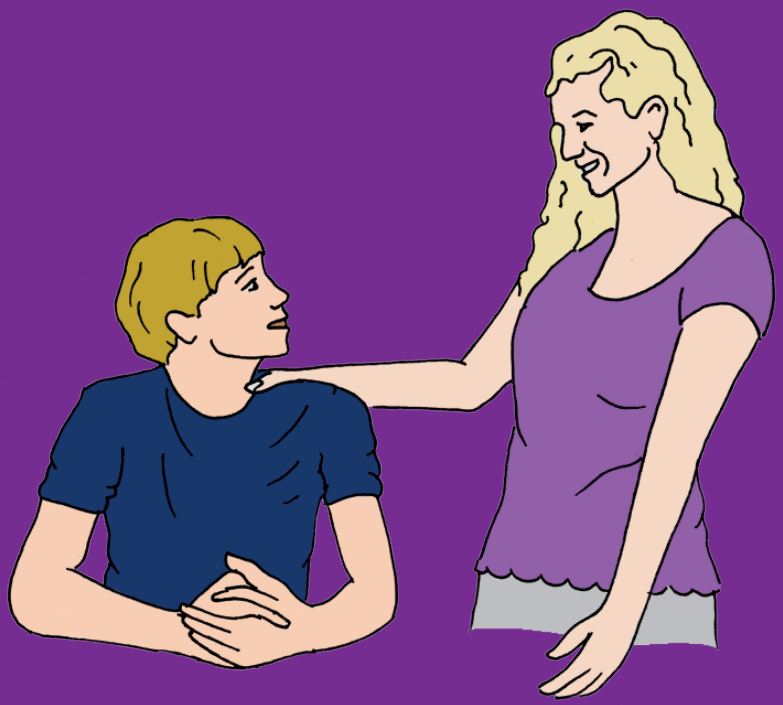
Restraint Reduction Network

# Restraint Reduction Network (RRN) Guidance for Government Departments 2023

# 11 Key Principles to Inform Government Policy



Please note that this document does not, and is not intended to, constitute legal advice. The RRN strives to provide accurate, well-researched information that is helpful to practitioners, professionals and people with lived experience.

# Contents

# 1. Human rights, legal framework and inequalities

Human rights are the fundamental freedoms and protections which everyone is entitled to. They cannot be taken away; but some rights can be restricted in specific circumstances for a legitimate reason, also they ensure that any restriction is proportionate. Some rights, including freedom from torture, inhuman and degrading treatment are absolute and can never be restricted. Human rights interact with the six core strategies of restraint reduction to support positive organisational culture and prompt culture change. (RRN, 2023)

## Useful policy and guidance

**The Mental Health Units (Use of Force) Act 2018**

The Mental Health Units (Use of Force) Act 2018 actively seeks to end the disproportionate use of force on people sharing protected characteristics, particularly race, sex, age, and disability.

**UN Committee on the Rights of Persons with Disabilities, 2013**

The need for the UK to "adopt appropriate measures to eradicate the use of restraint for reasons related to disability within all settings" was noted by the UN Committee on the Rights of Persons with Disabilities in 2013.

**Welsh Government: Reducing Restrictive Practices Framework, 2021**

The Welsh Government is clear that the use of restrictive practices should be within the context of the European Convention on Human Rights and in line with the principles described in the Human Rights Framework on Restraint produced by the Equality and Human Rights Commission. The approach set out in the Framework for Reducing Restrictive Practices seeks to promote the rights and principles set out in the United Nations Convention on the Rights of the Child (UNCRC), United Nations Principles for Older Persons and the United Nations Convention on the Rights of Persons with Disabilities.

**Scottish Government: Physical Intervention in Schools draft guidance, 2022**

The United Nations Convention on the Rights of the Child (UNCRC) sets out the fundamental rights of all children and young people. The Scottish Government is committed to protecting the rights of children and young people and remains committed to the incorporation of the UNCRC into Scottish law.

It is never lawful to use:

1. Restraint with intent to torture, humiliate, distress or degrade someone.
2. A method of restraining someone that is inherently inhuman or degrading, or which amounts to torture.
3. Physical force as a means of punishment.
4. Restraint that unnecessarily humiliates or otherwise subjects a person to serious ill–treatment or conditions that are inhuman or degrading.

**Equality and Human Rights Commission: Human Rights Framework for Restraint, 2019**

The disproportionate use of restraint on an identifiable section of the population without justification is evidence that unnecessary and discriminatory restraint may be occurring.

**CQC Inspections and Regulation of Whorlton Hall 2015-2019: An independent review, 2020**

Human rights breaches are not inevitable in any setting. To uphold people's human rights, providers need to always assess and keep under review if there is a less restrictive option for the people they are caring for. Under the Equality Act 2010, all healthcare providers have a duty to make reasonable adjustments for disabled people. This includes, for example, adjustments to the environment and communication.

**Royal College of Psychiatrists: Stopping the Overmedication of People with Intellectual Disability, Autism or Both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) 2021**

The issue on the overuse of psychotropic medication in people with intellectual disability was raised by parents in the Serious Case Review into Winterbourne View Hospital in 2012. People were using medications without there being clear, clinical, indications for needing them. The ensuing debate on people with intellectual disability and autistic people using psychotropic medication, has been salutary and has helped improve clinical practice. For psychiatrists and prescribers, the challenge is to use medication judiciously in order to avoid the unnecessary and inappropriate use of such potent drugs. The Royal College of Psychiatrists supports the STOMP pledge. Psychotropic medication is indicated as part of a treatment plan for mental disorder and not to manage behavioural difficulties that require a psychological approach.

## Resources

- RRN Six Core Strategies plus Human Rights infographic
- British Institute of Human Rights: Know Your Human Rights
- Equality and Human Rights Commission
- Welsh Government Reducing Restrictive Practices Framework
- Scottish Government Physical Intervention In Schools: draft guidance
- STOMP
- UNCRC

# 2. Coproduction

In the simplest of terms, coproduction means professionals working with people with lived experience to do or change something. Coproduction is recommended in law (e.g., the Care Act, 2014; Use of Force Act, 2018) and has been shown to help services improve care at an individual and system-wide level. However, the concept is often misunderstood or applied without adequate consideration. This can result in services, staff, and people with lived experience, finding coproduction difficult, ineffective, and even traumatic.

The RRN advocate a model of coproduction that focusses on how people interact with one another and the environment (how we work), whilst working together towards shared outcomes (what we do). Any policy directive should increase people's understanding of ethical coproduction and improve everyone's experience of it. All training in restraint should be prefaced by people hearing from people with lived experience of restraint and all restraint reduction initiatives should be informed by the expertise of people and families who have experienced restrictive practices. Coproduction is one of the six core strategies of restraint reduction. (RRN, 2022)

## Useful policy and guidance

**Mental Health Units (Use of Force) Act 2018 Statutory Guidance. Section 3: Policy on use of force**

It is important that staff working in mental health units recognise the valuable contribution people with personal experience can have in the design and improvement of services. The responsible person should ensure that the policy on use of force is coproduced with people with personal experience of mental health services, along with their families and carers. Meaningful coproduction in service design is critical to ensuring services respond to the needs of patients using their services, and that they are trauma-informed and person-centred.

**Restraint Reduction Network Training Standards, 2019**

*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.

1.5.1 Training providers must ensure that the views and experiences of people with lived experience of being in receipt of restrictive interventions should both inform, and be explicit, in training content. Coproduction of materials and training with people who have lived experience may include the use of monologues, video diaries or other forms to support discussion and interaction with participants. It is recognised that access to the views and experiences of people with lived experience may be through the training provider or in direct partnership with commissioners of training who may have developed opportunities and networks which support participation.

1.5.2 Training providers must ensure that any direct engagement with people with lived experience is managed sensitively and safely and is viewed in the context of a professional relationship. People with lived experience involved in the training must also receive adequate recompense. People with lived experience must be acknowledged as subject matter experts who are able to enrich and enhance training programmes and play a valuable role in supporting restraint reduction measures.

1.5.3 Training providers must ensure proper consideration and planning is given to any coproduced training session, if any sessions are to be coproduced and/or codelivered with a person with lived experience. Sharing lived experiences can be an emotionally intensive experience for both the person with lived experience and the participants. The appropriate support arrangements must be in place.

**The Care Act 2014**

The Care Act (2014) requires that paid staff actively promote participation in providing interventions that are coproduced with individuals, families, friends, carers and the community. Coproduction should be embedded in settings that are responsible for people's care and treatment. It should be trauma-informed, characterised by mutuality and involve people from the project's conception to finish, according to the person's motivation and preference.

**Winterbourne View – Time for Change (NHS England, 2014)**

*Page 16, section 8, final bullet point*

People with learning disabilities gave a strong message that a good system will be codesigned with, and employ, people with learning disabilities and or autism.

*Page 18, point 14*

People with learning disabilities and/or autism... are being asked to play a central role – speaking up for their rights, acting as partners in designing packages of support, challenging poor practice. But, too often, they experience it as an exhausting battle against the system.

*Page 22, 1.9, last bullet point*

Employing and working in genuine partnership with people with learning disabilities throughout the system in ensuring providers meet quality standards.

**Positive and Proactive Care (Department of Health, 2014)**

*Page 34, point 113*

To help protect the interests of people with whom restrictive interventions are used, it is good practice to involve the person, wherever possible, in planning, monitoring and reviewing how and when they are used. This includes ensuring reasonable adjustments and that documentation is in a format the individual understands.

**A Positive and Proactive Workforce (Skills for Care/Skills for Health, 2014)**

*Pages 20–21*

Being a person-centred organisation, *"This involves adopting person-centred approaches to all areas of organisational activity in a way that recognises the person including, [bullet point 3] involving and nurturing the individual and their support network; [bullet point 7] promoting choice and control for individuals in all decisions made about their lives; [bullet point 8] providing a space for the individuals' voices and preferences to be heard; giving access to independent accessible information advice and advocacy to ensure that choices are well informed and current; [bullet point 14] wherever possible, working with the individual and supporting them to understand the restrictive practices that are affecting them, preferably prior to use."*

**No Voice Unheard, No Right Ignored. Green Paper Consultation (Department of Health, 2015)**

*Page 25, Section 2 Rights, 2.2*

It is a core principle of the social care system that people themselves, often with the support of close friends, family and carers, have the right to be involved in planning their own care and support. It is enshrined in the Care Act.

## Resources

- RRN Relational Model of Coproduction Explainer
- RRN Relational Model of Coproduction video
- RRN Training Standards

# 3. Supporting positive cultures, including language and behaviour

The language used in policy/guidance is very important and sets the tones. It should be carefully chosen to make sure it supports positive, inclusive, person-centred cultures. The language we use and the way we describe other people reflects our ideology and values, and influences our attitudes and behaviour.

The policy should be written in plain English so that most staff, the people they support and their families, can understand it. Language should be neutral, inclusive, and promote human rights. It must avoid biased or discriminative terms and concepts that are, for example, racist, ableist, or otherwise stigmatising. Language should reflect a commitment to prevention, reduction, and elimination of force, as well as liberation, emancipation, care and support. Language should reflect what is most beneficial and not simply the principle of least restriction.

An overreliance on blanket restrictions (rules applied to everyone regardless of risk) is likely to be an indicator of an institutional and closed culture. (RRN, 2022)

| Often used words | Alternative words |
|---|---|
| Violence and aggression | Distress that harms or behaviour of concern |
| Service user/patient | Person |
| Manage... 'behaviour/the person...' | Support |
| Least restrictive | Most beneficial |

## Useful policy and guidance

**The Mental Health Units (Use of Force) Act 2018**

*"Restraint always has the risk of being of traumatic experience, it is considered to be a failure to meet needs and it is not therapeutic. It must be clear that we are moving away from the normalisation of restraint use to a culture of prevention. We must move away from restraint being expected practice to restraint being seen as a failure to meet needs and a learning opportunity. Good practice focuses on preventing, rather than managing, crisis situations."* The Mental Health Units (Use of Force) Act 2018 actively seeks to end the disproportionate use of force on people sharing protected characteristics, particularly race, sex, age, and disability.

**Restraint Reduction Policy: RRN Guidance for Government Departments. Human rights/legal framework/inequalities**

Human rights are the fundamental freedoms and protections which everyone is entitled to. They cannot be taken away, but some rights can be restricted in specific circumstances for a legitimate reason. Also they ensure that any restriction is proportionate. Some rights, including freedom from torture, inhuman and degrading treatment, are absolute and can never be restricted. Human rights interact with the six core strategies of restraint reduction to support positive organisational culture and prompt change where it is needed.

**UN Committee on the Rights of Persons with Disabilities, 2013**

The need for the UK to *"adopt appropriate measures to eradicate the use of restraint for reasons related to disability within all settings"* was noted by the UN Committee on the Rights of Persons with Disabilities in 2013.

**Welsh Government: Reducing Restrictive Practices Framework, 2021**

The Welsh Government is clear that the use of restrictive practices should be within the context of the European Convention on Human Rights and in line with the principles described in the Human Rights Framework on Restraint, produced by the Equality and Human Rights Commission. The approach set out in the Framework for Reducing

Restrictive Practices seeks to promote the rights and principles set out in the United Nations Convention on the Rights of the Child (UNCRC), United Nations Principles for Older Persons and the United Nations Convention on the Rights of Persons with Disabilities.

**Scottish Government: Physical Intervention in Schools draft guidance, 2022**

*"All behaviour is communication and a child or young person's distressed behaviour may indicate unmet needs. All efforts should be made to understand and address those needs."*

**World Health Organization (WHO): Guidance on Community Mental Health Services: Promoting person-centred and rights-based approaches, 2021**

*"Stigmatizing attitudes and mindsets that exist among the general population, policy makers and others, concerning people with psychosocial disabilities and mental health conditions – for example, that they are at risk of harming themselves or others, or that they need medical treatment to keep them safe – also leads to an over-emphasis on biomedical treatment options and a general acceptance of coercive practices, such as involuntary admission and treatment or seclusion and restraint."*

**Care Quality Commission: Identifying and Responding to Closed Cultures. Supporting information for CQC staff, 2020**

*"We found too many examples of undignified and inhumane care, in hospital and care settings, where people were seen, not as individual, but as a condition or a collection of negative behaviours. The response to this has often been to restrain, seclude or segregate them."*

## Resources

- RRN Six Core Strategies Restrictive Cultures table

# 4. Relationships and relational working

A focus on the importance of good relationships and relational working is under-represented in policy and best practice guidance. Relational working increases staff understanding and decreases levels of restrictive intervention and people's distress.

The role of the therapeutic alliance/relationship in impacting treatment outcomes has been demonstrated with diverse clinical populations. The therapeutic alliance/relationship is the extent to which the person and staff jointly agree on the goals of treatment and the means or tasks by which to achieve these. These are directly mediated by the quality of the affective bond, in other words, the relationship that develops between staff and the person. The correlation between the therapeutic relationship and positive treatment outcome is well established. Participation in treatment and the degree of engagement is predictive of treatment outcomes which is directly related to relationship quality (Meichenbaum, 2017). People with weaker therapeutic alliance/relationships with staff are more likely to drop out of treatment (Meichenbaum, 2017). The relationship between the quality and nature of the therapeutic alliance and the treatment outcomes is further strengthened when staff respond to people's feedback and alter their practices.

In social care and education, where positive outcomes may be measured in terms of good quality of life, or educational achievement success is very substantially enhanced by good quality relationships between support workers and the people they support and teachers and students any prevention work is likely to be unsuccessful if relationships are based on power coercion and mutual distrust. Poor relationships are an indicator of closed and toxic culture. All evidence shows that people are more likely to thrive and suffer less distress if they are liked by the people supporting them. (RRN, 2023)

## Useful policy and guidance

**Capable environments** (Mc Gill et al, 2021)

Standards for a capable environment.
People at risk of displaying challenging behaviour should be:

1. Liked and frequently interacted with in a meaningful way.

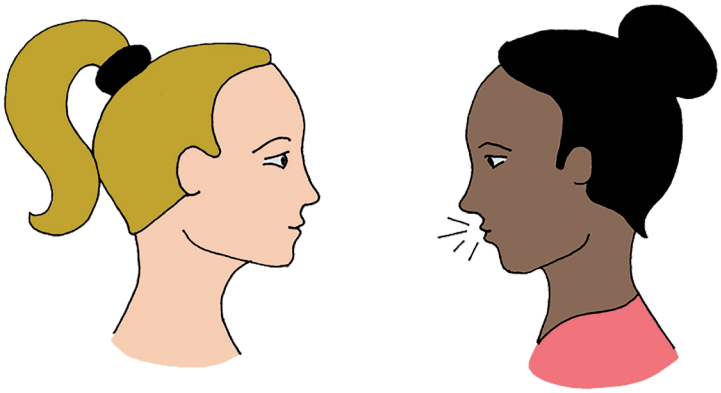
**Care Quality Commission: How CQC Identifies and Responds to Closed Cultures**

CQC guidance for inspectors. Indicators of closed cultures. Warning signs that people may experience poor care, including unlawful restrictions include:

- Staff not understanding or speaking warmly about the people they are caring for.
- Staff belittling, excluding or taunting people.

### Resources

- How CQC identifies and responds to closed cultures – Care Quality Commission
- Capable environments paper
- Capable environments infographic



# 5. Leadership

Leadership has overall responsibility for policy and use of restrictive practices within the organisation and must explicitly set out mission and pathway to reduce restrictive practice, and focus on better meeting needs to prevent crisis .Good practice leaders are also necessary, as they work alongside colleagues and show them how to work in a person-centred way. Skilled practice leaders support the maintenance of a positive culture.

## Useful policy and guidance

**The Mental Health Units (Use of Force) Act 2018**

It is essential that there is accountability and responsibility for the use of force at the highest level within an organisation. Organisation or trust boards have a legal, professional and ethical obligation to minimise harm to service users, staff and others, and therefore must be accountable for the use of force within their organisation. Organisation or trust boards should have a good understanding of why force is used within their services, develop wider action plans for reducing the use of force, and regularly review the organisation's or trust's performance in reducing the use of force.

**Scottish Government: Physical Intervention in Schools draft guidance, 2022**

**Post-incident support and learning review:**

Point 88. Following the use of any form of restraint, post-incident support should be offered immediately to the child or young person. Support should then be followed by a learning review, conducted on another day, but within a prompt timescale. This process, which can also be followed after any instance of distressed behaviour, is outlined below.

> **Post-incident support**
>
> This is the support that is immediately offered to the child or young person and staff members involved and forms the beginning of a restorative approach[40]. Its purpose is to ensure physical and

emotional safety of the child or young person and all involved, provide emotional and physical wellbeing support and to assess and respond appropriately to any harm caused. The immediate steps outlined in the recording, monitoring and reporting section should also be followed.

**Post-incident learning review**

This is a factual review, which takes place at a later date (sometimes referred to as a debrief). It is recommended that this take place as close to the time of the incident as possible taking full cognisance of the emotional wellbeing of the child or young person and all those involved in the incident. Its purpose is to examine the factors that led to the restraint being used, decisions taken, establish a time line and agree actions to support the prevention of future incidents of distressed behaviour. It will also examine ways to minimise the impact of the form of restraint used and facilitate less restrictive interventions in future (see Annex G). The views of the child or young person and staff members involved should be sought, with appropriate support to participate provided. It should be noted, however that this may not be possible or desirable in every instance, for example, where a child or young person's stage of cognitive development would prevent them participating in a reflective exercise. Any agreed actions or changes in approach should be recorded in the appropriate support plan for the child or young person. It is important that children and young people and staff have the time and opportunity to engage in this kind of reflective practice.

**Welsh Government: Reducing Restrictive Practices Framework, 2021**

**Leadership**

- The reduction of restrictive practices can only be properly implemented and maintained through a whole organisational approach, supported through strong leadership. Messages about reduction should be clear at all levels, throughout all organisational systems and policies and workforce development programmes. Leadership is needed at sector, organisation, service and direct practice level.

- Supervision and team meetings should include restrictive practices as a standing agenda item to allow for the identification of any issues, to ensure practitioners are clear on the organisational position on reducing restrictive practices and to identify any learning and/or support needs.
- Managers should be watchful for signs of restrictive cultures developing. They should facilitate regular discussion about restrictive practices and create a non-blaming environment where practice can be discussed and questioned.
- Service managers should ensure that the monitoring and review of individual personal plans includes consideration of planned restrictive practices and reduction guidelines. Particular attention should be paid to the language that is used to describe individuals and incidents; it should be objective, accurate and respectful.
- Organisations have a duty of care towards practitioners and should recognise that workplace stress can have an adverse impact on the quality of practice. Appropriate measures to support the wellbeing of the workforce should be in place.

**Care Quality Commission: How CQC Identifies and Responds to Closed Cultures**

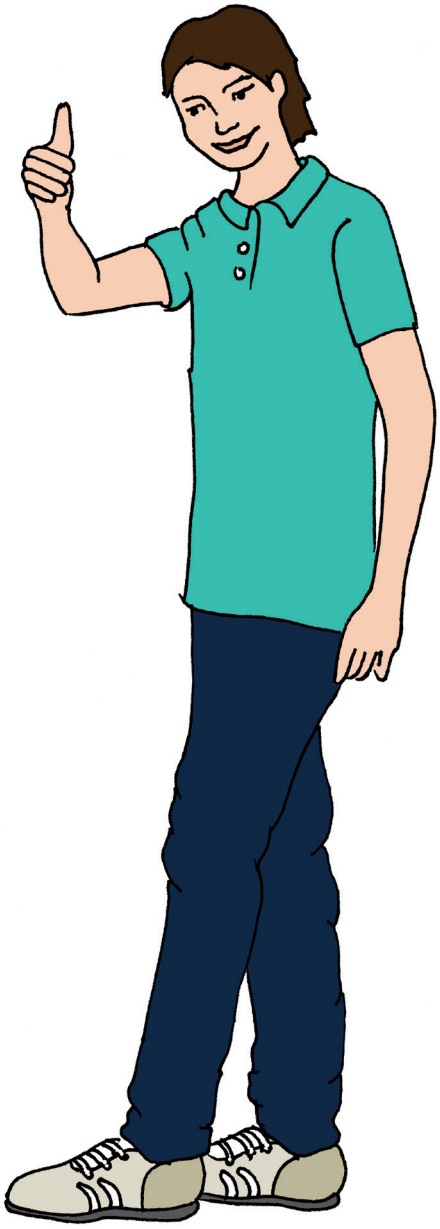
Signs of poor leadership. Indicator: Weak leadership and management

Inherent risk factors:

- The service sometimes runs without a manager or leader. Reasons for this include frequent changes in management and management responsibility for more than one site.
- The workforce comprises members of staff who are either related or friends, causing ‘cliques’ to form.
- There is a lack of openness and transparency between managers, staff, people using the service and external professionals and organisations.
- Managers do not lead by example and governance is poor.

## Resources

- Towards Safer Services
- RRN Reducing the use of Blanket Restrictions - a reflective guide for senior leaders
- Bild Practice Leadership infographic
- Welsh Government Reducing Restrictive Practices Framework
- How CQC identifies and responds to closed cultures – Care Quality Commission



# 6. Prevention and reduction

Kevin Huckshorn has identified six evidence-based reduction/ prevention strategies after analysing the results from state-wide reduction programmes.

These include:

- leadership
- using data to inform practice
- workforce development
- using prevention tools
- coproduction
- Post-incident debriefing.

## Useful policy and guidance

**Scottish Government: Physical Intervention in Schools draft guidance, 2022**

25. All behaviour is communication, and distressed behaviour in a child or young person may indicate an unmet learning or wellbeing need, or a child or young person experiencing a stressor too great for them to manage. Disabled children may display behaviours related to their disability over which they cannot exercise control. The purpose of preventative approaches is to understand their needs and, where possible, meet those needs. Preventative approaches form part of the provision that schools may be required to make for children and young people under 'the 2004 Act' and/or reasonable adjustments under the 2010 Act. Where a child or young person is beginning to evidence distress in an educational context, an assessment of their needs should be undertaken with the aim of preventing the behaviours occurring over time.

**Welsh Government Reducing Restrictive Practices Framework, 2021**

The best way to avoid restrictive practices is to work preventatively and meet needs before crisis arises. However, there may be rare occasions when it is necessary to use restrictive practices to prevent harm to an individual or others. It is never lawful to use restraint to humiliate, degrade or punish people.

## Resources

- RRN Six Core Strategies Restrictive Cultures table
- RRN Post-incident Debriefing and Support Toolkit
- RRN Training Standards
- RRN Blanket Restrictions Toolkit
- UK PBS Alliance Organisational and Workforce Development Framework
- UK PBS Alliance 'What is PBS' infographic
- UK PBS Alliance PBS Framework Infographic
- Transforming Psychological Trauma – A knowledge and skills framework for the Scottish workforce. NHS Scotland
- Safewards
- Healthcare Improvement Scotland. Dementia in Hospitals. An improvement toolkit for proactive and person-centred responses to stress and distress

# 7. Workforce development

There are a number of workforce development frameworks that support the development maintenance of a competent caring workforce.

Research indicates the development of a culture of practice leadership is key to support the maintenance of good standards of support.

A practice leader is a person who knows how to do something well and helps other people to do it better. They are good at the job and show others how to do it well, providing role modelling and feedback.

Good quality training is important, but without practice leadership, much of the training does not translate into practice. This is sometimes known as the train and hope model. The most powerful influence on people's behaviour at work is other staff.

Restraint training is potentially lethal and should be quality assured.

## Useful policy and guidance

**Mental Health Units (Use of Force) Act 2018 Statutory Guidance**

The RRN Training Standards 2019 provide a national benchmark for training and have been endorsed by a wide range of professional bodies, charities and government arm's length bodies.

The Training Standards aim to facilitate culture change, not just technical competence, and are designed to:

- protect people's fundamental human rights and promote person-centred, best interest and therapeutic approaches to supporting people when they are distressed;
- improve the quality of life of those being restrained and those supporting them;
- reduce reliance on restrictive practices by promoting positive culture and practice that focuses on prevention, de-escalation and reflective practice;

- increase understanding of the root causes of behaviour and recognition that many behaviours are the result of distress due to unmet needs;
- where required, focus on the safest and most dignified use of restrictive interventions, including physical restraint.

Training providers must be certified as complying with the RRN Training Standards. Certification bodies must be accredited by the UK Accreditation Service (UKAS) as complying with the ISO standards for certification. UKAS is the government-recognised national accreditation body for the UK. UKAS ensure the competence, impartiality and integrity of the certification scheme.

Certified training that complies with the RRN Training Standards became a requirement of NHS-commissioned services for people with learning disabilities, autism or mental health conditions in April 2020. Recognising the time required to achieve certification for training providers, and then for service providers to complete all staff training, NHS commissioners were asked to agree Service Development Improvement Plans with service providers, giving assurance that action is underway to deliver on this new contractual requirement within the agreed timeframe. The CQC will expect services across health and social care to have certified training that complies with the RRN Training Standards from April 2021.

**Positive and Proactive Care: Reducing the need for restrictive interventions, 2014**

- The use of force must never be used to punish or be for the sole intention of inflicting pain, suffering or humiliation.
- There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken.
- The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm.
- Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need.
- Any restriction must be imposed for no longer than absolutely necessary.

- What is done to people, why and with what consequences, must be subject to audit and monitoring and must be open and transparent.
- Use of force must only ever be used as a last resort.
- The involvement of people who use services, carers and independent advocates is essential when reviewing plans for the use of force.
- Understanding of human rights and discrimination legislation, and how this interacts with other mental health, and health and social care legislation.

**Equality and Human Rights Commission: Restraint in schools inquiry: using meaningful data to protect children's rights**

**National standards for training and guidance**

There are concerns about whether training on restraint could in some instances be encouraging its use. National training standards would help ensure that training focused on minimising restraint and taking a human rights-based approach. There is already a model for this, which has departmental support in other sectors, applicable in the school sector. The Restraint Reduction Network has developed national training standards for restraint – which are accepted by the NHS – that could be adapted for schools.

**Training**

National training standards for restraint should be developed. These should take a human rights approach to minimising the use of restraint and draw on existing resources, such as the RRN Training Standards. Training standards need to be tailored by school phase and type, with the participation of schools, parents and children (including with those with autism and learning disabilities).

**Scottish Government: Physical Intervention in Schools draft guidance, 2022**

Where restraint is a foreseeable possibility, schools should use restraint training that is certified as complying with Restraint Reduction Network (RRN) Training Standards This will ensure:

- training is human rights-focused;
- that staff also receive training in preventative approaches;

- that trainers have the appropriate expertise to train in schools;
- that training in techniques is safe and proportional to that required within the schools and is appropriate for use on children;
- that training includes hearing from people who have been restrained;
- that training is accredited by the United Kingdom Accreditation Service as meeting the ISO standards for certification.

No member of staff should attempt to undertake any form of restraint without having completed training in its safe use, which should be Restraint Reduction Network certified, given the risk of harm to the child or young person and themselves. The only exception to this would be in the unforeseen and unavoidable exercise of their duty of care.

## Resources

- Mental Health Units (Use of Force) Act 2018 Statutory Guidance
- Equality and Human Rights Commission Restraint in Schools Inquiry: using meaningful data to protect children's rights
- Bild Practice Leadership infographic
- United Response Practice Leadership booklet
- RRN Training Standards
- Transforming Psychological Trauma – A knowledge and skills framework for the Scottish workforce. NHS Scotland
- PBS Academy Competence Framework
- UK PBS Alliance Organisational and Workforce Development Framework
- Safewards
- Healthcare Improvement Scotland. Dementia in Hospitals. An improvement toolkit for proactive and person-centred responses to stress and distress

# 8. Post-incident debriefing

Post-incident debriefing should be conducted after any incident of restrictive practice that is likely to cause ongoing harm.

Debriefings are a central part of the Department of Health's Positive and Proactive Care: Reducing the need for restrictive interventions (2014) guidance. They are also a very important part of restraint reduction initiatives and trauma informed approaches, such as the Six Core Strategies© (Huckshorn, 2004), REsTRAIN yourself (Duxbury et al, 2019), Talk 1st and Safewards (www.safewards.net). It is essential to separate the two components of debriefing to avoid potential re-traumatisation: post-incident support (emotional support) and post-incident learning. (RRN, 202)

## Useful policy and guidance

**Equality and Human Rights Commission: Restraint in schools inquiry: using meaningful data to protect children's rights**

**Analysing and using information on restraint**

Local authorities in Wales and schools in England and Wales should be required to analyse restraint in post-incident reviews and to use that analysis in behaviour management planning with the aim of minimising its future use.

**Welsh Government Reducing Restrictive Practices Framework, 2021**

**Post-incident review and support**

People with lived experience clearly tell us that the use of restraints and other restrictive practices can trigger traumatic memories for them and care should be taken to find out what support they need after an incident that has involved a restrictive practice.

It is equally likely that employees who work in challenging services will find some aspects of their work very stressful and will experience restrictive practices as traumatic.

An individualised approach is needed in both cases, as both personal

and organisational factors will influence the level of distress that people experience.

The provision of the right post-incident support is likely to have a positive influence on restrictive practice reduction initiatives through its role in the repair of trusting relationships and re-establishment of feelings of safety. However, it needs to be implemented well and alongside other strategies as part of a whole organisational approach to reduction. There is a small but emerging evidence base that indicates that care should be taken with the range of post-incident practices that are often grouped under the umbrella term debriefing.

The limited evidence base suggests there are two main components of post-incident practice, each with a distinct purpose:

1. Post-incident support: attention to physical and emotional wellbeing of the individuals involved.
2. Post-incident review: to learn from the incident and reflect on practice.

Post-incident support should be available after any incident where restrictive practice has been used and after any incident that may have had an impact on the individual and others. It should also be available to those who have witnessed the incident.

Organisations should have a person-centred policy for providing both immediate and longer-term support after any use of restrictive practices, and this should also inform the review of the individual plan for the person following any incident. Each sector, organisation and setting will need to consider what the most appropriate approach to achieving this for the people they support, and others effected by an incident.

Post-incident learning reviews should be clearly separated from immediate post-incident support. They should be conducted in a blame-free manner by experienced and trained senior staff members. They should contribute to organisational learning.

**Mental Health Units (Use of Force) Act 2018 Statutory Guidance Section 3: policy on use of force**

The responsible person must publish and keep under review a policy regarding the use of force on patients by staff who work in the mental

health units run by that organisation or trust.

This must include:

m) details of how patients, their families, carers and independent advocates can raise concerns about the use of force, and how they will be involved in post-incident reviews following the use of force, and how the impact (physical or emotional) will be reflected in the patient's follow-up care.

**Resources**

- Post-Incident Debriefing and Support Toolkit

# 9. Reporting and recording

Good data collection is at the heart of any restraint reduction initiative and policy. Without accurate data there is only opinion and that is likely to be consciously or unconsciously biased. There should be the regulatory and organisational requirements for recording the use of any restrictive interventions and injuries associated with the use of restrictive interventions.

It is recommended that an independent review should take place if any injuries occur during the use of any restrictive interventions. The importance of accurate and objective recording should be reflected in any policy. Only relevant data should be collected and data should be analysed to support restraint reduction by identifying identification of trends, such as frequency and seriousness of different types of restraint over time and across different areas of any provider's work.

Analysis of data must be used to inform individual and organisational restraint reduction plans. It can help identify patterns that inform preventative working – by highlighting the conditions in which incidents are more or less likely to occur it should be possible to develop primary strategies that meet people's needs before behaviours of concern arise.

## Useful policy and guidance

**Equality and Human Rights Commission: Restraint in schools inquiry: using meaningful data to protect children's rights**

Mandatory national minimum standards should be set for recording the use of restraint in schools, including:

- the type of restraint;
- the reason(s) for the use of restraint;
- where and when the restraint was used;
- the length of the restraint;
- the impact on the child, including any injuries, and any risks to their physical or mental wellbeing;

- – the protected characteristics of the child (including age, sex, disability broken down by impairment type and race);
- the outcome of any incident review, including any measures that will be taken to avoid or minimise restraint and the risk of harm in future.

**Welsh Government Reducing Restrictive Practices Framework, 2021**

### Recording the use of restrictive practices and using data to improve practice

Senior leaders should have knowledge of the range and extent of restrictive practices that are used within the organisation. There should be a system for collecting this information across the whole organisation and for each setting.

Service managers should ensure that there are regular audits and reviews of restrictions within their services. Effective recording and data collection can highlight equality and diversity issues, inform decisions about further workforce development and identify individuals where the current approach to their support needs to be reviewed and improved.

Any injuries sustained as a result of the use of restrictive practices must be recorded and reported as a safeguarding issue in line with the safeguarding policy and procedures of the setting/organisation.

Good data collection practice is an essential element in any plan to reduce restrictive practices and supports transparency. Monitoring current practice is dependent on robust but user-friendly recording systems that support good analysis.

Any data collected should have a clear purpose, i.e., to enhance an individual's quality of life. All data collection activities should be undertaken in line with UK-General Data Protection Regulations.

Organisations and settings should consider when developing their plans for reducing restrictive practices the information they will record, which should include as a minimum:

a. The type of restrictive practice used.
b. The reason(s) for the use of restrictive practice;
c. Where and when the restrictive practice was used.
d. The length of the restrictive practice.

e. The known impact on the individual, including any injuries, and any risks to their physical or mental wellbeing.
f. The protected characteristics of the individual (including age, gender, sex, disability, broken down by impairment type, and race).
g. The outcome of any incident review, including any measures that will be taken to avoid or minimise restrictive practices and the risk of harm in future.
h. The individual's involvement in the review.
i. A record to confirm that the relevant family members and carers have been informed and when this happened.

**Royal College of Psychiatrists Restrictive interventions in Inpatient intellectual Disability Services: How to Record Monitor and Regulate, 2018**

Services must demonstrate the use of data to support restrictive intervention reduction.

Service level reports should include:

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

h. The number of individual patients represented within the data, expressed as a percentage of total patients treated within this timeframe.

i. Progress of all patients against the aims of the service's chosen restrictive intervention programme, ideally using the 'traffic light audit'.

j. The contribution of individual patient rates to the overall total for the ward or the service. If there are any outlier(s) which significantly affect the overall total, or trends, report rates with and without the outlier data.

k. Details of how rates compare to a national benchmark.

l. Number of beds, and occupancy level of service for timeframe.

m. Cohort characteristics, such as gender, ethnicity, diagnoses, behavioural and/or offence profile).

**Equality and Human Rights Commission: Restraint in schools inquiry: using meaningful data to protect children's rights**

### National data collection and oversight

Restraint data from schools should be collated, published and analysed, including by protected characteristic in line with recommendations from the UN Committee on the Rights of the Child, ensuring that disaggregated data is available for England and Wales.

## Resources

- Children and Young People's Commissioner Scotland. No Safe Place: Restraint and seclusion in Scotland's schools
- Welsh Government. Reducing Restrictive Practices Framework
- Royal College of Psychiatrists. Restrictive Interventions in Inpatient Intellectual Disability Services: How to record, monitor and regulate
- Darren Bowring, Reducing Restrictive Practices through Data Informed Positive Behaviour Support, Bild CAPBS
- Equality and Human Rights Commission. Restraint in Schools Inquiry: Using meaningful data to protect children's rights

# 10. Trauma informed supportive and capable environments

Good quality environments that understand people and their unique needs mean distress and restriction become exceptional events. The aim is to provide the right conditions for people to flourish. (RRN, 2023)

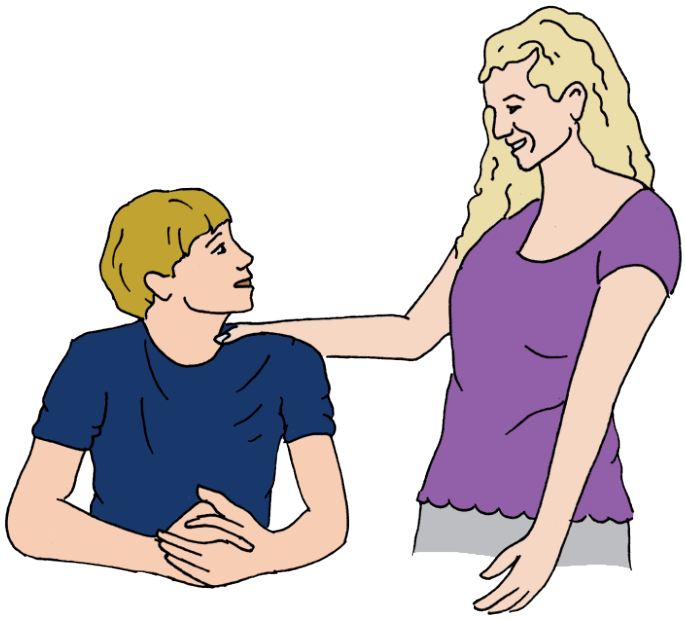
## Useful policy and guidance

**Out of Sight – Who Cares?: Restraint, segregation and seclusion review, CQC, 2020**

Being placed in an inappropriate environment can be damaging and creates a pattern of distress, restraint and seclusion, which often cannot be broken. In many cases, we found that the impact of the environment on people, such as the noise, heating and lights of the wards, had not been considered. In many cases staff did not understand people's individual needs and the distress that being in the wrong environment could cause, particularly for people with sensory needs. This could lead to people expressing their distress in a way that others find challenging, leading to staff resorting to using restrictive practice.

**Welsh Government Reducing Restrictive Practices Framework, 2021**

People who have past trauma, who experience communication barriers, or who have other differences, may find certain restrictive practices particularly distressing and may find some situations particularly challenging and harmful.



## Resources

- CQC – Out of Sight – who cares?
- Capable environments paper
- Capable environments infographic
- UK PBS Alliance Organisational and Workforce Development Framework
- Safewards
- RRN Training Standards
- Transforming Psychological Trauma – A knowledge and skills framework for the Scottish workforce. NHS Scotland
- PBS Academy Competence Framework
- Healthcare Improvement Scotland. Dementia in Hospitals. An improvement toolkit for proactive and person-centred responses to stress and distress

# 11. Definitions

A definition should clarify when an action becomes a restraint/restrictive practice. Conflating the purpose with the act of restriction itself is not helpful and can have the effect of confusing staff and/or making the action justifiable. The justification for applying a restriction can be setting-specific and contained in setting specific-practice guidance .

Restrictive practice is an umbrella term which covers a wide range of activities that stop individuals from doing things that they want to do or makes them do things that they don't want to do. They can be obvious or very subtle. It includes:

- physical restraint;
- chemical restraint;
- environmental restraint;
- mechanical restraint;
- seclusion or enforced isolation;
- long term segregation;
- coercion, also known as psychological restraint and cultural restraint.

## Useful policy and guidance

**Welsh Government Reducing Restrictive Practices Framework, 2021**

**Restrictive practices**

*"Restrictive practices are a wide range of activities that stop individuals from doing things that they want to do or encourages them to do things that they don't want to do. They can be very obvious or very subtle."* (Care Council for Wales, 2016) This term covers a wide range of activities that restrict people.

The term restrictive practices can apply to a number of different acts (for example, physical restraint, chemical restraint, mechanical restraint, seclusion, social restraint, psychological restraint, and long-term segregation). Restrictive practice does not necessarily require the use of force, it can also include acts of interference, for example, moving someone's walking frame out of reach.

**National Disability Insurance Scheme ( Au) 2013**

Any practice or intervention that has the effect of restricting the rights or freedom of movement.

**World Health Organization (WHO): Guidance on Community Mental Health Services: Promoting person-centred and rights-based approaches, 2021**

Coercive practices refer to the use of forceful persuasion, threat or compulsion to get a person to do something against their will (41). In this way coercive practices also involve the denial of people's right to exercise their legal capacity. In the mental health service context, coercive practices may include, for example, involuntary admission, involuntary treatment, the use of seclusion and of physical, mechanical, or chemical restraint.

## Resources

- RRN 8 types of restraint infographic

# References


Calsyn, RJ, Morse, GA, Klinkenberg, WD and Lemming MR (2004) Client outcomes and the Working Alliance in assertive community treatment programmes. *Care Manag J*, 5:199–202.

Catty, J (2004) The 'vehicle of success': theoretical and empirical perspectives on the therapeutic alliance in psychotherapy and psychiatry. *Psychol Psychother*, 77(pt 2):255–272.

Catty, J, Winfield, H and Clement, S (2007) The therapeutic relationship in secondary mental health care: a conceptual review of measures. *Acta Psychiatry Scand*, 116:238–252.

Fakhoury, W, White, I and Priebe, S (2007) PLAO Study Group: Be good to your patient: how the therapeutic relationship in the treatment of patients admitted to assertive outreach affects outcome. *J Nerv Ment Dis*, 195:789–791.

Johansson, H and Eklund, M (2003) Patients' opinion on what constitutes good psychiatric care. *Scand J Caring Sci*,17:339–346.

Kirsch, B and Tate, E (2006) Developing a comprehensive understanding of the working alliance in community mental health. *Qual Health Res*, 16:1054–1074.

Priebe. S, Watts. J, Chase. M and Matanov, A (2005) Processes of disengagement and engagement in assertive outreach patients: qualitative study. *Br J Psychiatry*, 187:438–443.

Svensson, B and Hansson L (1999) Therapeutic alliance in cognitive therapy for schizophrenic and other long-term mentally ill patients: development and relationship to outcome in an in-patient treatment programme. *Acta Psychiatr Scand*, 99:281–287.



Restraint Reduction Network, 2023.

restraintreductionnetwork.org