

1. Introduction

The use of restrictive practices (such as restraint, seclusion and as required medication) are unfortunately commonplace in services that support people with intellectual disabilities who present additional complex behavioural or mental health needs. Concerns about such interventions regularly surface in official investigations into the quality of care afforded to such individuals, in media exposés, in individual stories about service user experience and, to a lesser extent, in the research literature.

Since the mid-1990s, the British Institute of Learning Disabilities (BILD) has been engaged in a programme of work that has aimed to address many of these concerns. Recognising that reactive behaviour management interventions are sometimes an important, albeit minor, component of effective intervention plans for people with challenging behaviours, this initially focussed on improving and regulating how physical intervention training was delivered to carers in the UK (Harris et al, 1996; Jefferson, 2009). This was leading-edge work given that the prevailing form of training in UK services at that time posed significant ethical issues and that there was no existing form of accreditation for such training available. Later, guidance was provided on both the use of time-out and seclusion (Paley, 2009). In more recent years, the organisation's focus has changed and it has now more appropriately located its continuing interest in improving practice in physical intervention within an overall context of developing positive behavioural support (PBS) as a preferred intervention model.

BILD has therefore already done a great deal to improve how restrictive physical practices are trained and delivered in the UK. However, even though we can make significant improvements in how we restrain (notably by avoiding the use of deliberate pain and particularly high-risk restraint positions) and contain (by improving the traditionally barren

nature of environments used for this purpose), the use of restrictive practices is likely to remain inherently aversive for those who experience them. Therefore, we must be able to ensure that their use is always minimal, ethical and justifiable. Unfortunately, rather than being a last resort, in many services they remain a first and only resort in the absence of carers being able to deliver effective therapeutic alternatives.

This book continues BILD's strategy to improve practice in this area by focussing on reducing the use of restrictive procedures in a structured and accessible way.

The content is laid out as follows. First, what we know about how often restrictive practices are used with people with intellectual disabilities and their potential impact is discussed; this is sobering reading and in itself provides justification for this publication. Next, lessons about the key individual and organisational factors that can lead to reduced use of restrictive practices are outlined. As much of this work has been conducted with other populations, such as people with mental health needs and the elderly, these findings will be translated into an intellectual disability context where necessary. In order to try and merge what might otherwise be seen as complementary, but potentially separate work streams, the possible role of PBS in helping deliver these necessary organisational conditions will then be explored. Finally, a suggested project template for reducing restrictive practices in an organisation will be described. The overall aim is to help services who wish to reduce their use of restrictive procedures to do so in practice.

Though the use of physical intervention and, more specifically restraint, has probably received the greatest attention to date, it is of course only one form of restrictive practice. Therefore, this publication will also make reference to the use of seclusion and as required medication. For clarity, the following definitions of each of these restrictive management strategies are provided at the outset:

Physical restraint:

Physical restraint has been defined as:

'... any method of responding to challenging behaviour which involves some degree of direct physical force to limit or restrict movement of mobility.' (Harris et al, 2000)

Restraint can either be:

- personal (ie, applied by one or more persons restricting the movement of another)
- mechanical (ie, achieved by the use of some sort of device or apparatus, such as splints or harnesses)
- environmental (ie, achieved by certain restrictions in the environment, such as locked doors)

Seclusion:

The Code of Practice for the Mental Health Act (2008) in England defines seclusion as:

'... the supervised containment of a person¹ in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.' (Department of Health, 2008)

Rapid tranquillisation/as required medication:

Rapid tranquillisation is defined as 'the use of medication to calm/lightly sedate the service user and reduce the risk to self and/or others'. Its aim is:

¹ The Mental Health Act Code of Practice uses the term 'patient'

'... to achieve an optimal reduction in agitation and aggression, thereby allowing a thorough psychiatric evaluation to take place, whilst allowing comprehension and response to spoken messages throughout.' (NICE, 2005)

Pro re nata or PRN (as needed or as required) medication is often used in a similar way to rapid tranquillisation with people who have intellectual disabilities and challenging behaviour

In terms of general terminology, 'intellectual disability' has been preferred to 'learning disability' throughout.