



## Positive and proactive care Reducing the need for restrictive intervention

### Key points

- All forms of restrictive practices should be reduced over two years.
- Restrictive practices should only be used as a last resort in emergency situations.
- There is an objective to end prone (face-down) restraint.
- Board members should be fully informed of their trust's position on restrictive practices and the management plan to reduce their use.
- The board should identify an executive director to lead on recovery approaches and reducing restrictive practices.
- Providers should publish an annual report on the use of restrictive interventions.
- The CQC will monitor and inspect against compliance with the guidance.
- This briefing provides a summary of new Department of Health guidance on minimising the use of restrictive practices.

### Introduction

The Department of Health (DH) launched *Positive and proactive care: reducing the need for restrictive interventions* in April 2014.<sup>1</sup> The guidance is aimed at promoting the development of therapeutic environments and minimising all forms of restrictive practices so they are only used as a last resort. It is part of a wider two-year initiative – the Positive and Safe programme<sup>2</sup> – to deliver this transformation across all health and adult social care.

This briefing, produced in collaboration with the Care Quality Commission (CQC), provides a summary of the guidance, highlighting what it means for providers in practice.

## Background

Restrictive interventions can delay recovery, and cause both physical and psychological trauma to people who use services and staff. The DH guidance is a response to:

- *Transforming care: a national response to Winterbourne View Hospital*<sup>3</sup>
- CQC inspections of nearly 150 learning disability inpatient services, which found “over reliance” on the use of restraint<sup>4</sup>
- MIND’s report, *Mental health crisis care: physical restraint in crisis*<sup>5</sup>
- The Francis Inquiry and report,<sup>6</sup> and the need for compassionate care, respect and dignity across all health and care settings.

At Winterbourne View, abuse clearly took place. However, many staff who use restrictive practices are doing what they have been trained to do, often in very difficult situations. The guidance makes clear that the culture, environments and training which enable staff to make the right decisions in a given situation, and to de-escalate at an early stage, are the best ways to keep both patients and staff safe and to promote dignity and respect at all times.

**“Restrictive interventions can delay recovery, and cause both physical and psychological trauma to people who use services and staff.”**

## Positive and proactive care

*Positive and proactive care: reducing the need for restrictive interventions* sets out mechanisms to ensure accountability to reduce the use of restrictive practices, including effective governance, transparent reporting and monitoring.

The guidance says recovery-based approaches are essential. It introduces positive behavioural support, an approach rooted in learning disability services, which promotes understanding the context and meaning of behaviour to inform the development of supportive environments and skills that can enhance a person’s quality of life.

The guidance applies equally to health and social care staff working in non-health settings such as police cells, immigration removal centres and prisons. It does not apply to staff from other professions, including the police and people working within criminal justice settings (for whom their own professional guidance will apply).

The DH will develop accompanying guidance in relation to children, young people and those in transition in healthcare settings, due to be published by March 2015. Existing age-appropriate guidance should be referred to in the interim.

### Key aims

Within two years, *Positive and proactive care* aims to:

- encourage a culture across health and social care organisations that is committed to developing therapeutic environments where physical interventions are only used as a last resort
- provide guidance on the use of effective governance arrangements and models of restrictive intervention reduction so that lasting reductions in the use of restrictive interventions of all forms can be achieved
- help promote best practice principles across a range of health and social care settings
- ensure that restrictive interventions are used in a transparent, legal and ethical manner.

## Reducing the use of physical interventions

The Positive and Safe programme aims to bring about sustained changes to practice and culture. At the same time, and as part of the initiative, Skills for Health and Skills for Care published guidance on staff development and training.<sup>7</sup>

There are five proposed work streams covering the main levers of system change: standards, guidance and maintaining compliance; workforce, training and development; contracts and commissioning; communications, culture and leadership; and transparency, monitoring, recording and reporting.

The Positive and Safe programme will see:

- the launch of a National Champions Network for local and national leaders for change
- a new process on reporting and recording restraint via the National Reporting Learning System introduced by NHS England
- encouragement to report using the national Mental Health Minimum Data Set
- products focusing on quality issues, for example, excessive use of physical interventions for individuals of African-Caribbean descent
- new fundamental standards underpinning regulation and inspection, to be introduced by March 2015
- a one and two-year review of progress from April 2015 to March 2016.

## Current policy and practice

The Safewards programme<sup>8</sup> and No Force First<sup>9</sup> already aim to improve safety and quality of care on inpatient wards and in hospital settings. Professor Joy Duxbury at the University of Central Lancashire is also leading on a restraint reduction project, evaluating a set of evidence-based strategies developed in the US and Canada primarily to reduce seclusion and restraint.

### Further reading

A number of documents complement the DH guidance and Positive and Safe programme:

- NHS Protect (2013) *Meeting needs and reducing distress*<sup>10</sup>
- *Mental Health Crisis Care Concordat: improving outcomes for people experiencing mental health crisis* (2014)<sup>11</sup>
- NHS England and Local Government Association, *Core principles commissioning tool* (for services for people who display behaviour that challenges)
- Skills for Health and Skills for Care (2014), *A positive and proactive workforce*
- Mental Health Act Code of Practice (consultation July to September 2014)<sup>12</sup>
- National Institute of Clinical Excellence Clinical Guideline 25, *Violence: the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments* (updated version expected 2015/16)
- Children's volume of Positive and proactive care (in progress).

## Defining restraint

The DH guidance defines restrictive interventions as:

“Deliberate acts on the part of other person(s) that restrict an individual’s movements, liberty and/or freedom to act independently in order to take control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken, end or reduce significantly the danger to person and others, and contain or limit the patient’s freedom for no longer than is necessary.”

Restrictive practices refer to physical, mechanical and chemical restraint, seclusion and long-term segregation.

The guidance gives definitions and detail of these strategies and advised use of the terminology for reporting. There are some changes to current practices within these, notably the objective to end use of prone (face-down) restraint.

## The legal context

Current legislation, policy and accepted good practice are consistent that any restrictive practice should only be carried out where it is legally and ethically justified. This means it must be essential to prevent serious harm to a person and it must be the least restrictive option. Staff will draw on a number of legislative frameworks to work within, including:

- the Human Rights Act 1998 and the European Convention on Human Rights<sup>13</sup>
- the Mental Health Act 1983 as amended by the Mental Health Act 2007<sup>14</sup>
- the Mental Capacity Act 2005, including the Deprivation of Liberty Safeguards.<sup>15</sup>

Staff must always judge whether restrictive interventions are acceptable and legitimate based on all presenting circumstances. The guidance recommends that concerns about the misuse of restrictive interventions should always be escalated through local safeguarding procedures and protocols.

## Implementation – what do providers need to do now?

When planning a restrictive intervention reduction programme, a provider must put in place robust governance arrangements, fully understand the legal context for applying restrictions and provide effective training and development for staff.

### Supporting individuals

All services should establish primary preventative strategies and environments that support individuals appropriately, such as ‘safe wards’. They should also adopt secondary preventative strategies which aim to avert any escalation to crisis. These include distraction and diversion. The service should decide what tertiary strategies or restrictive practices should be used if a person’s agitation escalates to the point that they place either themselves or others at significant risk of harm. These might include physical, mechanical, chemical, segregation and long-term seclusion.

### Individualised support plans

The guidance advises a human rights-based approach which includes positive behaviour support plans, although other similar evidence-based models of intervention are also acceptable. Care planning must always be within the principles of the Mental Capacity Act 2005.

Following the positive behaviour support approach, care plans should be person-centred, values-based and informed by skilled assessment of the probable reasons why a person presents behaviours of concern. They should be formulated with the person using the service and others if appropriate, for example, advocate, carer or family. Where the person lacks the mental capacity to consent to their plans, staff may need to make a decision about their care and treatment on their behalf within the best interests provision of the Mental Capacity Act 2005.

Staff should record all plans and secondary preventative strategies or de-escalation techniques. The plan should reflect any experiences and wishes of the service user which could impact on the use of restrictive interventions, such as a history of past abuse or trauma. It should also describe any risks associated with their general health or with the care environment.

Guidance is included for use of restrictive interventions for unforeseen behaviours that challenge. NHS Protect's document and the *Mental Health Crisis Care Concordat* offer guidance on managing behaviour that challenges in different service settings.

### Post-incident reviews

Following any physical interventions, those directly involved should meet for a debrief which should include a review of the positive behaviour support plan (or similar). A separate debrief should occur for witnesses not directly involved.

Reviews should be in a blame-free context and aim to help people who use services and staff identify what led to the incident and what could have been done differently. The staff who meet should recommend changes to the service's philosophy, policies, care environment, treatment approaches, staff education or training, if this is indicated.

### Police assistance

NHS Protect guidance indicates trigger points for the need for assistance from the police. The police will use techniques and act in accordance with their professional training while care and support staff have a continuing responsibility to alert police officers to any specific risks or health problems, and monitor the person's physical and emotional wellbeing.

### External monitoring

All commissioners should receive reports on the use of restrictive interventions in services, monitor these and act on any concerns.

The CQC's current inspection methodology already focuses on the use of restrictive practices within an organisation. The CQC was involved in the development of the guidance and has agreed that the new inspection methodology for mental health providers, that will be fully in place from October 2014, will include inspection against the DH guidance on restrictive intervention.

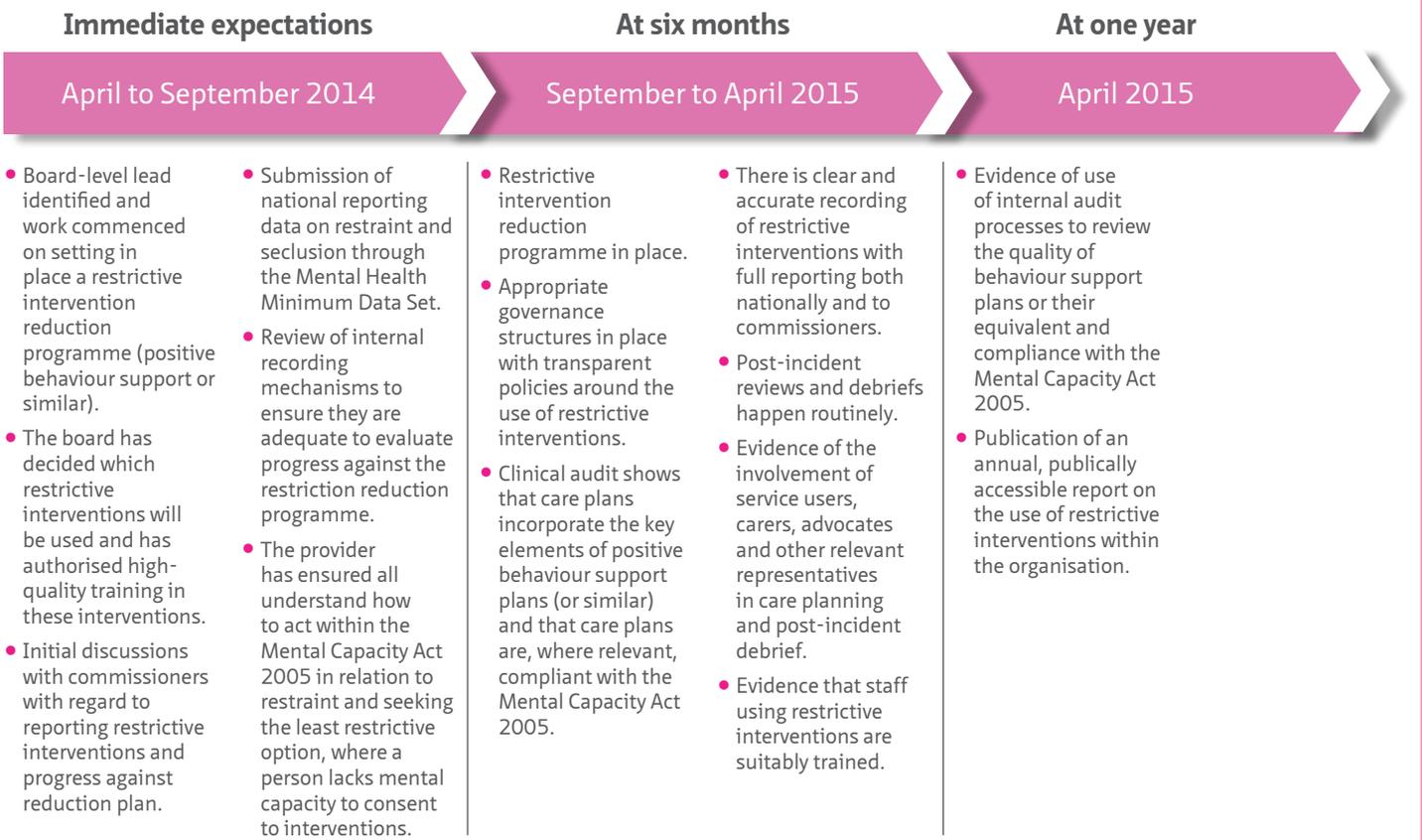
### Annual reports

Providers will be required to develop and publish a plan or policy to reduce restrictive interventions within its Quality Account (or similar) annually. This should be written and presented in a way that is accessible to the person using the service and carers. The annual reports should include evidence that shows:

- effective leadership on the issue
- the provider has developed a culture with models such as safe wards and recovery-orientated practices
- all staff are appropriately trained in preventative strategies, positive behaviour support planning (or similar) and safe use of physical interventions
- incidents of restriction/restraint are recorded in accordance with the Mental Capacity Act 2005
- restrictive interventions are monitored using agreed terminology
- annual audits of positive behaviour support plans (or similar) are undertaken which include evidence of compliance with the Mental Capacity Act 2005
- lessons learned from debriefs result in change
- progress on the policy to reduce restrictive interventions is reported to the board.

## Timeline for implementation

It takes time to implement new guidance. The timeline below outlines the activities providers will be expected to have undertaken immediately, six months on and a year after publication of the guidance.



## Challenges

### Training

The Mental Health Network (MHN) fully supports minimising physical restraint, but recognises there are some situations where clear, timely and skilled intervention protects the patient and others. It is essential that these are carried out in the safest manner possible by highly trained staff, and that there is a focus on the use of behaviour support and preventative work ensuring restrictive interventions are genuinely a last resort. It will be important for organisations to support their staff in this and ensure there is a positive focus on the improvement in patient care and the therapeutic environment rather than an assumption that all use of restrictive intervention is negative.

It is important to note that as yet there is no accredited training for restrictive practice and that positive behaviour support is not widely recognised in adult mental health settings. Further detail is awaited from the Positive and Safe programme workforce and training workstream.

### Reporting and monitoring restrictive practice

The reporting of restrictive interventions has been a significant challenge over the last few years. Therefore, it is essential that this is an early focus to allow a clear understanding of the impact of the work being undertaken. It is important to understand that in the short term reporting figures may increase as reporting procedures improve, and that this should be seen as a positive change in safety culture rather than a change of practice.

## Mental Health Network viewpoint

The guidance helpfully starts to clarify definitions of restrictive practice and sets a clearer framework for reporting. However, further guidance will be needed after the new fundamental standards of care are introduced (currently awaiting parliamentary approval) and the Mental Health Act Code of Practice is revised and updated.

All of these factors have implications for the use of restraint and seclusion and will inform definitions for reporting; for example, staff may need to adapt their reporting practice of restrictive interventions to meet the new guidelines. Such changes may also distort the emerging baseline of data about the frequency of use of restrictive practices. This may make it harder to demonstrate progress with reduction management programmes.

### Developing the workforce

There is a clear link to the safer staffing work. In order to promote a therapeutic environment where restrictive interventions are used as a last resort, it is essential that there are sufficient numbers of staff of an appropriate skill mix and competencies.

### Legislative framework

Staff need to understand the appropriate use of the Mental Capacity Act 2005 and create systems to record time-specific and decision-specific assessments of mental capacity and how best interests decisions have been reached. The Mental Health Act Code of Practice gives guidance on the delivery of safe and therapeutic care and safeguards around the use of restrictive interventions.

The Positive and Safe programme has, importantly, distinguished the abusive restrictive practices at Winterbourne View from circumstances where timely, skilled intervention is used to protect the patient and others. Building confidence in staff to deliver more recovery-based approaches and practices is key to developing compassionate therapeutic environments where restraint is only used as a last resort.

The MHN is pleased that the DH guidance moved away from being very prescriptive about using positive behaviour support and took on our recommendation for providers to be able to choose to implement either positive behaviour support or an equivalent evidence-based intervention. However, clarity is needed on the detail required to go into positive behaviour support plans and their equivalents.

It will take time to embed change and to see significant progress. We are pleased the CQC acknowledges this in their approach to inspecting by outlining what 'good' looks like now and in six and 12 months' time. Different organisations will of course be at different starting points on this agenda.

Moving forward, it is important that the wider system is supportive and understands it will take time to demonstrate real progress.

For more information on the issues covered in this briefing, contact [claire.mallett@nhsconfed.org](mailto:claire.mallett@nhsconfed.org)

### Key recommendations for national organisations

- The Positive and Safe programme should provide clarity on accredited training for restrictive practice.
- The Positive and Safe programme needs to signpost organisations to high-quality training and support, to implement positive behaviour support in adult settings.
- NHS England needs to ensure any burden of reporting is kept to a minimum.
- The Positive and Safe programme needs to clarify how it will provide key opportunities for provider engagement and ensure that any outputs are accessible and widely disseminated.
- The DH, CQC, NHS England and local providers should understand that better reporting of restraint is likely to create the false impression that the use of restrictive interventions is increasing.

# References

1. Department of Health (2014) **Positive and proactive care: reducing the need for restrictive interventions.**
2. Department of Health (2014) *Positive and Safe programme.*
3. Department of Health (2012) **Transforming Care: a national response to Winterbourne View Hospital.**
4. CQC (2012) **Review of learning disability services.**
5. MIND (2013) *Mental health crisis care: physical restraint in crisis.*
6. **Francis Inquiry final report 2012.**
7. Department of Health, Skills for Health and Skills for Care (2014) *A positive and proactive workforce.*
8. Institute of Psychiatry (2014) *Safewards: a new model of conflict and containment on psychiatric wards.*
9. Ashcraft, L, Bloss, M & Anthony, W (2012) 'The Development and Implementation of "No Force First" as a Best Practice', *Psychiatric Services*, Vol 63, No 5.
10. NHS Protect (2013) *Meeting needs and reducing distress.*
11. HM Government (2014) *The Mental Health Crisis Care Concordat: improving outcomes for people experiencing mental health crisis.*
12. Department of Health (2014) *Stronger code: better care consultation on proposed changes to the Code of Practice Mental Health Act 1983.*
13. Human Rights Act 1998
14. Mental Health Act 1984
15. Mental Capacity Act 2005

## The Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care services in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. It also has a statutory role in protecting the rights of vulnerable people, including those detained under the Mental Health Act.

For more information about its work, visit [www.cqc.org.uk](http://www.cqc.org.uk)

## Mental Health Network

The Mental Health Network is the voice of mental health and learning disability service providers for the NHS in England. We represent providers from across the statutory, for-profit and voluntary sectors.

We work with government, NHS bodies, parliamentarians, opinion formers and the media to promote the views and interests of our members and to influence policy on their behalf.

For more information about our work, visit [www.nhsconfed.org/mhn](http://www.nhsconfed.org/mhn) or email [mentalhealthnetwork@nhsconfed.org](mailto:mentalhealthnetwork@nhsconfed.org)



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