An evaluation of the implementation of the 'Restraint Reduction Network (RRN) Training Standards' in mental health and learning disability settings

Final Report

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Alina Haines-Delmont, Katie Goodall, Joy Duxbury

Manchester Metropolitan University

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Introduction

Training is an integral part of programmes aimed at reducing restrictive practices. Evidence suggests, however, that there is too much emphasis on reactive techniques and technical competence rather than preventative approaches, as well as too much inconsistency regarding quality of training and quality assurance across healthcare settings. The Restraint Reduction Network (RRN) Training Standards were launched in England, UK, to encourage a positive change in practice and provide a framework on which training can become more standardised across health and social care services. Since April 2020, it has been a statutory requirement that organisations delivering training on restrictive practices including restraint must be certified. This timely research study examines views and experiences regarding the processes involved in the implementation of the Standards to learn and share good practice and identify ways to improve practice, with the view to inform future iterations of the Standards, as well as the potential transferability/application to other areas of practice or countries.

Aim and objectives

The aim of this study was to explore the extent to which the Restraint Reduction Network (RRN) Training Standards (referred to as 'the Standards') have been adopted and implemented in in-house, commercial and affiliate training organisations in the UK. The objectives were to:

- Scope the current extent to which organisations are certified against the Standards in the UK;
- Explore views and experiences of implementation and certification processes of organisations certified against the Standards or working towards certification;
- Identify benefits and good practice, as well as barriers and facilitators to implementation; and
- Identify priority areas for improvement and implications for future iterations of the Standards.

Methods

A sequential mixed methods approach combining an online survey, in-depth interviews and consultation workshops was used to address these objectives. The online survey included 114 representatives from in-house, commercial and affiliate organisations in the UK, either certified or working towards certification in relation to the Standards. Emerging results from the survey were used to inform the interview schedule for 12 in depth semi-structured qualitative interviews with professionals who had a key strategic/senior role regarding training and the reduction of restrictive practices in their organisation. Data from the survey and the interviews were analysed by the research team inductively and deductively to identify key themes. These were then discussed and further validated with key stakeholders with strategic roles in this area of work, people with lived experience and representatives from services who might not have participated in the main data collection (approximately 77 individuals). These additional consultations were key to enable the research team to sense-check emerging findings and recommendations and refine them to reflect current practice and priorities, as well as to discuss the feasibility and reality of implementing them both in the short and long term.

Ethical approval for the study was granted by Manchester Metropolitan University's Research Ethics and Governance Team in August 2021 (REF: 32594).

Key Findings and Recommendations

Findings indicate that experiences of the implementation of the Standards differ depending on type of organisation, the timing within their journey to certification or implementation, and their organisational culture and strategies with regards to reducing restrictive practices. Whether positive or negative, these experiences appear to have been crucial in shaping the organisations' overall views of the Standards and the certification process, as well as their relationship with the RRN, BILD Association of Certified Training (BILD Act) or regulators.

A key finding of this research was that the Standards were recognised as an important contributor towards a wider organisational cultural shift needed in the use of restrictive practices in mental health settings and beyond. This is about moving away from physical skills only training to a wider, person-centered, trauma informed care approach to training, with more emphasis on prevention and de-escalation, which is in line with the use of training approaches, internationally. Findings also indicate that the Standards have raised the overall

quality of training in those organisations certified under the certification scheme, helping towards creating consistency and improving quality assurance. Interestingly, there is a recognition that having mandatory standards for training provide organisations with some form of leverage, reassurance, or legitimacy when trying to implement their strategies to reduce restrictive practices across services, including training.

Given the new heavily regulated processes involved in the certification and the implementation of the Standards, it is not surprising that that participants in this study found these processes time consuming and resource intensive, sometimes too rigid, or lacking flexibility. One of the key challenges to implementation appears to be when supporting affiliate organisations through the process, especially following accreditation to ensure they maintain compliance with the Standards.

Involving people with lived experience was seen as a key priority, but a challenging aspect in relation to co-production and training delivery. Benefits and challenges identified in this research were used to identify solutions to improve practice. Key recommendations are summarised below.

Conclusion

The RRN Training Standards are just one piece of the puzzle, a step towards changing practice and organisational culture regarding the use of restrictive practices and approaches used to minimise these, including training. Although training is seen as a key element to reducing restrictive practices within the international literature and practice, training approaches differ greatly and there is little or no regulation (outside of the UK). The RRN Training Standards represent a positive shift in informing training to guide practice and the first to provide a mandatory framework for training within health and social care services. This research has explored experiences and views of those implementing the Standards to share lessons learnt, to inform future iterations of the Standards, as well as the potential application of the Standards in other areas of work/settings or countries outside of the UK.

Key recommendations

Make the Standards more accessible	• Improve clarity of some Standards (2.5/2.6) • Develop visual, accessible summaries/diagrams outlining key principles and responsibilities • Encourage collaboration/community of practice and strengthen pathways for sharing of information and good practice
Allow for some flexibility in how the Standards are met	• Consider exceptional circumstances with regards to key requirements for certification (e.g., 2 years of data) • Shift focus to concentrate on output rather than input and prescriptive processes to achieve that
Support co-production and involvement of people with lived experience	• Develop accessible summary of Standards with and for people with lived experience • Develop national framework for involvement of people with lived experience, including families • Offer support to people with lived experience, e.g. training opportunities, support post involvement, attendance to events, conferences, etc.
Support shared decision making with services	• Encourage and enable service representation on RRN Standards Sub-groups • Work towards better integration of 'RRN Training Standards' with 'Towards Safer Services' practice framework for reducing restrictive interventions
Strengthen communication pathways	• Flag up regulators (e.g., CQC) in the Standards, as somewhere organisations can go to ask specific questions • Identify key (expert) contacts for questions regarding the Standards • Consult with organisations to identify best way to filter information to organisations
Revisit content of the Standards	• Revisit language used in the Standards to allow for differences in services - a bespoke version of the Standards per type of service could be made accessible • Consult with NHS Professionals (NHSP) and staff on the ground to find the best way forward to address Bank/agency training needs and responsibilities for training providers • Consider inequalities and disproportionality in the curriculum
Expand mandate beyond mental health and social care	• Consider developing Standards (in version 2) beyond health and social care settings, for example children and young people services, education, acute and emergency settings, devolved nations

Evaluation of the Restraint Reduction Network (RRN) Training Standards

Full Report

BACKGROUND

1. The impact of using of restrictive practices

There are concerns that restrictive practices including physical restraint, seclusion and chemical restraint are overused on vulnerable people. There have been shocking scandals exposing the unnecessary and inappropriate use of restrictive interventions on people with mental health conditions and learning disabilities (Transforming Care and Commissioning Steering Group, 2014). They are often a response to what is referred to as 'behaviours of concern' or 'challenging behaviour'. Whilst these behaviours can occasionally include willful acts that cause or have the potential to cause harm to themselves or others around them, they are often a symptom of being in a situation that causes them distress and the result of unmet needs (Cross et al., 2019).

The use of restraint on patients with autism and learning disabilities in hospitals in England has risen at an alarming rate. In 2017, 22,000 incidents of restraint were reported, which rose to 38000 incidents by 2020. This equates to an average of 100 restraints a day, or 1 restraint every 15 minutes (Care Quality Commission, 2020a). The implication of the use of restrictive practices not only affects service users, but it can also have adverse physical and psychological effects on staff (Department of Health, 2014; Renwick et al., 2016) and damage the therapeutic relationship between them (Duxbury et al., 2019).

1. What is being done?

UK Government and regulatory responses have resulted in guidance such as Positive and Proactive Care and the Patient Safety Improvement programme(Department of Health, 2014; NHS England, 2021a). The Council of Europe have unanimously adopted a resolution to 'immediately start to transition to the abolition of coercive practices in mental health settings' (Parliamentary Assembly Council of Europe, 2019). Despite this, there is evidence that physical restraint is used too frequently and not always as a last resort (Department of Health, 2014; Renwick et al., 2016).

The latest legislation in the UK, the Mental Health Units (Use of Force) Act (Department of Health & Social Care, 2021), has been developed to ensure there is consistency in practice and reporting. The Act focuses on appropriate oversight and management to ensure that information regarding the use of force is recorded and distributed correctly. In addition, all mental health units are expected to provide a good standard of training to staff working with patients within the unit.

A strand of the recent NHSI/CQC Patient Safety Improvement Programme (NHS England, 2021a) that was requested by the Secretary of State focused specifically on the quality of training for staff who use restrictive interventions. The main areas of concern were the range of quality of training and the lack of quality assurance. They also noted that many training programmes focused on reactive techniques and technical competence and did not put sufficient focus on human rights, prevention, and de-escalation to reduce the use of restraint and promote a positive culture.

The CQC recently published a report entitled *Out of sight – who cares?* looking at the use of restraint, seclusion, and segregation in care services for people with a mental health condition, a learning disability or autistic people (Care Quality Commission, 2020b). The

findings showed that training was being delivered inconsistently throughout the sector. While some organisations were providing person-centred and bespoke training courses specifically tailored to those being cared for within the service, others were not training staff appropriately to care for individuals' specific needs. This calls attention to the need for standardisation of training to ensure staff feel supported in providing the highest standard of patient care.

2. The Restraint Reduction Network and National Training Standards

The Restraint Reduction Network (RRN) is a registered charity bringing together an extensive network of professionals, academics, regulators, charities, and people with lived experience who are passionate about reducing reliance on restrictive practices across education, health and social care and protecting human rights.

The RRN has worked with Health Education England (a national leadership organisation for education, training, and workforce development in the health sector) and a wide range of stakeholders (e.g. endorsing organisations, critical readers, services) to produce a set of ethical training standards referred to as the Restraint Reduction Network (RRN) Training Standards (First edition) (Ridley & Leitch, 2019). They can be understood in the wider context of the Towards Safer Services Framework (Cross et al., 2019), a document supporting care providers in the reduction of the use of restrictive practices, and encouraging services to review practices and philosophies of person centred care in order to maximise the rights of everyone, including wellbeing and safety. The aims of the Standards are to: (1) protect people's fundamental human rights and promote person centred, best interest and therapeutic approaches to supporting people when they are distressed; (2) improve the quality of life of those being restrained and those supporting them; (3) reduce reliance on restrictive practices by promoting positive culture and practice that focuses on prevention, de-escalation and reflective practice; (4) increase understanding of the root causes of behaviour and

recognition that many behaviours are the result of distress due to unmet needs; and (5) where required, focus on the safest and most dignified use of restrictive interventions including physical restraint.

The Standards are a comprehensive document that are written for health, education, and social care settings within the UK, with appendices for specific populations and settings. They outline a rights-based framework for training that underpins the overall law and values within which any training with a restrictive practices element must be provided. There are four key sections: (i) pre-delivery processes, (ii) curriculum content, (iii) post-delivery processes and (iv) trainer standards, that cover the process from engagement with an organisation to development of the curriculum, its delivery, and the cycle of feedback afterwards. The document contains 37 Standards which consist of 128 mandatory sub-standards and training providers must show that they have a process in place which meets each Standard, providing the evidence needed to achieve certification at all the different stages.

3. Certification process

The implementation of the Standards is supported through the NHS commissioning framework (NHS England, 2021b) making it mandatory for all NHS providers of mental health and learning disability services to be certified against the Standards. The Mental Health Units (Use of Force Act) also states: “Training providers must be certified as complying with the RRN Training Standards” (Department of Health & Social Care, 2021) and the CQC expects regulated services across health and social care to use certified training, advising that failure to do so is likely to be a breach of Regulation 18 relating to staff training (CQC, 2014).

A certification body (BILD Act) has been registered with UKAS (United Kingdom Accreditation Service) to certify training providers against the Training Standards. The purpose of the certification process is to (1) demonstrate compliance with the Standards; (2) provide a quality mark to support commissioning of high-quality training; (3) provide an enabling scheme that not only offers quality assurance but also supports a culture of continuous improvement; (4) provide a robust, effective, consistent system and to be equitable and impartial in its application; and (5) reduce risks associated with poor training and practice.

To gain (and preserve) certification, organisations must pay a one-off fee of £6,995 (and several other annual costs totaling £1540) and complete a nine-step process briefly summarised below:

(1) ***Submit eligibility criteria –*** The training provider submits a fully completed initial application that will be scrutinised by the lead assessor. The application requires the curricula they wish to be approved, names of senior trainers who will be listed and affiliate service providers (where applicable).

(2) ***Initial self assessment*** – The training provider completes a self-assessment form providing supporting evidence demonstrating that they meet each standard and all corresponding mandatory sub-standards.

(3) ***Evaluation and scrutiny*** – The training provider is assigned an assessor who scrutinises and reviews self-assessment form and gives feedback.

(4) ***Update self assessment –*** The training provider submits action plan to address nonconformities and then updates self-assessment form and supporting evidence.

(5) ***Observation and feedback*** – The assigned assessor reviews self-assessment form and supporting evidence for a second time and observes training, providing feedback from both.

(6) ***Update self assessment*** - The training provider submits action plan to address nonconformities and then updates self-assessment form and supporting evidence.

(7) ***Review panel and decision*** - Assigned assessors reviews self-assessment form and supporting evidence for a final time before referring the training organisation for review. Scheme manager (or lead assessor) and review panel review the evidence and make a recommendation regarding certification

(8) ***Certification award*** – The Director of Certification Body reviews process and makes decision, and if successful, the training provider receives certification award.

(9) ***Ongoing surveillance and scrutiny*** – Once certified, the training provider is required to update and submit a self-assessment form at least annually.

4. RRN Training Standards and Certification Pilot Work

In 2020, the RRN conducted preliminary work including a pilot study with 5 organisations going through certification, as well as a survey of training providers in the pipeline consisting of 11 participants (9 from organisations certified against the standards and 2 working towards certification) (Restraint Reduction Network, 2020). The aim of the work was to explore what was working well, whether there were any areas of implementation that should be added, how effective quality assurance processes were and how bureaucracy could be reduced based on training providers initial experiences when implementing the Training Standards. A key finding from the data analysis suggested that it was too soon to be able to identify the impact that the Training Standards were having on practice and what additions should be made, hence contributing to the justification for this evaluation.

5. Rationale for the research

This is the first time there have been mandatory standards for training with a restrictive intervention component (Barr, Wynaden, & Heslop, 2019). It is critical that their application is evaluated so that we can identify early implementation challenges and the best way forward to ensure the safe and proportionate use of restraint and the protection of vulnerable individuals using a human rights and preventive framework.

Training is an integral part of programmes aimed at reducing restrictive practices. In a systematic review of the effectiveness of interventions aimed at reducing restraint and seclusion in mental health and learning disability settings, findings showed that training was one of six key components and included in 21 out of 23 identified programmes (Goulet, Larue, & Dumais, 2017). Similarly, in a rapid evidence review summarising the interventions used to reduce restraint in mental health, learning disability and autism spectrum disorder inpatient settings, training was built into over half of the interventions outlined in the 47 included studies (Goodall, Haines-Delmont, Duxbury, & Tsang, n.d.). Many studies referred to training as a component of a wider model (Guzman-Parra et al., 2016; Riahi, Thomson, & Duxbury, 2016), the most common was the Six Core Strategies to Reduce Seclusion and Restraint Use (Huckshorn, 2004). Many of the studies in this review outlined different training approaches which included: De-escalation Training (Bell & Gallacher, 2016; Laker, Gray, & Flach, 2010), Non Violence Crisis Intervention (NVCI) (Godfrey, McGill, Jones, Oxley, & Carr, 2014; McCue, Urcuyo, Lilu, Tobias, & Chambers, 2004), Prevention and Management of Violence and Aggression (PMVA) (Kontio, Pitkänen, Joffe, Katajisto, & Välimäki, 2014; Long, Afford, Harris, & Dolley, 2016) and Positive Behavioural Support (PBS) (Riding, 2016; Singh, Lancioni, Karazsia, Chan, & Winton, 2016). These findings suggests that, although training is seen as a key element to reducing restrictive practices, the variety of training approaches is extensive.

The RRN Training Standards were launched in England at the House of Lords in 2019 to encourage a positive change in practice and provide a framework on which training can become more standardised across health and social care services. Since April 2020, it has been a statutory requirement that organisations delivering training on restrictive practices including restraint must be certified. This is therefore a timely research study to examine views and experiences regarding the implementation and certification processes of the Standards, to identify ways to improve these processes and to learn and share good practice, with the view to inform future iterations of the Standards, as well as their potential transferability/application to other areas of practice or countries.

RESEARCH AIMS AND OBJECTIVES

The aim of this evaluation was to explore the extent to which the Restraint Reduction Network (RRN) Training Standards (hereinafter referred to as "the Standards") have been adopted and implemented in in-house, commercial and affiliate training organisations in the UK. The objectives were to:

(1) To scope the current extent to which organisations are certified against the Standards;

(2) To explore views and experiences of implementation and certification processes of organisations certified against the Standards or working towards certification;

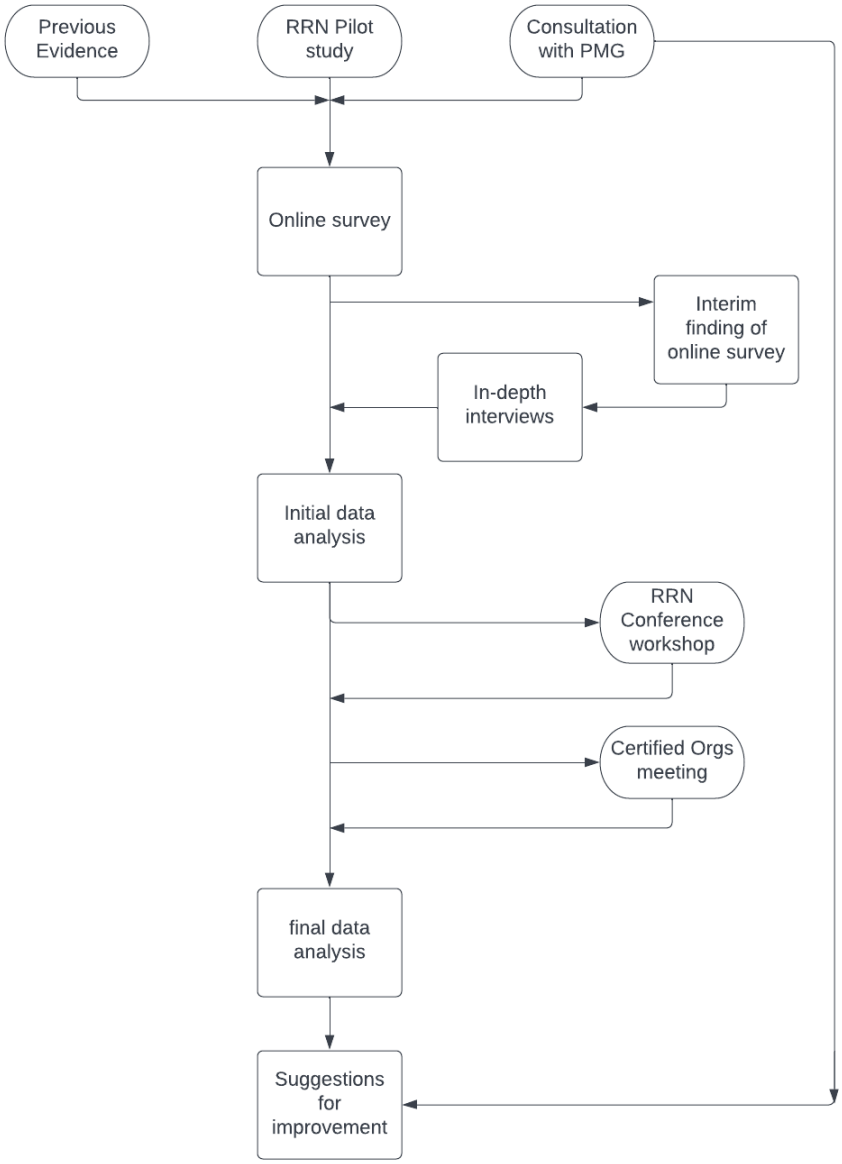
(3) To identify benefits and good practice, as well as barriers and facilitators to implementation; and

(4) To identify priority areas for improvement and implications for future iterations of the Standards.

METHODOLOGY

A sequential mixed methods approach combining an online survey, in-depth interviews and consultation workshops was used to address these objectives. ***Fig 1*** below shows how multiple stages of the research informed one another.

Figure 1 : An iterative sequential mixed method approach



1. Online Survey

A survey was designed to address the study objectives. After initial consultation with the project management group (PMG), it was agreed that it would be optimal to design multiple surveys specifically curated to reflect the three types of organisations certified against the Standards or on their way to certification:

(i) *Commercial Training Provider*: a training provider that provides Restrictive Intervention training commercially to service provider organisations. At present there are 34 Commercial Certified Organisations registered with BILD Act;

(ii) *In-house training provider*: an organisation that delivers training to its employed staff only and does not engage in training outside of their employed staff group. There are currently 29 Certified in-house providers registered with BILD Act; and

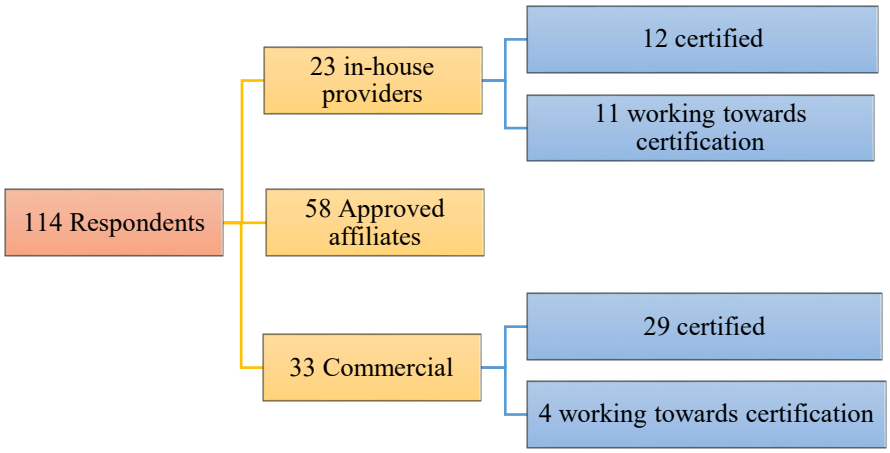
(iii) *Affiliate Organisation*: a provider organisation that delivers a commercial training provider's certified training in-house. The affiliate must to meet all the RRN Standards and deliver the training as per the Certified Organisations quality criteria. There are approximately 360 affiliated organisations registered with BILD Act.

Therefore, three surveys were developed (see Appendix 1), with consultation from PMG members and using the RRN Training Standards and Certification Survey 2020 Pilot Study as a foundation. The surveys were then piloted by the PMG members who read through the questionnaires to sense check for face validity and evaluate whether the questions effectively addressed the research aims and that they were appropriate for the audience. They were then asked to complete the survey online to provide the research team feedback regarding ease of completion, whether the questions were clear and

concise (e.g., not leading, double-barrelled, confusing) and the time needed to complete the survey.

The surveys were then finalised and created in Survey Monkey with a separate access link for each of the three iterations. They were then distributed by a third party (i.e., BILD Act) using the most up-to-date list of organisations either certified or working towards to certification against the Standards (n=285). The survey remained open to respondents for three months between the dates of 02.08.21 and 05.11.21. Reminder emails were sent by a representative from BILD Act once per month (three in total, including a final reminder, one week before the survey closed). Based on the number of organisation (i.e., email addresses) that the survey was distributed to, we estimate a response rate of 40% (n=114). ***Fig. 2*** below outlines the response numbers for each of the three surveys:

Figure 2: Online survey respondents



2. Semi-structured qualitative interviews

After consultations with key stakeholders, members of the project management group (PMG), it was evident that implementation experiences were likely to be different depending on the type and size of organisations. Therefore, four key sites were chosen to reflect larger and smaller training providers and the experience of in-house, commercial and affiliate organisations. Participants were recruited from the four key study sites and the only inclusion criteria was that they must have some experience of the implementation of the RRN Training Standards. In total, 12 interviews were conducted (three from each of the four key study sites). The 12 participants included male and female professionals, the majority with a key strategic or senior role regarding training and the reduction of restrictive practices in their organisation, e.g. executive chairmen/chief executives, (senior) trainers or training managers, NHS Trust leads for the reduction of restrictive practices/implementation of the Standards/behaviour and welfare, quality improvement partners, deputy chief nurses or nurse consultants, and learning and development advisors. Interviews took place online using Microsoft Teams and on average, lasted around one hour, although two were as long as 90 minutes.

The interview schedule was informed by consultations with members of the PMG, as well as interim findings of the online survey. For example, while analysing survey responses, it was clear that issues surrounding lived experience and quality assurance were a common occurrence, so the interview questions aimed to explore these issues more in depth. The interviews were semi-structured in nature and easily adaptable to the interviewee's role and experience of the Standards and the certification process. In main, the interview covered issues such as: participants' role in relation to the Standards, their views about the use of restrictive practices in their own organisation and strategies to prevent this, quality assurance in relation to training, involvement of people with lived experience of restraint, perceived

impact of the Standards, recommendations for future iterations/versions of the Standards, and general/overall views about the Standards and the certification scheme. For a detailed interview schedule see Appendix 2.

3. Research governance

Ethical approval for the study was granted by Manchester Metropolitan University's Research Ethics and Governance Team in August 2021 (REF: 32594) prior to commencement of the study. As some participants were NHS staff, ethical approval was also sought and granted by the NHS Health Research Authority (HRA) in June 2021 (IRAS ID: 294523). Participation was subject to informed consent. For one-to-one interviews, all participants were provided with a Participant Information Sheet (PIS) and a consent form, which was completed and returned via email. For the online survey, participants received a participant information sheet along with a link to the survey if they wished to take part. The survey itself contained information about consent, and participants were informed that by following the link and responding to the questions, they were giving their informed consent. The stakeholders workshops were not used to collect additional research data, but to validate survey and interview data and discuss the feasibility of recommendations to improve practice and best way forward to implement these. Those attending the consultation workshops were however informed about the purpose of the consultation and made aware that their name would be kept confidential, and the information collected during the session will be anonymised and used to validate and consolidate the research findings.

4. Consultation with key stakeholders

Throughout this project, the research team have had consistent consultation with the Project Management Group (PMG) who consisted of experts in this field, including representatives from different types of training providers and organisations, members of the Restraint Reduction Network (RRN), BILD Act, and people with lived experience of services and restraint. The members of the PMG have been instrumental in the oversight of research throughout the duration of the project advising the team at each key stage. As outlined above, the PMG piloted the online survey before its launch and helped inform the interview schedule. During data collection they assisted with participant recruitment for and distribution of the online survey, as well as assisting the research team in recruiting participants for the in-depth qualitative interviews. Finally, they helped the research team validate the emerging recommendations, assessing their feasibility and potential ways to overcome any implementation challenges and inform future iterations of the Standards, e.g., Version 2.

Independent validation workshops with a wider audience (people outside of the PMG and research participants) were held after data collection to test and triangulate the research findings. Firstly, at the RRN Conference in December 2021, the research team held a workshop that was attended by around 30 participants consisting of practitioners, trainers, and assessors (Haines-Delmont, Goodall, & Duxbury, 2021). The research team gave a brief background of the study and presented interim findings to attendees. Feedback was used to validate interim findings from interviews and the online survey and inform the next stages of the analysis.

A second validation workshop was held to authenticate the second draft of the findings in January 2022. This was hosted by BILD Act online using zoom and was attended by 37 representatives from organisations currently certified against the Standards, providing

an opportunity to explore if emerging findings were representative of a wider group and/or to highlight any gaps. The findings were presented, and a multiple-choice interactive poll was conducted where participants identified the scenarios most representative of their experience. Overall, these consultation workshops offered a great opportunity to sense-check emerging findings with grass roots practitioners who may not have been consulted in the survey and interviews and move from individual to collective stories.

5. Data analysis

The survey responses were exported from Survey Monkey and saved in a PDF format. For all open responses, data was downloaded using the question summary function that produced a document that included all responses to each question. This was then imported onto NVivo v.2020 (QSR International) for analysis alongside the interview transcripts. Data from closed questions e.g., those that required a 'yes/no', rating question or multiple choice, was downloaded into excel before being analysed using descriptive statistics and then presented as charts using Microsoft Word.

The interview transcripts (and the responses to the open questions in the online survey) were imported onto NVivo v.2020 (QSR International) for reading, coding and analysis. The project researchers analysed the data thematically to identify patterns of meaning across the qualitative dataset (Braun & Clarke, 2021). The usual 6 steps in thematic analysis were used, moving from data familiarisation, assigning preliminary codes to the data to describe the content, searching for patterns or themes in the identified codes across the different data sources, reviewing, defining and naming the themes, to producing the report.

Data was analysed both inductively and deductively. Codes were developed followed by an iterative process of theme development and refinement. Most codes were clustered into 'higher level' patterns to identify candidate themes. Consensus meetings within the research

team were held to agree on the emerging themes and develop analytic narratives for each of these themes. These were then discussed with the study's project management group (PMG) and validated in stakeholders workshops to ensure the thematic analysis answered the study questions and the results were reflective of current practice and relevant to enable change.

Anonymised excerpts from interviews are used to illustrate the points being made. Each participant was given a code (e.g., 'Survey respondent, type of organisation' or 'Interviewee #1') and cross-reference to their exact role and organisation was removed to ensure they cannot be identified based on the excerpts presented.

FINDINGS

This section reports the findings that emerged from the analysis of both the online survey and in-depth interviews. The findings are split in two parts: the first provides an overview of settings and populations who are supported by the organisations certified against the Standards or working towards certification (results emerging solely from analysis of responses to questions within the online survey); the second reports a detailed picture regarding views and experiences of the Standards' implementation and certification processes (results based on thematic analysis of both responses to the online survey and the in-depth qualitative interviews).

1. Extent to which organisations are certified against the Standards: the national picture (Study Objective #1)

1.1 Settings supported by certified training

The online survey asked respondents whether their approved BILD Act certified training supported health, education, or social care settings (respondents may have picked more than one option). Findings show that the most common setting is social care, although it is not clear whether some of the older people/dementia specific settings were considered when answering this question. Certified training in social care settings is provided by all types of providers, but most frequently by affiliate organisations, while in-house and commercial providers appear to focus more on health settings. See ***Table 1*** below.

Table 1: Certified training by setting and type of provider

	In-house	**Commercial**	**Affiliate**	**Total***
Health	15 (65%)	29 (89%)	12 (21%)	56
Education	7 (30%)	23 (70%)	8 (14%)	38
Social Care	12 (52%)	31 (94%)	50 (88%)	93
Totals	34	83	70	187

*Percentages do not total 100% since respondents could choose multiple answers

1.2 Populations supported by certified training

The online survey asked respondents which populations their approved BILD Act certified training supported (respondents may have picked more than one option). Findings show that the most common population was adults which was supported by 100% of commercial providers, and over two thirds of in-house providers and affiliate organisations (87%, 73% respectively). Learning Disability settings were also highlighted as a commonly supported setting, and although supported by a large proportion of commercial providers (94%), they were less likely to be supported by in-house providers (65%).

Less commonly supported settings included children, who although supported by over two thirds of in-house and commercial providers (74%, 82% respectively) were less likely to be supported by affiliate organisations (30%). This was also true of dementia which was supported by 85% of commercial organisations but only 33% affiliate organisations. The least commonly supported setting was patients with Acquired Brain Injury which, while supported by 70% of commercial organisations, was supported by less than a third of in-house and affiliate providers (22%, 32% respectively). See ***Table 2*** below for detailed findings.

Table 2: Populations within the settings supported by certified training

	In-house	**Commercial**	**Affiliate**	**Total***
Adults	20 (87%)	33 (100%)	42 (73%)	95
Children	17 (74%)	27 (82%)	17 (30%)	61
Autism	15 (65%)	31 (94%)	42 (74%)	88
Acquired Brain Injury (ABI)	5 (22%)	23 (70%)	18 (32%)	46
Dementia	14 (61%)	28 (85%)	19 (33%)	61
Learning Disabilities (LD)	15 (65%)	31 (94%)	49 (86%)	95
Mental health	15 (65%)	29 (88%)	36 (63%)	80

*Percentages do not total 100% since respondents could choose multiple answers

1.3 Level of certification

The majority of in-house and commercial providers were already certified against the Standards (n=40) at the time the research was conducted, but some were still working towards certification (n=16). All respondents gained certification between 2018 and 2021. See ***Table 3*** below for detailed results on the year of certification.

Table 3: Year of certification broken down by year and organisation type

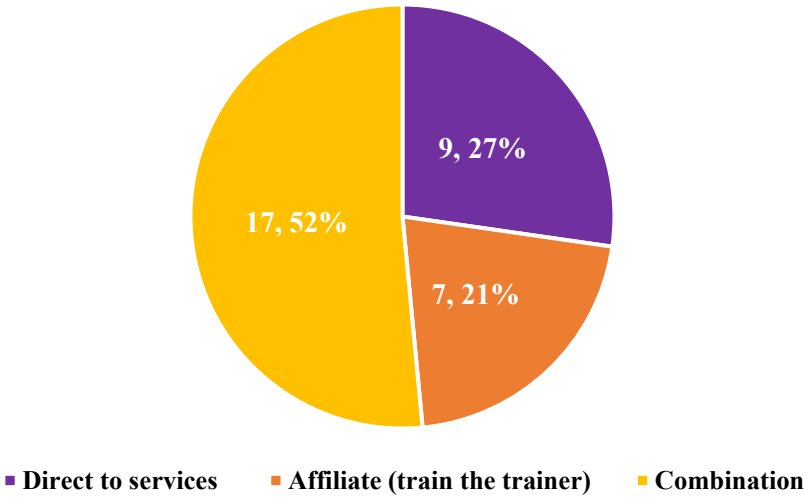
	2018	2019	2020	2021
In-house	2	2	2	6
Commercial	0	8	9	8
Total	2	10	11	14

Of those organisations still working towards certification (n=16), they had either just formally applied (n=6), had completed self-assessment (n=4), had been working alongside a BILD Act assessor (n=6) or had submitted their final application the panel (n=1).

1.4 The Affiliate Scheme

Of the commercial organisations who took part in the online survey, around 50% delivered training exclusively direct to services (n=9) or used the affiliate 'train the trainer' model (n=7). The other half delivered a combination of the two (n=17). This is illustrated in ***Fig 3*** below.

Figure 3: Commissioning of training



When asked how many affiliates their organisation has supported through the certification process, whilst some commercial organisations reported they had not yet got any affiliates, others reported supporting up to sixty (see ***Table 4*** below). This reflects the range of organisational size of commercial providers certified against the Standards.

Table 4: Number of affiliate organisations supported by training providers

Number of affiliates	Number of responses (%)
No affiliates	9 (33%)
1-10 affiliates	7 (25%)
10-20 affiliates	2 (7%)
20-30 affiliates	1 (4%)
30+ affiliates	8 (31%)
Total	27

Organisations using the affiliate model reported that transitioning their client's services to becoming an approved affiliate took between 1 and 18 months (see ***Table 5*** below), but they argued that this varied greatly depending on the affiliate organisation.

Table 5: Estimated time to becoming certified affiliate

Length of time	Number of responses (%)
1-3 months	5 (29%)
3-6 months	10 (59%)
6-12 months	0 (0%)
12-18 months	2 (12%)
Total	17

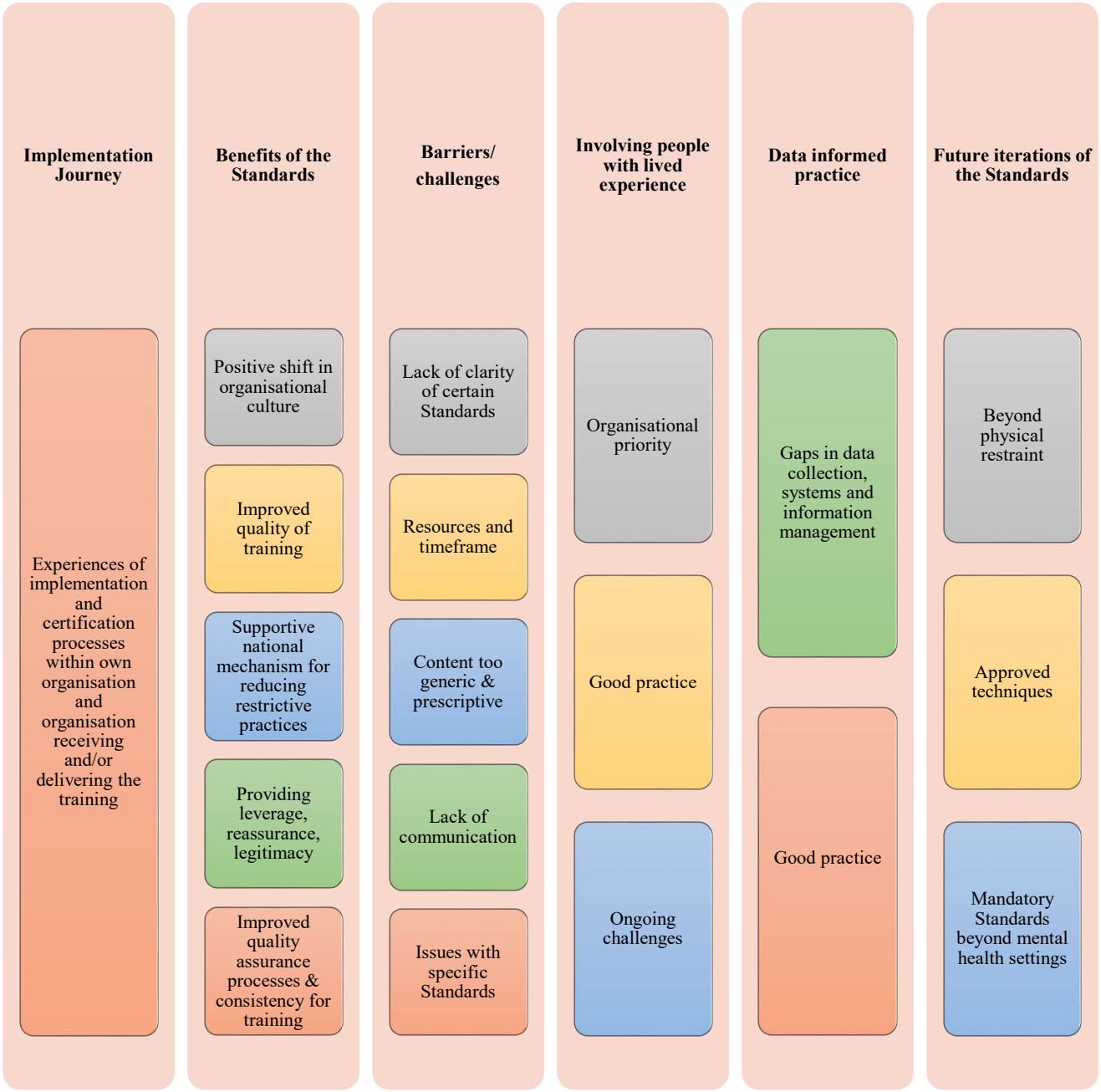
1.5 Overarching organisational models/programmes to reduce restrictive practices

The mostly commonly referred reducing restrictive practice programme was the Positive Behavioural Support (PBS) approach (n=5) (British Institute of Learning Disabilities, 2014; Gore et al., 2013), followed by the Prevention Management of Violence and Aggression (PMVA) (NHS England, 2016) (n=3) and the Six Core Strategies approach (n=2) (Huckshorn, 2004). Other models mentioned were: Positive and Proactive Care or Positive and Safe (n=2) (Department of Health, 2014; NHS England, 2016), Positive interventions in dementia care (n=1) (3SpiritUK, n.d.), Violence Reduction Training (VRT) (n=1) (NHS England, 2016), MEAS behaviour support (n=1) (KISIMUL, n.d.) or organisations' own behaviour support programmes (n=1).

2. Implementation of the Standards: key issues regarding practice, processes, benefits, and challenges (Objectives 2-3 of the study)

This section reports findings emerging from the thematic analysis of both interviews' transcripts and the responses to the questions in the online survey. Respondents were asked to talk about their experiences regarding the implementation and certification processes and express their views about key benefits of the Standards, as well as barriers and facilitators to implementation in their respective organisations. Views about how practice can be improved, especially with the view to inform the new version of the Standards which is currently being developed, were also gathered. ***Fig 4*** below shows the emerging themes and sub-themes.

Figure 4: Themes and sub-themes



2.1 Implementation Journey

Respondents to the interviews shared their experience of implementing the Standards in their organisation or the affiliate partners/service providers they worked with. It is however important to recognise that respondents were representatives of organisations that had regulation imposed upon them. While most of them were more supportive of the Standards, others were less so. Additionally, their experiences significantly differed based on their own role in their organisation, the type and size of organisation they were representing (e.g., commercial, in-house and affiliate) or the organisation's prior strategy and practice regarding training, trauma informed care, and the reduction of restrictive practices. This means that, prior to the launch of the Standards, some organisations had already been implementing strategies or approaches to improve training with the view to prevent the use of 'unnecessary force' and embrace alternatives to restrictive practices.

The implementation of the Standards, therefore, needs to be understood in the context of some key prior developments and the organisation's prior experience in this area. One example is the positive and safe violence reduction and management programme manual (NHS England, 2016), which was co-developed by the high secure hospitals in England and Scotland to ensure that a standard programme of approved training skills was being delivered. The manual was the first attempt to unify approaches to prevention and management of violence and aggression (PMVA) in healthcare settings and the only one of its kind to be endorsed by the National Institute for Health and Clinical Excellence (NICE) in their guidelines on violence and aggression NG10 (National Institute for Health and Care Excellence (NICE), 2015).

In addition, some mental health Trusts would have done extensive work on reducing restrictive practice across their services prior to the launch of the Standards in 2019, developing their own strategy and clinical guide, e.g., (Mersey Care NHS Foundation Trust,

2015). In doing so, these organisations would have recognised the importance of their mandatory personal safety service training in ensuring positive outcomes regarding the use of restrictive practices. This means that, prior to the launch of the Standards, some organisations already had the motivation, philosophy, strategy, and systems in place to develop and deliver a training package that was less focused on physical techniques and with more emphasis on preventing conflict and incidents through using partnership working between people with lived experience and staff. This prior work would have been helpful to meet a number of Standards when the process was formally started.

However, even those organisations who had systems in place to enable change in this area recognised that the certification process was overwhelming and time consuming and that they initially had doubts about meeting the deadlines. Some respondents mentioned that their assigned assessor provided clarity that helped them achieve the targets within a more realistic timeframe. Others were quite open, expressing their frustration with the complex and time-consuming nature of the implementation process.

It appears that the more significant difficulties experienced by training providers (commercial organisations) were not necessarily linked to the implementation of the Standards within their own organisation (e.g., in relation to mapping the Standards against their own procedures, practices and policies, training content, conducting gap analysis, addressing the areas that needed change to comply with the Standards and evidencing the change, developing and operationalising training in line with the requirements of the Standards), but their implementation in the services they support (affiliates) - everything from helping them, advising, guiding and monitoring and assessing their ability to implement the Standards themselves, to maintaining, building, and ongoing monitoring, and especially ensuring that they continue to stay compliant with the Standards:

> *"[…] compliance has become a bit of a job. It might be a full–time job at some point if we expand… At the moment it's not but it could be, moving forwards, which is something we never really would have thought that hard about under the old scheme. So there's that kind of change."* (Interviewee #12)

Some interviewees mention the journey they had to go through to reach the level where they can offer support and monitor outcomes within the organisations they provide training for, for example having enough 'Standards competent' staff to monitor compliance:

> *"This has been one of the big challenges with the Standards, where it's not really a binary situation where an organisation is compliant or they're not compliant. There's an awful lot of grey. And so, there's a lot of subjective assessment that needs to happen by competent people. And there's an absence of competent people in the sense of the Standards are new for everyone. So, there's only now starting to be some people in my team, for example, that I recognise as an expert in the RRN Standards because they've all been learning it for a couple of years. So, day one, no one knew what they were. And we've kind of been getting there. So, yeah. So, we're trying to quantify it and find a sustainable mechanism for ensuring ongoing compliance*." (Interviewee #4)

Some respondents argued that there was a bit of a financial hit for the private sector, especially with regards to having to employ two trainers (rather than the one, for what they would have previously budgeted for delivering that); or having had an impact on their organisation's resources (this may be through having to provide greater quality assurance or having created an unintended/unexpected consultancy role for certain commercial organisations); or having created an unintended/unexpected consultancy role for certain commercial organisations:

> *"So, if you like it's forced a consultancy service in our business, which we're doing and now we're doing for free. And it's so heavy that now we're thinking we can't do this for free. We've either got to put our prices up on our training that we eventually get from it or we're going to have to start charging upfront for the consultancy. I mean, we're talking in some cases, hundreds of hours of one of our most specialised experts before we can do a day's training for someone, you know, before we can earn any money. But there's now thousands of pounds worth of cost."* (Interviewee #7)

While some respondents mentioned practice and implementation challenges they might have had in the early days (particularly with regards to the affiliate scheme), some of which might have been addressed since then, it is important to recognise that these experiences were key in shaping the organisations' views of the Standards and the certification process, as well as their relationship with RRN and BILD Act. For example, some respondents commented that the affiliate scheme had been a huge barrier to implementation when the Standards first came to be adopted by commercial organisations:

> *"The training Standards hadn't been written with an affiliate scheme in mind… that meant for those of us who were early adopters, it was very confusing and at times a very frustrating process. It was a bumpy journey and often we would go down, follow one set of guidelines and then we'd have to do an about turn and go in another direction because they'd change."* (Interviewee #1)

The following quote illustrates, however, how the Standards and linked certification and implementation processes have changed over time, emphasising the role of feedback and lessons learnt to improve practice, as well as the place of training within the wider organisational culture and strategy with regards to reducing restrictive practices:

"Implementation, I think we started from a place where we were looking at the course that we were delivering already and deciding how that needed to be tweaked to meet the Standards. So that was our kind of first run through it and we were successful in being certified against that with some changes, but we've kind of shifted in how we're working now. We're actually in the process of designing an entirely new course that is based on feedback and a lot of consultation with a wide range of stakeholders, but at its core, is also about properly meeting our interpretation of the Standards, which is much more at an organisational level. So, it's less about necessarily what's happening in the classroom and it's how do you build those key themes like a right space to approach into every aspect of what we do as a trust?" (Interviewee #10)

Implementing the Standards was also perceived as a positive experience, validating, and confirming ongoing good practice. As it will be noted in the next section, this is often mentioned as a key benefit of the Standards:

"I think it was reassuring when we were going through the Standards and mapping them against our training to see that a lot of what was in the Standards, we were already doing. There were certain areas that maybe we could do more or better in, and there were certain areas that perhaps we needed to improve upon. But on the whole, we were already doing it, which I think was a really nice thing to realise" (Interviewee #11)

2.2. Benefits of the Standards

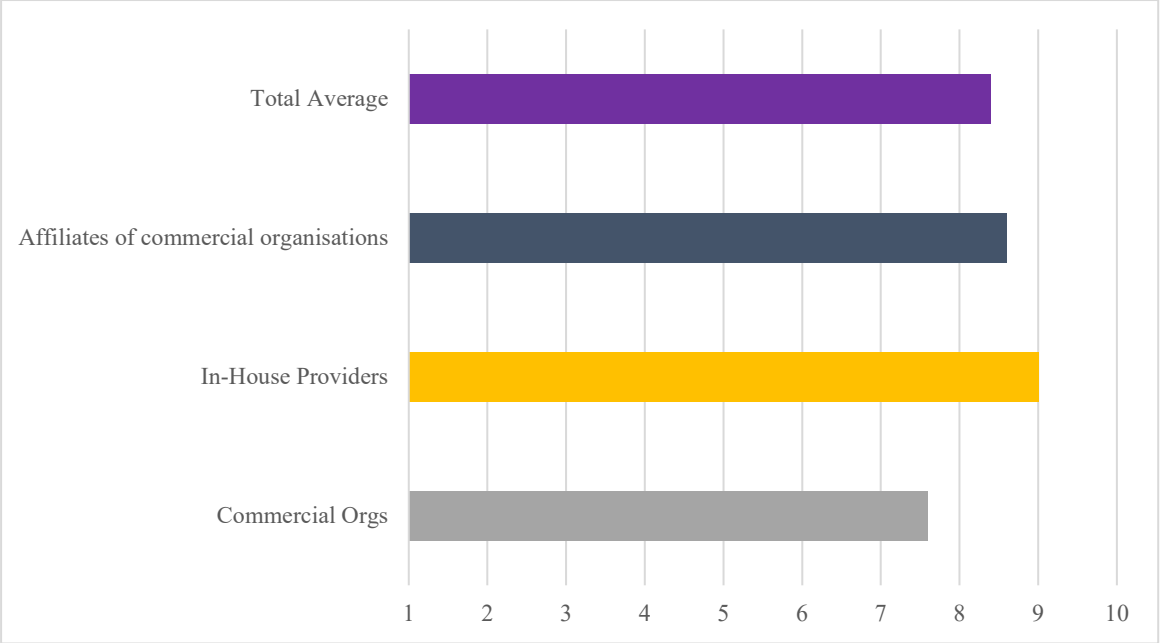
Whilst one of the purposes of this research study was to identify implementation challenges and areas for improvement, it is also important to highlight that there was a consensus that having mandatory Standards in place is a positive step. The key benefits identified by participants in both the online survey and the interviews are outlined below.

2.2.1. The Standards are a contributor to a shift in organisational culture

While participants in this study acknowledge that training is only one aspect of reducing restrictive practices, they do recognise that the Standards have definitely played a role in contributing to a systemic organisational culture change. A key perceived benefit is therefore the shift in training approach and focus from physical skills to the psychology aspect, with more emphasis on prevention and de-escalation and less so on physical interventions. There is an understanding that, by educating staff to use a more person-centred, trauma informed approach, there is potential for a greater understanding of the individual and their needs which can help prevent the use of restrictive practices.

This is also reflected in the findings of the online survey, where respondents were asked to rate the importance of having mandatory training Standards. Ratings were given between 1 (not important) and 10 (extremely important). On average, organisations who completed the online survey rated the importance of the Standards at 8.4 out of 10. For a breakdown of results by type of organisation, see ***Fig 5*** below.

Figure 5: Ratings of importance of the Standards per type of organisation



In addition, one third of commercial organisations and around two thirds of in-house providers and approved affiliates said that they had observed evidence of a reduction in the teaching and or use of restrictive practices in their service and their client's services as a result of the Standards. This is highlighted by the following quote from a respondent to the online survey who shared what they had observed:

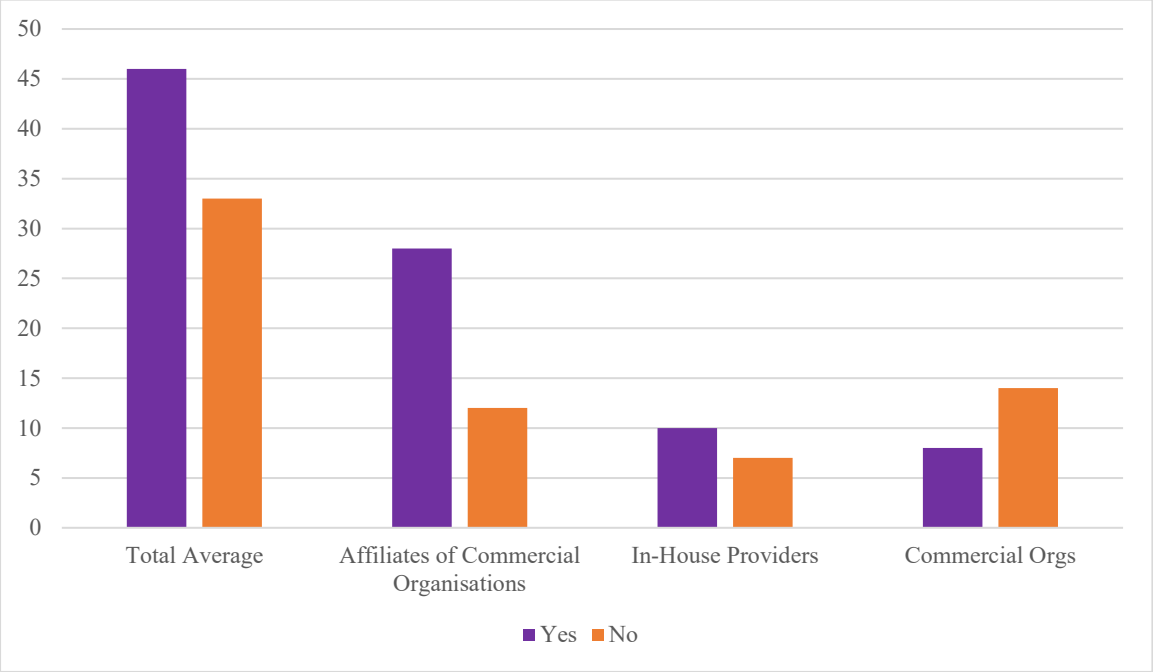
> *"One of our clients supported a person to transition from a secure hospital setting to a supported living service in the community. The person was subject to an average of 119 physical restraints per month according to the evidence that was available at the time. Our organisation worked with the service provider to train the staff team in the RRN and PBS. The outcome was that 12 months later the person has received 5 physical restraints in 2 years at his new placement. We also worked with a children and young people service (both education and residential). We have worked with this organisation for over 7 years and in that time they have experienced an 87%*

reduction in the use of physical skills (breakaway/self-protection and/or physical restraint).” (Survey Respondent, Commercial Provider).

Some of the interviewees also mentioned indicators of reduction of restrictive practices as a result of implementing the Standards and a shift in practice on the wards, especially with regards to the use of pain associated techniques e.g. prone restraint. Others believed that, while the Standards were an integral facet of a wider strategic and organisational culture change, it was difficult to attribute the reduction in the use of restrictive practices directly to the Standards alone.

The positive response to perceived evidence of a reduction in the teaching and or use or restrictive practices in services as a result of the Standards from both affiliate organisations and in-house providers could be explained by the fact that they are in the best position to measure outcomes within their service. Commercial providers rely on information being fed back from their affiliates in order to demonstrate impact, so it may be that this has influenced their perceptions. ***Fig 6*** below summarises online survey responses in regard to the impact of the Standards on the teaching and use of restrictive practices, broken down by type of organisation.

Figure 6: Perceived evidence of a reduction in the teaching and or use or restrictive practices in services as a result of the Standards



2.2.2. The Standards have raised the overall quality of training in this area

In both the online surveys and the semi-structured interviews, there was a universal agreement that the Standards have raised the overall quality of training in certified organisations. For some, it has provided additional information that they have been able to use to enhance their existing training, including the use of theoretical curriculums and Trauma Informed Care (Classen & Clark, 2017). The following quote reflects how the Standards have motivated organisations to review current processes/curriculums and made real changes to training:

> *"We were person-centred and human rights focused, but I think what the Standards taught us is that we hadn't done enough to move in that direction… we needed some sort of national guidance to really galvanize us and move us forward to really sort of*

establish the person-centred, theoretical underpinnings in the way that we needed really." (Interviewee #4)

2.2.3. The Standards are a supportive national mechanism for reducing restrictive practices

There was consensus amongst respondents that reducing the use of restrictive practices is a national priority. In this context, the Standards have provided a strong framework by which training can be reviewed for all to follow:

> *"It's important to have standards as a supportive national mechanism when people both internally and externally have challenged the move towards least restrictive, person centred interventions."* (Survey Respondent, Commercial Provider)

2.2.4. The Standards provide leverage, reassurance, legitimacy

As mentioned earlier in the report, respondents commented that the Standards had been instrumental in supporting their priority for reducing restraint which had in turn reaffirmed the organisational values and principles regarding reducing restrictive practices. One such example is some organisations' position to use Trauma Informed Care and/or move away from 'pain induced interventions' and develop and embrace alternative practices, especially across high secure settings. This form of legitimacy was seen as potentially helpful to counteract organisational resistance to change. The Standards were referred to by some as "leverage" or "a bargaining tool" of which they could use to sanction change in this area. For in-house training providers, it has provided back up when approaching more senior colleagues to encourage organisational culture change:

> *"… it's a really good bargaining tool in terms of that transaction, where you're having legitimate debates with people about what's proportionate and what's*

reasonable and arguing for less restricted practice that you've now got this national framework." (Interviewee #2)

For commercial training providers, the Standards have given them opportunity to have much closer involvement in the needs analysis requirements and the confidence to choose to work only with those willing to work towards meeting the Standards:

"Setting the length of training has backed up our recommendations to clients, and any clients who have not accosted this have not been invited back to re-certify" (Survey Respondent, Commercial Provider)

"It's got us talking, not just to training managers but talking to directors, the people who really can make a difference in services. We've moved now, the conversation has moved to leadership level and simply because they cannot continue to use our training or they cannot adopt our training if they want to, they cannot get Bild Act certification unless they are doing their bit so that's really big and not to be underplayed, that's the massive benefit." (Interviewee #7)

2.2.5. The Standards create consistency for training and improve quality assurance

Respondents felt that the Standards provided a concrete framework that organisations can refer to and align all their training, ensuring consistency and giving them something to measure outcomes against:

"*I don't feel like there was a quality assurance process before the standards came in…If there was, it was very informal so there wasn't really any way of knowing that exactly the same learning objectives were being hit in every single course. There didn't really seem to be a very clear way of addressing where maybe a tutor's going a bit rogue and perhaps going off message*" (Interviewee #6)

While there was existing practice in terms of quality assurance, for example regarding tutor development and peer observations etc., it transpires that the Standards supported an implementation of better frameworks around that. Respondents appreciated having a concrete framework that they can now refer to and align all their training, ensuring consistency and giving them something to measure things against:

> *"[…] it was happening, but it was happening a slightly haphazard way, and I think it's just reinforced the importance of it and kind of forced us, although that's probably not the right word, because that would suggest we don't want do it, but it gives you that drive that you need, doesn't it, and once you have that, I think things become easier. So, yes, quality assurance is definitely an area which, I think, has improved. That's also down to changes that have been made in the department, but I think it's largely driven by these Standards."* (Interviewee #3)

Despite the Standards having raised overall quality assurance, there were concerns by some interviewees that monitoring of trainers by the certification body is not always sufficient, and that the current review system could be more rigorous. In comparison to the amount organisations used to report on in the old scheme, some mentioned feeling less monitored, although these views could have been influenced by the changes due to COVID, during which monitoring was compromised to a certain extent. One participant commented during an interview:

> *"I don't feel at the minute, obviously we've got an accredited model within (name of organisation), it doesn't feel that it's as robust as it was in terms of some of the things that we used to report and feedback on"* (Interviewee #4)

2.3. Barriers to implementation

The following section reports on respondents' views regarding key barriers to the implementation of the Standards. As explained in section 2.1 above ('implementation journey'), experiences of the implementation of the Standards differed depending on type of organisation (e.g., commercial, in-house or affiliate), the timing within their journey to implementation, organisational culture, existing strategies and systems in place, prior experience.

2.3.1. Some of the Standards lack clarity

There was an overall feeling that there was a lack of clarity surrounding some of the Standards:

> *"Certain things are not clear so it's very difficult when you're implementing the Standards to work through that ambiguity and therefore we will go to BILD Act and say what do you think? This is our interpretation of it, are we right? Are we wrong?"* (Interviewee #1)

This appears to have caused difficulties in implementation because some of the Standards are too vague and open to interpretation. Standards 2.5 and 2.6 are often exemplified to illustrate this: *"The curriculum must give proportional time (no less than one day or six hours) to exploring primary strategies and preventative approaches (unless the commissioning organisation already provides an evidence based model of preventative training to all staff)"* and *"The curriculum must give proportional time (typically at least three hours) to covering the use of secondary strategies which alleviate the situation and prevent distress or behaviours of concern from escalating".* (Ridley & Leitch, 2019)*, pp. 60-62.*

The need to clarify the ambiguity of these two Standards is highlighted by another respondent:

If they [RRN] said we are only going to be reviewing two standards in the next 30 years, which would you want it to be? It would be 2.5 and 2.6." (Interviewee #10)

2.3.2. There is difficulty in allocating resources to meet the requirements of the Standards

One of the main barriers to implementation raised by all types of organisations and across both the online survey and the in-depth interviews was the sheer amount of resources needed to meet the Standards, e.g., workload, time, staffing and cost. Firstly, there was consensus that the amount of work that goes into mapping an organisation against the Standards in order to gain certification can be overwhelming:

"The perception that the work required to achieve certification is overwhelming. So that hasn't been our experience, but it was tough at times. So, I'm conscious that we're well resourced. We're a huge organisation. We've got people who can, like me and my colleagues who can take time out and do this. Are we convinced that smaller organisations feel that this is achievable? See if like, when I speak to other areas, that's a bit of a recurring theme. People have said to us, "Oh, it's okay for (name of organisation). You've got the resources. You employ ten thousand people, so you're bound to find somebody to do it," that's the nature of some of the conversations we have. So that's something whether that's based on actual facts or it's just perception, it's something that has to be addressed. There's a psychological barrier there, that I'm sure won't surprise anyone" (Interviewee #3)

Some added that the time limit of pre-course requirements, where organisations are only given 6 months to complete pre-course requirements, exacerbated this issue:

"*The sheer volume of paperwork needed at a time when we have the least amount of time to allocate to their implementation*." (Survey Respondent, In-house Provider)

Because of the workload and time pressures, some pointed to the necessary staff adjustments needed:

> *"It requires a dedicated person/s to keep abreast of the ongoing developments that are involved with certification and implementation of the standards but we have had myself and another colleague as the leads on this. I can imagine for an organisation with no previous experience of accreditation/certification it could be quite daunting due to the amount of work required to meet the standards for certification."* (Survey Respondent, In-house Provider)

Respondents also identified cost as a financial barrier:

> "[…] *costs involved which for smaller organisations, again, it's whether that becomes impractical in terms of do you then just buy your training in as opposed to having your own in-house trainers that come under because that's what we've done with a couple of organisations, they sit under us as the affiliate trainers*" (Interviewee #4)

The impact on resources was also identified in relation to delivering training and quality assurance of Bank/agency staff.

> *"[…] we know there are more bank and agency staff that we need to deliver the training too than our own staff…if they're to do our model of training which I think we would want them to do, and I know there seems there's a bit of flex in the standards that technically I think they could do their own training and we can decide whether we find that acceptable. We're quite keen that they do our specific training, but it basically creates another organisation's worth of people that we have to deliver that training to, and we're not set up to do that at the moment. We struggle to get through the numbers that we have currently. So, I think we're kind of stuck at that*

stage and then we're also stuck in the kind of contracting conversation about who is going to pay for this." (Interviewee #6)

As well as issues to do with quality assurance of training Bank staff, there was also a concern raised by respondents in relation to accountability/responsibility for training:

"one of our bank staff was ringing up to book on his refresher because he's coming up out of date here but he's in date in another organisation…I think you should, if you're working for one organisation you should have that organisation's training. I've heard over the years of other organisations that don't even train their regular staff never mind the agency staff. They can be in post for six months before they even see any training and then it's what do you do in that six-month interim period." (Interviewee #9)

2.3.3. The content of the Standards is too generic and prescriptive

There seems to be concern across the board that the Standards are input rather than output focused. Participants in both the online survey and interviews felt that, although they are being told they do not have to reinvent the wheel, the Standards dictate *how* things must be done, even though services have their own long-established ways of doing things that can achieve the same outcome. This appears to create what is seen as unnecessary work for in-house providers who already have working systems in place, as well as for commercial organisations supporting them through this process.

It was felt by some respondents that the Standards are very much written for NHS in-house healthcare settings. This was raised by commercial organisations who felt that the language made it difficult to allocate responsibility between themselves and affiliate

organisations. This was also echoed by those outside of mental health, such as those from acute health settings:

> *"[…] how they're written at the moment because they're having to obviously … they're written in a way that applies to both NHS and private sectors, and also to inhouse delivery models and private by our delivery model. The language you have to kind of remember that even if you're an inhouse delivery model you're also the commissioning organisation for it."* (Interviewee #6)

A key point raised from several interviews was that the Standards miss out any support with regards to staff wellbeing. Whilst there is a lot of focus around the wellbeing of patients/people with lived experience, staff also experience compassionate fatigue and burn out, which if not supported, can be a determinant of increased conflict on the wards. It is evident from the following quote that some feel adding staff wellbeing to the syllabus could enhance training:

> *"Our reducing restrictive programme was about being compassionate about service users and staff. One of the ways in which that we've been able to land that is around enhancing our personal safety service training syllabus to touch on staff health and wellbeing because often what we locate all our difficulties and challenges in is the person who we're supporting. So we educate our staff around the five ways of wellbeing that was developed by the Economics Foundation in 2008 and we just find that would be something that would enhance the training syllabus, is to have a specific focus on the importance of staff health and wellbeing and resilience because, as you know, we are often supporting people who have got complex needs, who are traumatised, who often become extremely distressed in patient areas and display behaviours of concern."* (Interviewee #3)

Standard 2.1.3 (Ridley & Leitch, 2019), *pp 54* does state that "training providers and trainers must be aware of current Health and Safety Executive guidance around work-based violence. Training content must be congruent with the guidance, and it must also be referred to in training content". However, respondents argue that there is a need for staff wellbeing to be directly referred to in the Standards.

2.3.4. The voice of the service (i.e., affiliates) is missing

Some respondents talked about a divide between RRN/BILD Act and the services implementing the Standards, especially the affiliate organisations:

> *"I guess sometimes it's slightly felt like there was a bit of a disconnect between the Trusts and the people on the floor trying to implement the Standards and what people within the RRN or whoever was kind of behind the Standards…but sometimes there was a bit of a disconnect there where you think, well us on the floor see it this way, and have this experience which seems very valid to be wanting to do it this way versus we're being told to do it a certain way which doesn't seem to make a lot of sense, and where's the discussion around that."* (Interviewee #3)

Respondents argue that services should have equal say and input in any future developments of the Standards, others mention that there should be more direction/guidelines from the CQC/DHSC, which might help clarify accountability and responsibility issues.

2.3.5. Specific Standards that respondents would like to see reviewed

The following section enumerates specific Standards that respondents have identified as challenging in implementing and would like to see reviewed in future iterations of the Standards (although a clear explanation why that was the case was not always given, therefore would merit further investigation).

Section 1.1.1 of the Standards, "*As part of the commissioning process the training provider must request a training needs analysis (TNA) from the commissioning organisation*" (Ridley & Leitch, 2019) *pp.37*, was referred to multiple times in the online survey and the in-depth interviews. For clarification, the purpose of TNA is to ensure training is proportional. It was thought by some that clarification is required regarding the 'scope' of TNA. A survey respondent wrote:

> *"They are written as if it is one per organisation but this contradicts other Standards.*" (Survey Respondent, Commercial Provider).

In addition, this respondent also highlighted that the link to some of the downloadable templates e.g., checklists in this section is no longer relevant, which was also something mentioned by some of the interview participants.

Some commercial organisations believed that asking for two years' worth of incident data can be impossible in some cases, particularly for new services or units that have a high turnover of patients/people with lived experience or for other sectors such as education or acute settings.

Section 1.2 of the Standards, "*A named person in the training provider organisation must develop a written proposal for a curriculum including the rationale for teaching specific restrictive interventions*" (Ridley & Leitch, 2019), *pp. 39-42* was referred by some as being too prescriptive. Within this section, Standard 1.2.3, "*If the TNA identifies specific staff groups whose job role means there is only ever a small risk of them being involved in challenging situations (for example administrative staff or maintenance staff) they may only require a short course that covers de-escalation and breakaway skills*" *pp.41*, where a one-day course can be developed, was perceived by some as unnecessary. It was suggested that a

smaller familiarisation course (e.g., a 2 hours course) to upskill staff would be more appropriate and attainable.

Section 1.3 of the Standards, "*Training providers must ensure that each physical restraint technique that is included in the curriculum is holistically risk assesse*d" (Ridley & Leitch, 2019), *pp.43* was another Standard that respondents raised concerns about and would like to see reviewed. It was felt that standard 1.3.7 "*These standards do not support the use of pain to gain compliance. Training providers must not include the teaching of any restrictive intervention that uses pain to force an individual to comply"* (Ridley & Leitch, 2019)*, pp. 45* was difficult to comply with, particularly in high secure settings, even though respondents understood its necessity.

In Standard 1.4.4, *"Training providers must have a restraint reduction plan which details measurable outcomes and actions that support the reduction of the use of restrictive practices"* (Ridley & Leitch, 2019)*, pp. 46,* respondents identified that the terminology used for "Training providers" was not appropriate and should be changed to "Commissioning organisations", and that referring to a restraint reduction strategy as opposed to a restraint reduction plan would be more appropriate.

Several respondents also referred to Standard 1.5, "*Training providers must ensure that people with lived experience are involved in the development and delivery of training which involves the use of restrictive interventions*" (Ridley & Leitch, 2019) *pp.47* when asked which Standards where in need of review. While they have not provided a reason for this, benefits and challenges regarding the involvement of people with lived experience are highlighted and discussed in the following section.

While this was only reflected in the comments of a couple of respondents to the online survey, it was felt that Standards 1.6.1 and 1.6.5 should be reviewed. Standard 1.6.1,

"*Plans for competency testing and refresher programmes must be agreed with the commissioning organisation in advance and be part of the agreed delivery plan*" (Ridley & Leitch, 2019), *pp. 48*, should allow for the consideration of a core refresher course curricular with interchangeable additional modules to meet needs at the current time. Standard 1.6.5, *"The ratio of trainers to participants when teaching people theory and practical skills must be part of the agreed delivery plan."* (Ridley & Leitch, 2019), *pp. 49*, should consider the fact that *"Having adequate trainer numbers is not just about supervision and safety, it is a huge factor in training effectiveness and being able to deliver a more practical learning experience."* (Survey Respondent, Commercial Provider)

Multiple respondents both in the online survey and in-depth interviews referred specifically to Standard 2.5 (Ridley & Leitch, 2019) *pp.60-62*, *"The curriculum must give proportional time (no less than one day or six hours) to exploring primary strategies and preventative approaches (unless the commissioning organisation already provides an evidence based model of preventative training to all staff)"* and Standard 2.6, *"The curriculum must give proportional time (typically at least three hours) to covering the use of secondary strategies which alleviate the situation and prevent distress or behaviours of concern from escalating".* It was felt that the suggested timescales are too arbitrary and that the focus should be less on the duration and more the content of training. One participant explained:

> *"Provider A may spend 6 hours rambling on about very abstract information based upon old research and guidance, and proprietary acronyms or models. Whereas Provider B may spend 3 hours giving very relevant, transferable and practical training that far outweighs Provider A's 6 hours in practice it may be easy for an organisation to meet these Standards on the basis of timescales, but the content of the*

training may not equate to the quality of training in other organisations." (Survey Respondent, Commercial Provider)

While the purpose of the Standards is to prevent and reduce the need for the use of restrictive practices (prevention rather than reaction focus), some participants were concerned that 6 hours primary training may be difficult to achieve for some organisations that may only need low level techniques (even if they are still referred to as restrictive). It was suggested that there should be an option for this to be lessened if there is a clear rationale for doing so.

One respondent referred to Standard 2.8, *"Teaching the use of restrictive interventions (may include physical restraint, physical restraint to facilitate seclusion or long-term segregation, clinical holding, or mechanical restraint)"*(Ridley & Leitch, 2019)*, pp. 64-69,* as not being broad enough. They also expressed a need for this section to include specific health guidance e.g., monitoring a patient, use of NEWS2 as a tool, risk illnesses such as diabetes, and cardiac issues care of older persons.

There were issues raised by some regarding a lack of scrutiny and consistency surrounding Standard 4.2 (Ridley & Leitch, 2019), *pp. 42*, *"All trainers who are delivering training must be able to demonstrate that they are qualified and competent to train"* and Standard 4.3, *"All trainers must be able to evidence that they have the qualifications, experience and competence in supporting people in the sector in which they are delivering training are assessed".* Their views was that that there are trainers who do not have any professional experience in areas they are training or supporting and that this should be a requirement in future iterations of the Standards.

In addition, although not referring to a specific standard, one respondent raised the issue that, according to the new guidelines, trainers no longer need to hold appropriate

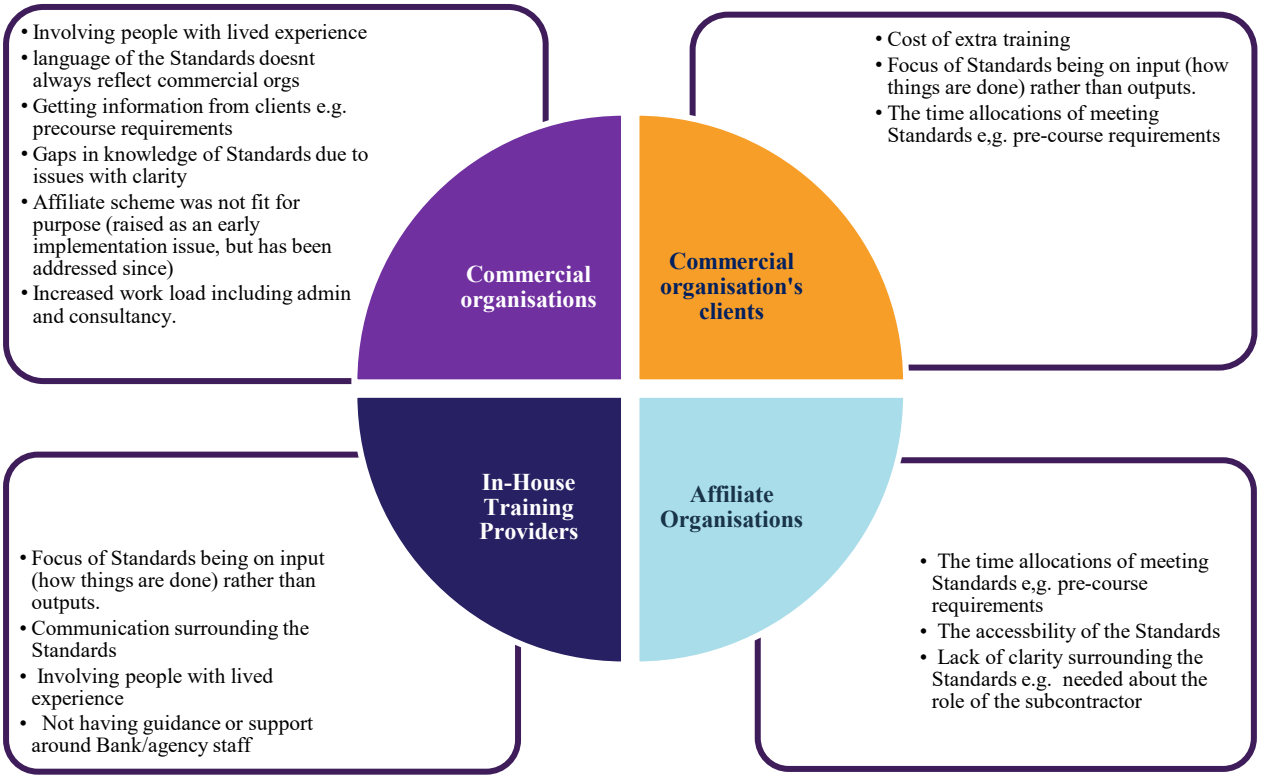
teaching qualifications. They saw this as a significant dilution from an earlier version of the Standards and believed that to reintroduce this would be a positive step:

> "*A model that is taught but not learnt is unlikely to achieve the outcomes RRN Standards were first developed to encourage."* (Survey Respondent, Commercial Provider)

Finally, Standard 3.1: "*Training must include a competence-based assessment within each programme, with participants being assessed for both knowledge and skills. It is recognised that such assessments can only assess participants' skills within a training environment*" (Ridley & Leitch, 2019), *pp. 82-83,* and Standard 3.5, *"Training providers must have internal quality assurance systems and be able to provide evidence that they effectively monitor the quality and consistency of all of their training services. Training providers must be able to evidence that their training services are being consistently delivered and that they routinely adhere to all the training standards. Training providers must use their quality assurance process to identify and action improvement priorities*"(Ridley & Leitch, 2019), *pp. 85*, were identified by respondents as in need of review (although no rationale for this was provided).

To conclude this section, ***Fig. 7*** below summarises key barriers to implementation of the Standards identified by respondents, broken down by type of organisation:

Figure 7: Key barriers by type of organisation



2.4 Involving people with lived experience in the design/delivery of training

2.4.1 An organisational priority

A common thread throughout all aspects of implementation was around involving people with lived experience. It was believed that this is a sector-wide responsibility, not an individual organisational responsibility, a key priority area:

> *"Lived experience is the most valuable source of information, how situations feel to the person and how that can be linked to trauma are things that we can only imagine if we haven't lived it"* (Survey Respondent, In-house Provider).

Respondents do believe that the Standards have had a positive impact on involving people with lived experience in training:

> *"Standard 1.5 involving the people with lived experience, contributing to training content was integral. This standard also pushed us, as an organisation, forward with the implementation of our plans to have service users with lived experience standing alongside trainers co-delivering key messages across all services including secure services"* (Interviewee #5)

There was also a large breadth of good practice reported, for example, having people with lived experience co-support or co-deliver training, which was most commonly achieved by supporting an existing training programme and sharing their story:

> *"We provide examples of how implementing the principles of Positive Behaviour Support has helped improve the quality of life of people we support and led to a reduction in restrictive practices compared to how they were supported in other settings extrinsic to our services. We also use videos or films from other individuals extrinsic to our organisation e.g. Alexis Quinn's powerful book - Unbroken - or panorama films which*

expose poor practice, patient mistreatment and abuse." (Survey Respondent, In-house provider)

Another example of good practice was with regards to involving people with lived experience directly in the development of training, done in a way allowing for them to be appropriately reimbursed and financially supported for their valuable contribution e.g., having them employed as part of a co-production team.

2.4.2 Ongoing challenges

Whilst it is clear that good practice is taking place, it was universally agreed that involving people with lived experience in the development and delivery of training comes with some significant challenges. The first challenge identified mostly by in-house training providers was around how best to involve and reflect on the needs of people with lived experience who lacked capacity at the time of involvement. Due to the nature of their learning disabilities or complexity of their needs, many respondents found this particularly challenging.

Another key issue raised by participants was around getting the right balance between engaging with people in a meaningful way, maximizing the value of their lived experience, whilst avoiding the risk of re-traumatisation. This unease was also echoed during the follow up stakeholders consultation workshops.

"So say for example, one of the courses that we're developing at the moment is likely to be a half day, so they'll be delivering that course twice in a day. If they're having to tell their story twice, and it's really challenging for them to do that, how can we make sure that it's not harmful for them?... I think it's also…it's not just about lived experience; the person has to have the right qualities that they're a good teacher as well…So…there's absolutely value in somebody with lived experience coming in and telling their story, but we want them to be part of the faculty so they have to have the same level of skill in

delivery as our tutors, but, they also bring that added experience of whatever their experience was with mental health services." (Interviewee #6)

One interviewee was particularly candid about the transition of power necessary when involving people with lived experience and the need for an organisational cultural shift to enable meaningful involvement:

"It's difficult for people to come to terms with, to accept… I've never felt particularly threatened by people having a more powerful voice, and talking about their experiences and bringing that particular expertise to the table but I think, you know, I work with people who are really used to traditional power structures within health services, and the thing is, we've got to constantly guard against is tokenism" (Interviewee #4)

Finally, there was a mutual feeling that Covid-19 had impacted good practice in this area. Not only did restrictions have had a significant impact on organisation's ability to deliver training as planned, but they also created additional challenges on how people with lived experience could take part in the delivery of training, particularly where in-person involvement was embedded into courses:

"Covid has been a significant factor in slowing us down in this area despite our real aspirations. We probably need the RRN to take this into account in terms of what is expected from us in this area." (Survey Respondent, Commercial Organisation)

In-house providers and commercial organisations identified different challenges in this area. Respondents from in-house providers spoke more about continuing to keep people with lived experience engaged and expressed that involving those who lacked capacity was a persistent challenge. In contrast, some participants from commercial organisations believed that accessing in-person lived experience in training design and delivery is a lot easier for in-house providers as they are more likely to have patient groups that they can access

specifically for this purpose. Commercial organisations were therefore much more likely to rely on electronic resources e.g., recorded videos in their training.

2.5 Data informed practice

Respondents were asked about their views on the role of data to inform practice, as a key factor in reducing reliance on restrictive practices (RCN, 2013). Gaps in data collection, systems and information management were highlighted by respondents and the importance of the Standards in improving practice:

> "[…] *for a lot of our organisations that when we've now asked for data, data has been always something people record and it just goes somewhere. So now they're actually digging it up and having a look at it, they're finding there's gaps in it, there's incidents that have been reported incorrectly. Even across different services in on organisation, they access different data which is quite bizarre. So I think for all of our organisations, where they couldn't provide accurate or two years of data, they've also got parts of their restraint reduction plan to improve their data collection system which could help monitor incidents, help restraint reduction. So I think that's been a massive, huge positive*." (Interviewee #2)

The need to collect accurate data regarding the use of restrictive practices and establish effective monitoring and feedback arrangements to inform training practice is therefore important. Examples of good practice were provided by respondents:

> "*We have a monitoring group, again one on each site that feeds into a main overall reducing restrictive practice group, he's just moved into a full time position looking at that. Again, there's one for each division that they've put into place. So our training feeds into those meetings and then similarly it comes back in terms of if there's a need around looking at what we need to change."* (Interviewee #4)

"[…] *The mental health services data set have provided specific definitions in relation to restrictive interventions that are embedded within our incident report and its systems which enables us to pull out developing data to analyse.*" (Interviewee #3)

"I think the plan is to have that a bit more embedded. But saying that, when we teach the physical skills, for example, and we teach things around kind of the pod and prone restraint and just use of restraint in general, we are always referring back to areas where success has been had in terms of reducing and why we think that's happening, and how we can learn from that and transfer that to other areas. So, it's a theme throughout. It may become a bit more specific, but it's certainly within the training and then signposting to various datasets is also part of the training as well." (Interviewee #3)

2.6 Future iterations of the Standards

This section combines the findings from both the online survey and the in-depth interviews surrounding three key main areas:

- Expanding the mandate of the Standards to include other forms of restrictive practices such as social and chemical restraint and long term segregation/seclusion;
- Including as part of the Standards a more standardised curriculum or approved set of techniques; and
- Expanding the mandate of the Standards to other settings (e.g., education).

2.6.1. Standards expanded to include other forms of restrictive practices (e.g., social or chemical restraint, segregation/seclusion)

The majority of survey respondents (70%) agreed that the Standards needed to be expanded to include other forms of restrictive practices, while a small proportion were unsure (13%) or

did not agree (17%). Commercial organisations were more likely to be in agreement of the Standards including more forms of restrictive practices than affiliates or in-house providers (see ***Table 6***).

Table 6: Views on the expansion of the Standards to include other forms of restrictive practices

Response	Commercial Organisations	Approved Affiliates	In-house Providers	Total
Yes	17 (77%)	25 (68%)	9 (64%)	51 (70%)
No	3 (14%)	5 (13%)	4 (29%)	12 (17%)
Unsure	2 (9%)	7 (19%)	1 (7%)	10 (13%)

However, when the responses to the open questions were analysed, there was less agreement regarding this issue. Some respondents expressed that all forms of restrictive practices should be subject to the same requirements. There was a feeling that the Standards being so focused on physical interventions can mean other forms are discounted in discussions around reducing the use of restrictive practices:

> *"At the moment, our teams do not understand what can be classed as restrictive practice, only seeing physical restraints as a restraint and not that other practices can be restrictive"* (Survey Respondent, Approved Affiliate)

Another respondent commented on how this expansion might impact individual care plans:

> *"As an organisation we have very specific restrictions around mechanical and environmental restraint and they are specific to individuals. They are tied to individual assessments and DoLS [Deprivation of Liberty Safeguards]. They are trained on a bespoke basis to the staff supporting those individuals."* (Survey Respondent, Approved Affiliate)

There was a recognition that some other forms of restrictive practices are already mentioned in the Standards and therefore covered in training:

> *"We already cover this on our training and a deeper understanding of restraint and restrictive practices is helpful in identifying blanket restrictions for example, as well as recognising that restraint/restrictive is not always a bad thing and can provide quality of life outcomes if used and implemented ethically and legally"* (Survey Respondent, In-house provider)

Despite this, some respondents said they would welcome more guidance. Others stated that if more guidance was added in should be in form of an appendix as not every service uses all other forms of restrictive practices, or have already irradicated their use:

> *"The focus is developing and implementing a primary prevention strategy as per the Bild Accreditation introducing theses restraints would be a contradiction of what we are trying to achieve via a prevention strategy, The course plan would have to be extended to incorporate the additional restrictive practices and would the restrictive practices be relevant to the commissioning organisations we work with."* (Survey Respondent, In-house Provider)

There was some concern, mostly from commercial organisations, that the Standards do not need to be explicit in every domain, the key message to take away is the intent behind practice. Several respondents expressed concern that by expanding the Standards, we might be taking a step backwards:

> *"[…] would be too much emphasis on having to comply with the Standards and actually, this may have a detrimental effect on the safety of staff and service users. The use of mechanical restraints can be necessary, proportionate and reasonable force to prevent further harm, but I feel the lack of knowledge some people have*

including Trusts and RRN, will mean they will enforce standards and people will feel the need to comply with them, when the standards, themselves may be flawed. People may not therefore use mechanical restraints because of this when they actually have a lawful power and reason to use them." (Survey Respondent, Commercial Provider)

The following quote builds on this, expressing that it may contradict what the Standards already seek to achieve:

"The focus is developing and implementing a primary prevention strategy as per the Bild Accreditation introducing theses restraints would be a contradiction of what we are trying to achieve via a prevention strategy, The course plan would have to be extended to incorporate the additional restrictive practices and would the restrictive practices be relevant to the commissioning organisations we work with." (Survey Respondent, In-house Provider)

2.6.2. A standardised curriculum or set of approved techniques

When asked about the possibility of implementing a more standardised curriculum or a set of approved techniques, responses were polarised. The idea of a standardised curriculum was met with more enthusiasm than that of a set of approved techniques. Most respondents who were in favour of a standardised curriculum recognised that a potential benefit would be that it might mean more consistency between training providers:

"Given the purpose of the Standards, it would have been easier for the RRN/BILD Act to have provided standardised theoretical training programmes which covered the core elements of reducing restrictive practices, which providers could have added to, to fit the needs of their service, this would have saved organisations huge amounts of time and money, instead of creating their own which are measured against the RRN standards anyway." (Survey Respondent, Commercial Provider)

Others felt that whilst it is a well-intended idea and a seemingly rational solution in theory, in practice it would be a lot harder to implement. This was echoed by the overwhelming concern that if a more standardised curriculum existed, it would not suit the diversity of service demographics both in regard to setting (health, education, and social care) and across age groups (adults, young people, and children). This would mean the addition of appendices for every possible patient need. Because services differ widely in terms of the needs of the people they support, an approach that is too prescriptive would be a move away from individualised and person-centred care. One survey respondent explained:

> *"Yes, I would welcome this however there must be a caveat which would give guidance to use other techniques through an professional framework. One size does not fit all and patient care delivery needs to be person centred."* (Survey Respondent, In-house Provider)

There was also a feeling that a standardised curriculum might work better for some organisations but not for others. One respondent from a commercial organisation supporting a large proportion of NHS acute settings welcomed the idea, saying it would be of great to use to their organisation, but other commercial providers thought it would not work for them:

> *"I think this would be useful for NHS settings but for commercial providers, like ourselves we pride ourselves on our content and our individual approach to helping people learn and develop - a standardised curriculum would take innovation out."* (Survey Respondent, Commercial Provider)

On the other hand, in regards to a set of approved techniques, most respondents of the online survey felt strongly that this would be problematic, whilst a few did consider its benefits:

> *"In an ideal world, having an approved 'suite' of skills and interventions could be very beneficial and have positive implications for practice, such as greater*

compatibility between staff who have received training from different providers…" (Survey Respondent, In-house Provider)

The biggest concern for respondents was regarding the decision-making processes around this, e.g., who would decide on the approved set of techniques and how they would be decided upon. Respondents were concerned that it would need input from a wealth of different people/organisations beyond the Restraint Reduction Network so that the needs of all services were reflected. A consensus would therefore be difficult to reach. This is reflected in the following quote:

"Formation of an appropriately qualified group of professionals would be of paramount importance, requiring wider expertise whilst being entirely independent of any existing model of intervention, to avoid considerable legal challenge" (Survey Respondent, Commercial Provider)

Most also recognised it as being detrimental to the service they already provide:

"*It would be devastating, we have spent 20 years developing, assessing and reviewing our techniques and we know from customer feedback that they are very good, it would be terrible to lose them.*" (Survey Respondent, Commercial Provider)

2.6.3. Standards expanded to be mandatory in other settings (e.g., education)

Respondents were asked whether the mandate of the Standards should be expanded beyond adult health and social care settings. There was a strong agreement that this should be the case, however, there was less agreement on how this could work, for example the degree of adaptation needed for Standards for children and schools. Respondents believed that there is a real disconnect between how people are treated in acute and emergency wards for example and how they would be treated in mental health services. Security staff or people working in education are believed to be less aware regarding the type and impact of restrictive

practices/potential for trauma than nurses or healthcare workers. Staff might therefore be less comfortable to react in crisis situations and potentially be more restrictive. One interviewee respondent emphasized the need to cover children services:

> *"[…] why are children left out? The Standards were penned to cover, I believe it's health, adult social care and education. Why are children left out? I know in education of course that does cover children. There's appendices about applying these things to children. I'm not saying the standards has left them out but Ofsted, as the regulator for education, this not being in their inspection framework means that it's not mandatory. I have an issue with that when we're talking about arguably the most vulnerable. This should absolutely be a mandatory requirement for all of those settings and sectors" (*Interviewee #2)

3. Suggestions for improvement (Objective 4 of the study)

While this report shows evidence of good practice and highlights the benefits of the Standards, it also draws attention to some challenges respondents faced during implementation. Ideas on how some of these areas could be improved were provided by the survey respondents, interviewees and key stakeholders during the consultation workshops. These were then used to identify several suggestions that the RRN, BILD Act, and relevant regulators (e.g., UKAS, CQC) could use to review, inform, and improve future iterations of the Standards, including the certification process. These suggestions are summarised below:

3.1. Make the Standards more accessible

It was suggested by participants that some of the Standards lacked clarity (e.g., Standards 2.5 and 2.6) and are too open to interpretation. Solutions provided include: (i) providing examples of appropriate ways in which that specific Standard might be met; or (ii) giving visual and clear summaries regarding responsibilities (e.g., service provider vs. trainer provider) that outline who does what and when. Following consultation with key stakeholders from the RRN and BILD Act, it emerged that an infographic and a recorded webinar (including Q&A) were made available in response to previous feedback asking for more clarity about these two Standards. Work is currently being done around providing clarity, e.g., an Appendix with more detail to inform Standard 2.5 is awaiting approval by the RRN Standards Sub-group, which includes a representative from the Care Quality Commission (CQC), but ongoing discussions are taking place with the CQC, indicating that this needs more work.

Participants believed that the alliance between certified organisations could be strengthened in the following ways: (i) by creating opportunities to share best practice in this area, e.g., via webinars; (ii) by building a platform where people can support each other (peer support); or (iii) by having a ‘buddy system’ where organisations who have gone through the

process can support others who are new to it and would benefit from advice. RRN and BILD Act are happy to support organisations to work together more effectively and share good practice, but they do have concerns regarding the feasibility around sharing information, due to commercial sensitivity and that some organisations would be reluctant to do this in practice.

Interestingly, while consultation with BILD Act indicates that the certification handbook is extensive and self-explanatory, respondents still felt that, at the point of registration, the process was a little unclear regarding how much work was required to move from requirement to registration. They suggested putting together a simple, easy read 'what you will need' document that would help organisations prepare for what is coming ahead. This could then be a tool used by commercial organisations to give to training providers to alleviate some of the consultancy time and resources required to help organisations to become certified. As indicated above, BILD Act argue that the process is transparent and meetings with lead assessors outline exactly what the process will be like and what is needed; it is uncertain why this study participants felt this way – a way to remind organisations about what resources and information are already available and where the can find them could alleviate some of these concerns.

There was however consensus regarding the content and presentation of the Standards, in that they are too long and content heavy, therefore it would be more useful to have a shorter, more easily accessible (including plain English) and visual document for people to use. Our consultation meetings with the RRN confirmed that this is currently being addressed and an executive summary outlining core principles of the Standards is being developed and will be included in the Standards, v2. However, having a clear diagram outlining the service provider and commercial provider's responsibilities would be beneficial,

suggestion which is linked to the first point above about having a clear summary outlining who does what.

3.2. Allow for some flexibility in how the Standards are met

Participants felt that the timeframe set out for pre-course requirements should account for the amount or type of resources needed to provide evidence. While it is evident that an open-ended timeframe would not be acceptable, it was believed that this issue could be alleviated by allowing for extended timeframes in exceptional circumstances, especially where organisations are struggling to collect evidence within the 6-month deadline for pre-course requirements.

Similarly, some organisations stated that a barrier to becoming certified against the Standards was having to provide two years' worth of incident data. Some suggestions on how to address this included (i) having an alternative assessment criterion in cases where data were not available; or (ii) accepting a commitment to improve data monitoring and provide incident data going forward where past data was not collected.

It was argued by some respondents that the Standards were too input or content focused and too prescriptive in places, e.g., Standards 2.5 and 2.6, especially with regards to the amount of required training hours. Discussions with the RRN indicate that, whilst training hours could be reviewed, RRN's priority is prevention and training in physical techniques will always be a minority within the certified training course.

Allowing for differences in how outcomes are evidenced was believed to be a potential solution. While this is something that the RRN or the regulators are keen to explore, it should be noted that it might actually result in more work for training organisations in the long term, as they will still have to show how this has been achieved and spend time evidencing how they met those outcomes, e.g., through Kirkpatrick's model of evaluation

(https://kirkpatrickpartners.com/the-kirkpatrick-model/). RRN indicate that they are supportive of this but will need to engage and consult with training organisations to inform the development of Standards, v2.

3.3.Support co-production and involvement of people with lived experience

Respondents to the national survey identified that involving people with lived experience in the design and delivery of training was a priority but also a challenge. They identified some strategies that would help, for example having access to case studies or opportunities to discuss concerns and share good practice with other organisations going through the process. While better, more meaningful, non-tokenistic involvement of people with lived experience should be an aspiration for all training organisations certified or working towards certification (and generally, within services, to improve care via shared decision making), participants welcomed advice or ideas around how to involve those with lived experience in the best way. Co-developing a framework/principle guide document to inform practice in this area and encourage a shift in philosophy would be therefore useful. This would allow the opportunity for those with lived experience to share how they feel best empowered to be involved in the design and delivery of training and enable meaningful co-design. The 'involving people with lived experience framework' would then be recognised by all organisations as the 'go to' place for information and used in a systematic way across all types of services.

It was believed that broadening the scope of consultations to involve family members, to complement or replace involvement from people with lived experience who may not be able to be directly involved, would be a positive step towards improving involvement and including the voice of those who are usually silenced due to communication challenges. This should be clarified in the Standards or included within the new framework. To ensure a comprehensive, safe and supportive approach to involvement and encourage engagement, more support should be offered to people with lived experience, including offering training

opportunities/personal development, support post involvement (as this can be traumatic), and attendance to events, conferences, etc. where they can engage with the community, peers and services, to find out about the latest evidence and practice and share experiences.

It was also thought that organisations might benefit from specific advice and guidance regarding GDPR linked to involving people with lived experience in training, including some advice to improve understanding around capacity. Some clarity is also needed regarding the way to approach involvement of people with lived experience and incorporate it in training, for example there were questions whether they should be asked to observe the training provided by organisations and comment or allow practitioners to test out physical techniques on them and then comment.

Co-producing an easy read version of the Standards, particularly involving those with learning disabilities (and other templates such as information leaflets or pro forma surveys) to support organisations in involving people with lived experience in the design and delivery of training was a key suggestion. Respondents also called for templates to be available such as information leaflets and pro forma surveys to make the process easier. Consultation with the RRN indicates that they are committed and willing to develop this and make it available when the Standards, v2 are released.

3.4. Support shared decision-making with services

With regards to co-production with services, there was a common view, especially amongst interviewees, that the voice of the service (i.e., affiliates) is missing in the Standards, and that they should have more of an equal say/input when these are developed and/or amended. A suggestion on how to address this was having appropriate representation on RRN Standards subgroups to ensure they are being consulted and involved in all decision-making. Consultation with key stakeholders from RRN/BILD Act or other organisations also points out to a gap in practice and how a greater alignment between ‘Towards Safer Services’

(Cross et al., 2019) and the 'RRN Training Standards' (Ridley & Leitch, 2019) would facilitate a better understanding and shared decision making process. While discussing this issue with the RRN, they acknowledged they are currently exploring how to achieve better coordination between these two key documents, suggesting that the version of 2 of these documents should be developed together.

3.5. Strengthen communication surrounding the Standards

Some respondents experienced scenarios in which they were unsure of certain Standards and they reached out to RRN/BILD Act for advice, but did not get a clear or timely response. While consultation with the RRN and BILD Act suggests that this is not necessarily the case, if organisations are experiencing problems and do need to reach out for advice (beyond what is already available to them via the RRN/BILD Act communication platforms), a solution might be to flag up regulators (e.g., the CQC) in the Standards, as somewhere organisations can go to ask specific questions, especially when it comes to service provider responsibilities. It should, however, be noted, that there is a limit to how much the accreditor UKAS would permit BILD Act to help and coach organisations through certification; BILD Act are expected to provide general guidelines.

Other solutions were provided and these were put forward to the RRN and BILD Act for consideration, for example: (i) considering one key (expert) contact for questions regarding the Standards, that commercial organisations could give to their affiliates and feel confident they would get a timely and useful response; or (ii) revisiting how communication is filtered to organisations, especially when changed within the Standards take place (e.g., via appendices). While consultation with the RRN and BILD Act suggests that organisations are being informed about the Standards and any changes on a regular basis (e.g., via formal communication, emails/newsletters or at specific certified organisations meetings), it might

therefore be useful to ask organisations how they would like to be involved or be informed, so that the information is being shared in a meaningful and timely manner.

3.6.Revisit the content of the Standards

Some participants felt that the language used in the Standards did not reflect/apply to their organisation and that this created confusion. They thought that revisiting some of the language to reflect commercial organisations who have affiliates, as well as considering settings outside of mental health would be useful. Having a screening option when accessing the Standards, profiling organisations based on the information they provide (e.g., type of service, or population they serve) and creating a bespoke version of the Standards for that service would be a valuable modification to the Standards. This is something that the RRN are currently exploring the feasibility of.

Issues surrounding the training of bank and agency staff were also raised and respondents believed that holding consultations with NHS Professionals (NHSP) and staff on the ground might help to find the best way forward to address this. Consultation with the RRN suggests that there is currently an Appendix for temporary staff being developed that is informed by an ongoing pilot study.

From feedback through this research and more generally via stakeholders consultations and reducing restrictive practices forums, it is clear that inequalities in the use of restrictive interventions and disproportionality are clear national concerns. Currently the Standards do not address this issue directly. We believe that the provision of a second iteration of the Standards is an ideal opportunity to explore how training organisations can address this in their curriculum and content and in aspects related to cultural competency.

3.7. Consider expanding the mandate of the Standards

Opinions about how or when the Standards should become mandatory in other settings or with regards to other forms of restrictive practices (e.g., social and chemical restraint, long term segregation) were mixed, however respondents supported the idea of regulating training in educational and children services. Consultation with the RRN indicates that these changes have already been agreed and are being considered in future iterations of the Standards. This is in line with the recommendations from the Equality and Human Rights Commission (EHRC) report (Equality and Human Rights Commission, 2021) looking at the use of restraint in schools, calling for action to prioritise the monitoring and restraint used in schools and develop national training standards that "should take a human rights approach to minimising the use of restraint and draw on the Restraint Reduction Network Training Standards"(Equality and Human Rights Commission, 2021), *pp.45*. As argued in the introduction of this report, this has also been brought up by the latest CQC progress report (2022), calling for the government 'to consider a cross-departmental review of restrictive practices for children with special educational needs and disabilities, including schools and anywhere children are living away from home'(Care Quality Commission, 2022), *pp 62*.

The RRN are currently engaging with endorsing organisations such as the National Association of Independent Schools & Non-Maintained Special Schools (NASS) to support with the adaptation of the Standards is appropriate for implementation in schools, as well as other devolved nations in the UK.

DISCUSSION

This report presents the results from a study looking at views about the implementation of The RRN Training Standards in the UK.

1. Summary of findings

Findings included here were based on views, perceptions and experiences of representatives from in-house, commercial and affiliate organisations either certified or working towards certification in relation to the Restraint Reduction Network (RRN) Training Standards (First edition) (Ridley & Leitch, 2019), gathered through online surveys (n=114 participants) and face to face semi-structured interviews (n=12 participants). These findings were also validated with key stakeholders with strategic roles in this area of work, people with lived experience and representatives from services whom might not have participated in the main data collection, i.e., regular feedback meetings with the project management group (PMG) (n=11 members), two RRN Conference workshops (Leeds, 2022) (n=30 attendees, approximately), and one validation workshop with representatives from organisations certified against the Standards (n=37 attendees). These additional stakeholders meetings and workshops were key to enable the research team to sense-check emerging findings and recommendations and refine them to reflect current practice and priorities, as well as to discuss the feasibility and reality of implementing them both in the short and long term.

The findings should be understood in the wider context of the Standards outlined in the background section regarding where they were introduced and the UKAS accreditation process which has been found by many to be extensive and time consuming.

Findings indicate that experiences of the implementation of the Standards differ depending on type of organisation, the timing within their journey to certification or implementation, their organisational culture and strategies with regards to reducing restrictive

practices. Whether positive or negative, these experiences appear to have been crucial in shaping the organisations' overall views of the Standards and the certification process, as well as their relationship with RRN, BILD Act or regulators.

A key finding of this research was that the Standards were recognised as an important contributor towards a wider organisational cultural shift needed in the use of restrictive practices in mental health settings and beyond. This is about moving away from physical skills only training to a wider, person-centered, trauma informed care approach to training, with more emphasis on prevention and de-escalation, which is in line with the use of training approaches, internationally.

Results indicate that the most common overarching restrictive practice programme used by participants in this research was Positive Behavioural Support, understood as a person centred approach that "blends values about the rights of people with disabilities with a practical science about how learning and behavior change occur" (Horner, Sugai, Todd, & Lewis-Palmer, 2000). Overall, the models mentioned by research participants reflect the rights-based approach to the reduction of the use of restrictive practices. These findings highlight that although the Standards are a step towards standardising training in this area, even within those certified, training is still underpinned by a wide range of approaches. For some this is a positive notion as it allows for an innovative approach to training staff and gives freedom to training organisations to tailor training to the needs of the individuals they care for.

Findings also indicate that the Standards have raised the overall quality of training in those organisations certified under the certification scheme, helping towards creating consistency and improving quality assurance. Interestingly, there is a recognition that having mandatory standards for training provide organisations with some form of leverage,

reassurance, or legitimacy when trying to implement their strategies to reduce restrictive practices across services, including training.

Given the new heavily regulated processes involved in the certification and the implementation of the Standards, it is not surprising that that participants in this study found these processes time consuming and resource intensive, sometimes too rigid or lacking flexibility. One of the key challenges to implementation appears to be when supporting affiliate organisations through the process, especially following accreditation to ensure they maintain compliance with the Standards.

Involving people with lived experience was seen as a key priority, but a challenging aspect in relation to co-production and training delivery. Benefits and challenges identified in this research (Sections 2.2 and 2.3) were used to identify solutions to improve practice. Key recommendations (Section 2.6) are summarised in ***Fig 8*** below.

Figure 8: Key recommendations

Make the Standards more accessible	• Improve clarity of some Standards (2.5/2.6) • Develop visual, accessible summaries/diagrams outlining key principles and responsibilities • Encourage collaboration/community of practice and strengthen pathways for sharing of information and good practice
Allow for some flexibility in how the Standards are met	• Consider exceptional circumstances with regards to key requirements for certification (e.g., 2 years of data) • Shift focus to concentrate on output rather than input and prescriptive processes to achieve that
Support co-production and involvement of people with lived experience	• Develop accessible summary of Standards with and for people with lived experience • Develop national framework for involvement of people with lived experience, including families • Offer support to people with lived experience, e.g. training opportunities, support post involvement, attendance to events, conferences, etc.
Support shared decision making with services	• Encourage and enable service representation on RRN Standards Sub-groups • Work towards better integration of 'RRN Training Standards' with 'Towards Safer Services' practice framework for reducing restrictive interventions
Strengthen communication pathways	• Flag up regulators (e.g., CQC) in the Standards, as somewhere organisations can go to ask specific questions • Identify key (expert) contacts for questions regarding the Standards • Consult with organisations to identify best way to filter information to organisations
Revisit content of the Standards	• Revisit language used in the Standards to allow for differences in services - a bespoke version of the Standards per type of service could be made accessible • Consult with NHS Professionals (NHSP) and staff on the ground to find the best way forward to address Bank/agency training needs and responsibilities for training providers • Consider inequalities and disproportionality in the curriculum
Expand mandate beyond mental health and social care	• Consider developing Standards (in version 2) beyond health and social care settings, for example children and young people services, education, acute and emergency settings, devolved nations

2. Strengths and limitations

This research project is the first study of its kind collecting in-depth views about the implementation of the first mandatory standards for training with a restrictive practices element. It is a national study collecting data from in-house, commercial and affiliate training providers that are certified and/or in the process of being certified against the Standards. Although the results are comprehensive and have generalisibility, they are not representative of the views and experiences of every organisation to have completed (or be working towards) the certification process.

Whilst the four case study sites were carefully selected to represent all organisation types (in-house, commercial, affiliate), sizes (small and large training providers) and experience of the implementation of the Standards, we also recognise that these might not have been representative of the experience of all types of providers or services, especially those at the beginning of their journey of developing or receiving training and/or implementing strategies to reduced restrictive practices in their organisation. However, by consulting with stakeholder groups and iteratively considering our findings, we believe that these were validated from individual to collective stories and the emerging recommendations are reflective of a range of organisations' key experiences and needs.

By collaborating with the key organisations responsible for developing and refining the Standards and the certification process (i.e., RRN and BILD Act) we also believe that the results from this evaluation will be used to inform future iterations of the Standards are developed.

CONCLUSION

The RRN Training Standards are just one piece of the puzzle, a step towards changing practice and organisational culture regarding the use of restrictive practices and approaches used to minimise these, including training. Although training is seen as a key element to reducing restrictive practices within the international literature and practice, training approaches differ greatly and there is little or no regulation (outside of the UK). The RRN Training Standards represent a positive shift in informing training to guide practice and the first to provide a mandatory framework for training within health and social care services. This research has explored experiences and views of those implementing the Standards to share lessons learnt, to inform future iterations of the Standards, as well as the potential application of the Standards in other areas of work/settings or countries outside of the UK.

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APPENDICES

Appendix 1: Online Surveys

1.1 Evaluation of the RRN Standards: Approved affiliates

Manchester Metropolitan University has been funded by the Burdett Trust for Nursing to conduct a research study to evaluate the implementation of the 'Restraint Reduction Network (RRN) Training Standards 2019' in mental health Trusts and commercial organisations in England. You are being invited to complete a brief questionnaire capturing your views about the Training Standards and their implementation in the organisation you work for.

It is important that you know your answers will be fully anonymous and will only be seen by the research team at Manchester Metropolitan University. You will not be asked for your name or contact details and it will not be possible to link you or your computer to your responses. Before you begin, we encourage you to read the participant information sheet that is attached to the email you received that contained the link to this questionnaire.

We appreciate that we are experiencing unprecedented times and staff are incredibly busy, but do consider that research is the most reliable way to capture change, experiences and views to help preserve or improve practice. Please be open and honest as this is the only way to identify good practice or gaps that could be addressed to make things better in the long term.

Please read the information below to help you complete the survey correctly:

· Only complete this survey once
· The survey takes around 15 mins to complete (this may vary depending on how much you choose to engage with it)
· Please click 'Submit' to save and submit your response at the end - by doing so you are consenting to take part in this study.

If you have any questions or would like more information please get in touch with our researchers via email [Miss Katie Goodall, at: k.goodall@mmu.ac.uk or Dr Alina Haines-Delmont at: a.haines@mmu.ac.uk].

Thank you very much for taking the time to read this information and taking part in this survey

By continuing with the survey, you are agreeing that:
• you have read the Participant Information Sheet (v1 23.03.21)
• you are at least 18 years of age
• you voluntarily agree to participate
• you understand that once you have submitted your response, you will not be able to withdraw your data from this study
• you are happy for information from your response to be used (anonymously) in reports, published papers and conferences
• you agree that Manchester Metropolitan University can keep your anonymised data for 10 years after the study has ended

Information about your organisation:

1. What service provider organisation do you work for?

2. Which training organisation are you an approved affiliated of?

3. What settings are supported by your approved BILD ACT certified training?
   - ☐ Health
   - ☐ Education
   - ☐ Social care

4. What populations are supported by your approved BILD ACT certified training? (tick all that apply):

- ☐ Adults
- ☐ Children
- ☐ People with autism
- ☐ People with Acquired Brain Injury (ABI)
- ☐ People with dementia
- ☐ People with learning disabilities
- ☐ People with mental health conditions

Implementation of the Standards/affiliate model: Pre-delivery

5. How have the Training Standards helped identify your organisational needs?

6. What can be done to support your organisation to overcome any challenges in involving people with lived experience in the design and/or delivery of training?

Implementation of the Standards: Content and delivery of training

7. How have the Training Standards helped with content and delivery of training?

8. Approximately how many frontline staff have you delivered BILD ACT certified training to?

Implementation of the Standards: Post-delivery

9. Have you observed evidence of a reduction in the teaching and/or use of restrictive practices in your service as a result of your implementation of the Standards with them?

- ☐ Yes
- ☐ No

10. Can you identify 1 key benefit that people who use your services have experienced as a result of the Training Standards?

11. Can you identify 1 key benefit for your staff or services?

Version 2 of the Standards

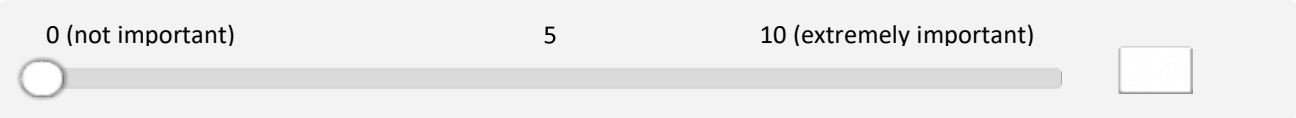
12. Can you think of 1-2 ways to improve the Standards?

13. Do you think the Standards should include other forms of restrictive practices e.g. mechanical and environmental restraint? Why?

14. What are your thoughts about version 2 of the Training Standards having a more standardised curriculum and/or set of approved techniques?

15. Please list which Standards you would like to see reviewed in version 2 of the Standards (you can do this by listing up to 5 Standards e.g. 3.1.1 Assessment criteria, or indicating specific areas):

16. How do you rate the importance of the implementation of the Training Standards?



Thank you for taking the time to respond to our survey. Please click 'Submit' at the bottom of the page to send your response (remember that if you do this we wont be able to withdraw your information from this study).

1.2 Evaluation of the RRN Standards: In-House Providers

Manchester Metropolitan University has been funded by the Burdett Trust for Nursing to conduct a research study to evaluate the implementation of the 'Restraint Reduction Network (RRN) Training Standards 2019' in mental health Trusts and commercial organisations in England. You are being invited to complete a brief questionnaire capturing your views about the Training Standards and their implementation in the organisation you work for.

It is important that you know your answers will be fully anonymous and will only be seen by the research team at Manchester Metropolitan University. You will not be asked for your name or contact details and it will not be possible to link you or your computer to your responses. Before you begin, we encourage you to read the participant information sheet that is attached to the email you received that contained the link to this questionnaire.

We appreciate that we are experiencing unprecedented times and staff are incredibly busy, but do consider that research is the most reliable way to capture change, experiences and views to help preserve or improve practice. Please be open and honest as this is the only way to identify good practice or gaps that could be addressed to make things better in the long term.

Please read the information below to help you complete the survey correctly:

· Only complete this survey once
· The survey takes around 15 mins to complete (this may vary depending on how much you choose to engage with it)
· Please click 'Submit' to save and submit your response at the end - by doing so you are consenting to take part in this study.

If you have any questions or would like more information please get in touch with our researchers via email [Miss Katie Goodall, at: k.goodall@mmu.ac.uk or Dr Alina Haines-Delmont at: a.haines@mmu.ac.uk].

Thank you very much for taking the time to read this information and taking part in this survey

By continuing with the survey, you are agreeing that:
• you have read the Participant Information Sheet (v1 23.03.21)
• you are at least 18 years of age
• you voluntarily agree to participate
• you understand that once you have submitted your response, you will not be able to withdraw your data from this study
• you are happy for information from your response to be used (anonymously) in reports, published papers and conferences
• you agree that Manchester Metropolitan University can keep your anonymised data for 10 years after the study has ended

Information about your organisation:

1. What service provider organisation do you work for?

2. What settings are supported by your approved BILD ACT certified training?

- ☐ Health
- ☐ Education
- ☐ Social care

3. What populations are supported by your approved BILD ACT certified training? (tick all that apply):

- ☐ Adults
- ☐ Children
- ☐ People with autism
- ☐ People with Acquired Brain Injury (ABI)
- ☐ People with dementia
- ☐ People with learning disabilities
- ☐ People with mental health conditions

4. At what level is your organisation certified against the standards?

- ☐ Certified
- ☐ Working towards certification

5. What stage of certification are you at?

- ☐ Formally applied
- ☐ Self-assessment against all Standards
- ☐ Working towards certification with BILD ACT assessor
- ☐ Submitted application to panel
- ☐ Attended panel meeting
- ☐ Certified
- ☐ Other (please specify)

6. If applicable, when did you become certified? (MM/YYYY)
7. What is your overarching restrictive practice programme and how does training fit into this?

Implementation of the Standards: Pre-delivery

8. How have the Standards helped identify your organisational needs?

9. What can be done to support your organisation to overcome any challenges in involving people with lived experience in the design and/or delivery of training?

Implementation of the Standards: Content and delivery of training

10. Approximately how many frontline staff have you delivered BILD ACT certified training to?

11. How have the Standards helped with content and delivery of training?

12. Can you identify 1-2 key aspects of introducing the Standards have been most challenging for your organisation?

Implementation of the Standards: Post-delivery

13. Have you observed evidence of a reduction in the teaching and/or use of restrictive practices in your service as a result of your implementation of the Standards with them?

    ☐ Yes
    ☐ No

14. Can you identify 1 key benefit that people who use your services have experienced as a result of the Training Standards?

15. Can you identify 1 key benefit for your staff or services?

Version 2 of the Standards

16. Can you think of 1-2 ways to improve the Standards for in-house training providers?

17. Do you think the Standards should include other forms of restrictive practices e.g. mechanical and environmental restraint? Why?

18. What are your thoughts about version 2 of the Training Standards having a more standardised curriculum and/or set of approved techniques?

19. Please list which Standards you would like to see reviewed in version 2 of the Standards (you can do this by listing up to 5 Standards e.g. 3.1.1 Assessment criteria, or indicating specific areas):

20. How do you rate the importance of the implementation of the Training Standards?

0 (not important) 5 10 (extremely important)

1.3 Evaluation of the RRN Standards: Commercial Providers

Manchester Metropolitan University has been funded by the Burdett Trust for Nursing to conduct a research study to evaluate the implementation of the 'Restraint Reduction Network (RRN) Training Standards 2019' in mental health Trusts and commercial organisations in England. You are being invited to complete a brief questionnaire capturing your views about the Training Standards and their implementation in the organisation you work for.

It is important that you know your answers will be fully anonymous and will only be seen by the research team at Manchester Metropolitan University. You will not be asked for your name or contact details and it will not be possible to link you or your computer to your responses. Before you begin, we encourage you to read the participant information sheet that is attached to the email you received that contained the link to this questionnaire.

We appreciate that we are experiencing unprecedented times and staff are incredibly busy, but do consider that research is the most reliable way to capture change, experiences and views to help preserve or improve practice. Please be open and honest as this is the only way to identify good practice or gaps that could be addressed to make things better in the long term.

Please read the information below to help you complete the survey correctly:

· Only complete this survey once
· The survey takes around 15 mins to complete (this may vary depending on how much you choose to engage with it)
· Please click 'Submit' to save and submit your response at the end - by doing so you are consenting to take part in this study.

If you have any questions or would like more information please get in touch with our researchers via email [Miss Katie Goodall, at: k.goodall@mmu.ac.uk or Dr Alina Haines-Delmont at: a.haines@mmu.ac.uk].

Thank you very much for taking the time to read this information and taking part in this survey

By continuing with the survey, you are agreeing that:
• you have read the Participant Information Sheet (v1 23.03.21)
• you are at least 18 years of age
• you voluntarily agree to participate
• you understand that once you have submitted your response, you will not be able to withdraw your data from this study
• you are happy for information from your response to be used (anonymously) in reports, published papers and conferences
• you agree that Manchester Metropolitan University can keep your anonymised data for 10 years after the study has ended

Information about your organisation:

1. What service provider organisation do you work for?

2. What settings are supported by your approved BILD ACT certified training?

- ☐ Health
- ☐ Education
- ☐ Social care

3. What populations are supported by your approved BILD ACT certified training? (tick all that apply):

- ☐ Adults
- ☐ Children
- ☐ People with autism
- ☐ People with Acquired Brain Injury (ABI)
- ☐ People with dementia
- ☐ People with learning disabilities
- ☐ People with mental health conditions

4. At what level is your organisation certified against the standards?

- ☐ Certified
- ☐ Working towards certification

5. What stage of certification are you at?

- ☐ Formally applied
- ☐ Self-assessment against all Standards
- ☐ Working towards certification with BILD ACT assessor
- ☐ Submitted application to panel
- ☐ Attended panel meeting
- ☐ Certified
- ☐ Other (please specify)

6. If applicable, when did you become certified? (MM/YYYY)
7. Do you deliver or plan to deliver BILD ACT certified training direct to services using your own senior trainers and/or through the Affiliate Train the Trainer model?

- ☐ Direct to services
- ☐ Affiliate (train the trainer) model
- ☐ Both
- ☐ Unsure
- ☐ Other (please specify)

8. How many affiliates has your organisation supported through the certification process?

9. If you are certified and using the affiliate model, how long on average has it taken to transition client services to becoming an affiliate? (in months)

Implementation of the Standards: Pre-delivery

10. How have the Standards helped your organisation in preparing for training delivery? (e.g. developing processes, curricula and staffing)

11. How have the Standards helped your organisation identify client's training needs?

12. What can be done to support your organisation to overcome any challenges in involving people with lived experience in the design and/or delivery of training?

13. Approximately how many clients have you delivered BILD ACT certified training to?

14. How have the Standards helped with content and delivery of training to your clients?

15. Can you identify 1-2 key aspects of introducing the Standards have been most challenging for you as a commercial provider

16. Can you identify 1-2 key aspects of introducing the Standards have been most challenging for your client's services?

Implementation of the Standards: Post-delivery

17. Have you observed evidence of a reduction in the teaching and/or use of restrictive practices in your service as a result of your implementation of the Standards with them?

- ☐ Yes
- ☐ No

Version 2 of the Standards

18. Can you think of 1-2 ways to improve the Standards for in-house training providers?

19. Do you think the Standards should include other forms of restrictive practices e.g. mechanical and environmental restraint? Why?

20. What are your thoughts about version 2 of the Training Standards having a more standardised curriculum and/or set of approved techniques?

21. Please list which Standards you would like to see reviewed in version 2 of the Standards (you can do this by listing up to 5 Standards e.g. 3.1.1 Assessment criteria, or indicating specific areas):

22. How do you rate the importance of the implementation of the Training Standards?

0 (not important) 5 10 (extremely important)

Appendix 2: Interview Schedule

Indicative in-depth interview schedule

1. ***Role in relation to the Standards***
   - Describe your current role, especially with regards to the Standards and/or certification
   - What has implementing the RRN Training Standards into your organisation involved?

2. ***Restrictive practices in your organisation:***
   - What is your training model/philosophy in regard to restrictive practices? [*What are the key components/curriculum?*]
   - How does your organisation map the training against the Training Standards?
   - How do you use data recording and reporting regarding the use of Restrictive Practices to improve your training or practice?
   - Which definitions of Restrictive Practices do you use?
   - How many trainers do you use? [*In your view at what point does one organisation need more than 1 trainer? Why?*]
   - How do you make sure that people are able to transfer what they have learned safely into real situations (physical techniques)?
   - Are staff in your organisation aware of Standards and their requirements? (affiliates, in particular)

3. ***Quality assurance***
   - Has the implementation of the RRN Training Standards improved your quality assurance processes in regard to training?
4. ***Service user involvement in training***
   - What is your organisation's stance and approach regarding service user involvement in developing and delivering training? [*How is it done*?]
   - What are, in your view the key benefits and challenges? what can be done to make it meaningful?

5. ***Impact***
   - Have you observed any changes in your organisation as a result of the Standards? [impact at all levels: organisation/clients/staff/patients/people they serve – changes on the floor, in practice; culture, etc.]
   - E.g. To what extent has implementing the RRN Training Standards led to a reduction in the teaching of restrictive practices within your organisation?
   - E.g. To what extent has implementing the RRN Training Standards led to a reduction in the use of restrictive practices within your organisation?
   - How do you record/measure these changes? [if not, what are the difficulties of measuring impact?]

6. ***Recommendations for V2 standards***
   - What are your thoughts about widening the scope of the Standards? [both in terms of other forms of RP (chemical, NG feeding environmental restraint) and services (education, social care, NHS ambulance/acute NHS car etc.)]
   - Would it be a good idea to have a list of approved risk assessments and techniques? [What would the advantages and disadvantages of this be?]
   - NHSE & CQC have been very supportive of the Standards. Are there any other government departments you would like to see supporting the standards?

- Should there be a requirement for affiliates to feedback summary of data of incidents etc to training org to improve training?
- Are there any standards that you would like to see reviewed in version 2 of standards?

7. ***General views about the Standards and Certification scheme***
   - In your view, are there benefits of having statutory regulations with regards to training in this area of work?
   - What are your views about responsibilities with regards to the Standards – is it clear who is responsible for what? (affiliates in relation to training organisations)
   - What are your views about the costs of regulation [*do you think this is an issue for small providers?*]
   - With the spotlight being on reducing restrictive practices in organisations are there any approaches you have considered or have already implemented that are not included in the RRN Training Standards but should be?
   - How has the certification scheme enabled and supported your organisation to implement the RRN Training Standards?

8. ***Final thoughts***
   - To sum up, will you please identify 1-2 key barriers to the Standards? What about 1-2 key facilitators?
   - If you identify one thing that you would like to see change in terms of the standards or certification process – what would that be?
   - In hindsight if you were to implement the RRN Training Standards again what would you do differently
   - what support could third parties offer e.g. regulators, training provider, certification body?
   - Anything else we might have missed or you'd like to add?