Reducing restrictive interventions in people with ‘challenging’ behaviours

The management and support of vulnerable people who may have behaviours that challenge services need to minimise restrictive practices and promote an understanding of human rights and person-centred care.

Key points

- Those caring for vulnerable people who may have behaviours that challenge services need to minimise restrictive practices and promote an understanding of human rights and person-centred care.
- Staff who need to use restrictive interventions should understand their responsibilities in upholding a person’s human rights.
- New mandatory training standards focus on working preventatively and using restrictions as a last resort.
- Positive behaviour support (PBS) is a preventative approach that can reduce reliance on restrictive practice.
- PBS can help care staff understand why behaviours that challenge occur and how to use early intervention.

Authors

Glyn Connolly is certification manager, British Institute of Learning Disabilities (BILD) Association of Certified Training; Tom Evans is positive behaviour support development lead, BILD; Sarah Leitch is director of programme development, Restraint Reduction Network; all part of the BILD group, Birmingham; Anne MacDonald is senior research fellow (mental health and wellbeing), University of Glasgow; James Ridley is senior lecturer (nurse education), Edge Hill University, Ormskirk.

Abstract

Recent scandals involving institutional abuse and ill treatment of people with “challenging” behaviours have led to new guidelines for the safe and humane use of restrictive interventions, with a focus on preventing and reducing their use. This article advises staff supporting people with mental health conditions, learning disabilities, autism and dementia on what they need to know to be confident they are acting lawfully, in the person’s best interests and using least-restrictive approaches. It describes new mandatory training standards and an alternative approach to restrictive interventions that can help prevent or limit behavioural crisis from arising.

Citation

Box 1. Key guidance on the safe and humane use of restrictive interventions

**Department of Health (2014) Positive and Proactive Care: Reducing the Need for Restrictive Interventions** includes recommendations for good leadership, data collection and transparency that aim to encourage a culture across health and social care organisations that is committed to developing therapeutic environments in which physical interventions are only used as a last resort [Bit.ly/DHPositiveProactive]

**Care Quality Commission (2015) Regulation 20: Duty of Candour** Promotes, “a culture that encourages candour, openness and honesty at all levels [...] as an integral part of a culture of safety that supports organisational and personal learning” [Bit.ly/CGCCReg20Candour]

- Article 3 (prohibition on torture, inhuman and degrading treatment)
- Article 8 (respect for autonomy, physical and psychological integrity)
- Article 14 (non-discrimination) [Bit.ly/EHRCRestraint]

**National Institute for Health and Care Excellence (2018) Learning Disabilities and Behaviour that Challenges: Service Design and Delivery** Focuses on maximising people choice and control, prevention, and person-centred care and support [nice.org.uk/ng93]


**Royal College of Nursing (2017) Three Steps to Positive Practice** Principles for practice for health and social care professionals [Bit.ly/RCNPositivePractice]

and reducing their use (Box 1). A campaign led by the family of Seni Lewis resulted in the Mental Health Units (Use of Force) Act 2018 [Bit.ly/UsesofForceAct2018] – or “Seni’s Law” – which contains requirements for training, governance and the recording of restraint.

In 2019, new training standards [Bit.ly/RRNStandards] from the Restraint Reduction Network and commissioned by NHS England to minimise the use of restrictive interventions were launched. These will be mandatory from 2020 in NHS-commissioned services in England for people with mental health conditions, learning disabilities, autism and dementia via NHS contracts, the Care Quality Commission framework and Use of Force Act statutory guidance. The standards will support staff in health, education and social care services to understand and apply the principles of minimising use of force, with the aim of promoting the human rights and person-centred care of the people they are supporting.

Reducing restrictive practices requires alternative, preventative approaches. This article outlines what nurses and other practitioners working in this area need to know about the use of restrictive practices, including the range of restrictions and the human rights and legal framework in which they are applied. It also discusses two frameworks that support human rights and promote alternatives to using restrictive interventions, namely:

- The new RRN training standards;
- Positive Behaviour Support (PBS), an ethical, evidence-based framework that can help prevent or limit behavioural crises from arising to reduce the need for restrictive interventions (Allen et al, 2012).

### Restrictive interventions

Understanding what restrictive interventions are, and when they are necessary, should be part of workforce development, practice guidance and support. Nurses need advice, guidance and good-quality training to be confident they are acting lawfully, in the person’s best interests and using least-restrictive approaches.

One source of confusion is that different terms are often used to describe use of restrictions in health, social care and education, and the terms “restraint” and “restrictive intervention” are sometimes used interchangeably. The term “restrictive practices” is often used to describe a wider range of activities that either stop individuals from doing what they want to do or encourage them to do things they do not want to do. The Department of Health and Social Care (2015) defines restrictive interventions as: “Deliberate acts on the part of other person(s) that restrict an individual’s movement, liberty and/or freedom to act independently in order to:
- Take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and
- End or reduce significantly the danger to the person or others.”

A year earlier, Skills for Care and Skills for Health (2014) defined restrictive interventions in the same way but specified that they be used to “contain or limit the person’s freedom for no longer than is necessary”. These definitions are useful as they identify some of the rationale that may lead practitioners to use restrictive interventions.

RRN’s training standards offer an overview of restrictive interventions and link them to the impact on a person’s human rights, defining them as “interventions that may infringe a person’s human rights and freedom of movement, including observation, seclusion, physical restraint, mechanical restraint, and rapid tranquillisation and other chemical restraint” (Ridley and Leitch, 2019).

All of these definitions offer some clarity on what a restrictive intervention is and what it involves. The link to human rights is further made in the Equality and Human Rights Commission’s (2019) Human Rights Framework for Restraint; this includes a reminder that:

- Restraint does not necessarily require the use of force, but can also include acts of interference, such as moving someone’s walking frame out of reach;
- Any act of restraint has a potential to interfere with a person’s human rights.

In some clinical areas there may be a need to consider more broadly what a restrictive intervention is and how forms of restrictive practice are influenced by the care planned. An example might be use of a plaster cast to restrict someone’s voluntary movement due to having a broken leg – the use of the cast will likely restrict a person’s liberty, and so fits with the definitions given; however, the rationale for the restriction is planned to support the healing process (Royal College of Nursing, 2008). The term “therapeutic holding” or “clinical holding” is commonly used in
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children’s acute care (Bray et al, 2015). This is a purposeful restriction or immobilisation (needing the child’s permission) that can be justified by the need to manage a painful clinical intervention quickly and effectively (Bray et al, 2015; RCN, 2010).

Table 1 explains some common terms that are associated with the use of restrictive interventions.

RRN training standards
Providing high-quality, evidence-based support to people with mental health conditions, autism, learning disabilities and dementia is a highly skilled activity. Staff in education, health and social care settings do an important and challenging job that requires balancing risk, welfare and safety. This requires specialist training so staff can understand and meet the needs of the people they are serving, both to minimise distress and provide support for people who are distressed.

The RRN training standards focus on protecting human rights and supporting the cultural change that is necessary to reduce reliance on restrictive practices so they are only used as a last resort. Where the use of restrictive practices is unavoidable, they must be safe and dignified and there needs to be a clear plan to reduce their use over time.

Legal and ethical considerations
Restrictive interventions can impact on individuals’ liberty and staff need to understand the legal and ethical implications to ensure restrictions are “rights respecting” (Ridley and Leitch, 2019). The Human Rights Act 1998 (Bit.ly/GOVHumRa) is a core piece of legislation, and provides the foundation on which to build further legislation and practice to support a human rights-based approach (Fig 1). The legislation gives a robust framework for establishing clear processes to ensure relevant interventions are used proportionally, so that restrictions are seen as appropriate and not excessive (British Institute of Human Rights, 2013; Bailey et al, 2010; DH, 2007).

Consideration should also be given to the person’s previous or current lived experiences, including additional diagnoses that may require further assessment (Sheldon, 2011). Codes of practice for the Mental Capacity Act 2005 and Mental Health Act 1983 – published by the Department for Constitutional Affairs (2007) and the DH (2015) respectively – offer comprehensive guidance on the use of restrictive interventions.

Table 1. Meanings of terms associated with use of restrictive interventions

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning/notes</th>
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<tbody>
<tr>
<td>Restrictive intervention</td>
<td>Umbrella term for a whole range of acts that may infringe a person’s human rights and freedom of movement, some of which are listed below. May also be called restraints</td>
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<tr>
<td>Chemical restraint</td>
<td>Use of medication – by intramuscular injection or given orally – to manage an individual’s behaviour. Includes medication routinely prescribed or used “as required”</td>
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<tr>
<td>Physical restraint</td>
<td>Use of direct physical force to restrict freedom of movement</td>
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<tr>
<td>Clinical holding</td>
<td>Use of physical restraint to allow essential clinical assessment and treatment. Involves “immobilisation, which may be by splinting, or by using limited force”. It can be a way to help children and adults, with their permission, to manage a painful procedure quickly or effectively (Royal College of Nursing, 2010). Should be recorded as a restraint</td>
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<tr>
<td>Prone restraint</td>
<td>A face-down, floor-based physical restraint, which is restrictive and risky for the person being restrained. Associated with high rates of injury and, in certain circumstances, death due to positional asphyxia</td>
</tr>
<tr>
<td>Seclusion</td>
<td>A particular type of environmental restriction whereby a person’s freedom is restricted by confining them to a specific space (for example, a bedroom) or specially designated seclusion room. Does not necessitate locking of doors, as it could involve a worker holding the door from outside. Not to be confused with “time out”, which is a punishment-based behavioural technique, or diversion to a low-stimulus environment (such as a quiet room) if an individual is over-stimulated or distressed – provided people are not confined there against their will and are free to leave at any point</td>
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<tr>
<td>Environmental restraint</td>
<td>Use of physical barriers to restrict freedom of movement, such as locked doors to restrict someone to an area (for example, a kitchen)</td>
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<td>Long-term segregation</td>
<td>The outcome when a multidisciplinary review and a representative from the responsible commissioning authority determine that a person should not be allowed to mix freely with other patients on the ward/unit on a long-term basis to reduce sustained risk of harm posed by the person to others (a constant feature of their presentation)</td>
</tr>
<tr>
<td>Mechanical restraint</td>
<td>Use of equipment that restricts freedom of movement – for example, handcuffs, belts, arm splints, some types of harness and restraint chairs</td>
</tr>
<tr>
<td>Restriction by default</td>
<td>Restricting someone in a more subtle way – for example, removing someone’s walking aid so they cannot mobilise independently or placing furniture so that someone is unable to leave a room</td>
</tr>
<tr>
<td>Observations</td>
<td>Staff observations of an individual that may be required to maintain safety, depending on an individual’s history and particular behaviours of concern. As this may be an invasion of the individual’s dignity and privacy, it is regarded as a restriction</td>
</tr>
<tr>
<td>Technological surveillance</td>
<td>Use of technology (such as electronic systems, tracking devices or CCTV) to monitor a person’s movements – although they may not, in themselves, restrict a person</td>
</tr>
<tr>
<td>Coercive practices</td>
<td>Use of threats, implied threats or other social pressures, such as taunting, mockery or humiliating, by people in positions of power (such as staff) to force supported individuals to do something against their will or stop them from doing something they would like to do</td>
</tr>
</tbody>
</table>
As registered practitioners, nurses must ensure their work is ethically sound and professionally relevant; they must work within the Nursing and Midwifery Council’s code to:

- Prioritise people;
- Practise effectively;
- Preserve safety;
- Promote professionalism and trust (Nursing and Midwifery Council, 2018).

The use of restrictive interventions is traumatic and can have long-term effects on nurse–patient relationships, so nurses must ensure all practice is person-centred and promotes positive relationships with individuals, carers/families, and other members of the health and social care team.

**Positive behaviour support**

PBS has been evolving over 25 years; it is a values-led framework that supports the human rights and community inclusion of:

- People who may sometimes have behaviours that challenge or concern other people;
- People at risk of developing such behaviours.

PBS has its roots in behavioural science and has an evidence base showing it can help reduce behaviours that challenge (Goh and Bambara, 2012; LaVigna and Willis, 2012; Carr et al, 1999).

When people show behaviours others consider to be risky, they are likely to have restrictions placed on them. These might include restraints, but can also include reduced access to personal possessions, people and community facilities. People’s lives become increasingly limited, and they are less able to make choices and experience ordinary lives even in their own homes and communities. Their basic needs – such as access to good healthcare, communication, social networks and finding meaningful ways to spend their time – may not be met. This creates more frustration and distress and, ultimately, results in more restriction.

PBS uses early intervention to break the cycle of restriction, with a primary focus on improving the person’s quality of life. Instead of ignoring or simply managing behaviours when they arise (short-term solutions that do not change things for the person), PBS helps staff develop an understanding of the individual’s problems by recognising that concerning/challenging behaviours have a function and are meaningful to the individual, even if they may be unhelpful or even harmful (Hastings et al, 2013).

By understanding the messages people are passing to us through their behaviour and getting to the root cause of their difficulties, and by working alongside them and their loved ones, PBS allows people to learn alternative skills and be better supported to meet their individual needs. A PBS approach, using data-based decision making, a positive approach to risk taking and personalised plans to enhance people’s learning can support people to access the everyday opportunities that most of us take for granted.

**PBS framework**

PBS is regarded as best practice and is recommended in a number of government policy documents and practice guidance throughout the UK (Scottish Government 2019; Care Council for Wales, 2016; DH,
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Fig 3. Getting things right for people at service level

1 Universal for all

2 Specialist support including brief functional assessment and behaviour support plans for those at risk

3 Intensive, individualised support for those few with high need (includes full functional behavioural assessment and individual support plan)

Source: adapted by the British Institute of Learning Disabilities from pbs.org

2014). It is at the heart of a new framework, currently out to consultation, to reduce restrictive practices across all sectors in Wales. The skills and knowledge needed to deliver good PBS are outlined in Positive Behavioural Support Coalition UK’s (2015) competence framework, while an academic definition by Gore et al (2013) sets out the values, theory and processes on which PBS is based.

As shown in Fig 2, there are four key components of PBS:

● Values-led: upholding people rights;
● Promoting quality of life;
● Understanding behaviour and meeting people’s needs;
● Making systems work for the person.

Each of these four components is expanded in Box 2.

PBS is often likened to a house: it always has the same framework, but can look different for every individual. The pyramid in Fig 3 shows tiers of support in a PBS system-wide approach, based on a public-health model. In tier one, people receive high-quality support, delivered by skilled and empathetic people and services that understand the basic principles of PBS and how best to meet people needs so they can thrive. Occasionally people may need tier-two support, usually involving targeted strategies or extra support for a specific time period. The top tier is for people who are in crisis (often described as complex), who need an in-depth assessment and support plan from a range of professionals.

Most PBS work takes place in tier one, where skilled staff develop good relationships and an understanding of people’s needs to prevent problems from arising. This reduces:

● The likelihood of people needing the tier-two and tier-three interventions;
● An individual’s vulnerability to a whole range of restrictive practices and community exclusion.

Conclusion

People with learning disabilities and those with autism, who may at times have behaviours that are described as challenging, are particularly vulnerable to community exclusion and having a range of restrictions placed on them. PBS, when implemented properly, can help prevent or limit behavioural crisis from arising and reduce the use of restrictive interventions.

Historically, many support-service staff have been taught a whole range of restrictive interventions, without learning about alternative approaches such as PBS. Hopefully, the renewed focus on PBS as a framework for supporting vulnerable populations, along with the new mandatory training standards, will prompt a cultural change and a move to preventative rather than reactive support. NT

References


For more on this topic online

● View on restrictive practice on young people in psychiatric wards. Bit.ly/NTRestrictiveYoungPeople