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**Restrictive Interventions in
Inpatient Intellectual
Disability Services:
How to Record, Monitor and
Regulate**

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Acknowledgments

The author and editors wish to extend their thanks to the following groups for their valuable feedback on this report during the consultation process:

- Learning Disability Professional Senate
- Royal College of Nursing
- The British Institute of Learning Disabilities Restraint Reduction Network (RRN)
- The Quality Network for Inpatient Learning Disability Services (QLND)

Foreword

This report is both welcome and timely. In their report, *“The state of care in mental health services 2014 to 2017”*, the Care Quality Commission commented on the *‘great variation between wards in how frequently staff use restrictive practices and physical restraint to deescalate challenging behaviour. Those wards where the level of restraint is low or where it is reducing over time have staff trained in the specialised skill required to anticipate and de-escalate behaviours or situations that might lead to aggression or self-harm’*. We went on to say that *‘this has also been a development area for CQC – in the past we may have been too tolerant when we have seen evidence of restraint and restrictive practices (including blanket restrictions) used too readily. We now want to send a clear message to providers that we will be asking searching questions when we find services where staff frequently resort to restrictive interventions’*.

At the time we published the *state of care in mental health services*, we flagged up three issues that limit CQC’s ability to carry out its commitment to regulate physical restraint better. Firstly, there is no widely accepted and used set of definitions of types and levels of physical restraint. Secondly, and partly linked to the lack of definitions, providers are highly inconsistent in how they report physical restraint. Thirdly, there is no system for assuring the quality of training provided to staff in how to prevent, minimise and manage challenging behaviour. As a result, the many providers of training teach provide staff a wide range of approaches.

As this report says, as things stand, we cannot conclude that provider A that reports 100 uses of physical restraint each month is of more concern than provider B that reports 10 uses each month. It could well be that staff in provider A are highly attuned to the issue and that the great majority of incidents reported are of them gently redirecting a person from possible harm; whereas staff in provider B only report instances where they have held a person on the ground.

In response to CQC’s concerns, and at the request of the Secretary of State for Health and Social Care, NHS England and partners are working to develop common definitions, improve reporting and establish a mechanism for accrediting training. This report will greatly inform and influence this work.

I welcome the emphasis that the report places on the importance of the culture of care. Research into the factors that contribute to aggressive behaviour in residential settings find that most instances are not caused directly by the person’s ‘psychopathology’. Most are fully understandable at the human and inter-personal level; and are due to every day frustrations that come from communal living in a setting where the people lack autonomy and control over their lives. If staff can create an environment that minimises these general frustrations and work with individuals to identify and anticipate specific triggers that cause them distress, they will reduce the need to resort to restrictive interventions.

Dr Paul Lelliott

Deputy Chief Inspector of Hospitals (Lead for Mental Health)
Care Quality Commission

Executive summary and recommendations

This report is concerned with the standards of recording, monitoring, and regulation of **restrictive interventions** involving people with **intellectual disabilities with mental health and/or behaviour that challenges** within **inpatient services**.

Restrictive interventions, a central concern for all stakeholders of intellectual disability services, has come under increased scrutiny following the abuse scandal at Winterbourne View. Current efforts to monitor them rely almost exclusively on the numbers of such incidents. This approach is fundamentally flawed because numbers alone do not assess the quality of a services' overall restrictive interventions practice and cannot be used to infer good or poor standards of practice and abuse. Further, there are problems with the variable use of definitions, the failure to distinguish between various degrees of physical restraint, the impact of outliers, the failure to capture individual patient progress and the absence of meaningful benchmarking.

Service providers and regulators must therefore rely on other methods to evaluate the use of restrictive interventions and move from basing their conclusions on just the total number of restrictive interventions to one of examining a wider range of quality parameters.

With representative examples, this document makes recommendations on how restrictive interventions should be recorded, monitored, regulated and published.

Recommendations on Recording

1. Incident records within this system should be well written and present a cohesive representation of the events leading to, and during the restrictive intervention, particularly focusing on justification for their use, stating how the intervention represented the least restrictive option, and what physical health observations was undertaken.
2. Services should consider moving away from paper based recording systems to using IT software packages or databases. The latter are more robust and help in examining trends within the quantitative and qualitative restrictive interventions data.
3. Such systems should be developed in conjunction with all stakeholders of the software, including those who will be entering incident reports, and those who will access the data for monitoring / regulation.
4. The system should consider "forced response" formats to ensure that all required data is completed within incident report entries.
5. The system should be kept up to date with new patient details on their admission to the service, new staff member information on their appointment, and particular

MVA techniques taught in the service.

6. The system should prompt those entering data to ensure their incident report demonstrates compliance with current government guidance (Department of Health, 2014; 2015), with statements such as “describe how this intervention represented the least restrictive response to the patient’s behaviour” or “describe the physical health observations which were undertaken during the restrictive intervention”.
7. The system should be reviewed and updated in an ongoing manner, to maintain its quality and utility.
8. Staff who are required to write incident reports as part of their role should be given full training in the correct process. This training must emphasise the importance of quality incident reports, and cover government requirements (Department of Health, 2014; 2015). Services should provide supervision and mentorship to staff in this element of their role.
9. Incident reports should be checked and signed off by a senior member of staff.
10. Services should regularly audit incident reports to ensure they meet the required standard.

Recommendations on Monitoring and Regulation

11. Services should generate statistics / reports on restrictive interventions, as defined by the Department of Health (2014; 2015), for any reasonably requested time-frame, on a whole service, ward, and individual patient level.
12. Service or ward level reports should include
 - a. Total frequency of each restrictive intervention.
 - b. Total number, level and type of incidents which do not result in restrictive intervention.
 - c. Duration of restrictive interventions, with a full categorical breakdown, in addition to average and range.
 - d. Holds / techniques used for physical restraint, with a full categorical breakdown (this figure is likely to be higher than the total frequency of restrictive interventions, due to incidents of restraint which utilise more than one holding technique).
 - e. Trends in rates over time, day, week in month, month. If incidents peak at particular days or times, this can direct the exploration of individual / ward / service activities, procedures, staffing levels etc. and interventions as necessary.
 - f. An investigation or analysis of decreases, increases, or maintenance.
 - g. Total number and breakdown of any patient injuries sustained within restrictive interventions.

- h. The number of individual patients represented within the data, expressed as a percentage of total patients treated within this timeframe.
 - i. The progress of all patients against the aims of the services chosen restrictive intervention programme, ideally using the “traffic light audit”.
 - j. The contribution of individual patient rates to the overall total for the ward or the service. If there are any outlier(s) which significantly affect the overall total, or trends, report rates with and without the outlier data.
 - k. Details of how rates compare to a national benchmark.
 - l. Number of beds, and occupancy level of service for timeframe.
 - m. Cohort characteristics, such as gender, diagnoses, behavioural and / or offence profile.
 - n. Information about the number and degree of patient injuries sustained within restrictive interventions.
13. Individual patient level reports should include
- a. Items a-g above along with a brief description of a patient’s demographic information, psychiatric and forensic history (where relevant).
 - b. statistics on the levels of restrictive interventions for the entirety of a patients’ admission, and if available, pre-admission.
 - c. details of the patient’s management plan, e.g. level of observation, medication, level of engagement, assessments and treatment plans.

Recommendations to overcome some of the identified limitations with current restrictive interventions data

14. To truly capture the quality of a service’s restrictive intervention practice, there must be less focus on the number of restrictive interventions, and more on services adherence to the standards outlined by government guidance (Department of Health, 2014; 2015). This is likely to encompass restrictive intervention factors such as
- a. staff training in primary and tertiary strategies, training in safe restrictive intervention techniques, restrictive intervention reduction programme, the quality of advance statements and individualised restrictive intervention care plans, physical health observations and debriefing processes
 - b. wider practice quality issues, such as; leadership, staffing levels, environmental considerations, engagement, patient assessment, therapies and management, etc.
15. Incident accounts, or a representative subsample, should be inspected on an incident by incident basis, in order to assess whether the note adheres to the principles of least restrictive practice. For example, was the decision making process for restrictive intervention by staff described, was this decision justified, for the patient’s own, or others safety? Was it reasonable and proportionate? Was it the least restrictive way the behaviour described could be managed? Was the intervention subject to regular review by staff and curtailed as soon as possible?

Though more time consuming, this is a more meaningful approach.

16. If it appears that restrictive interventions are being carried out for any other purpose than to take immediate control of a dangerous situation, concerns should be escalated through local safeguarding procedures and protocols.
17. Services should routinely record, and regulators should request information on, the number patient injuries sustained during restrictive interventions, except where these relate primarily to instances of self harm / injury.
18. Regulators should cross reference data on restrictive interventions with information from other sources, including their observations, patient and carer reports, safeguarding referrals, police reports, etc.
19. Policy makers should develop a framework of restrictive intervention severity / intensity. This should encompass the full range of physical restraint techniques used by multiple training providers, as well as the duration of physical restraint, seclusion, and long term segregation. This would provide an element of standardisation, move towards more consistent recording between service providers and support the comparability of data. Till this framework is developed, services should record, monitor, and report the full range of techniques used.
20. Services which report comparatively lower numbers of restrictive interventions should have their practice inspected as rigorously as those which report higher numbers.
21. Services should provide a breakdown of restrictive intervention data from the total number for a whole service, to the ward level, and individual patient level. This can be done utilising widely available software, Microsoft Excel, using the Pivot Table function, which can facilitate the analysis of a large, detailed datasets quickly and easily. This function can also be used to view the proportion of restrictive interventions accounted for by individual patients, and ward or service level data can be viewed and presented with and without the data of individual outlier patients. Service providers should report multiple measures of central tendency, such as the median, in addition to the mean, which is particularly susceptible to the effects of outliers.
22. Services should analyse the progress of individual patients for a clearly specified timeframe. This can be achieved using the “traffic light” audit method. The traffic light method involves viewing the restrictive interventions rates of all patients within the service, and then categorising them into one of the three categories. This can be useful through the audit cycle, or ideally the whole duration of a patient’s admission.
23. Services should have a record of the number of patients treated in the timeframe specified, and the proportion who have been involved in restrictive interventions.

24. Services should request information about the levels of restrictive interventions and management plans from the referring service, report these alongside current levels, and pass on this information when discharging patients, with clear reporting parameters, if this information is available.
25. Services should monitor and report all types of restrictive interventions used with an individual patient. This should take into any specific patient preferences as specified in advance statements or similar, and recognise that restrictive interventions represent only one element of patient care, and does not capture other domains, such as wellbeing, quality of life, physical health, engagement with friends and relatives, occupational activities, etc.
26. National benchmarking data should be strengthened via the inclusion of a wider range of variables, and be publicly available to all. Benchmarking processes must consider the highlighted issues with restrictive interventions data, and take steps to counter these in reports.
27. Services must demonstrate the use of data to support restrictive intervention reduction.
 - a. This might involve regular reviewing of incidents and subsequent debriefs, identifying any triggers, or learning points and feeding these back in to care plans. It could involve viewing of restrictive intervention rates in team meetings and care reviews, identifying patterns of use, and addressing any underlying reasons for these.
 - b. Services may also choose to record a wider range of measures in addition to restrictive intervention rates, as identified by Bowring (2015). These might include behaviour rating scales, quality of life measures, patient satisfaction etc.
28. Any publication of restrictive intervention data should adhere to the standards and guidance as set out in this document. The reports should relate to a clearly specified timeframe.

Recommendations on Publishing

29. Any publication of restrictive intervention data should adhere to the above guidance.
30. Reports should relate to a clearly specified timeframe.

Definitions and Scope

The scope of this report includes standards of recording, monitoring, and regulation of **restrictive interventions** involving people with **intellectual disabilities with mental health and/or behaviour that challenges** within **inpatient services**, terms which are defined in the below subsections.

Intellectual disability (ID)

Within this report, we will use the term “intellectual disability” or “ID”. Intellectual disability is known by a number of terms which are often interchangeably. The UK government uses the term learning disability, and the main international classificatory systems, *Diagnostic and statistical manual of mental disorders* (DSM-IV) (American Psychiatric Association, 1994) and *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines* (ICD-10, World Health Organization, 1992) currently use the term mental retardation.

Intellectual disability is characterised by significant degrees of cognitive impairment together with deficits in adaptive behaviour manifest from childhood (Carulla, 2011), and has an onset before the age of 18 (World Health Organization, 1992). The degree can be mild, moderate, severe or profound, with over 90% of those with ID falling within the mild range (Department of Health, 2001).

Inpatient Services

People with ID are reported to suffer from a higher prevalence of mental health problems when compared with the general population (Cooper et al. 2007; Bhaumik et al. 2008). When a person with ID develops comorbid mental health issues, there is an emphasis on providing care within the community, but inpatient settings remains a necessity for some patients (Xenitidis, Gratsa, Bouras, Hammond, Ditchfield, Holt, Martin, & Brooks, 2004). This may be provided in mainstream mental health services, or in specialist ID services (Chaplin, 2009).

In 2012 the NHS Confederation defined inpatient mental health services as a unit with ‘hospital beds’ that provides 24-hour nursing care. The unit is able to care for patients detained under the Mental Health Act, with a consultant psychiatrist or other professional acting as responsible clinician, but not all patients will be detained. Such a unit may be in a hospital campus or a community setting, and may be provided by NHS or the independent sector. The document stated that inpatient beds should be distinguished from placements registered for the provision of care, such as those provided by local authorities. The report described the scope, typical care pathways and patients treated within:

- Acute inpatient beds,
- Psychiatric intensive care unit (PICU),

- Forensic services, and
- Child and Adolescent Mental Health Services (CAMHS).

The purpose and functions of the different types of specialist inpatient beds for people with ID in the United Kingdom, within the context of a tiered model of service provision have been described (Royal College of Psychiatrists' Faculty of Psychiatry of Intellectual Disability, 2013). Tiers 1 (enabling role working with other agencies) to 3 (intensive case management in the community) constitute community ID services, and tier 4 constitutes the inpatient element of care. Within tier 4, there are subcategories:

- Category 1: high, medium and low secure forensic beds,
- Category 2: acute admission beds within specialized ID units,
- Category 3: acute admission beds within generic mental health settings,
- Category 4: forensic rehabilitation beds,
- Category 5: complex continuing care and rehabilitation beds, and
- Category 6: other beds including those for specialist neuropsychiatric conditions.

Challenging behaviour

Challenging behaviour is defined as:

'Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion.' (Royal College of Psychiatrists et al., 2007, p.10).

Challenging behaviour is a socially constructed, descriptive concept that has no diagnostic significance, and makes no inferences about the aetiology of the behaviour, covering a heterogeneous group of behavioural phenomena across different groups of people (Royal College of Psychiatrists' Faculty of Psychiatry of Intellectual Disability, 2013). Among many causes, challenging behaviour has been reported to (Koritsas & Iacono, 2012):

- represent a form of communication
- be caused by skills deficits
- be associated with psychiatric disorder or symptoms or physical illness or
- develop through operant conditioning and reinforcement.

Restrictive practices

The terms "restrictive practices" and "restrictive interventions" are often used interchangeably, despite their differing meanings. Restrictive practices are defined as:

"Making someone do something they don't want to do or stopping someone doing something they want to do." (Skills for Care & Skills for Health, 2014, p. 9).

Restrictive practices therefore includes, but are not limited to, restrictive interventions. In addition to restrictive interventions, restrictive practices also include deprivations of liberty,

as well as broader activities which restrict people. These restrictions might be used as a routine feature of someone's care and support, rather than solely in response to some form of crisis, may be deliberate or less so, and tend to occur in one of the following ways (Skills for Care & Skills for Health, 2014):

1. **Restrictions that arise because of habit or blanket rules:** e.g. everyone having to be up by a certain time, rules on whether people can have their phones or doors being routinely locked. These are sometimes called "de facto" restrictions.
2. **Safety:** restrictions such as locking a room to keep household cleaning products or medicine out of someone's reach. This could also mean responding to violence or aggression towards the individual themselves, or to workers or others.
3. **Treatment or care:** restrictive practices may be used in a planned or unplanned way in order to provide essential care, support or medical treatment.

Restrictive interventions

Restrictive interventions are defined as:

"deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken" (Department of Health, 2014, p. 14).

Restrictive interventions include; physical restraint, mechanical restraint, rapid tranquillisation, seclusion and long-term segregation (Department of Health, 2015, p. 281).

Chapter 1: Background and Context

In England, with a population of about 53 million people, around 900000 adults have an ID (Devapriam, Rosenbach & Alexander, 2015). Of those, approximately 191000 (21%) are in contact with ID services (Emerson 2010) and 3035 (0.3%) are receiving treatment in inpatient psychiatric units at any point in time (Health and Social Care Information Centre 2013). The latter number tends to fluctuate and includes secure, or forensic services, provided for those with offending behaviour, whose presentation is currently above a threshold which can be safely managed in the community. Individuals within inpatient ID services have predominantly mild levels of ID, and have a number of comorbidities in addition to their primary diagnosis, with high rates of autism spectrum disorder (ASD), epilepsy, schizophrenia and delusional disorders, bipolar affective disorder, depressive disorder, anxiety disorders and personality disorders (Xenitidis et al., 2004; Alexander et al., 2011).

People with ID in inpatient settings can display behavioural that challenges, which may present risks to themselves or to others (Department of Health, 2015). Behaviour that challenges within inpatient services arises from a complex interaction between factors intrinsic to the individual patient, and factors intrinsic to the service. Individual factors may include anger issues (Chilvers & Thomas, 2011), difficulties with social problem solving (Larkin, Jahoda & MacMahon, 2013), and communication issues (McNamara, 2012). Service factors might include excessive noise and general disruption, overcrowding, boredom, lack of clear communication by staff with patients, and the excessive or unreasonable application of demands and rules (Department of Health, 2015). Services which care for people who are liable to present with behaviour that challenges should focus primarily on providing a positive and therapeutic culture, which focusing on preventing behavioural disturbances, early recognition, and deescalation². Organisational responses to behaviour that challenges should include primary, secondary and tertiary strategies, which are defined in Table 1.

² **De-escalation** is defined as a secondary preventative strategy within the Mental Health Act Code of Practice (Department of Health, 2015). It involves the gradual resolution of a potentially violent or aggressive situation where an individual begins to show signs of agitation and/or arousal that may indicate an impending episode of behavioural disturbance. De-escalation strategies promote relaxation, e.g. through the use of verbal and physical expressions of empathy and alliance. They should be tailored to individual needs and should typically involve establishing rapport and the need for mutual co-operation, demonstrating compassion, negotiating realistic options, asking open questions, demonstrating concern and attentiveness, using empathic and non-judgemental listening, distracting, redirecting the individual into alternate pleasurable activities, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication.

Table 1: Primary, Secondary and Tertiary responses to behavioural disturbance defined by the Mental Health Act Code of Practice (Department of Health, 2015)

Primary	Primary preventative strategies aim to enhance a patient’s quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbances.
Secondary	Secondary preventative strategies focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to encourage the patient to be calm. Secondary strategies include de-escalation.
Tertiary	Tertiary strategies guide the responses of staff and carers when there is a behavioural disturbance. Responses should be individualised and wide ranging, possibly including continued attempts to de-escalate the situation, summoning assistance, removing sources of environmental stress or removing potential targets for aggression from the area. Where it can reasonably be predicted on the basis of risk assessment, that the use of restrictive interventions may be a necessary and proportionate response to behavioural disturbance, there should be clear instruction on their pre-planned use. Instructions should ensure that any proposed restrictive interventions are used in such a way as to minimise distress and risk of harm to the patient.

Statement of Principles

This report is primarily concerned with ensuring and evidencing that the use of restrictive interventions is in line with the following principles. The principles are derived from values outlined in best practice documents such as *Positive and Proactive Care: reducing the need for restrictive interventions* (Department of Health, 2014) and the *Mental Health Act 1983: Code of Practice* (Department of Health, 2015):

1. Restrictive interventions should only be used to:
 - a. take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken
 - b. to end or reduce significantly the danger to the person or others; and
 - c. should contain or limit the person’s freedom for no longer than is necessary.
2. When restrictive interventions are unavoidable, providers should have a robust approach to ensuring that they are used in the safest possible manner.
3. The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
4. Any action taken to restrict a person’s freedom of movement must be the least restrictive option that will meet the need.
5. Restrictive interventions should be used in a transparent, legal and ethical manner:

- a. Restrictive interventions must comply with the relevant rights in the European Convention on Human Rights.
 - b. People must be treated with compassion, dignity and kindness.
 - c. What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent.
6. Providers who treat people who are liable to present with behavioural disturbances should have individualised, ward and service level restrictive intervention reduction programmes which emphasise primary and secondary strategies, and which involves patients, [family] carers / advocates.

When restrictive interventions are carried out without a clear ethical basis and appropriate safeguards, such acts may be unlawful, and should always be escalated through local safeguarding procedures and protocols. The Panorama documentary “Undercover Care: The Abuse Exposed” depicted appalling scenes of abuse in an inpatient unit for patients with intellectual disability and mental health or behavioural problems, Winterbourne View (BBC, 2011). Much of the abuse was committed under the guise of restrictive interventions, and particularly, physical restraint. Yet it is important to recognise that the “physical restraint” observed at Winterbourne View would not be recognised as a lawful restrictive intervention. Not only were patients subjected to clearly illegal actions (e.g. sitting on a chair placed on top of a vulnerable patient), there were instances of staff provocation prior to restraint being initiated (Flynn, 2012) and instances of restraint being used to bully, punish and humiliate. Patients sustained numerous significant physical injuries following restraint, such as broken bones, loss of teeth, and carpet burns (Flynn, 2012). Due to their actions, staff involved subsequently faced criminal charges and in some cases, prison sentences (BBC News, 2012).

A core area of the response to Winterbourne View has been a focus on restrictive interventions, particularly physical restraint. The regulatory body of health and social care services in the UK, Care Quality Commission (CQC), undertook 150 unannounced inspections of care providers for people with intellectual disabilities and challenging behaviours, including 71 NHS Trusts, 47 private services and 32 care homes (Care Quality Commission, 2012). In *Transforming care: a national response to Winterbourne View Hospital* (Department of Health, 2012, p. 44), the government outlined their response not only to the Winterbourne View abuse scandal, but also on the wider issues highlighted by the subsequent review of services by the CQC. This led to the publication of *Positive and Proactive Care: reducing the need for restrictive interventions* (Department of Health, 2014).

Following the Winterbourne View scandal, emotions relative to restrictive interventions, particularly physical restraint have remained high. Citarella (2013) repeatedly likened physical restraint to the combative sport of wrestling, and stated that there was “*no justification for pinning intellectual disabled to the ground*”. Other headlines have said that physical restraint should be banned altogether (e.g. Calkin, 2012). While the wrestling comparison may stand up when referring to the illegal “restraints” undertaken at Winterbourne View, the inference that there is no justification whatsoever for physical restraint does not. There is a long established legal framework surrounding the use of

physical restraint, and other restrictive interventions, within the Mental Health Act (1983, amended 2007) and the accompanying Code of Practice (Department of Health, 2015) which outlines the most common reasons for needing to consider the use of restrictive interventions:

- physical assault by the patient,
- dangerous, threatening or destructive behaviour,
- self-harm or risk of physical injury by accident,
- extreme and prolonged over-activity that is likely to lead to physical exhaustion, or
- attempts to escape or abscond (where the patient is detained under the Act or deprived of their liberty under the Mental Capacity Act).

The Department of Health (2014) definition of restrictive intervention also indirectly highlights the need for their use where necessary:

“deliberate acts on the part of other person(s) that restrict an individual’s movement, liberty and/or freedom to act independently in order to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken” (Department of Health, 2014, p. 14).

A number of such situations have been outlined, for example, a patient running out into a busy road. At such times, the physical restraint by staff is likely to save a patient from serious injury. Furthermore, in a statement for a Royal College of Nursing report (2008, p.11) the then Chief Executive of the National Patient Safety Agency, Martin Fletcher, noted serious problems in services which would not tolerate restraint in their organisation in any circumstances. These problems included allowing delirious or suicidal clients get into risky situations, because staff thought it was wrong to stop a client doing what they wanted to do. He stated,

“if an organisation takes the position ‘it doesn’t happen here’ any problems just get hidden...if staff don’t have a clear understanding of the circumstances where restraint is justified or positively required, they won’t be able to recognise the circumstances where restraint is wrong or abusive.”

In these situations, the presence of a diagnosis of ID should not preclude intervention from staff members. The abuse observed in the Winterbourne View documentary has driven a universal desire to protect and keep patients within services safe, to avoid such tragedies happening again, and reignited widespread criticism on the use of restrictive interventions within inpatient services. But in condemning those who abuse patients, we must be careful not to reject all forms of restrictive interventions. If restrictive interventions are applied safely and appropriately, they can form part of a responsible provider’s care package and an individuals personal care plan. Rather than banning restrictive interventions, risking driving the practice underground, and potentially placing patients at further risk, focus should instead be shifted onto strengthening the process of recording and monitoring of restrictive interventions practice. While there have been welcome efforts to adequately monitor and inspect services in which such interventions take place, this approach has been flawed because of an almost exclusive reliance on restrictive interventions statistics and data. It has become increasingly clear that this strategy is not providing an accurate picture of

restrictive interventions practice within inpatient ID services and that there is a need for further guidance in this area.

The report will go on to:

1. Critique the current, predominantly data centric, approach to assessing restrictive interventions practice, and describe some specific issues which should be considered when interpreting restrictive intervention data.
2. Describe current guidance on recording, monitoring, publishing and regulation of restrictive interventions data.
3. Make recommendations and set standards for services wishing to self assess their restrictive intervention recording and monitoring processes, and regulators wishing to inspect such processes.
4. Promote the use of safe and legal restrictive interventions.

Chapter 2: Relying on Numbers: The Current Approach to Reporting, Monitoring and Regulating Restrictive Intervention Practices

At present, the monitoring and inspecting of practice largely focuses on the total number of restrictive interventions at the ward or service level, via service provided data and statistics. Since the Winterbourne scandal, these statistics have received unprecedented interest among the multiple stakeholders of services; patients, families, staff, clinicians, academics, commissioners, charities, government, the media and the general public. The complexity of this data is often underappreciated, and in the best case scenario references have been simplistic, reductionist, emotive, and subjective, and in the worst case; biased, misrepresentative, and sensationalist.

In 2013, Mind published the report *Mental Health Crisis Care: Physical Restraint in Crisis*; following freedom of information requests to 51 NHS mental health trusts. Widely reported within the media, and featuring within *Positive and Proactive Care: reducing the need for restrictive interventions* (Department of Health, 2014), the report concluded there were:

- *excessive and disturbing* levels of restraint, with 39,883 incidents of restraint reported across mental health services in the UK in one year.
- *significant variations* in the use of restraint across the country, with one trust reporting 38 incidents while another reported over 3,000 incidents.

However, the report fails to include important context regarding the figures quoted. For example, although 39,883 restraints sounds exceptionally high, a key contextual factor is the number of patients treated in services during this timeframe. Taking data from the 2010 Count Me In Census (Care Quality Commission and National Mental Health Development Unit, 2011), there were 29,840 inpatients within the mental health services of 261 NHS and independent healthcare organisations in England and Wales. Dividing the number of restraints (39,883) by the number of patients (29,840), equates to 1.3 incidents of restraint per patient through the year. However, the census stated that not all patients are subject to physical restraint, with 12% of patients experiencing one or more episodes in the year. This suggests that 3581 patients accounted for the 39,883 incidents of restraint, and assuming this is equally distributed among those patients, approximately 11 incidents of restraint per patient per year.

Regarding the reference to significant variations in restraint across the country, “this level of variation is appalling” (Mind, 2013, p. 14), the report took no account of the differential bed capacity of services. This was reflected on in a statement by Tees, Esk and Wear Valleys NHS Foundation Trust, who reported the highest number of incidents at 3,346 (The Guardian, 2013): “*The number of incidents may seem high. However, we are one of the largest mental health and intellectual disability trusts in the country, with over 1,000 beds and a high proportion of specialist units caring for people with extremely challenging behaviour*”. There is caution therefore needed in interpreting and responding to figures that may lack a critical appraisal and contextualisation. The following sections will describe a number of issues

which should be taken into consideration when interpreting and reporting data on restrictive interventions.

Issue 1: Practice Quality, the Last Resort, Least Restrictive, Poor Practice and Abuse

Numbers and statistics are often used alongside headlines, or statements which suggest that due to their levels, restrictive interventions are not used as a last resort, or are over relied upon. For example, Agenda (2017) stated that *“Around 1 in 5 women (6,393 female patients) admitted to mental health facilities were physically restrained, despite guidance it should be used as a last resort.”* Guidance states that if a restrictive intervention has to be used, it must always represent the least restrictive option to meet the immediate need (Department of Health, 2014).

Unfortunately, simply looking at numbers does not actually evidence that physical restraint was not the least restrictive option, whether its use was as a last resort, and will not uncover poor practice or abuse. One of the most important figures when establishing whether a service uses restrictive interventions as a last resort is the number of incidents which are not managed using restrictive interventions and are managed using primary or secondary strategies. Numbers alone do not infer anything about the standard of a service’s wider restrictive intervention practice, such as robust policies, training programmes, care plan quality, safety processes, debrief procedures, as outlined by the Department of Health (2014; 2015). In Box 1 below, an example of this is illustrated:

Box 1: Do numbers correlate with poor practice or abuse?

Service A and Service B care for a similar patient population, and have the same number of beds and occupancy level. Service A reports 5 restraints, while for the same timeframe, Service B reports 50. Using numbers alone, Service A “looks better” than Service B. However, upon further investigation of the incident accounts, the 5 restraints reported by Service A were “heavy handed”, carried out by untrained staff, using untrained techniques, and “unjustified” in the eyes of the Mental Health Act Code of Practice (2015), i.e. in response to low level behaviour which could have been managed via de-escalation. On the other hand, the 50 restraints reported by Service B, were justified, in response to high risk behaviour unmanageable in any other short term method, and fully in accordance with the Mental Health Act Code of Practice (2015).

The factors which support the development of a culture not reliant on restrictive interventions have been the subject of extensive research in healthcare settings internationally. Many of these factors are highlighted in Colton’s (2004) nine domain checklist, which provides organisations with a systematic approach to the reduction of seclusion and physical restraint, as detailed in Box 2. When these areas are systematically

addressed, restrictive interventions have been successfully reduced in services (Bjorkdahl, Hansebo, & Palmstierna, 2013). An example of how this manifests in clinical practice is detailed in Box 3. Factors considered might include the quality of; the services restrictive intervention reduction programme, individualised care plans and advance statements, programme of educational and occupational activities, among many others.

Box 2: Summary of Colton’s (2004) Checklist

1. Leadership
2. Orientation and Training
3. Staffing
4. Environmental Factors
5. Programmatic Structure
6. Timely and Responsive Treatment Planning
7. Processing after the Event (debriefing)
8. Communication and Consumer Involvement
9. Systems evaluation and quality

Box 3: Colton’s (2004) Checklist in Clinical Practice

Rachel* a 42 year old lady admitted to an inpatient intellectual disability service is sitting in an armchair on the corner of a ward, occasionally muttering to herself and biting her nails.

Scenario 1	Scenario 2
<p>Service A has strong leadership and management. Staff are confident that their managers will support them with their decisions. There is an experienced nursing team, who all know Rachel well. The ward is well staffed, and therefore staff have time to spend with patients and respond to their needs. Her key nurse developed an extensive care plan which detailed how Rachel presents when she is upset or agitated, and how to respond to her in these situations. The team know that when she behaves in this way, Rachel is experiencing a problem she needs help with, as after a previous incident, where Rachel became violent and destroyed property on the ward, was reviewed,</p>	<p>Service B is currently experiencing a staffing crisis. Leadership is poor, staff are experiencing stress and burnout, and there is a high rate of sickness. The ward is currently being staffed by agency workers. Many of them have never worked on this ward before, and didn’t get a very good handover. They haven’t had any time to read the care plans, and in any case, as Rachel’s key nurse has been off sick for 6 months, it hasn’t been reviewed and updated with up to date knowledge about her. The nurse in charge assumes her mutterings are due to psychosis, and as she is being quiet and not causing any trouble, pays no further attention.</p>

trigger factors were identified, and strategies put in place.

One of Rachel's support workers notices she has withdrawn, and approaches her sensitively, asking if she would like a chat. Rachel confides that she has had an argument with her mum over the phone and is feeling a bit low and upset. They talk it through and Rachel calls her mum back to resolve things. Rachel feels better and reengages with everyone on the ward. There is no further incident.

Another patient approaches Rachel and makes a comment about how miserable she looks. This is the last straw for her, and she becomes even more agitated, verbally abusing the other patient, which escalates further into a huge argument. Nurses begin to approach the situation. One asks if she could move into a quiet room to calm down, and places a hand on her arm to direct her. Rachel perceives this as a threat and becomes physically violent, requiring the initiation of physical restraint and seclusion.

The "last resort" concept has gained prominence in recent years. The Department of Health (2014, p. 9) state that services should be developing cultures where restrictive interventions are only ever used when all other alternatives have been exhausted and deemed ineffective (Bonner et al., 2002; Moran et al., 2009; Riahi, Thomson, & Duxbury, 2016). This makes sense in many scenarios in which restrictive interventions could be used, such as when staff observe early signs of a behavioural incident developing, which may be unique to an individual patient, and initiate early interventions. However some scenarios are too high risk to attempt to use a restrictive intervention as a last resort, for example if a patient ran out into a busy road. In this instance, physical restraint is likely to be the first resort. Deveau and McDonnell (2009) argue that the 'last resort' principle has the major drawback that it is an easily voiced rhetorical device and very difficult to observe or challenge (p. 175). This opinion was echoed by Citarella (2013, p. 1) who noted that *all policies concerning physical restraint emphasise that it should be the "last resort response, indeed Castlebeck Ltd's [the service provider of Winterbourne View] own policy concerning physical restraint was no exception and yet it bore no resemblance to the practice filmed by an undercover journalist"*.

Uncovering Poor or Abusive Practice

The Department of Health (2014) states that if restrictive interventions are carried out for any other purpose than to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, concerns should always be escalated through local safeguarding procedures and protocols. Without a clear ethical basis and appropriate safeguards, such acts may be unlawful. Again, establishing the presence of poor practice, or indeed abuse, is not possible from figures and data. Lower numbers are meaningless, if the interventions forming those low numbers were either unjustified, or disproportionate to the risk posed. Establishing poor or abusive practice is challenging, especially if people are deliberately hiding their wrongdoing, as was the case at Winterbourne View.

A current oversight is the lack of focus on routinely collected data on patient [and staff] injuries resulting from physical restraint, despite the findings of the Serious Case Review, which highlighted that patients at Winterbourne sustained numerous significant injuries following restraint, including broken bones and teeth (Flynn, 2012), which was certainly a missed indicator of the level of abuse.

Issue 2: Definitions and Degrees of Restrictive Interventions

One of the main problems with restrictive interventions data, particularly physical restraint, is that data is self reported by service providers, utilising their own definitions, which may not be aligned with the definitions provided by the government (Department of Health, 2014; 2015). This is partially related to the volume of Management of Violence and Aggression (MVA) training providers commissioned by care services, all of which use different techniques and terminology. This currently precludes the meaningful pooling and comparison of data between services.

Commentators tend to perceive the word “physical restraint” as always involving patients being held on the floor, for example “pinning intellectual disabled to the ground” (Citarella, 2013, p. 1). However, this is not the case. The Mental Health Act Code of Practice (Department of Health, 2015, p. 295) provide the following definition, “*Physical restraint refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person.*” Mind (2011) found that the vast majority (91.4%) of physical restraints were not in the prone position.

Within most programmes of taught MVA techniques, there are levels of restraint from a lower to a higher intensity, which are initiated dependent on a number of factors, but usually the level of behaviour demonstrated by the patient. Table 2 details an example of the levels / intensity of physical restraint. As evident, a Stage 1 Hold looks very different, and is much less restrictive than a physical restraint in the Prone or Supine position. Another important factor is the duration of the physical restraint, and the interaction between duration and the holds / techniques used, as there are demonstrated links between long instances of physical restraint in the prone position, and patient death (Duxbury, Aiken, & Dale, 2011). The example in Box 4 demonstrates this point. Little attention is given to these nuances within the reporting of physical restraint statistics, which means that all types are collated and reported together.

Table 2: Example of MVA Hold / Technique levels / intensity

MVA Holds / Techniques	Description
1. Stage One Hold	Patient held at elbow.
2. Stage Two Hold	Patient held at elbow and wrist.
3. Figure-of-Four Hold	Patient held at wrist and by over reaching arm.
4. Finger and Thumb Hold	More containing hold. Patient held by arm placed inside the patient’s, and finger and thumb held without flexion

	beyond 45°.
5. Fore-arm Hold	Inside arm hold with hand upon patients wrist.
6. Palm Hold	Inside arm hold with hand hold mirroring patient's thumb.
7. Restraint in Chair	Patient restrained in a chair by staff in adjacent seats.
8. Prone	Restraint on the ground in a face down position.
9. Supine	Restraint on the ground in a face up position.

Box 4: Intensity and Duration of Physical Restraint

Service A reports 5 restraints, and Service B reports 50 restraints for the same timeframe. It is assumed that Service A is demonstrating better practice. However, on further investigation, all of Service A's 5 restraints are in the prone position, for two to three hours each. On the other hand, 40 of Service B's restraints are in the Stage 1 hold detailed in Table 1, 9 are in a Stage 2 hold, and 1 is in the prone hold for 2 minutes, prior to turning the position into supine at the earliest opportunity.

A further area of confusion within recording and reporting, is where more than one incident of physical restraint happens within one overall incident. An example of this is where a person within restraint appears to be calming, leading the physical restraint to be ended, but who begins to become aggressive again as soon as holds are released. Some services may report this as one incident in which physical restraint was used twice, while another may report this as two incidents of physical restraint. This can contribute to wide discrepancies in rates between services. In such instances, the antecedent to the physical restraint likely to be the same as that immediately prior, with the same staff members involved etc. As such, it makes sense to have one overall incident report, in which multiple restraints can be recorded, in order to reduce the burden of "paperwork" yet which can identify the exact numbers of physical restraint used.

Failure to Record or Under Reporting

There are also instances of staff and services either unintentionally, or intentionally under reporting rates of restrictive interventions. This can range from poor or inconsistent record keeping, to the intentional misrepresenting of events within incident records, or failing to report incidents, in order to keep levels looking low. In 2012, the CQC (2012, p. 42-43) found that not all service providers recognised that their practices constituted restrictive interventions, and were therefore not documented as such:

- *"We were advised by the registered manager that figure of four and thumb holds are used... the registered manager did not recognise this as restraint... it was evident there was not a clear plan or understanding of...what constituted restraint and what was reportable as restraint."*

- *“we found a number of incidents where seclusion had been used and not recognised... a patient was being cared for separately by two staff in the management suite...While it was clear that this patient needed to be cared for in segregation due to the threat she posed to other patients and staff, the service was not managing this as seclusion. The service stated that the patient was in ‘therapeutic segregation’”.*

This issue was reported as an ongoing concern in the recent Care Quality Commission report (2017) “The state of care in mental health services 2014 to 2017”, which stated that a number of instances were found where staff were not recording all incidents of restraint, seclusion or long-term segregation. Box 5 provides a transcript from the “Undercover Care: The Abuse Exposed” Panorama documentary (BBC Panorama, 2011), where the undercover journalist and Wayne Rogers, the ring leader of the abusive staff group at Winterbourne View, are discussing the fraudulent record keeping of an incident of physical restraint. A similar transcript could be included from a more recent documentary which highlighted widespread abuse within a youth custody centre (BBC Panorama, 2016), where staff were deliberately concealing their behaviour out of sight of CCTV and covering up violent incidents to avoid investigation (Horn, 2016). Clearly, this practice happens, to an unknown extent, and has proven difficult for regulators to highlight, as noted by Flynn (2012, p. 91), *“How the recommendation rendering restraint the intervention of last resort will address the falsified recording of restraint events witnessed during the Panorama broadcast is not clear”.*

Box 5: Transcript from the “Undercover Care: The Abuse Exposed” Panorama documentary

Commentator:	Physical restraint, restraint, is such a serious step that each time it is used, official records must be kept.
Undercover reporter:	I need to go write that statement from earlier. What were you saying about it?
Commentator:	Wayne has to describe exactly what led to him dragging a patient from her bed. His account could be inspected by the bosses, or even the regulator, to make sure patients aren’t being abused.
Wayne:	...was reluctant to rise this morning and refused to attend to her personal hygiene. At 8:30 and despite staff’s efforts to direct her and offer of female support, myself and Joe attended and she became aggressive and started hitting out at myself. As a result she was led her from her bedroom by myself and Joseph.
Commentator:	That’s not what happened. But a lot goes on at this hospital that doesn’t go into official records.

Services which operate in this way are likely to have substantially lower rates of reported restrictive interventions, despite using interventions at similar rate to other services. This could further explain some of the wide variation in reported rates. The most worrying aspect of such cases is that restrictive interventions are happening, in the absence of any of

the relevant governance processes and safeguards which should accompany their use, as described in Box 6.

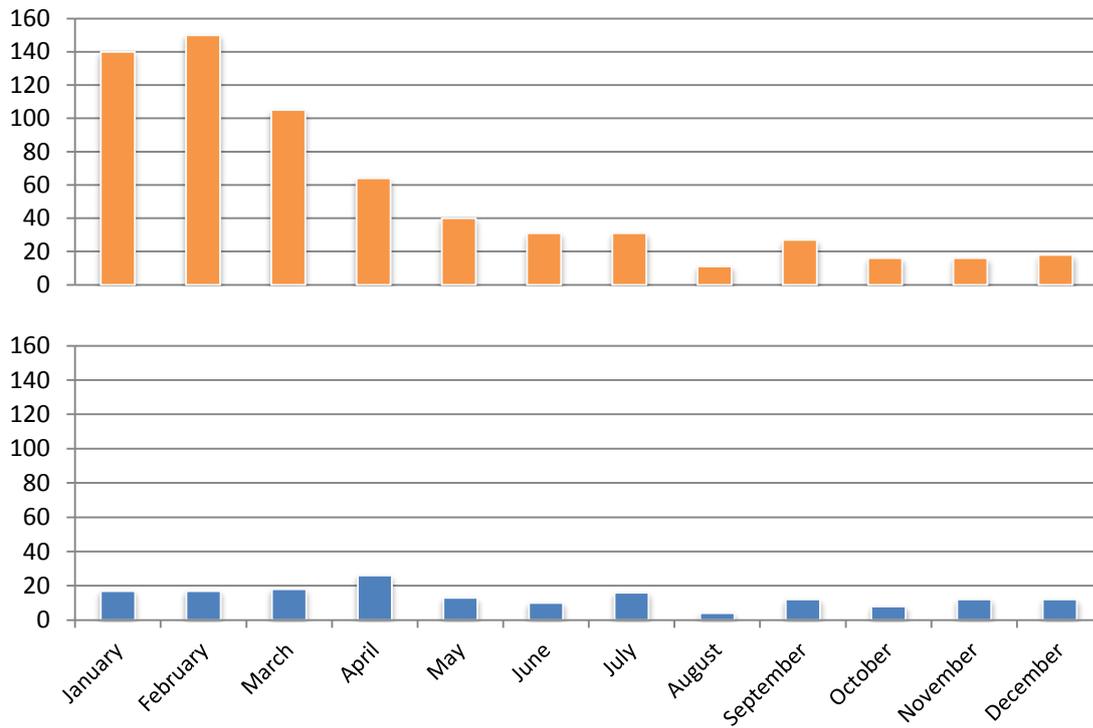
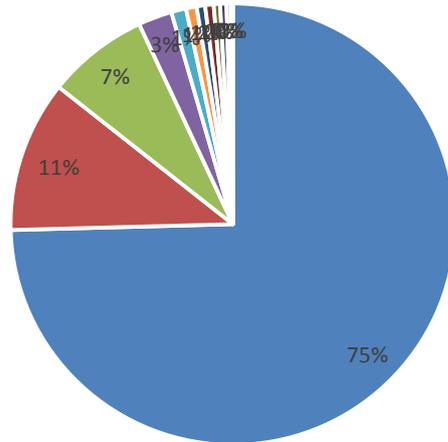
Box 6: Consequences of lack of recognition of restrictive interventions.

Service A reports 0 physical restraints, while Service B reports 15. The physical restraints reported by Service B are thoroughly documented, following the guidance set out in the *Mental Health Act Code of Practice* (Department of Health, 2015). Having access to these records mean that the manager can look at the statistics and accurately review the care plans of patients involved, training needs for staff, and assess whether recommended processes are being followed, such as conducting a debrief and physical health observations. The managers of Service A think that their service doesn't use any physical restraint because their statistics are so low. Due to this, they don't offer relevant training, audit whether procedures are being followed, and are out of touch with practices happening on the ward. However, a patient's family member complains that their relative has handprint bruises on his forearms, and that none of the staff will say how they got there. Upon further investigation, it appears that this person is regularly being restrained by staff to stop him from hitting himself when distressed.

Box 8: The effect of an “outlier” on ward level physical restraint data

The same patient’s individual rates also had a pronounced effect on ward level data, accounting for 75% of ward physical restraint.

The orange chart below shows the total number of physical restraints for the ward by month, including the “outlier” patient’s data, and the blue chart shows the rate without this patient’s data. Evidently, the picture of physical restraint use for the ward is completely different with this patient’s data removed, thus demonstrating how one patient can inflate and skew the overall picture of practice in wards and services. Despite this, and as shown in the orange graph, the rates of such patients can improve over time, as longer term interventions begin to take effect.



Issue 4: Capturing Individual Patient Progress, and the “Whole Picture” of Patient Care, Restrictive Interventions

Capturing Patient Progress

Most providers audit their restrictive intervention reduction programmes at the service level, looking for a downwards trend on a bar chart, as seen in Figure 1. This is a useful approach if service are attempting to measure the effect of a new programme, such as Positive Behaviour Support (PBS) on overall service restrictive intervention rates.

Figure 1: A downward restrictive intervention rate chart

However, these rates are contributed to by many patients, all at differing stages of the care pathway and as such, these graphs overlook the progress of individual patients within the service.

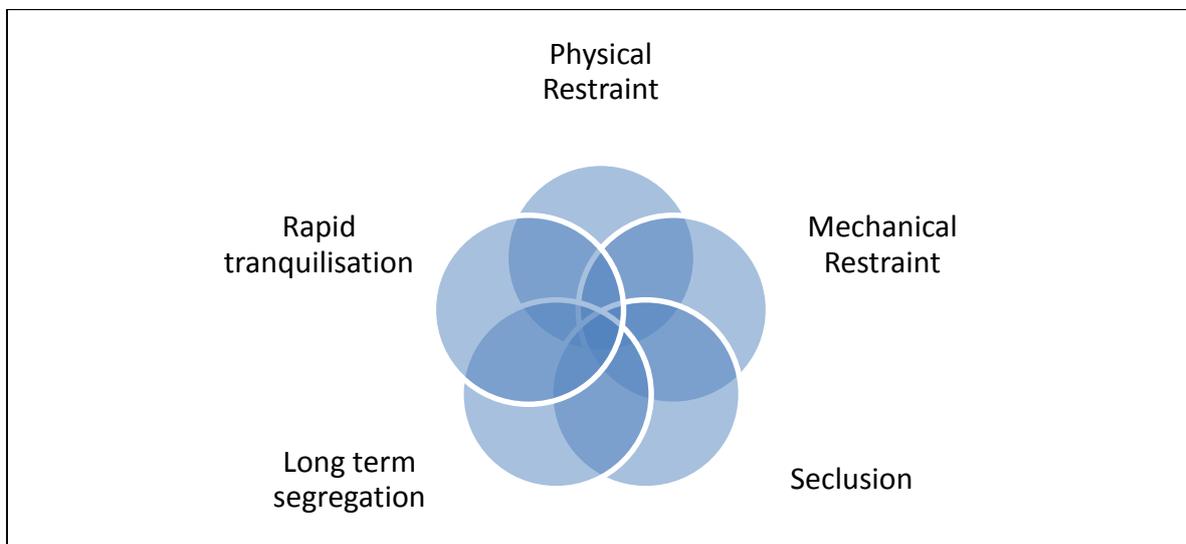
The “Whole Picture” of Patient Care and Restrictive Interventions

A further consideration when interpreting data, is that restrictive interventions should only be used in instances where staff have to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken. As such, this data represents only one element of patient care, and does not capture other domains, such as wellbeing, quality of life, physical health, engagement with friends and relatives, occupational activities, etc.

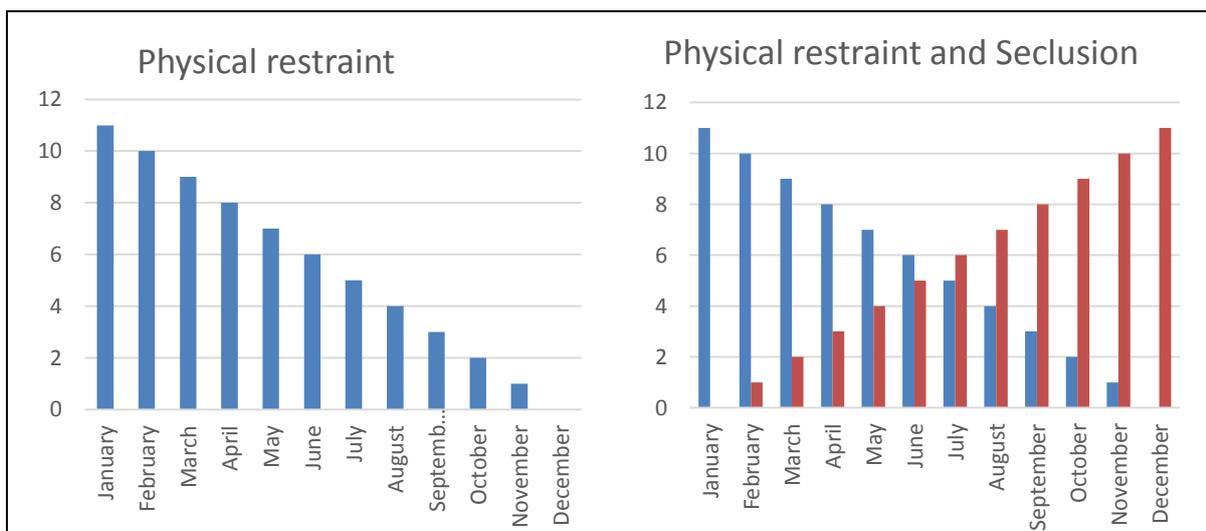
Furthermore, there are often intertwined relationships between different forms of restrictive interventions, such as physical restraint, mechanical restraint, seclusion, long term segregation, and rapid tranquilisation, as detailed in Box 9. The positive behaviour support model aims to improve quality of life by better understanding the function behind challenging behaviour, and implementing positive approaches to address these, thus reducing restrictive interventions. However, this progression is not always linear. For example, in order to support the reduction of long term segregation, an individual patient is often exposed to a wide range of possible environmental stressors and this may increase behavioural incidents in the short term, which may necessitate physical restraint. Yet the patient may simultaneously experience improved quality of life through the environmental access, by interacting with other people, increased levels of activities, etc.

It is therefore important to use data to establish the “whole picture” of restrictive interventions being utilised with an individual patient or within a service, such as physical restraint, seclusion and long term segregation, alongside other aspects of care. This is to ascertain that certain restrictive interventions are not being used in place of another, and to ensure that positive aspects of patients’ care are also being measured and reported on. This effect is depicted in Box 11, which details a seemingly positive trend of restrictive intervention reduction when viewing physical restraint data in isolation. However, when seclusion data is included on the same chart, it appears that seclusion use is increasing. Therefore aggregating data on all restrictive interventions being used with an individual or within a service provides a more accurate reflection of practice, or the whole picture of restrictive interventions used with an individual.

Box 9: Inter-related forms of restrictive interventions



Box 11: Aggregating data on all types of restrictive intervention



The consideration of patients' wishes is key in the interpretation of their rates of restrictive interventions, as the experience is highly subjective. For example, some people with ASD may find the touch experienced during a physical restraint extremely aversive. Others may be hypo-sensitive to touch and carry out actions in order to obtain the deep pressure of physical restraint, or find that physical restraint provides a "containing" function (Steckley, 2012). For some, the use of medication may be preferred to physical restraint, for others the sedative side effects may be too debilitating for them. For some, the withdrawal of staff during seclusion may be a good outcome, for others this may be highly aversive. As such, attention must be paid to individual patients preferences in the interpretation of their restrictive intervention rates, which may be recorded in care plans or advance statements.

Issue 5: Lack of a Benchmark

There is currently limited restrictive intervention benchmarking data available in the public domain. Benchmarking has a number of advantages in healthcare (Royal College of Nursing, 2014, p. 5), including:

- providing a systematic approach to the assessment of practice
- promoting reflective practice
- providing an avenue for change in clinical practice
- ensuring pockets of innovative practice are not wasted
- reducing repetition of effort and resources
- reducing fragmentation/geographical variations in care
- providing evidence for additional resources

Benchmarking is essential in order to ensure references to restrictive intervention rates are not subjective. There is a tendency in official reports to say that the rate of restrictive interventions is “high”- e.g.: Department of Health (2012, p. 14). The word “high” is problematic because it is subjective. What a staff nurse working on a high need medium secure ward perceives as “high” may be different to a care worker employed in a supported living service. A service may appear to have “high rates” but these are all accounted for by one patient at the beginning of their care pathway. A service may have high rates, but these are all restrictive interventions at a lower degree, for example physical restraints for short durations of time, in low level holds. To more accurately assess which services truly have the highest levels (bearing in mind the many reasons why this may be the case), a benchmark is required which regularly compares rates of restrictive interventions across services.

A benchmarking exercise was undertaken which investigated the use of restraint in mental health, child and adolescent, and intellectual disability services in 2015 (NHS Benchmarking Network, 2015). Data was contributed by 51 NHS Trusts and six Independent Sector organisations, on 23,415 beds in total, with 2,431 intellectual disability beds for Phase 2 which captured data for January 2015. Importantly, the benchmark uses the figure of restraint and prone restraint per 10 beds for one month, which takes service size / capacity into account.

The exercise reported a number of interesting findings. For example, rates of intervention between secure intellectual disability services followed a somewhat counterintuitive pattern, see Table 3 and Figure 2. The highest rates of restraint were observed in low secure services caring for lower risk patients, and the lowest levels of restraint were reported for high secure, caring for highest risk patients. There are a number of possible explanations for this. One is that patients in low secure services demonstrate lower risk but higher frequency behaviours, and are therefore involved in more restraints. Another is that patients in high secure services are in a more restrictive physical and procedural environment, are under high levels of observation, and higher proportions of patients are treated within conditions of long term segregation, all of which affects rates of restraint. This links back to the point made earlier, about assessing all aspects of patient care holistically.

Within intellectual disability services of the same category, there were also significant variations in restraint levels, as evidenced by the ranges in Table 3. In acute admission, although there was a mean rate of 17.5 restraints per month, individual service rates ranged from 0 to 120. This was raised by the CQC (2017, p. 5), *“we are concerned about the great variation across the country in how often staff physically restrain patients whose behaviour they find challenging. This wide variation is present even between wards that admit the same patient group.”* It is unclear why services of the same category have such varying rates of intervention. Is the service with the highest rate one to worry about? Possibly. It is also possible they are treating one or a number of individuals with individually high rates of restraint, which has skewed their service level figure. Or this service may be caring for more complex patients than other services within the same category. Although services share broad categories, such as “acute admission”, or “low secure”, their patient populations may not be directly comparable.

A number of patient factors impact restrictive intervention rates, which are rarely considered in the interpretation of data. Recent analysis of restrictive intervention rates have been reported between patients of differential characteristics within forensic intellectual disability services. Women had significantly higher rates than men (Chester et al., in press), and those with autism spectrum disorder (ASD) had higher rates than people without ASD (Esan et al., 2015). If service configuration means that one service has more female patients, or an ASD specific ward, it might be that rates of restrictive intervention are higher in that service. While the relationship between mental health problems and “challenging behaviour” and in people with ID is complex, multifaceted, and potentially bidirectional, a more recent study reported that diagnostic comorbidity is significantly correlated with aggression, self-injurious behaviour, and overall challenging behaviour ratings (Painter, Hastings, Ingham, Trevithick & Roy, 2018). People with more severe mental health problems exhibited more challenging behaviours, and people with more severe ASD exhibited more stereotyped behaviours and challenging behaviour overall.

Occupancy is another factor, if a service has been operating at 80% capacity, it is likely to have less incidents than a comparable service operating at 100% capacity. Another often cited disparity between services of the same category is between those “within area” and “out of area”. “Out of area” services relates to a patient using medium-long-term services away from their home area (Royal College of Psychiatrists, 2011) when demand for beds outstrips capacity or where specialist services are not available locally (Department of Health, 2012). A number of studies have found that patients sent to out of area placements are significantly different to those treated within area. McGill and Poynter (2012) found that out of area patients were largely young, male, with high rates of challenging behaviour and/or autism spectrum disorder. Allen, et al. (2007) found that predictors of out of area placement included behaviours resulting in physical injury, exclusion from service settings, a history of formal detention under the Mental Health Act, the presence of mental health problems, a diagnosis of autism and higher rates of behavioural problems. Again, it may be that services with a high proportion of out of area patients have higher rates of restrictive interventions.

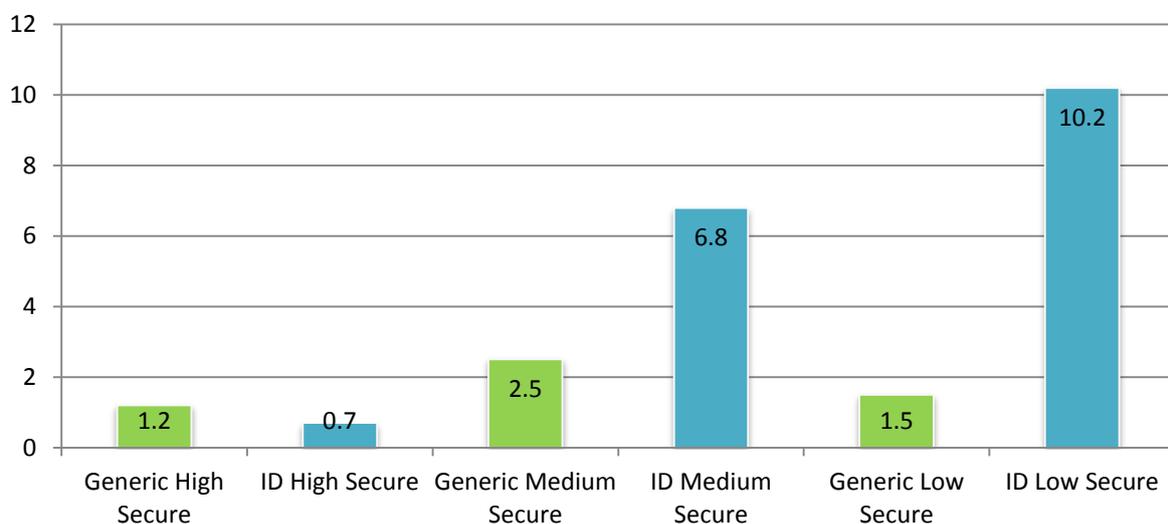
There were also differences between generic medium and low secure services, and ID specific secure services, where ID services reported much higher rates of restraint, see Table 3. This is not an isolated finding, as a number of research studies have reported increased rates of incidents among inpatients with ID (O’Shea, et al., 2015; Fitzgerald et al 2013; Uppal & McMurrin, 2009). The reasons for this are unclear. One explanation is that the patients with ID display more challenging behaviours, or present with increased risks than patients without ID. This is supported by studies which report elevated HCR-20 total and subscale scores among inpatients with ID, as compared to those without (e.g. Alexander et al., 2012; Morrissey, Milton & Beeley, 2014).

Table 3: Mean and between service ranges of restraint per 10 beds for one month in ID services*

Service category	Mean	Range	N services reporting above mean
Acute admission	17.5	0 - 120	5
Low secure	10.2	0 - 33	5
Medium secure	6.8	0 - 25	4
High secure	0.7	n/a*	n/a*

**As there is only one high secure ID service, there is no comparison data.*

Figure 2: Rates of restraint for one month, per 10 beds, ID vs. generic secure services



Throughout Chapter 2, we have demonstrated a number of problems when attempting to assess restrictive interventions Practice by solely relying on total numbers. These problems are summarised in Box 10.

Box 10: Problems with using numbers to assess restrictive interventions practice

Numbers alone:

1. Do not demonstrate over reliance on restrictive interventions, last resort / least restrictive practice, correlate with the overall standard of a service's restrictive intervention practices, or uncover poor practice or abuse.
2. Are largely self reported by services, using their own definitions of restrictive interventions, and do not discriminate between degrees of restrictive intervention.
3. Do not account for the impact of "outliers".
4. Do not capture the "whole picture" of care and individual patient progress.
5. Are difficult to interpret due to the absence of a publicly available benchmark.

Chapter 3: Critique of Current Guidance on the Recording, Monitoring and Regulation of Restrictive Interventions

It has become clear that there are problems with relying on data and statistics alone when assessing restrictive intervention practices within ID services, and that there is a need for further guidance in this area. This chapter will summarise and critique current guidance on the recording, monitoring and publishing of restrictive intervention data.

Recording

The primary function of incident records are to document on a micro level, the behaviour displayed by a particular patient on a given day, and the way in which this behaviour was managed. These documents communicate critical information about how the staff and service caring for an individual patient, contribute to a developing knowledge of the individual patient's triggers to aggression and violence, to the ongoing process of the assessment and management of risk, and for safeguarding. These documents are kept for a number of years, and can be referred back to in the case of litigation by the patients and staff members involved in the incident.

Regarding the recording of restrictive intervention incidents, *Positive and Proactive Care: reducing the need for restrictive interventions* (Department of Health, 2014) emphasise the need for rigorous reporting arrangements and is quite prescriptive about the need for a combination of quantitative and qualitative data:

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

- *the names of the staff and people involved*
- *the reason for using the specific type of restrictive intervention (rather than an alternative less restrictive strategy)*
- *the type of intervention employed*
- *the date and the duration of the intervention*
- *whether the person or anyone else experienced injury or distress*
- *what action was taken.”*

The Mental Health Act Code of Practice (Department of Health, 2015) provides slightly different recording guidelines for each type of restrictive intervention; as detailed in Table 4. The Department of Health (2015) also contains considerations such as evidencing that:

- a. verbal de-escalation is maintained through restrictive interventions.
- b. a doctor attended in response to staff requests concerning a psychiatric emergency, whether in relation to medication, restraint or seclusion (if relevant) (p. 295)
- c. family members were informed in accordance with any prior agreements (p. 295)

The quality and standards of restrictive intervention records completion has been criticised. Citarella (2013, p. 1) highlighted that at Winterbourne View, references to patients “having an unsettled day” were frequently written as justifications for physical restraint. The CQC (2012, p. 23) stated the incident reports they inspected during their national review of services; *“Incident reports were not always completed appropriately...There was no evidence that the poor recording of incidents was picked up at any level in the organisation.”* This is not acceptable.

Table 4: Department of Health (2015) restrictive intervention recording guidelines

Physical restraint	Where physical restraint has been used, staff should record the decision and the reasons for it, including details about how the intervention was implemented and the patient’s response (p. 296). A member of staff should monitor the individual’s airway and physical condition to minimise the potential of harm or injury. Observations, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/dicolouration), should be conducted and recorded (p. 295).
Mechanical restraint	The patient’s clinical record should provide details of the rationale for the decision to mechanically restrain them, the medical and psychiatric assessment, the patient’s condition at the beginning of mechanical restraint, the response to mechanical restraint and the outcomes of the medical reviews (p. 297).
Rapid tranquillisation	Records should indicate the reason for the use of rapid tranquillisation and provide a full account of both its efficacy and any adverse effects observed or reported by the patient (p. 299).
Seclusion	The seclusion record should provide the following details (pp. 307-308): <ul style="list-style-type: none"> • who authorised the seclusion • the date and time of commencement of seclusion • the reason(s) for seclusion • what the patient took into the seclusion room • if and when a family member, carer and/or advocate was informed of the use of seclusion • 15 minute recordings by the person undertaking continuous direct observation • details of who undertook the independent MDT review, their assessment and a record of the patient’s condition and recommendations • details of who undertook the scheduled MDT reviews, their assessment and a record of the patient’s condition and recommendations • the date and time seclusion ended, and • details of who determined that seclusion should come to an end.
Long term segregation	No specific instructions provided on recording instances where a patient is cared for in long term segregation.

Monitoring

There has been a recent initiative to move beyond simply recording or documenting incidents at the micro level, to using this data at the macro level to monitor and minimise restrictive interventions. Therefore ideally, a services' system of recording will also allow the exploration of incident reports to facilitate the monitoring of restrictive interventions. The Department of Health (2014) also emphasises the importance of collation and monitoring of data on restrictive interventions, however, the guidance is much less prescriptive here. The document states that restrictive reduction programmes should be based on the principles of "data-driven quality assurance" (p. 22) and "data informed practice" (p. 32). But that is where the guidance ends, leaving the question, how exactly should restrictive interventions be monitored in services?

The use of data to support restrictive intervention reduction is a practice which is patchy across services. Data has been described as a vital component of the Positive Behaviour Support (PBS) approach, which is concerned with the science of behaviour change, thus requiring observable measurements (Bowring, 2015). Bowring describes five purposes of data in relation to PBS. Firstly, data is required to determine the relevance of PBS interventions, and intervention should only occur following detailed consideration of the issue and whether it warrants any intervention. Secondly, data is required to analyse the function or purpose of any problem behaviour objectively which helps select the most appropriate, person centred intervention. Thirdly, data is required to measure changes in behaviour and study the impact and effectiveness of interventions, by maintaining direct and continuous contact with the behaviour under investigation. Fourthly, data is required to measure the acquisition of new skills and to assess whether these last and are being used in different settings (they have generalised). Fifthly, data is importantly required to measure lifestyle changes and the achievement of quality of life outcomes.

Following their national review of services, the CQC (2012, pp. 42-43) highlighted that the services which were compliant with their inspection criteria recorded incidents of restrictive interventions and analysed them to look for trends. Services learned from this and fed information back into people's care plans to reduce the chances of restraint being needed in the future. For example: *"The care plans we looked at showed us that incidents of challenging behaviour had been reviewed and analysed at each weekly meeting. When triggers to a young person's challenging behaviour were identified, the care plan was amended and this was confirmed by the young people we spoke to."*

Publishing

Further to the guidance and reporting, and recommendations on monitoring, the guidance states that *"Accurate internal data must be published by providers including progress against restrictive restraint reduction programmes...in annual quality accounts or equivalent"* (Department of Health, 2012, p. 11). However, again, the document gives no guidance as to exactly what services should be publishing. Few services routinely publish this data, and as

such, there is very limited information in the public domain. On the other hand, in the absence of prescriptive guidance on exactly what to publish, services are currently free to set their own reporting parameters, which could lead to misleading reports, and further difficulties in comparing rates between services.

Inspection / Regulation

While regulators always ask questions about restrictive interventions (Kelsall and Devapriam, 2015), inspectors largely rely on data and statistics to make assumptions about restrictive intervention practice. This fails to take into account a number of the problems with this data, that have been described earlier in this report, and is a critical challenge facing regulators. Table 5 describes and critiques the data typically requested by the Care Quality Commission prior to and during inspections of intellectual disability services.

Table 5: Information on restrictive interventions requested by the CQC

<p>Total incidents last six months for a whole service:</p> <ul style="list-style-type: none"> • Seclusion • Long-term segregation • Restraint • Prone restraint 	<p>Does not capture:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> whole service change over time <input checked="" type="checkbox"/> proportion of restrictive interventions accounted for by individual patients, particularly the impact of outliers / new admissions <input checked="" type="checkbox"/> individual patient progress, <input checked="" type="checkbox"/> information on intensity of the holds used or intervention duration, <input checked="" type="checkbox"/> any comparison to a publicly available benchmark, <input checked="" type="checkbox"/> information on injuries.
<p>How many of the 'prone restraints' resulted in rapid tranquilisation?</p>	
<p>On how many different service users was restraint used?</p>	

Chapter 4: Recommendations on Recording, Monitoring and Regulation of Restrictive Interventions

In chapters 2 and 3 the current approach to monitoring of restrictive interventions in ID services, which relies mainly on the analysis of service defined and provided data, is critiqued. As such, a number of recommendations are made relating to the recording, monitoring, publishing, and regulation of restrictive interventions practice.

Recording

Recording recommendations relate to improving the quality of incident reporting systems and information technology (IT) software / databases, and implementing processes to ensure the quality of information entered into incident reports. It is recommended that:

1. Services should have a good quality system of recording incidents of restrictive interventions, which incorporates variables specified by government guidance (Department of Health, 2014; 2015).
2. Incident records within this system should be well written and present a cohesive representation of the events leading to, and during the restrictive intervention, particularly focusing on justification for their use, and stating how the intervention represented the least restrictive option, and what physical health observations was undertaken.
3. Services should consider moving away from paper based recording systems, which have limited utility in the monitoring of restrictive interventions, in favour of IT software packages or databases. IT software systems are the preferred mode of recording, due to being more robust, and their potential to improve the quality of quantitative and qualitative restrictive interventions data.
4. Such systems should be developed in conjunction with all stakeholders of the software, including those who will be entering incident reports, and those who will access the data for monitoring / regulation.
5. Software developers should consider “forced response” formats to ensure that all required data is completed within incident report entries.
6. Software should be kept up to date with new patient details on their admission to the service, new staff member information on their appointment, and particular MVA techniques taught in the service.
7. Software should prompt those entering data to ensure their incident report demonstrates compliance with current government guidance (Department of Health, 2014; 2015), with statements such as “describe how this intervention represented the

least restrictive response to the patient's behaviour" or "describe the physical health observations which were undertaken during the restrictive intervention".

8. The system should be reviewed and updated in an ongoing manner, to maintain its quality and utility.
9. It is recommended that staff who are required to write incident reports as a requirement of their role are given full training in the correct process. This training must emphasise the importance of quality incident reports, and cover government requirements (Department of Health, 2014; 2015).
10. Services should provide supervision and mentorship to staff in this element of their role.
11. Incident reports should be checked and signed off by a senior member of staff.
12. Services should regularly audit incident reports to ensure they meet the required standard.

Monitoring and Regulation

In this section, we make recommendations which will assist services, regulators, and other stakeholders to analyse, interpret and report restrictive interventions data, and to assess wider restrictive intervention practice quality.

13. Services should generate statistics / reports on restrictive interventions, as defined by the Department of Health (2014; 2015), for any reasonably requested time-frame, on a whole service, ward, and individual patient level.

Service / Ward level reports should include:

- a. Total frequency of each restrictive intervention.
- b. Total number, level and type of incidents which do not result in restrictive intervention.
- c. Duration of restrictive interventions, with a full categorical breakdown, in addition to average and range.
- d. Holds / techniques used for physical restraint, with a full categorical breakdown (this figure is likely to be higher than the total frequency of restrictive interventions, due to incidents of restraint which utilise more than one holding technique).
- e. Trends in rates over time, day, week in month, month. If incidents peak at particular days or times, this can direct the exploration of individual / ward / service activities, procedures, staffing levels etc. and interventions as necessary.

- f. An investigation or analysis of decreases, increases, or maintenance.
- g. Total number and breakdown of any patient injuries sustained within restrictive interventions.
- h. The number of individual patients represented within the data, expressed as a percentage of total patients treated within this timeframe.
- i. Progress of all patients against the aims of the services chosen restrictive intervention programme, ideally using the “traffic light audit”.
- j. The contribution of individual patient rates to the overall total for the ward or the service. If there are any outlier(s) which significantly affect the overall total, or trends, report rates with and without the outlier data.
- k. Details of how rates compare to a national benchmark.
- l. Number of beds, and occupancy level of service for timeframe.
- m. Cohort characteristics, such as gender, diagnoses, behavioural and / or offence profile.
- n. Information about the number and degree of patient injuries sustained within restrictive interventions.

Individual patient level reports should include:

- Items a-h, as above.
- A brief description of a patient’s demographic information, psychiatric and forensic history (where relevant).
- Services should be able to generate statistics on the levels of restrictive interventions for the entirety of a patients’ admission, and if available, pre-admission.
- Reports should include details of the patients management plan, e.g. level of observation, medication, level of engagement, assessments and treatment plans.

We also make a number of recommendations in order to overcome some of the identified limitations with restrictive interventions data.

Overcoming Issue 1: Assessing Practice Quality, Over Reliance, the Last Resort, Least Restrictive, Poor Practice and Abuse

Assessing the quality standard of a service's restrictive intervention practices

14. To truly capture the quality of a service's restrictive intervention practice, there must be less focus on the number of restrictive interventions, and more on services adherence to the standards outlined by government guidance (Department of Health, 2014; 2015).
15. This is likely to encompass restrictive intervention factors such as:
 - a. staff training in primary and tertiary strategies, training in safer restrictive intervention techniques, restrictive intervention reduction programme, the quality of advance statements and individualised restrictive intervention care plans, physical health observations and debriefing processes, and;
 - b. wider practice quality issues, such as; leadership, staffing levels, environmental considerations, engagement, patient assessment, therapies and management, etc.

Assessing the principles of last resort and least restrictive practice

16. It is recommended that qualitative incident accounts, or a representative subsample of, are inspected on an incident by incident basis, in order to assess whether the note adheres to the principles of least restrictive practice. For example, was the decision making process for restrictive intervention by staff described, was this decision justified, for the patient's own, or others safety? Was it reasonable and proportionate? Was it the least restrictive way the behaviour described could be managed? Was the intervention subject to regular review by staff and curtailed as soon as possible? This is a much more time consuming task, but a much more meaningful one, and is dependent on a good standard of written incident reports.

Uncovering poor practice, or abuse of restrictive interventions

17. If it appears that restrictive interventions are being carried out for any other purpose than to take immediate control of a dangerous situation, it is recommended that concerns should be escalated through local safeguarding procedures and protocols.
18. It is recommended that services should routinely record, and regulators should request information on the number patient injuries sustained during restrictive interventions, except where these relate primarily to instances of self harm / injury.
19. Regulators should cross reference data on restrictive interventions with information from other sources, including their observations, patient and carer reports, safeguarding referrals, police reports, etc.

Overcoming Issue 2: Definitions and Degrees of Restrictive Interventions

20. It is recommended that policy makers develop a framework of restrictive intervention severity / intensity. This should encompass the full range of physical restraint techniques used by multiple training providers, as well as the duration of physical restraint, seclusion, and long term segregation. This would provide an element of standardisation, move towards more consistent recording between service providers, and support the comparability of data.
21. It is recommended that in the interim, services should record, monitor, and report the full framework of techniques used.
22. Services which report comparatively lower numbers of restrictive interventions should have their practice inspected as rigorously as those which report higher numbers.

Overcoming Issue 3: Accounting for the impact of “outliers”.

23. It is recommended that services provide a breakdown of restrictive intervention data from the total number for a whole service, to the ward level, and individual patient level. This can be done utilising widely available software, Microsoft Excel, using the Pivot Table function, which can facilitate the analysis of a large, detailed datasets quickly and easily. This function can also be used to view the proportion of restrictive interventions accounted for by individual patients, and ward or service level data can be viewed and presented with and without the data of individual outlier patients.
24. Service providers can also report multiple measures of central tendency, such as the median, in addition to the mean, which is particularly susceptible to the effects of outliers.

Overcoming Issue 4: Capturing the “whole picture” of patient care and restrictive interventions

Establishing individual patient progress

25. Services should analyse the progress of individual patients for a clearly specified timeframe. This can be achieved using the “traffic light” audit method. The traffic light method involves viewing the restrictive interventions rates of all patients within the service, and then categorising them into one of the three categories outlined in Box 12. This can be useful through the audit cycle, or ideally the whole duration of a patient’s admission, as detailed in Table 6.
26. This should include the number of patients treated in the timeframe specified, and the proportion who have been involved in restrictive interventions.

27. Services should request information about the levels of restrictive interventions and management plans from the referring service, report these alongside current levels, and pass on this information when discharging patients, with clear reporting parameters, if this information is available.

Box 12: “Traffic light” Restrictive Intervention Audit Method: Categories

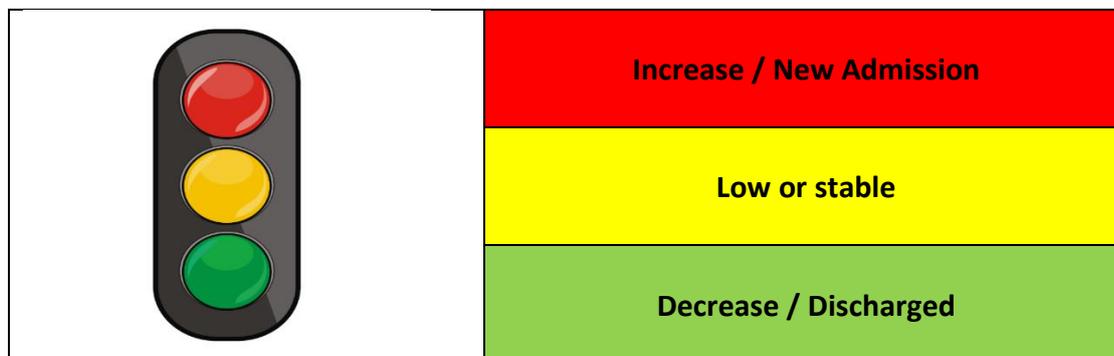


Table 6: “Traffic light” Restrictive Intervention Audit Method: Individual Patient Focus

Patient Name	Jan	Feb	Mar...	...Oct	Nov	Dec	Status
Isabelle				1	1		Increase
Emma	1				3	15	Increase
Pauline					9	4	New admission
Justine				4	2		New admission
Fauzia	3		3	1	2	2	Low / Stable
Joanne	1	1					Low / Stable
Julia							Low / Stable
Jessica	34	19	10	16	9	16	Decrease
Kerry	9	9	11	6	4	5	Decrease
Michelle	52	82	35	14	7	14	Decrease
Alia	18	18	11	2	4	2	Decrease
Jeanette	22	27	30	16	12	19	Decrease
Rebecca	39	18	45	20	19	15	Decrease

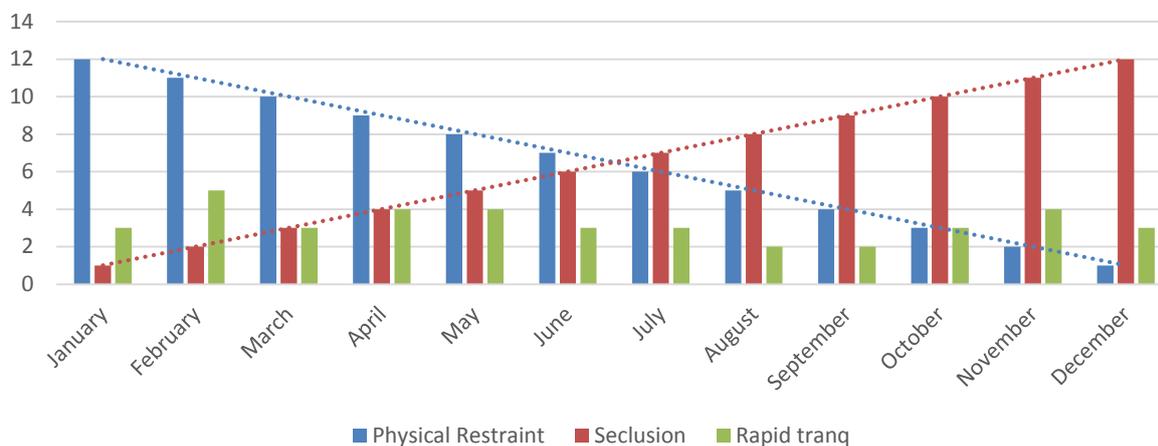
Capturing the “whole picture”

28. Services should monitor and report all types of restrictive interventions used with an individual patient, using visual aids such as the example depicted in Figure 3.

- a. This should take into any specific patient preferences as specified in advance statements or similar, and recognise that restrictive interventions, and recognise

that this data represents only one element of patient care, and does not capture other domains, such as wellbeing, quality of life, physical health, engagement with friends and relatives, occupational activities, etc.

Figure 3: Marie* Annual Restrictive Intervention Rates



Overcoming Issue 5: The absence of a publicly available benchmark.

- 29. National benchmarking data must be strengthened via the inclusion of a wider range of variables, and be publicly available to all.
- 30. Benchmarking processes must consider the highlighted issues with restrictive interventions data, and take steps to counter these in reports.

Using data to support the reduction of restrictive interventions

- 31. Services must demonstrate the use of data to support restrictive intervention reduction.
 - a) This might involve regular reviewing of incidents and subsequent debriefs, identifying any triggers, or learning points and feeding these back in to care plans. It could involve viewing of restrictive intervention rates in team meetings and care reviews, identifying patterns of use, and addressing any underlying reasons for these. This could involve highlighting particular times of day where incidents peak, as demonstrated in Figure 4, particular days of the week (Figure 5), differences between shift patterns, etc. When reviewing individual patients, these factors are likely to be highly personalised and their care plans should reflect this.

Figure 4: Peak times of day for incidents

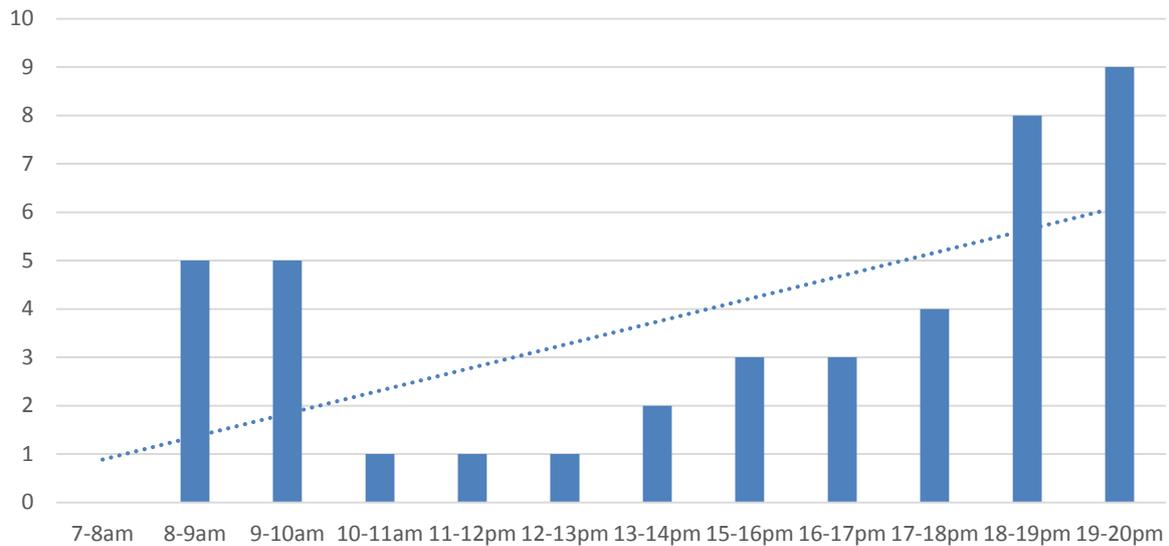
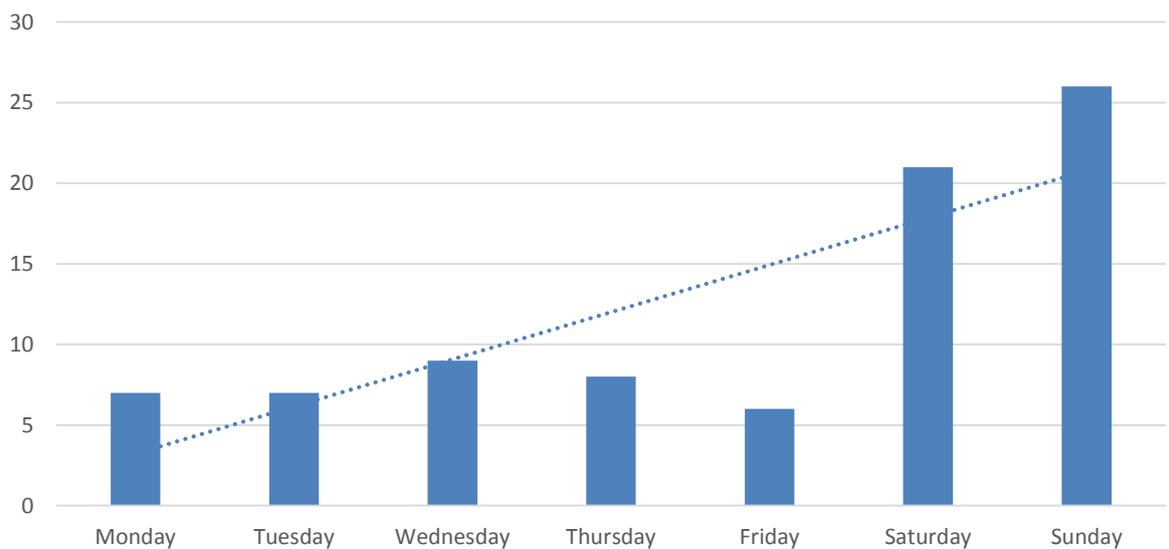


Figure 5: Peak days of the week for incidents



b) Services may also choose to record a wider range of measures in addition to restrictive intervention rates, as identified by Bowring (2015). These might include behaviour rating scales, quality of life measures, patient satisfaction etc.

Publishing

32. Any publication of restrictive intervention data should adhere to the above guidance.

33. Reports should relate to a clearly specified timeframe.

Conclusions

In the years following Winterbourne View, there has been an understandable level of concern surrounding the use of restrictive interventions involving people with mental disorders and intellectual disabilities, and a call to reduce such interventions. This alarm has been evident in the reporting of statistics and data pertaining to such practices, characterised by emotive headlines and reports. This reporting has arguably contributed to an increasing contrast between the public face of these interventions, compared to clinical reality. These points are not intended to downplay concerns about restrictive intervention use, but to highlight the importance of transparent, ethical and authentic data reporting (Marco and Larkin, 2000) to support the shared aim of all stakeholders in restrictive intervention reduction.

Data monitoring has numerous benefits, including the potential to support restrictive intervention reduction, but needs to be recognised as one tool in the toolbox, of a long term, multicomponent, whole service approach, such as that described by Colton (2004). Progress has been made in the form of rigorous recommendations relating to recording of restrictive interventions at the service level, in *Positive and Proactive Care: reducing the need for restrictive interventions* (Department of Health, 2014). However, the monitoring of data on restrictive interventions appears to be a neglected and underdeveloped area within services (CQC, 2012), and guidance on data monitoring has been less prescriptive. Furthermore, the complexity of this data is often underappreciated, and its interpretation needs to be approached in a considered way. This report has highlighted a number of contextual factors to consider when reporting and interpreting restrictive interventions data, for all stakeholders. There is clearly a need for guidance pertaining to the monitoring and communication of physical restraint and other restrictive intervention data, for both service providers and regulators, and starting points are offered in the form of recommendations. These points can be treated both as self assessment audit standards for services and guidance for regulators.

NHS England and Partners are currently working to develop common definitions, improve recording, monitoring and regulation of restrictive interventions in inpatient settings for people with ID. The recommendations made in this report will be useful to improve on existing guidance especially for people with ID in inpatient settings.

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How to cite this report: Royal College of Psychiatrists (2018). *Restrictive Interventions in Inpatient Intellectual Disability Services: How to Record, Monitor and Regulate*. London: Author.

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