Restrictive Interventions

This section is about the type of restrictive interventions your relative may experience, the laws and guidance about their use, what good practice looks like and what to do if you or your relative are unhappy about the way in which restrictive interventions are being used by either a service and/or health and social care staff. Whilst restrictive interventions are typically associated with mental health services and some can only be carried out lawfully for people detained under the Mental Health Act, e.g. seclusion and long-term segregation, they do take place in community settings.

What are restrictive interventions?

Restrictive interventions are deliberate acts on the part of another 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
- end or significantly reduce the danger to the person or others
- contain or limit the person's freedom for **no longer than is necessary**

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

Click here to read the full guidance

Read the summary of key actions here

Key message:

Restrictive interventions should only ever be used as a last resort

Examples of restrictive interventions include the following:

Chemical restraint

Chemical restraint is the use of medication which is prescribed and administered for the sole purpose of controlling or subduing behaviour. It is different from medication prescribed for the treatment of a formally diagnosed health condition, e.g. Clonazepam for seizures.

It includes the use of rapid tranquilisation medication, also known as RT, which has an immediate sedative effect (makes you sleepy). This medication is typically given by injection but can include a tablet form. Read the MHA Code of Practice para 26.91-26.102 for guidance which should be followed.

Stopping the over medication of people (STOMP) with a learning disability, autism or both

In 2015, NHS England led a 'call to action' after reports from Public Health England, NHS Improving Quality and the Care Quality Commission raised concerns that:

- there is a much higher rate of prescribing psychotropic medication amongst people with a learning disability, autism or both than the general population
- often more than one type of psychotropic medication in the same class is prescribed
- in most cases psychotropic medication is prescribed without a mental health diagnosis
- psychotropic medication is often used for long periods without adequate review, e.g. to monitor its impact (are things getting better or worse) and side effects which can affect quality of life for example, sedation (extreme tiredness), weight loss/gain, constipation
- there is poor communication with family carers and between different health and social care providers

The call to action led to the introduction of the STOMP project.

This resource about the STOMP project presents as a training course, but if you view/sign in you will be able to access video clips, written information and links to further resources. It includes:

- an introduction and explanation about what inappropriate prescribing of psychotropic medication is
- descriptions of the types of medications used and their correct and incorrect use
- how to challenge the inappropriate use of psychotropic medication
- alternatives to psychotropic medication, e.g. positive behaviour support or trauma informed care for behaviour described as challenging

This link takes you to the Challenging Behaviour Foundation's medication pathway. This resource was commissioned by NHSE as part of STOMP. The pathway focuses on how to make sure your relative only takes psychotropic medication they need, and that they are taking it safely:

Click here for the CBF's medication pathway

Organisations/services who have subscribed to the values of STOMP may display this logo:

STOMP

Stopping over medication of people with a learning disability, autism or both

If you feel that they are not following the values of STOMP, for example your relative has been prescribed psychotropic medication without a mental health diagnosis then challenge this decision with or on behalf of your relative. If you are unsure whether an organisation/service has subscribed to the values of STOMP, ask. If they don't know about STOMP this is a concern as your relative may be taking psychotropic medication they don't need. Raise this with whoever is responsible for commissioning (paying for) your relative's care, support and/or treatment.

Seclusion

Seclusion is the supervised confinement and isolation of a person, away from other people. The person is kept on their own in an area and prevented from leaving. It is intended to be used only to contain severe behavioural disturbance which is likely to cause harm to others.

It is important to recognise when seclusion is taking place to ensure that the Mental Health Act Code of Practice is followed, the restriction is lawful, and all the correct procedures are followed. The following examples are still seclusion:

- the door to a room is open, but the person is still prevented from leaving by staff in the room or staff either in or next to the doorway
- if the person does not know how to leave an area they have been placed in
- they feel they cannot leave, e.g. if they have been told they must stay in their bedroom between certain hours, including a threat of punishment
- called time out, quiet time or a specific name used by a service
- takes place in a non-designated seclusion room e.g. 'nursed in their room', sensory room, 'need to stay in the snug'
- if a person lacks capacity and does not understand that they are in seclusion and makes no attempts to leave

If a person decides to be on their own this is not seclusion, but care should be taken to ensure they do not isolate themselves for too long. Consideration should be given to why a person wants to remove themselves from a specific environment e.g. are they experiencing sensory overload, are they frightened (by something that has happened to them, or they have witnessed) or unwell.

Read the MHA Code of Practice (paragraphs 26.103-26.107) for the guidance which should be followed.

Long-term segregation

Long-term segregation is a situation where, in order to reduce a continuous risk of harm posed by the person to others, which is a constant feature of their behaviour, a multi-disciplinary review and representative from the responsible commissioning (funding the service) authority determines that a patient should not be allowed to mix freely with other patients on the ward on a long-term basis.

Long term segregation is not the same as seclusion.

This briefing written jointly by VoiceAbilty and Kate Mercer Training discusses the role of advocacy when people with a learning disability, autism or both are kept in long term segregation. It makes a number of recommendations about how advocacy needs to improve for people in long term segregation.

Read the MHA Code of Practice (paragraphs 26.150-26.160) for guidance which should be followed.

The HOPE(S) model is a human rights-based approach developed from research and clinical practice by Mersey Care. Its goal is to reduce the use of long-term segregation sometimes experienced by people with a learning disability, autism or both. It acknowledges that admission to hospital can cause distress, resulting in behaviour described as challenging and possibly leading to an increased risk of restrictive interventions being used. This can impact on people's wellbeing, human rights, cause trauma, impact on their length of stay in hospital and delay discharge.

If your relative is in long term segregation, ask about the HOPE(S) model.

Click here to read more about the HOPE(S) model

Physical (manual restraint)

Physical or manual restraint is the use of physical contact which is intended to prevent, restrict or subdue movement of any part of a person's body, e.g. two staff holding a person on either side whilst seated, two staff holding a person on either side and walking them to or away from somewhere.

Read the MHA Code of Practice (paragraphs 26.69–26.74) for guidance which should be followed.

If all other options have been explored and physical restraint is considered necessary, it must still be done in the least restrictive way and only carried out by trained health and social care professionals.

Environmental restraint

Environmental restraint is the use of obstacles, barriers or locks to prevent a person from moving around freely, e.g. seating a person against a wall and placing a table in front of them, doors with keypads with only staff having access to the code.

Psychological restraint

Psychological restraint involves depriving a person of choices, controlling them by not allowing or making them do something, or setting limits on what they can do. It includes the use of threats and coercion.

Mechanical restraint

Mechanical restraint is the use of a device which is intended to prevent, restrict or subdue movement of any part of a person's body, and is for the primary purpose of behavioural control, e.g. strapping somebody into a wheelchair or posture support chair to prevent them from getting out, arm splints that keep a person's arms straight (stop them bending at the elbow to reach something or hit themselves), handcuffs, spit hoods and restraint belts.

Read the MHA Code of Practice (paragraphs 26.75-26.87) for guidance which should be followed.

Clinical holding

Clinical holding is the use of physical intervention to support the assessment or delivery of clinical (medical) care and treatment to a person who is unlikely to be co-operative such as holding an arm during a vaccination. It should only be used after other options have been considered and tried, including any reasonable adjustments which may make the experience easier. For example, if somebody is nervous about injections, their flu vaccination can be given nasally.

Technological surveillance/observations

Technical surveillance includes equipment such as pressure pads, closed circuit television, or door alarms. It is used to alert staff that a person is trying to leave or to monitor their movement. This may trigger the use of restraint, e.g. a door alarm sounds which results in staff physically restraining a person who is trying to leave.

Observations of a person by staff are still considered a restrictive intervention as it is an invasion of their dignity and privacy however it may be required to maintain safety. The level of observation should depend on the person's individual history, risk and behaviours described as challenging, for example related to self-injurious behaviour.

The Restraint Reduction Network and the British Institute for Human Rights have produced a report and poster explaining the use of surveillance and how it impacts on human rights:

Click here to read the report

Click here to view the poster

Blanket restrictions

The MHA Code of Practice (paragraphs 8.5–8.9) defines blanket restrictions as 'rules or policies that restrict a person's liberty and other rights, which are routinely applied to everyone, or to classes of people, or within a service, without individual risk assessments to justify their application'.

This poster summarises what blanket restrictions are and your relative's rights

Read the Care Quality Commision's guide about the use of blanket restrictions in mental health services

This guide from the Restraint Reduction Network provides information about recognising blanket restrictions, quotes from people who have experienced blanket restrictions, ways to reduce their use and a self-assessment checklist:

Click here to read the guide

Use this tool to check whether your relative is being exposed to any blanket restrictions

Deprivation of access to normal daytime clothing

A person should never be deprived of appropriate clothing with the intention of restricting their freedom of movement, neither should they be deprived of other aids necessary for their daily living. Sometimes it is standard practice within mental health services to only provide special tear-proof clothing when a person is in seclusion or long-term segregation. This is a blanket restriction. A decision such as this should only be made following an individualised risk assessment e.g. because there is a risk of shredded clothing being used to self-harm, attempt suicide or because a person has pica. Any tear-proof clothing should fit the person in a way that preserves their dignity, is not demeaning or stigmatising and where possible meets any specific cultural or religious requirements. The person should know what they need to do so that they can wear their usual and preferred clothing.

Read the MHA Code of Practice (paragraphs 26.161-26.166) for guidance which should be followed.

Police attendance

Some services choose to use the police as a resource when they are unable to manage behaviour described as challenging. This includes the use of Tasers. A home office report found from April 2017 to March 2018, there were 18,000 incidents involving a Taser (actual discharge or threat, e.g. drawing Taser from holster or pointing it). Of these 2,400 incidents involved people with a mental health diagnosis which includes people with a learning disability, autism or both.

Read the protocol Police Use of Restraint in Mental Health & Learning Disability Settings It recognises that police involvement can be terrifying, make a person more anxious, leading to an increase in behaviour described as challenging, cause trauma, or contribute to a traumatising or retraumatising effect.

Click here to read the protocol

Read the College of Policing guidance on how they should engage with people, including providing support to health and social care professionals

When a situation is poorly managed it can escalate and lead to more than one restrictive intervention being used. This can result in a cycle of behaviour described as challenging which is difficult for the person and staff to come back from.

Read this scenario:

Gabe is a young man who was admitted to a mental health service the previous night. He has a severe learning disability and autism. He is finding the environment challenging, due to loud noises, the type of lighting, no access to a bath (only a shower), and the behaviour of other people on the ward. He is 29 years old and since he was 3 years old he has always had 2 slices of toast, 2 eggs and a drink of tea for

breakfast. He uses sign to communicate but the two staff who can sign are not at work today. He is in the dining room for breakfast and is trying to explain to staff he would like 2 slices of toast, 2 eggs and a drink of tea. He has managed to help himself to two slices of toast but this was not received well. There is a system, and it does not include leaping out of your seat and helping yourself. He starts to wander around the dining room signing eggs, drink of tea. He is asked to return to his seat but refuses. Physical intervention is used to try and return him to his seat. But holding his arms means he cannot use his hands to sign. His ability to communicate has been taken away. He becomes very distressed and in an attempt to free himself he bites one of the staff. Now, instead of taking him back to his seat, it is decided to remove him from the dining room to a quiet area. He is taken down the corridor, kicking, screaming, crying and trying to bite again. Two more members of staff become involved, and Gabe is now restrained on the floor. He is terrified and continues to try and break free. It is agreed that he should be moved to a seclusion room. Staff manage to get him into the room and shut the door. He is now so distressed he starts to bang his head on the door. It is decided that he needs rapid tranquilisation. Once Gabe recovers from the effects of the medication, he comes to the window of the seclusion room. He is hungry, thirsty and confused. Staff open the door, and he starts to sign egg, drink of tea but nobody understands him. He starts to get agitated again so staff shut the door to the seclusion room. Gabe starts banging on the door. He wants to be allowed out, but staff have decided not to allow this. He is given water in a plastic cup. Gabe doesn't drink water and he needs a straw to drink all fluids. There is information in his care and support plan – about the eggs, toast, drink of tea, bath not shower, the need for staff to sign, that he is tactile defensive which means he finds touch extremely uncomfortable.

Key issues relating to restrictive interventions:

- If your relative does not have the capacity to agree to the use of restrictive interventions, the Mental Capacity Act must be followed, including making best interest decisions and using the least restrictive option
- If the restrictions imposed on your relative meet the threshold for a Deprivation of Liberty an application to the Court of Protection may be necessary.

Read this Deprivation of Liberty Safeguards (DOLS) guide by SCIE for further information including case studies

- Depending on the circumstances the inappropriate use of restrictive interventions may be unlawful. Following an investigation, a range of charges could be considered including:
  - Assault or battery (if a person has the mental capacity to refuse the proposed restrictive practice)
  - Willful neglect or ill treatment of people lacking mental capacity (an offence undersection 44 of the Mental Capacity Act)
  - False imprisonment

Legal action may be possible to prevent further breaches of a person's rights. You or your relative can seek independent advice about how these laws apply to individual circumstances.

- The inappropriate use of restrictive interventions can have serious and fatal consequences. After the death of their son Seni following the use of force in a mental health service, the Lewis family campaigned to change the law which resulted in the introduction of the Mental Health Units (Use of Force) Act 2018. Key principles of the act, include:

- respecting all patients' rights
- providing skilled, trauma-informed and person-centred care
- following the principle of least restriction
- promoting recovery

Key messages from the Positive and Proactive Care Guidance, Department of Health, 2014, NICE guidelines and the Mental Health Act Code of Practice about the use of restrictive interventions include:

- Only ever be used as a last resort when there is a real possibility of harm to the person, staff or the public if no action is taken and then be:
  - proportionate to the risk of harm
  - the least restrictive option e.g. oral medication should always be considered before intravenous (injection)
  - imposed for no longer than necessary
- Never be used as a punishment or with the intention of causing pain, suffering or humiliation
- Never be used as an alternative to appropriate staffing levels. For example, if a service implements blanket policies to prevent the movement of people – such as everybody must go to their bedroom by 9.00 pm - because there are insufficient night staff
- Clear and accurate recording should take place within 24 hours when any type of restrictive intervention is used. This should include the following:
  - the names of the staff and person involved
  - the reason for using the specific type of restrictive intervention
  - the date and the duration of the intervention
  - whether the person or anyone else experienced injury or distress
  - debrief for the person and staff involved, for example, what could have been done to avoid the use of restrictive intervention, was the intervention used the least restrictive
  - what action was taken

This information is investigated during CQC inspections

- To demonstrate their commitment to reducing the use of restrictive interventions all services should have a comprehensive programme detailing how they will do this

The Human Rights Act and restrictive interventions

Read this report 'Human rights framework for restraint: principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions' published by the Equality and Human Rights Commission. It provides definitions of restrictive interventions, examples of how restrictive interventions interfere with human rights and the laws which apply:

Click here to read the report

Click here to watch the video Restraint: A Human Rights Issue

Read this blog published on the Equality and Human Rights Commission website by CQC focusing on human rights and restrictive interventions:

Click here to read the blog

Read the CQC's Out of Sight – Who Cares report which looks at the use of restraint, seclusion and segregation in mental health services for people with a learning disability, autism or both

Click here to read the report

Watch this video and read this co-produced report from the Advonet Group and Change which includes stories of people's lived experience of restrictive interventions and the impact it has had on them and their family carers/members:

Click here to watch the video

Click here to read the report

The culture and environment of services can create the situations where restraint is used. If people are not listened to or given the opportunity to have a say in their care, have nothing to do or no-one to talk to, tensions can rise, and people may become frustrated and distressed. Over-crowding, blanket or arbitrary rules and restrictions, and not being able to go out, all add to the pressure. Reducing the use of restraint starts with getting the quality of care right. (Source: Restraint in mental health - What the guidance says)

Read the full report by Mind and Network here which includes information about restraint, people's experiences, official guidance, good practice and campaigners' stories:

Click here to read the report

The Equality Act

Where there is a disproportionate use of force against people with a learning disability, autism or both this breaches the Equality Act 2010 as disability is a protected characteristic

What does good practice look like

If your relative is at risk of the use of restrictive interventions in a mental health or social care service, they should have a behaviour support plan.

The Positive and Proactive Care Guidance, Department of Health, 2014 NICE guidelines and the Mental Health Act Code of Practice all emphasise the importance of involving your relative and their family carer in the planning, reviewing and evaluation of all aspects of care and support and/or treatment, including the use of restrictive interventions.

If your relative has been assessed as having capacity they can work in partnership with those supporting them, either independently, alongside you (their family carer) and/or an advocate) to record the following information:

- what makes the behaviour more likely to happen (setting event: e.g. feeling unwell)
- what causes a behaviour to happen (trigger: e.g. being asked to go for a long walk when feeling unwell)
- the types of behaviour they use to communicate emotions such as distress, confusion, pain, anger
- what happens after the behaviour (consequence: the long walk is cancelled and your relative is told to stay in their room. As they are feeling unwell, this is a good outcome)
- what are the signs that your relative is calm
- what helps to calm things down
- what restrictive interventions will be used, if necessary, taking into consideration your relative's personal history (considering how to make this less distressing, how to ensure it does not cause trauma or retraumatise them, and considering any physical health needs such as a heart condition which impacts on their breathing).

If your relative has been assessed as not having capacity, they should still be supported to be involved in the development of their behaviour support plan as much as possible. Communication aids such as talking mats can be used to help your relative communicate their dislikes and the emotions they feel and as a family carer you will be able to provide valuable information including when they are likely to display behaviour described as challenging in response to certain situations and the best way to avoid this.

Key message:

If your relative has a good quality of life then the risk of behaviour described as challenging and therefore the use of restrictive interventions will be reduced.

It is important that you and your relative know and recognise what restrictive interventions are. They can easily become an established feature of your relative's care, support and/or treatment. For example, staff shortages mean that your relative must go to their room every evening at 8.00 pm – this is a blanket restriction.

Use this booklet co-produced by Speakup Self Advocacy and people who have firsthand experience of restrictive interventions to explain restrictive interventions to your relative, if appropriate. It starts from a human rights point of view, helps people understand their restrictions and be more involved in developing least restrictive options, decide when a restriction is fair or unfair, how people want to be supported and change the way someone is restricted. It also includes information about who to speak to if there are any concerns about the way restrictions are used:

Click here to read the report

Restrictive intervention reduction programmes

The Mental Health Act Code of Practice (2015) expects services to commit to reducing restrictive interventions. Here are some of the projects which are trying to achieve this:

This link takes you to the Restraint Reduction Network website

This report summarises some of the projects which are being introduced to reduce the use of restrictive interventions

This link provides more information about Safewards

For more information read the Challenging Behaviour Foundation's Reducing the use of restraint, seclusion and other restrictive practices here

Further information:

Mental Health Act Code of Practice:

Click here to read the Mental Health Act Code of Practice

Read this guidance "Let's talk about restraint - Rights, risks and responsibilities" from the Royal College of Nursing:

Click here to read the guidance