danger to the person or others may be ended or reduced significantly. Service providers and their staff have a legal, professional, and ethical obligation to minimise harm to everyone. Interventions to manage high risk situations must therefore take place in a culture that focuses on delivering safe and effective care, promoting recovery and respecting human rights.

Robust systems for incident reporting, meaningful post incident support/debrief, and clinical or other risk review must be in place to inform organisational learning. Providers must monitor which 'protected' or other characteristics interact with restraint in their own setting. Such characteristics may include gender, age, ethnicity, disability and other diversities or intersections.

The Six Core Strategies of restraint reduction are an evidence-based framework to which organisations may refer – see <https://bit.ly/3sG6h8c>. Combining the Six Core

Strategies with a human rights framework provides an effective approach to facilitate the culture change necessary to reduce restrictive practices.

The Mental Health Act Code of Practice, Ch26.15 (Department of Health, 2015), mandates the concept of primary, secondary and tertiary interventions. This concept has its roots in public health, and successive reports by the World Health Organisation. They originally referred to first, second and third steps in a trajectory or timeline of violence, but have come to mean universal, selected and indicated steps:

- Primary interventions aim to enhance a person's quality of life and meet their unique needs, thereby reducing the likelihood of behaviours of concern.
- Secondary interventions focus on recognition of early signs of impending behaviours of concern and how to respond to them in order, for example to encourage the person to be calm.
- Tertiary interventions guide the responses of staff and carers when there is an actual behaviour of concern. They can include restrictive interventions such as enhanced observation, physical restraint, mechanical restraint, rapid tranquillisation, seclusion, and segregation. There are also tertiary strategies that are non-restrictive and are effective even at crisis stage and these should be the first resort.

Providers must overtly focus on primary and secondary prevention to avoid or minimise recourse to tertiary interventions and promote a culture of rigorous organisational learning. The aim must be to avoid or minimise the use of restrictive interventions and always prefer joint working and learning, between the people cared for and those around them. This is the best way to ensure care is safe, rights-respecting and focuses on evidence-based therapeutic intervention.

Introduction

The minimum standards offer a framework to encourage services and professionals to review their practices and philosophies of care, to maximise everyone's rights, including their rights to wellbeing and safety.

Ongoing service review by provider organisations will be essential to maintain good performance against the standards. Ongoing education must shift the emphasis from the use of secondary and tertiary interventions (and the historical emphasis on crisis management) to a focus on prevention through organisational learning and individual human relationships. Thoughtful, planned, and strategic change is the priority.

These standards outline the leadership, assurance, accountability, and monitoring arrangements necessary to ensure transparency and inform an organisational learning culture. Named individuals at a senior level should be specifically tasked with and directly accountable for the development, implementation, and robust evaluation of a proactive, evidence-based strategy as part of their leadership function. It is also necessary to involve those who receive care, and to have clear terms for this. All staff and members of the leadership and board should be fully engaged with the arrangements within their organisation. An identified executive and non-executive lead to oversee implementation and monitoring is recommended and will be required in mental health units in England bearing in mind the legal obligation created by Seni's Law. Reducing the use of all unnecessary restrictive practice is a focus for regulators and commissioners.

Clear procedural documents are needed in organisations as part of restrictive intervention reduction plans. Many organisations will use terms like 'plan' and 'strategy' and so we use this introduction to set out what we mean by some of the terms that arise.

Individualised assessments, and plans arising from them, can be called 'care plans'. These are about one person. They aim to understand the difficulties a person is facing at a given time and can also suggest how to solve problems. This approach, of planning care, is vital to ensure respect for people's autonomy and human rights. It allows the person to speak up, and plans to be challenged, or feelings to be aired, as well as the obvious operational benefit of simply having a clear plan. Guidance for mental health and learning disability providers in England is included in the Mental Health Act Code of Practice Chapter 26 *Safe and therapeutic responses to behavioural disturbance*, and others may find it helpful.

A 'strategy' is a high-level approach, formulated by decision-making leaders such as directors, with a clear aim. It concentrates resources and informs prioritisation within an organisation. Successful strategies are simple enough to understand but

comprehensive enough to cover all foreseeable practice. Effective restraint reduction strategies promote cultural change to foster compassion, collaboration, and safe and therapeutic approaches should intervention be necessary. This is in line with services' duties under the Human Rights Act.

Simplistic strategies, overly reliant on target setting and bans, are less systemically effective and may have unintended and adverse human rights and safety implications for both those being supported and those providing support. Practices exist which may, exceptionally, be legally defensible *in extremis*, but are never trained for. So do those for which training is provided, and those that are legal but organisationally banned. Organisations must take a clear stance to classify these practices if there is ever any doubt.

Effective strategies take time to embed and require more than an aspirational or visionary statement to 'reduce violence and the use of restrictive intervention'. Organisational strategies led at a senior level are key to progressing thoughtful, planned, and sustainable culture change.

Using a human rights approach has improved the culture in our organisation. I think I started off skeptical about what difference it would make, but there has been a big turn around and the service is better as a result.

(Practitioner on BIHR's Delivering Compassionate Care project,
www.bihr.org.uk/evaluation-report)

Policies outline standards for practice that will help to embed the strategic goal. Policies must be compatible with the Human Rights Act and should be informed by evidence. Policies should pertain to specific care issues and collectively provide a framework for care decisions and operational management.

The Equalities and Human Rights Commission has produced a framework (<https://bit.ly/3z0hRyP>) which should be used to develop policies (EHRC 2019). Supporting documents should be reviewed in response to developments in practice, organisational learning and legislation change. Policy documents may be supported by 'practice guidance notes' or 'local standard operational procedures' (SOPs) which provide instructions for the practicing workers, promoting points of good practice.

The sharing of good practice in restraint reduction is important because doing so improves care and safety. Directors must hold values which are compatible with sharing good practice. Where market competition, or reputational competition, between services is at odds with reducing restraint, reducing restraint must win.

Primary prevention

Primary prevention in this context is good everyday care and support, which reduces the risk of distress and restraint. For primary prevention to be effective, it is essential to understand root causes rather than addressing superficial presenting symptoms and behaviours. Good formulation, ie structured understanding of problems, is necessary for person-centred preventative strategies. This requires individual assessment of needs from the outset.

Many incidents of behaviours of concern arise from the individual feeling frightened, frustrated, vulnerable, disregarded or ignored. The need for restrictive interventions can be reduced by engaging with the individual, prior to acute disturbance, identifying their triggers and 'co-producing' intervention plans, ie intentionally and genuinely making the person a co-author of plans. Family or other trusted people can be involved, especially if the person needs that help. Focusing on the individual and their particular needs and preferences in care helps protect their right to autonomy, a well-established ethical principle, protected by the right to private life in Article 8 of the Human Rights Act 1988.

By considering together the antecedent situation, the proposed intervention, the person's history and current presentation, teams can start to anticipate the likelihood of violence or behaviours of concern occurring, and construct plans to reduce the risk. These plans may use traffic light models to describe progressive preventative efforts.

While behaviours of concern may appear to be caused by an individual, the influence of broader organisational root causes cannot be ignored. The effects of the social and physical environment have been identified in the literature as potential causes of behaviours of concern. Developing an understanding of these factors, for example, where the person has a learning disability, may involve the completion of a functional and communication assessment. Communication passports have a significant role to play in many settings especially where cognitive differences, dementia, autistic spectrum features or a learning disability may be present.

Environmental factors are things in the service location, for example, the classroom or ward which affect behaviour. We hold them out as important because they are easy to overlook when a person is distressed. They may include difficulties in assessing people's needs, especially complex needs, and sensory and communication needs. Or they may be difficulties in physical hardware of the ward, housing or school, team dynamics, or people being cared for in places that are 'out of sight', or in parts of the organisation that do not provide good governance and learning from events. The recognition of environmental triggers (for example, unfamiliar environment, lack of privacy, restrictions on free movement or intense sensory experiences) should not be underestimated when planning care. The least restrictive option must be provided.

Therefore, good primary prevention in practice requires action across the whole organisation, including:

- the person cared for
- the individual worker (providing direct support)
- the staff team, family members and carers (as appropriate) and advocates
- the broader organisational management team

Overlapping or complementary implementation or therapeutic models, such as Six Core Strategies, Positive Behaviour Support, Safewards, Trauma Informed Care, Restrain Yourself, Aqua, No Force First, CALM and many others, have an important and increasingly evidence-based role to play in organisational approaches to providing safer management of behaviours of concern. Though we introduce them in this which is our section on primary interventions, most also include secondary intervention.

Many are informed by an explicit consideration of the impact of trauma, and all are deployed to reduce conflict and containment. The challenge is implementation. Legal responsibility for the choice of model and implementation sits with the board or equivalent.

Family members and carers can help inform the individual assessment of need and care and support planning. The Triangle of Care approach could be used to ensure appropriate inclusion throughout the treatment and recovery process.

Secondary prevention

Secondary prevention as defined above relies on effective observation and active engagement by staff so they are aware of warning signs and can intervene empathically and constructively. It relies upon the skilled practice of conflict resolution and de-escalation skills by staff and teams who can sustain reflective practice under what may be significant stress. In any setting, in-depth knowledge of the person being cared for, their background and history obviously is essential in both averting and managing crisis.

Conflict may occur due to a number of factors and staff should be sensitive to these in order to minimise the risk of situations escalating. Internal triggers can include symptoms, eg paranoid ideas that may impact on the person's interpretation of events, or affective or behavioural instability. Care and support plans should reflect the impact of relevant symptoms, trauma, or emotional themes. Emotional states, such as fear, frustration, or shame, can lead to poor communication and confrontation. Multidisciplinary team members must make every effort to positively engage with the children and adults being supported and be attuned to when people's emotional states have altered.

External triggers can include, for example, loss of liberty, autonomy, choice, excessive noise, loss of usual coping strategies such as exercise, perceived staff attitudes, being ignored and actual or perceived injustice. Staff must seek to behave respectfully and in a contained way even when exposed to violence or behaviours that challenge. Identifying the underlying needs indicated by the behaviour and finding ways to acknowledge or meet them is key. Training for staff in approaches such as mindfulness or other means of regulating their own wellbeing and mental state may help them to sustain reflective practice under stress.

De-escalation is always the preferred intervention when confronted with potential risk. This should only be superseded when delaying the use of other interventions would result in an increased risk of physical harm.

Tertiary prevention

In some areas it may be necessary to intervene promptly in line with duty of care principles to avoid a situation escalating and harm occurring. There is a positive obligation on practitioners under the Human Rights Act to protect people from an immediate risk to life or of serious harm (under the Right to Life and the Right to be Free from Inhuman/degrading Treatment, Articles 2 and 3, HRA).

Knowledge of the person's history and associated risk factors will help inform care judgments and decisions about necessary and proportionate responses. Subjective preferences and aversion to particular tertiary interventions are highly individualistic, may be culturally bound and should be discussed with individuals.

Any form of involuntary restriction on the liberty and free movement of people whether physical, mechanical, environmental, or pharmacological must be necessary and justified, in order to respect the person's Right to Liberty (Article 5, HRA).

The overarching principle of least restrictive intervention must always guide decision making. However, it is acknowledged that in certain circumstances the presenting risk may merit the need for restrictive intervention to be used in order to prevent a greater harm from occurring. It is therefore vital that whenever any restrictive procedures are used, staff are fully aware of the rights and risks involved. These must be addressed in training syllabuses which place them within the relevant legal, ethical, and professional context. Training standards for reducing restraint need to be seen in the context of learning about both human rights and the duty of care.

All forms of restrictive intervention are potentially hazardous; staff deploying restrictive physical interventions are also at risk of physical injury and potential psychological harm.

Anyone exposed to violence, behaviours of concern and the restrictive interventions used to manage such incidents, may experience a traumatic response. This can be kindled by repeated exposure. Certain staff may be selected to be involved in tertiary

responses due to skill mix, gender, and other human resource factors such as perceived skill or resilience. There should be systems in place to mitigate the risk of this leading to harm to them when it is happening.

To be considered legally, professionally, and ethically justifiable, the decision to use more than one restrictive intervention requires consideration of the interacting risks in addition to the tests of necessity, proportionality, and least restrictive care.

Restraint should never be inhuman and degrading, as human rights law sets out an absolute ban on such treatment (see Article 3, HRA).

Support and debrief are part of safer tertiary intervention

Tertiary interventions in practice should be seen as very serious processes which need structured and careful learning and 'care', in all senses of that word, on each occasion. This is necessary to ensure lessons are learned from incidents, and that action is taken to prevent the risk of re-occurrence and to minimise associated harm.

Post-incident review requirements for healthcare settings where restrictive physical interventions are used are outlined in NICE guidance – Quality Standard 154 to NICE Guideline 10 (2017). More general guidance, beyond the scope of NICE, for other sectors as well as healthcare, is in the RRN Training Standards. As is the case throughout this document, the general principles will be helpful in all settings where restraint may occur.

The RRN Training Standards defines 'post-incident support' as attention to physical and emotional wellbeing of the individuals involved. It happens first to ensure safety. Then 'Post-incident reflection and learning review' is then defined as a learning and reflective review to avoid future incidents, identify triggers, review plans and so forth. That happens second, to improve the ongoing situation. The present *Towards Safer Services* standards allow themselves the shorthand of 'debrief' for the second part. The person coordinating post incident support should consider whether a debrief is needed. The answer should usually be yes. Factors indicating that a full debrief is required include that someone was hurt, seclusion was used, any pattern of incidents involving the same person, prolonged restraint, or when there are specific lessons to be learned. It should happen when someone involved wishes it to happen, whether it is the person restrained, carer or member of staff.

Therefore, we aim to provide guidance for immediate post incident support, and for the learning and reflective review, which we call debrief. With reference to a review of current available evidence, these standards support a clear separation of these two components (Baker, 2017). The intention of each process should be clear to all those involved. All such processes should be carried out in a non-blaming way. Reasons why either of these components are not undertaken should be recorded, for example, refusal or where there are grounded concerns that attempting support or reflection may trigger further crisis.

Referring to how people's human rights were considered and balanced can provide an important element of defensible, informed decision-making. Organisations that provide good care will of course also have other general processes for learning, reflective practice, and similar activities. These may be mandated by professional registration. The agenda for more general activities should include the opportunity to discuss and reflect on any incidents. Exposure to behaviours of concern will sometimes generate negative feelings. Unless negative feelings are acknowledged and actively managed, this could influence staff wellbeing, or their behaviour towards the people that they support and ultimately impact on the service culture.

The intended use of these compliance statements

The following compliance statements define standards for the adoption and implementation of a total organisational approach to the safe and therapeutic reduction of restrictive interventions in mental health, learning disability and some related settings. They should also be applied as good practice where applicable in other settings where care is provided and there may be restraint, such as certain social care or educational settings. The compliance statements aim to provide a regulatory framework but do not provide a system of accreditation.

Clinical governance or similar governance arrangements within provider organisations should be used to assess compliance with the standards. Providers should take responsibility for this governance, and arrangements for peer review of compliance to the minimum standards could be used to gain additional assurance.

The Standards

Section 1: Board Level Organisational Compliance Standard

Section 1 of the standards provides positive practice indicators for accountable officers and delegated professional and operational managers. The following organisational arrangements should be in place to demonstrate a well-led organisation.

1.1 Strategy and policy

- I. The Board approves an evidence-based restraint reduction strategy informed by organisational risk assessment that describes actions to minimise the risk of behaviour that is challenging and the use of restrictive interventions.
- II. The strategy has an implementation procedure that is regularly reviewed.
- III. The strategy emphasises the need for rights-based, individual person-centred interventions and care.
- IV. The Responsible executive lead for reducing restrictive practice is identified in the strategy/policy.
- V. The Responsible non-executive lead is identified in the strategy/policy.
- VI. Board approved policies and procedures support the Restrictive Interventions Reduction Strategy.

1.2 Involvement of people who receive services and their carers in strategy development and implementation

- I. Board approved policies and procedures emphasise the need for clear and effective communication with people who receive the service and their carers. This should include arrangements for accessing communication aids, for example, signing, visual aids, and access to interpreters.
- II. Accessible organisational information is available for people who receive services, in respect of their human rights including personal safety and security. This is compliant with the Accessible Information Standard.
- III. Decision making teams at differing operational levels, such as boards, steering groups, project teams and leadership teams, especially in large

- organisations, include individuals with explicitly declared lived experience of services such as representatives of people receiving services, peer support workers, or governors with lived experience.
- IV. There is evidence of the involvement of people with lived experience in decisions, at different organisational levels.
 - V. Risk registers account clearly and at the right level for known organisational risks.
 - VI. Peer support workers, advocacy, and other defined processes aid care planning for individuals, within the constraints of ethics and expertise, supported by other professionals in the team, and are aware of where they fit into the organisation.
 - VII. In relevant settings, staff members, who are not employed on the basis of their lived experience but have themselves received care in mental health, learning disability or autism services are supported by culture, etiquette, and supervision. This may include guidelines and supervision for disclosure of lived experience, including support for decisions not to disclose, as they might for any other protected characteristic.

1.3 Training and education

- I. A Board approved education and training programme promotes recognition, prevention, and de-escalation as the first line approach when responding to behaviours that challenge. (Details are in Section 3).
- II. Training includes the Human Rights Act, which underpins other law and policy on reducing restrictive interventions. This allows understanding of how the Act underpins other aspects of law and policy on restrictive interventions, their duties under the Act, how to make defensible decisions, and how to balance rights and not just focus on risk.

1.4 Incident reporting, monitoring, and assurance

- I. Transparency, openness, and candour are promoted within the organisation through regular communications, training, and policy in order to demonstrate safe, effective, caring, responsive and well-led services.
- II. An incident reporting process is in place, which reports where applicable to the National Reporting and Learning System and other central agencies as required. This must address actual occurrences that have led to harm or potential harm and near miss incidents.
- III. Organisations must work with national bodies to foster fair and timely

- reporting of incidents. This will enable some comparisons of activities between providers notwithstanding their differing circumstances and the range of needs of the children, young people or adults served.
- IV. Procedures allow staff teams to benefit from the knowledge gained from incident reporting analysis and trends, as close to real time as possible.
 - V. Incident reviews inform organisational service improvement and training in order to ensure that learning from events is translated into safer care. Delivery of care should also be informed by learning from national inquiries such as the Ministerial Board on Deaths in Custody, and from local events. This would include themes emerging from near miss incidents and risks/issues pertaining to safe care. For example, issues arising from the delays in building works that affect the therapeutic environment may be held by directors and the board, whereas limitations in staffing may be held at unit, department, or service level. The organisational levels must communicate effectively.

1.5 Responsibilities of directors and the executive and non-executive lead

Directors and the executive and non-executive lead ensure the following:

- I. A robust incident reporting process is in place
- II. Systems ensure learning from incidents, complaints and inquiries is shared across services.
- III. Governance structures monitor incident reports and establish themes and trends.
- IV. Structures act on any emerging themes or trends.
- V. Systems ensure actions agreed in response to learning from incidents complaints and inquiries are implemented, and the impact is monitored.
- VI. There are periodical reports to the board and to the senior executive team in the organisation.
- VII. It is possible for external assurance to show evidence of changes to the restrictive intervention reduction strategies, policies, and/or practice guidance notes in the light of learning from incident reporting.

1.6 Incident reporting procedures should address:

- I. All incidents where physical interventions, rapid tranquillisation, restriction of liberty or seclusion are used must be formally reported.
- II. Procedures should allow the analysis of trends such as the frequency and

- seriousness of different types of restraint over time and in different areas of the provider services.
- III. Procedures should allow for the routine gathering of important demographic information relating to the individual, such as ethnicity, age, and gender, etc.
 - IV. Procedures allow for the routine gathering of important clinical and other care information, in line with current positive practice and legislative standards. This will mean such detail as anonymised reporting of the people involved, location and time of incident, duration of incident, different phases and postures of the incident, possible causes, and injuries to staff and the children or adults subject to restraint.
 - V. Procedures support routine information gathering, or where practicable, cross referencing to other databases containing proportionate employee information, such as injuries to staff, grade/role and or experience of staff involved in incidents, training level of staff involved in incidents etc.
 - VI. Directors show an ability to consider and synthesise the data presented in the light of service transitions, emerging themes and their other strategies, lessons to be learned and how practice improvement will be implemented.

1.7 Sharing lessons learned

- I. Documented reflective practice sessions occur to inform staff of lessons learned, in order to implement practice change.
- II. Supervision happens and is audited.
- III. Post-incident support and debrief arrangements are well defined and available for everyone.

1.8 Safer staffing

- I. Reporting incidents and learning lessons systems, include effective and supportive ways to learn from people's experience, but make clear that feedback is an offer and is not compulsory for the person that has been restrained.
- II. Organisations have a responsibility to ensure that staffing levels and skill mix are appropriate in order to ensure that services are caring, safe and effective. The arrangements in place must be compliant with the NHS England Safe Staffing Recommendations or other relevant organisational recommendations and the organisation's duties under the Human Rights Act.

1.9 Induction

- I. All staff, permanent or temporary, are provided with a thorough values-based induction programme which allows them to understand and safely use the principles and practice of restraint reduction in accordance with their occupational role.
- II. Induction includes reference to staff's legal duties under the Human Rights Act.
- III. Accessible organisational information is available for staff in respect of their rights including personal safety and security and the arrangements for these.
- IV. Volunteering service users, peer support workers and other groups including volunteering parents or other volunteers receive appropriate induction.

1.10 Temporary staffing and students on placement

- I. Arrangements with agency staff providers or higher education institutions ensure that the training provided to agency staff/students is compatible with the employing organisation's standards.
- II. Demonstrable organisational arrangements ensure bank and agency staff members and students are adequately trained for the environment they are expected to work in, for their own safety and the safety of others.

1.11 Health and wellbeing

- I. An appropriately resourced and effective occupational health service, with access to counselling services, is available.
- II. Proactive systems are in place for the promotion of health and management of sickness and annual leave in order to reduce the reliance on temporary staff.

1.12 Joint working arrangements

Organisations should have established multiagency partnership boards in place. In order to meet the joint working standards as outlined in the *Memorandum of Understanding* (College of Policing, 2017) these boards should include the police, Crown Prosecution Service (CPS), people who receive services, carers, advocates, health and local authority managers, ambulance service personnel, and other key stakeholders. A shared understanding between agencies is particularly important because of the

different organisational goals and cultural assumptions of each stakeholder. To reduce the possibility of a misunderstanding of the professional and operational boundaries within each contributor agency, the following should be established:

- I. Clear roles, responsibilities, and purpose when joint working is required in any way which may be restrictive.
- II. Joint working arrangements are made with external bodies such as police, health, or social services regarding the use of restrictive practice.
- III. Joint working arrangements are in place with other relevant stakeholders regarding the use of restrictive practice.
- IV. A joint protocol is in place with the police, where needed, such as one which meets the requirements of the Mental Health units (Use of Force) Act 2018, regarding how people's safety and rights will be maintained when police deploy restraint in the care setting.
- V. Joint working procedures and policies are in place outlining situations when police will and will not respond.

1.13 Communication between agencies

- I. Effective and mutually beneficial communication and information sharing systems are informed by common sense, confidentiality and Caldicott 2 (Department of Health, 2013).
- II. Joint approaches to education, training, policy, and practice.
- III. Shared lessons learned and positive practice initiatives regarding restrictive practice.
- IV. Tabletop multiagency incident planning.
- V. Reciprocal training and awareness sessions.
- VI. Allocation of resource to maintaining relationships, such as local police liaison meetings.

1.14 Criminal justice procedures

- I. Local security management specialist (or designated responsible person) should be in place.
- II. Agreed processes for the bringing of criminal proceedings and where appropriate, liaison with external bodies.
- III. Systems for the tracking of cases/proceedings through to conclusion, with

providers able to keep track of case outcomes through effective liaison with courts and police.

1.15 Environmental safety

- I. Organisations ensure that environments comply with statutory health and safety legislation. Providers must carry out and regularly review environmental risk assessments in order to manage identified environmental risks.
- II. Environments take into account the factors that influence recovery, for example, sleep, and privacy.
- III. Secure estates departments incorporate best practice design into developments to ensure personal space, access to fresh air, lines of sight, and sensory needs of certain populations.

1.16 Needs-led provision

- I. Services have systems in place that reduce the risk of people being placed or admitted to services that do not meet their needs in terms of recovery, safety, education, or security. These issues may impact on people's rights to be free from abuse/neglect (Article 3, HRA), right to liberty (Article 5, HRA) and the right to private and family life (Article 8, HRA).
- II. People receiving services can access worship space, faith leaders and spiritual/religious/faith groups.
- III. Staff are informed of and sensitive to religiously/culturally significant dates and practices, to support the right to be free from discrimination (Article 14, HRA) and the right to freedom of thought, conscience, and religion (Article 9, HRA).
- IV. All settings provide daily opportunities (not including mealtimes) for people to have effective communication and therapeutic engagement. Apart from being good practice this protects the right to wellbeing, protected by the right to private life (Article 8, HRA).

1.17 Environmental security

- I. Any policy on the use of cameras (including CCTV and body cams) is compliant with the relevant legal standards for the setting, including where relevant the Mental Health Units (Use of Force) Act 2018, and the right to respect for private life (Article 8, HRA). As part of this, children and adults who may be filmed, carers and parents or others who need it are given

- information explaining the organisational policy on the use of cameras.
- II. Any policy on the use of locked doors is compliant with the relevant legal standards including the right to liberty (Article 5, HRA) and children and adults, parents, and carers are given information explaining the organisational policy.

1.18 Audit

- I. Local audit and quality assurance arrangements differentiate the arrangements in place for the regulation of training providers and training programmes and the regulation of the care organisation. Training providers cannot assume responsibility for the wider aspects of organisational assurance.
- II. In instances where any aspects of the RRN Training Standards are not applicable, for example small provider organisations such as group homes, a documented rationale must be provided, and the bespoke safe practice arrangements described.
- III. Peer review can be used as part of organisational assurance.

1.19 Responsibilities of organisations

Organisations should ensure the following:

- I. Governance arrangements are in place to ensure that audit and monitoring is carried out to progress full compliance in line with the minimum standards outlined in this document.
- II. Peer review learning processes are considered best practice and a joint working approach to assess compliance should be progressed when feasible.

Section 2: Effective Care Planning and Multidisciplinary Team Compliance Standard

Section 2 of the Standards provides guidance for teams who give actual care and restrictive practices to people. Teams have a crucial role in the promotion of safe and therapeutic care. Their care and support to people, in often difficult circumstances, must be rights-respecting, safe, caring, effective and responsive. Organisational procedures are only effective if applied consistently in practice, at a personal level.

Individual staff members must comply with their duties under the Human Rights Act and demonstrate the values outlined by the organisation and their professional body. This includes compliance with the conduct and capability framework in accordance with their occupational role, for example, physical health, fitness to practice and adherence to any reasonable adjustments and attendance at training and development sessions.

Clear and effective communication is integral to restraint reduction. Communication tailored to the person being cared for is of absolute and central importance in primary and secondary interventions. They may have hearing or visual impairment, cognitive impairment, their first language or world view and values may not be the same as staff, in ways that may take time and care to discover. Communication and engagement help ensure effective collaboration between staff, those being supported, cared for, or educated, and their carers/advocates/parents. This will help to minimise the risk of misinterpretation of actions and behaviours on 'both sides'. Specific competencies in communication with people with relevant difficulties, eg intellectual difficulties, developmental spectrum conditions, or dementia, are crucial in both averting incidents and in their actual management.

In services a variety of terms may be used to describe what we call individual 'care planning'. These can include: crisis plan; personal safety plan; reactive management plan; reactive strategies plan; restraint safety and reduction plan; positive behaviour management plan or traffic light plan. For simplicity we use 'care plan' to cover all of these. The purpose of a care plan is to ensure a personalised, reasonably predictable and informed approach to the use of safe and therapeutic interventions and care. It allows challenge and defensibility. It allows new staff to care and support more safely. It allows services to respect the rights of people who receive their services. The care plan intervention must therefore be understood by and accessible to the care staff and be regularly reviewed and consistently applied.

2.1 Training

- I. Multidisciplinary team staff must attend relevant training programmes and refresher training as informed by the standards of their continuous professional development.
- II. Multidisciplinary team members should attend formulation, risk assessment, and training in care/support planning and interventions in accordance with their occupational role. This should reference the RRN Training Standards where applicable.
- III. Where there are needs for further training created by the possibility of being involved in restrictive practice, the delivery and frequency of that training should be based on Training Needs Analysis (TNA). This should reference the RRN Training Standards where applicable.
- V. Training should cover staff duties under the Human Rights Act and the Equalities Act and other relevant legislation and how these legal standards underpin other laws and policies relevant to restrictive interventions. This should reference the RRN Training Standards where applicable.

2.2 Initial risk assessment and safety planning

- I. On admission or placement, and after significant events or receipt of new information, a risk assessment should be carried out. The assessment should be based on as wide a set of information as possible and use structured professional judgement. A safety care plan should be put in place to inform the safe and therapeutic management of identified risks. Separate elements of the plan may be necessary to deal with separate risks, such as to self or others, or different types of risk to others.
- II. This should be conducted in collaboration with the person and, if appropriate, their parent and/or carer wherever possible and advance decisions clearly recorded and communicated.
- III. The risk assessment findings should be communicated to all relevant staff, typically at least the whole multidisciplinary/multiagency team, and other agencies such as MAPPA where appropriate in line with information sharing procedures.
- IV. If tertiary intervention strategies are foreseeable due to historical risk factors or current risk profile, any known vulnerabilities or those that become apparent after appropriate physical health assessments or otherwise should be clearly detailed in the care plan.
- VI. Risk assessments and risk management care plans should be recovery focused and reviewed in line with organisational policy and in response to any incidents occurring.

2.3 Care planning

- I. Care plans are, where practicable, co-produced with the person whose plan it is and, where appropriate, their family/carer from the outset.
- II. Staff teams work in collaboration with the individual and, where appropriate, their parent family or carer to develop individualised advanced decisions. This helps any interventions meet their specific needs and advance wishes, and respects people's right to autonomy (Article 8, HRA).
- III. Care plans record known triggers and early warning signs to distressed behaviours or behaviours that challenge.
- IV. Care plans clearly define the agreed, preferred or less preferred interventions.
- V. Discussions in relation to the use of tertiary interventions are conducted with the person themselves and family/carer (when appropriate) and identify preferred options/choices to be adhered to unless the presenting risk does not allow this.
- VI. Care plans should consider the influence of environmental factors, for example, boredom, client mix, and any limitations to access to fresh air and exercise, and individual sensitivities to changes in routine and sensory experience, all of which can lead to frustration and increase the risk of challenging or aggressive behaviour.
- VII. Care plans address any spiritual, religious, and cultural needs, beliefs and behaviours of the child or adult protecting the right to be free from discrimination (Article 14, HRA) and the right to freedom of thought, conscience, and religion (Article 9, HRA), or to a private life (Article 8, HRA).
- VIII. Care plans address any individual needs associated with physical disability, including communication with service users who have a sensory impairment (Article 14, HRA).
- IX. Care plans address any specific needs in relation to gender, for example, dysphoria, previous domestic violence, and associated trauma.
- X. Care plans address any specific issues in relation to older people's needs, for example, cognitive impairment, or physical health risks, in keeping with the right to wellbeing (Article 8, HRA).
- XI. Care plans address any specific issues in relation to children or younger people's needs, for example, impact of isolation from family, or changes to their developmental experiences which admission to hospital or change of placement may create, to respect their right to family life (Article 8, HRA).
- XII. Care plans should address any specific known triggers that may impact on behaviour, for example, the anniversary of a traumatic event.

- XIII. People receiving services benefit from personalised strategies as part of their care plan; this includes use of positive behaviour support planning or equivalent appropriate strategies, such as offence specific work.
- XIV. Care plans address any physical healthcare needs and psychological issues and clearly highlight factors that will increase risk of harm during restraint. Staff must understand that mechanisms of death in restraint include crush injury, chest wall mechanical restriction, cardiac exhaustion, and occlusion of the airway. Medical factors which worsen these must be assessed and treated where possible. Restraint techniques where there is an anticipated specific risk of serious harm or death must be avoided.
- XV. Care plans address any dignity issues associated with the use of physical intervention, to protect the right to be free from inhuman or degrading treatment (Article 3, HRA).
- XVI. Medication prescriptions, both regular and 'as needed', should be subject to regular review in a structured way, for example as part of weekly multidisciplinary meetings, in order to respect autonomy. The use of medication to manage behaviours that challenge is reviewed as part of a care planning process in particular for individuals with learning disability (The Challenging Behaviour Foundation, 2016).
- XVII. The individualised plan of care reflects any emotional needs and person-specific post-incident support in particular in relation to previous trauma.
- XVIII. Changes in levels of risk are recorded, communicated and risk management care plans updated accordingly.
- XIX. While post-incident support and debrief processes are defined and generally used, and variations to these that are needed for this person are in the care plan, for example the extent to which they will want to discuss things, or communication adaptations.
- XX. All people who have been subject to restraint have post-incident physical review, and individual needs for these stages of care are considered in the care plan.
- XXI. Review dates should be stated in the individual's care plan.

2.4 Communication needs in care planning

Safe interventions cannot occur without effective communication of need. Limitations in the ability of teams to communicate with people can foster behaviours that challenge, violence, and restrictive practice. People with developmental, learning, cognitive or organic problems, or combinations of these, are more likely to require specialist communication skills.

- I. Primary and secondary intervention plans in these areas reflect the importance of individualised communication strategies. This may include communication passports and should allow, as a minimum, a new staff member to communicate effectively with all people who are receiving a service. Specific needs in relation to learning disability, for example, communication needs and physical health risks, are informed where appropriate by speech and language therapist assessments, or communication aids such as visual tools.
- II. Interpreters can be accessed for those people whose first language is not English.
- III. There is access to staff with specific communication skills, eg signing, visual aids.
- IV. Literature is available in languages other than English in order to avoid discrimination (Article 14, HRA).
- V. Providers adhere to the Accessible Information Standard (NHSE 2016/17).
- VI. Providers adhere to 'the five good communication standards' of the Royal College of Speech and Language Therapists.
- VII. Where, due to reasonable adjustments for communication, paper-based care plans, co-produced wellness plans, or risk formulations are used (such as picture boards), there is a robust framework for reviewing these that mitigates the loss of governance that can occur with non-electronic records.

2.5 Monitoring physical healthcare during and after restraint

It is well established that people's lives can be at risk during, or post, restraint episodes due to direct airways obstruction, crush, respiratory restriction, cardiovascular collapse after physical exertion, other things, or combinations of these. Certain conditions may alter the balance of risk in relation to the application of tertiary interventions and are important to identify, formulate and plan for in advance of restraint occurring. These include conditions which impact on cardio-pulmonary function including prolonged QTc interval, or muscle and joint impairment, eg asthma, acute stimulant intoxication, large muscle bulk leading to increased oxygen demand, heart disease, obesity, medication, arthritis, high blood pressure, diabetes, or propensity for using illicit drugs and/or alcohol, and pregnancy.

The risk of fracture may be increased in people with schizophrenia.

Medical review, by which we mean a medical doctor reviewing the person and at least triaging them to determine whether they need a more detailed history and examination, should occur at the earliest opportunity in health care settings after the commencement of any physical restraint. There are variances in existing published guidance and any such standard is to some extent arbitrary. While best practice is review 'as soon as possible' we suggest a governance standard that all medical entries are timed, dated, and occur within one hour or include a documented rationale for delay. Onward reviews must occur and be proactively planned in line with a person's individual presentation and any identified risk factors. Such plans require careful and clear articulation, for example with specific stipulation of review periods, the actual physical observations to be taken, and what the care team must do if the individual's condition changes. This meets the positive duty to protect the right to life and to be free from inhuman/degrading treatment (Articles 2 and 3, HRA). Other settings must have clear routes to meet foreseeable but unanticipated emergency physical health care needs, for example knowledge of how to call an ambulance.

Physical monitoring is especially important:

- following a prolonged or violent or high intensity struggle
- if the person has been subject to enforced medication or rapid tranquillisation
- if the person is suspected to be under the influence of alcohol or illicit substances
- and consideration should also be given to risk and novel psychoactive substances
- if the person has a known physical condition which may inhibit cardio-pulmonary function, eg asthma or obesity
- if the person is held in a position that can compromise respiration (breathing)

2.6 Physical health preparedness standards for all people receiving health or similar services

- I. On admission to any health or similar residential service, it is important for safe interventions later, that individuals have a basic physical examination, and their physical needs are assessed within 24 hours.

- II. Prescribing staff consider possible drug interactions when prescribing antipsychotic medication, particularly high dose.
- III. People receiving health services are asked about consent to any prescribed medication, and whether they have been taking it prior to admission, to meet with good care, the Mental Health Act and to respect their autonomy (Article 8, HRA).
- IV. Health services must ensure medication is reviewed as part of a care planning process for individuals with a learning disability in keeping with advice from The Challenging Behaviour Foundation (Stomped) (2016).
- V. There is a recorded capacity assessment especially in relation to 'as needed' medication.
- VI. Any physical condition which may increase the risk to the person of collapse or injury during restraint is clearly documented in the person's records and communicated to all multidisciplinary team members. Staff should be sensitive to the possibility of undocumented health conditions especially in people with severe or profound disabilities.
- VII. Where there is a foreseeable risk a care plan clearly identifies the physical condition and the strategies to minimise the risk to the person.
- VII. The care plan is communicated to all multidisciplinary team members and regularly reviewed and evaluated with the person themselves and, where appropriate, their carer/advocate.

2.7 Staff who may be involved in the restraint process

Staff in health services who may be involved in the restraint process are trained in the following:

- I. Basic life support skills (annual update is required).
- II. Qualified staff are trained in Immediate Life Support (ILS).
- III. The physical risks associated with restraint.
- IV. Recognising conditions of physical and respiratory distress, signs of physical collapse, side effects of medication and the effects of illicit substance misuse and how to take appropriate action.
- V. Use of emergency equipment.
- VI. How to summon appropriate assistance.
- VII. The Human Rights Act, and how this applies to everyday decision-making

- and practice, in particular the right to life, the right to be free from inhuman/degrading treatment, the right to liberty, the right to wellbeing and the right to autonomy (Articles 2, 3, 5 and 8, HRA).
- VIII. In all wards where the use of restraint is foreseeable there is immediate access to life support equipment, which is checked weekly, as a minimum, and maintained in working condition.
 - IX. The physical health of any person subject to restraint is continuously considered and evaluated and there is vigilant observation with the best information available for signs of deterioration, such as where possible counts of respiration rate, use of pulse oximetry, talking to the person. Warning signs of deterioration should be in the care plan and a contingency plan for their emergence should be in place.
 - X. In all settings where the use of restraint is foreseeable and where urgent medical assistance may be required, there are systems in place to access medical/para-medical assistance via on-call duty doctor, cardio-pulmonary resuscitation teams, or para-medical services.
 - XI. Any person subject to physical restraint should be medically assessed within one hour of the commencement of the restraint, or the reason for the delay recorded. The Mental Health Act (MHA) Code of Practice implies that in health settings this examination should be by a registered medical doctor where it says that organisations must have clear arrangements for this.
 - XII. The MHA Code of Practice mandates at Ch26.82 medical review at least one hour after the beginning of mechanical restraint. Subsequently there should be ongoing medical reviews at least every four hours by a registered medical practitioner. Local policies should determine 'which of their registered medical practitioners should undertake medical reviews'. Reviews should be undertaken more frequently if requested by nursing or other staff. Reviews should ensure that the individual is as comfortable as possible and should include a full evaluation of the person's physical and mental health condition.
 - XIII. In all settings any, and all, injuries are clearly documented and reported to service management. In health settings these are summarised for the directors and board and reported into the National Reporting and Learning System and the Mental Health Services Dataset. Frequency of subsequent medical reviews will be planned at this point in accordance with individual needs and risk factors.
 - XIV. If consent and co-operation for post-restraint physical observations is not

given, or if other problems arise, eg failure of technology, then it should be clearly documented in the person's records why certain checks could not be performed and what alternative actions have been taken.

XV. Person-specific post-incident monitoring needs are defined in the care plan. For lengthy, invasive, or more restrictive practices, independent review should be considered.

XVI. Individualised care plans reflect any relevant sensory or prosthetic needs.

XVII. Individualised care/support plans stipulate the frequency and length of monitoring of physical status. These checks should include:

- care in the recovery position where appropriate
- pulse
- blood pressure
- respiration
- temperature
- fluid and food intake and output

Section 3: Training and Trainer Content Compliance Standard

Effective training that is informed by contemporary evidence and subject to regular review promotes a culture of human rights, safety, and recovery. Organisations must have arrangements for education and training programmes for the positive and proactive prevention and therapeutic management of aggression and violence. These should be delivered as part of staff induction, for staff in post and include updates covering both theory and physical skills. Organisations should ensure training is certified as complying with the RRN Training Standards (whether commissioned from an external training provider or delivered in house) – see <https://bit.ly/3IIIAIJ>.

Training with a restrictive intervention component should be certified against the RRN Training Standards by a body accredited by the United Kingdom Accreditation Service (UKAS). These training standards and their principles and governance should be extended through care sectors, as applicable, in a spirit of good practice.

Best practice complements formal training and refresher courses with frequent local skills/group supervision sessions informed by learning from routine reporting procedures, audits, and incident reviews.

Annual updates are recommended as best practice in Positive and Proactive Care (Department of Health, 2014b) guidance and a requirement within the RRN Training Standards. Updating practice should reflect what is needed in order to maintain competence. This may require more regular but shorter practice sessions.

3.1 Theoretical content

Detailed guidance on staff development and training has been published jointly by Skills for Care and Skills for Health, in A Positive and Proactive Workforce (Skills for Care and Skills for Health, 2014). Aspects of training in non-physical intervention require interaction and engagement and the full package cannot be delivered via e-learning. Any aspects addressed via e-learning or via pre-course reading should be outlined in the training assessment and a clear rationale given for that teaching approach. Section 2 of the RRN Training Standards covers content that must also be included if people are being taught to use restrictive interventions.

Training strategies need to be explicit regarding learning outcomes relating to the following:

- I. The experience of people who use services.

- II. Trauma informed care.
- III. Core skills in building therapeutic relationships.
- IV. The principles of Positive Behaviour Support (or equivalent interventions aimed at understanding and safely and therapeutically supporting behaviour).
- V. Legal and ethical issues, including services' duties under the Human Rights Act.
- VI. Risks associated with restrictive interventions.
- VII. Staff thoughts and feelings on being exposed to disturbed behaviour.
- VIII. The use of safety planning tools and advance decisions.
- IX. Alternatives to restrictive interventions.
- X. Effective use of de-escalation techniques.
- XI. Conflict resolution styles.
- XII. The risks associated with restrictive interventions and how these risks can be minimized.
- XIII. The use of breakaway techniques by which to disengage from grabs and holds.
- XIV. Safe implementation of restrictive physical interventions.
- XV. Post-incident review and support for both staff and people who use services.

3.2 Training safety

Care providers that do not have access to in-house occupational health provision should work with organisations to ensure pre-course health and safety arrangements are addressed as part of the training needs assessment.

The training environment should be risk assessed and fit for purpose, any emerging environmental risks should be clearly outlined to participants and safety protocols described. The ratio of trainer to participant must be risk assessed in accordance with the activity occurring and the rationale for the agreed ratio outlined in the course risk assessment and TNA.

3.3 Physical intervention – avoidance of pain compliance

The European Committee for the Prevention of Torture advise that pain should never be used to gain compliance. Any physical intervention technique can potentially result in pain and the perception of pain will be changed by individual circumstances. This guidance takes the position that deliberately eliciting pain must be strenuously avoided.

Professional Codes of Practice clearly define that the deliberate application of pain is not an acceptable practice and therefore should not be taught. It may, in exceptional circumstances, represent the 'least bad' intervention capable of providing safe care; rare examples include extreme emergencies or rescue type situations. Individual practitioners are professionally and personally accountable for their role in the application of restrictive interventions and are obliged to report any actions that cause concern.

Certain actions or practices which may exceptionally be legally defensible in extremis, for absolute life and limb emergencies, will be inappropriate to provide training in. If exceptional measures are trained for, they can become normalised. If banned practices continue but are not reported, they cannot be legally challenged or monitored. This balancing act of expectations is the legal responsibility of the board. The implementation is ultimately the responsibility of the worker.

3.4 Organisational context of training

- I. Non-physical intervention training in the positive and proactive prevention and therapeutic management of aggression and violence is informed by a risk assessment and needs-based approach to ensure and evidence that training is 'fit for purpose'.
- II. The Training Needs Analysis (TNA) should be agreed between the service provider and training provider and should be signed off by the executive lead for reducing restrictive practice in the provider organisation.
- III. The training approach arising from the TNA should be signed off by the executive lead responsible in the provider.
- IV. Responsibilities arising from sub-contractual arrangements for training, for example for injuries to staff occurring during training with an external training provider, should be addressed clearly in the service level agreement.

- V. Service providers must work with training providers to ensure that any training delivered is appropriate to the needs of the people being supported and the staff providing support and that it is proportional and takes into account any elevated risks. It should be based on a TNA and the analysis should be reviewed regularly to avoid 'a one size fits all' approach to training. Any restrictive intervention component of training should be regularly reviewed to see if it is still a necessary part of the training content.

3.5 Training Needs Analysis (TNA) and training delivery

The TNA should outline the following:

- I. The specification of which staff need training.
- II. The level of training required.
- III. The frequency of training.
- IV. The non-physical and physical content of the training specific to the service area.
- V. Learning outcomes for physical and non-physical training.
- VI. Arrangements for testing knowledge, competency, and attitudes against identified learning outcomes.
- VII. The rationale for inclusion of the physical interventions.
- VIII. Training for any sub-specialty issues such as gender, diversity, dementia, the Children's Act, PBS, attachment etc, as indicated by service need.
- IX. The duration of the course based on the agreed content.
- X. Physical intervention training is not delivered in the absence of an evidence based theoretical training package.
- XI. Training updates include changes to legislation, national guidance, supporting organisational policy and procedure, lessons learned and reinforce non-physical intervention elements.
- XII. Staff attending training are provided with pre-course information which outlines expected conduct, dress code and course content.
- XIII. Organisational arrangements are made to manage staff who are unable to participate on a temporary or permanent basis, including occupational health support, where necessary.
- XIV. Staff attending training complete an occupational health checklist prior to

commencing physical aspects of training. This should:

- a. address any pre-existing conditions that may impact on participation
 - b. inform staff of the range of movement and activity required to participate safely
- XV. Trainers are informed of any adjustments that can be made to support the individual which are recorded in writing.
- XVI. Links between training and occupational health are established in order that occupational health practitioners understand what is being taught in training and used in practice so that when a member of staff is referred, they can be effectively assessed and treated.
- XVII. All theoretical training courses are outlined in a training manual covering the training content including the relevant legal frameworks and organisational policy. The manual is held by the training provider and should be evidence based and fit for purpose.
- XVIII. The training manual is subject to review in line with policy and practice developments and, for example, relevant legislative changes.
- XIX. Physical intervention techniques are taught in accordance with the rights protected in the Human Rights Act, explaining which rights can be restricted (where lawful, necessary, and proportionate) and which rights cannot be restricted.
- XX. Physical intervention training includes interventions to facilitate assault avoidance, escape or disengagement from a risk situation and restraint interventions in accordance with the assessed service needs.
- XXI. Physical interventions follow an intervention hierarchy that is mapped to the presenting risk.
- XXII. Training includes services' duties under the right to life (Article 2, Human Rights Act) and reinforces that the breathing and airway must not be obstructed, and monitoring of wellbeing throughout the restraint procedure is designated to an identified staff member.
- XXIII. Training reinforces that physical interventions should be used if a failure to intervene will result in harm that is judged likely to be greater than that caused by the use of intervention; this includes intervention to provide essential care and treatment.
- XXIV. Physical interventions taught within the syllabus and approved for use within services are clearly outlined and recorded in a written training

manual.

- XXV. Physical interventions noted in the training manual have been risk assessed and the balance of these risks has been signed off by the executive lead.
- XXVI. The risk assessment outlines the risks in training and in practice and is conducted by an appropriately qualified professional. This may include medical or legal staff for relevant assessments.
- XXVII. The use of simulated resistance during training may pose significant risks. Only trainers must role play resistance in any such simulations.
- XXVIII. Role plays must be directly managed by a separate trainer who should immediately stop the scenario if there is evidence of risk.
- XXIX. Physical interventions are regularly reviewed to ensure they remain fit for purpose.
- XXX. The physical intervention risk assessment highlights risks in practice and outlines mitigating factors to reduce risk.
- XXXI. The risks associated with physical intervention use are clearly articulated in the training manual; this must include both physical and psychological risks.
- XXXII. In services with environmental restraint such as de-escalation, seclusion or low stimulus rooms, training includes reference to organisational policy and procedure.
- XXXIII. The use of mechanical restraint equipment. In services using mechanical restraint, equipment training includes procedures to safely manage procurement, maintenance, specification (eg weight limits) and the use of the equipment in line with organisational policy and procedure.
- XXXIV. The use of pharmacological restraint. In services using pharmacological restraint, training includes reference to the relevant organisational policy and procedure for medication management and rapid tranquillisation and references STOMPaLD (The Challenging Behaviour Foundation, 2016) appropriately.
- XXXV. In services using lone worker devices, training includes procedures to safely manage the use of the equipment in line with organisational policy and procedure.
- XXXVI. High Secure Services. Training in High Secure Services must be delivered in accordance with the approved High Secure training manual, Positive and Safe: Violence Reduction and Management Programme (West London

NHS Trust, 2016).

XXXVII. Trainers ensure that any injuries or incidents and near misses which occur during education and training programmes are accurately recorded and reported through established reporting systems.

XXXVIII. Trainers complete course reports outlining the course content and any issues arising so information can be sourced or reviewed as part of the quality assurance process.

XXXIX. Training programmes include a system of competency assessment for participants and a reporting structure that informs line managers of the individual's outcomes from training. A written plan for any staff that have not achieved competence details the actions needed to achieve the required level of competence to undertake their duties and an interim management plan.

XL. Evaluation procedures establish the efficacy of training.

XLI. Injuries or incidents are audited and reviewed on a regular basis.

3.6 Trainer competencies compliance standard

Good trainers, who are committed to protecting people's human rights and reducing restrictive practices, improve practice and support an organisation-wide approach to reducing restrictive practices. Trainers must be able to evidence skills to teach, experience of supporting people with learning disabilities or mental health conditions, and experience in education, health, or social care settings.

The executive lead and non-executive lead should maintain accountability for ensuring suitability of trainers (either in-house or commissioned from a commercial training provider) and ensure that 'train the trainer' courses are suitable and sufficient to the needs of their service. Prior to commencement, non-service-based training providers should work with the provider's executive and non-executive lead to confirm responsibilities in relation to completion of the training needs analysis, issue of pre-course information, liability for injuries, learning points about provider culture and similar things.

Where the service provider commissions an external commercial training provider to train their own staff to deliver the commercial training provider's programmes, the executive lead must ensure sufficient quality assurance from the external training provider. In addition, the executive lead must

ensure that the training provider is certified, and that the training provider has registered their service provider organisation as an affiliate organisation.

Organisations should be able to demonstrate a clear and accountable process for the selection and continuous monitoring of their trainers or training providers in line with the following standards:

- I. Internal (service-based) trainers' portfolios are reviewed annually by their employing organisation, and evidence of this should be presented in summary form to the executive and non-executive leads in the service provider which is buying the teaching service.
- II. Organisations have a trainer's Code of Conduct that clearly outlines organisational and individual professional and value-based expectations.
- III. Trainers are professionally credible and can demonstrate an understanding of services through experience and/or relevant professional qualifications.
- IV. Trainers can demonstrate teaching skills through formal qualifications and/or relevant organisational educational programmes.
- V. Trainers attend annual updates tailored to meet the needs of the organisation.
- VI. Trainers receive the essential exposure to the current and emerging best practice literature and guidance. This is supported by individual reflection and learning portfolios.
- VII. Trainers understand the value and practice of involving people who receive services and are able to work effectively with people with lived experiences.
- VIII. Trainers demonstrate the organisational and professional values and recognise the responsibility and accountability for what they teach and their influence on practice and culture.
- IX. Trainers reinforce a culture of prevention through positive engagement and communication.
- X. External training providers have evidence of the experience, qualifications, and credibility of trainers.
- XI. External training providers can evidence that issues of indemnity insurance are clarified.
- XII. 'Train the trainer' programmes demonstrate compliance to the training content standards outlined in this document and the Restraint Reduction Network (RRN) Training Standards and the commercial training provider

organisation has in place a competency assessment framework for trainers.

XIII. All trainers are quality assured and subject to annual competency monitoring arrangements.

Contextual editorial

The impetus for these National Minimum Standards goes as far back as 2004 when the National Institute for Mental Health in England (NIMHE) and the National Patient Safety Agency (NPSA) launched a joint project, entitled Prevention and Management of Aggression and Violence in Mental Health Services. The project was established in the wake of a number of national reports and inquiries which raised concerns on the level of violence and aggression and the management of safety in mental health units, and the tragic death of David 'Rocky' Bennett.

The project was led by Colin Dale and Gary O'Hare and overseen by Malcolm Rae. It had 17 main objectives, many of which were successfully delivered within the life of the project. In 2004 NIMHE published the Mental Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-patient Settings (Department of Health, 2004a), setting out a range of positive practice standards to promote transparency and improvements in safety and managing violence. The project concluded with a published report in June 2006, outlining progress and successes of each of the 17 objectives.

Two main proposals were not advanced further until recently. The first was to 'develop proposals for accreditation and regulation of PI trainers and programmes of education and training'. PI in this context meant Physical Intervention. This has now been developed and published by the UK Restraint Reduction Network (RRN) as the National Training Standards 2019. The second was to 'publish definitive standards (for services) for the safe and therapeutic management of aggression and violence'. The agenda for reducing restrictive practices is widely established. It has been supported through various publications, regulation, an NHSE Expert Reference Group and more recently has been augmented by the Reducing Restrictive Practice (RRP) Collaborative established by NHS Improvement (NHSE) in response to a request made by the Secretary of State.

In 2016 Dr Ben Thomas and Guy Cross, working for the Department of Health, organised a national focus group to bring together a 'coalition of willing experts' to review current literature and agree what form new organisational standards in reducing restrictive interventions should take. This document has been informed by the original NIMHE/NPSA project, and the advances in practice and understanding in the reducing restrictive practices agenda expressed in a growing evidence base and the focus group deliberations. For most of the difficult year of 2020 the document was in consultation based on a public facing version. In Spring 2021 responses to these

and the plain language summary were coordinated by Dr Reid, Dr Paterson, Guy Cross and Alexis Quinn, an expert by experience and RRN manager.

We aim to prescribe the strategic approach and steps necessary to attempt to reduce restraint. The intended audience is any UK organisation in the sectors of health, social care, education, or related fields, which provides care which may lead to restraint. The guidance at points reflects implementation of the Mental Health Units Use of Force Act 2018, informally referred to as 'Seni's law'.

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Legislation

Statutes

(All available at [legislation.gov.uk](https://www.legislation.gov.uk))

Human Rights Act 1998 c. 42

Mental Health Unit (Use of Force) Act 2018 c.27 (Also known as Seni's Law, named for the late Olaseni Lewis. We have permission from Mr Lewis's family to say the pronunciation of Seni is /ən-i, "sh", "a" as in "bay", "i" as in "we".)

Criminal Law Act 1967 Chapter 58

Health and Safety at Work Act 1974 Chapter 37

Human Rights Act 1998 Chapter 42

Mental Capacity Act 2005

Statutory instruments

Management of Health and Safety at Work Regulations. SI 1999/3242.

Accessible Information Standard – Making Health and Social Care Information Accessible

NHSE 2016/17

Appendix 1

Exemplar titles for supporting policies

Policies should be signed off and governed by providers' boards under a coherent strategy and could include the areas below:

- Access to independent advocates
- Anti-discrimination and anti-bullying
- Approaches for the management of aggression and violence
- Basic/Immediate life support (in line with organisational/role expectations)
- Board approved values statement
- Care Programme Approach (CPA) and Care Co-ordination
- Clinical risk assessment, positive and safe risk management
- Clinical risk assessment, recognition, prevention, and de-escalation strategies
- Complaints procedures
- Debrief and Post Incident Support and Debrief
- Disability Discrimination Act
- Duty of candour
- Engagement and observation
- Equality Act/gender equality duty
- Health and safety policies in accordance with the Health and Safety Legislation
- Human Rights Act (1998)
- Information governance and information sharing procedures
- Joint working arrangements with criminal justice system
- Joint working arrangements with other relevant providers
- Legislation in relation to the use of restrictive intervention and best interests
- Lone working safety procedures

- Mental Capacity Act 2005
- Mental Health Act – The Code of Practice (2015)
- Physical care and observation during and post restraint
- Positive Behaviour support
- Post-incident support, review, and reconciliation
- Procedures for disciplinary, grievance and attendance management
- Professional accountability and responsibility
- Race Relations Amendment Act (2000)
- Raising concerns procedures
- Recording, reporting, monitoring, and audit
- Root cause analysis and sharing lessons learned
- Safe sharing of information including Caldicott 2 and common sense confidentiality
- Safeguarding procedures
- Staff management procedures for clinical and managerial supervision
- Staff wellbeing
- Supervision
- Supporting legislation including Mental Health Act 1983
- Terms of reference for inclusion of people with lived experience in organisational decision making
- The use of mechanical restraint equipment.
- The use of medication and tranquillisation
- The use of segregation and/or seclusion
- Use of extra care areas or low stimulus environments
- Use of long-term segregation

Appendix 2

Restraint Reduction Network Pledge Action Plan Six core strategies template

The Restraint Reduction Network Pledge Action Plan provides you with an opportunity to review what you have done so far in each of the SIX STRATEGY domains below and identify your three top priority actions that you would aim to complete within the next 12 months.

On submission you will receive a Restraint Reduction Network member logo™ and your top three priorities (only) will be published on the Restraint Reduction Network website (we will not share contact info).

Here is the link to the full RPI self-assessment checklist that we would recommend you work through in the next 12 months <https://bit.ly/2KqJRRi>

Organisation name	
Sector (eg academy trust, NHS trust)	
Restraint reduction lead	
Contact email	
Date	

Our top priorities for the next 12 months	Our measure of success
1.	
2.	
3.	

Strategy 1: LEADERSHIP AND GOVERNANCE

The organisation develops an organisation wide plan designed to increase the quality of life for service recipients as well as reduce and minimise the use of restrictive interventions and restrictive practices. Such a systems approach should have review and planning mechanisms

- What is the main priority in this area?
- What have we done so far?
- What we plan to do next in this area?

Strategy 2: USING DATA TO INFORM PRACTICE

The organisation uses data to identify, plan and review the overall organisation wide plan to reduce restrictive practice/interventions, improve service delivery and/or increase quality of life

- What is the main priority in this area?
- What have we done so far?
- What we plan to do next in this area?

Strategy 3: STAFF TRAINING AND DEVELOPMENT

The organisation ensures that all members of its workforce have the knowledge and skills they require to implement improvement measures and prevent and respond sensitively to any behaviours of concern

- What is the main priority in this area?
- What have we done so far?
- What we plan to do next in this area?

Strategy 4: PREVENTATIVE MEASURES AND PERSONALISED SUPPORT

The organisation ensures that staff have access to the tools they require to manage risks, to improve or enhance service delivery as well as personalise the support provided to people using the services

- What is the main priority in this area?
- What have we done so far?
- What we plan to do next in this area?

Strategy 5: INVOLVING THOSE WHO RECEIVE YOUR SERVICES

The organisation fully involves the people who use services in order to establish a clear understanding of their needs and to determine whether or not the service that is delivered meets their needs and expectations

- What is the main priority in this area?
- What have we done so far?
- What we plan to do next in this area?

Strategy 6: CONTINUOUS IMPROVEMENT

The organisation adopts a culture of reflection and positive learning in order to ensure the necessary change can be embedded and implemented at service level, through the workforce scheme of working as well finding its way into everyday interactions between staff and people using the services

- What is the main priority in this area?
- What have we done so far?
- What we plan to do next in this area?