Restrictive interventions and practices: An organisation's reduction strategy

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Centre for the Advancement of PBS Practice Paper 2 in a series of 12 practice papers commissioned by the CAPBS to provide a reference point and discussion tool for teams wishing to develop their positive behaviour practice.

Southdown Housing Association established its Positive Behaviour Support (PBS) team at the start of 2014 as part of a strategy to provide a total organisational approach to PBS. The team works collaboratively with all our learning disability services across Sussex.
For us, adopting an organisational approach to PBS was initially inspired by Mansell, McGill & Emerson's description of a service provider system with four sub-systems: broadly, prevention, early intervention, crisis response and ongoing specialist support (Mansell, McGill & Emerson 1994). Other key influences on the approach that we have adopted were papers in the 2013 special issue of the International Journal of PBS (specifically Gore et al's Definition and scope for positive behavioural support) and Allen's project plan for reducing restrictive practices (Allen 2011). As Allen (2011) points out, adopting an organisational approach to PBS is likely to be effective in reducing the use of restrictive interventions.

Colton (2004) and Huckshorn (2005), though only focused on physical restraint and seclusion, are forerunners of the restrictive practice reduction movement; Colton's *Checklist for Assessing an Organisation's Readiness for Reducing Restrictive Practices* and Huckshorn's *Six Strategies for Restraint Reduction* are practical tools which suggest how to move beyond theoretical discussion and towards actually reducing restriction.

At Southdown, when developing our PBS strategy we wanted to apply theoretical principles alongside implementing practical changes that would really impact on people's quality of life. We were determined that we would 'walk the walk'.

We had also been inspired by the Family Mosaic report *No Going Back - Is institutionalisation being recreated in modern care and support settings?* (2010) exploring the extent of institutional practice in its services and the assertion that: *"unless organisations are vigilant, the older*

institutional culture can re-emerge anywhere" (Family Mosaic 2010). We were impressed by the transparency that publishing this report demonstrated and shared Family Mosaic's assertion that it was unrealistic to think that any organisation had 'no problem with institutional practices'.

Institutionalisation includes situations where people do not have, or are not allowed to exercise control over their lives and their day-to day decisions. Key features are depersonalisation, block treatment, rigidity of routine, inappropriate use of medication and authoritarian staff.

Examples of institutional practice (from the Mosaic report) include:

• Locked cupboards/doors
• Lack of choice in everyday activities
• Set getting up/bed/meal times
• Excessive use of restraint
• Staff controlling access to areas

Positive and Proactive Care: reducing the need for restrictive interventions (DH, 2014) says*:*

> *"Oppressive environments and the use of blanket restrictions such as locked doors, lack of access to outdoor space or refreshments can have a negative impact on how people behave, their care and recovery. They are inconsistent with a human rights-based approach. Providers should ensure that they abide by the Human Rights Act and where possible do not have blanket restrictions in place. Where these are considered necessary, providers should have a clear policy in place and ensure that the reasons are communicated and justified to people who use services, family members and carers. Providers may be challenged to justify the use of such restrictions under the Human Rights Act"* (paragraph 39)

We recognised that claiming to be values led whilst actual practice did not reflect these values was common in the sector and wanted to identify any institutional practice in our own services, of which we knew restrictive practices are an indicator, as well as assessing our staff team's (and especially managers') attitude towards these. We also recognised that institutional practices, restrictive practices and challenging behaviour often are very interrelated and it was therefore essential to address all of these areas when developing our PBS strategy.

We were clear that our services needed to be capable environments that were competent to support people with a range of behaviour that challenges without resorting to excessive restrictions. We needed to be confident that support couldn't be provided in less restrictive ways and our PBS strategy involves an organisational approach to approving any restrictions and sharing any risk associated with removing existing restrictions.

Our experience as a service provider is that restrictions can increase the likelihood of behaviour that challenges despite often being employed in the first place with the intention of preventing or managing such behaviours. Perhaps most importantly restrictions can have a negative impact on the person's quality of life and so reducing restrictions can be a quality of life intervention.

We launched our full PBS strategy in early 2014, the aim of which was: *To embed an organisational approach to the governance of PBS and use it to improve people's quality of life as well as reducing both challenging behaviour and restrictive practices.* Our strategy has 9 key principles:

1. Improving quality of life will be an intervention and improved quality of life is an outcome measure.
2. Primary prevention and a planned multi-element approach will shape support to alter the context in which behaviour occurs.
3. Services will have strong leadership and be capable environments, competent to support the individual.
4. Staff will understand how they need to behave.
5. Changes in behaviour and potential problems will be identified early leading to prompt, appropriate intervention.
6. Staff members' will be provided with the necessary support to remain resilient.
7. Analysis of data and functional assessment will be used to inform evidence based practice.
8. Any restrictive practices will be ethical and justifiable; their use will reduce over time.
9. There will be an organisational approach to governance with accountability at every level.

Whilst the term 'restrictive practice' has been widely used to cover physical, chemical, mechanical restraint and seclusion, *Positive and Proactive Care* refers to these as 'restrictive interventions'

Using a broader definition : *A Positive and Proactive Workforce* **(2014) uses 'restrictive practice' to mean "making someone do something they don't want to do or stopping someone doing something they want to do".**

Having identified all uses of physical, mechanical and chemical restraint within our organisation (and established that seclusion was not used) we wanted to use this broader definition of restrictive practice to ensure that people were not being stopped from doing something they wanted to do or made to do something they didn't want to do unless there was a clear reason why this was unavoidable. For us the process of identifying all restrictive practices and then assessing their appropriateness aimed to:

- comply with national policy
- ensure cross-organisation standards in quality of practice
- reduce risk to individuals and the organisation
- get intelligence in order to know which teams need what support to reduce restrictions
- encourage teams, and especially managers, to consider their practice
- flag up the need to be able to justify restrictions
- reduce the risk of 'low-level' restrictions developing into greater restrictive practices
- raise the issue of restraint during personal care
- establish restriction reduction plans for all services

We needed to ensure that any restriction which was part of someone's planned support was sound, reasonable and legal. We were clear that if staff used restrictive practices (and

the person didn't have capacity to consent to the restriction) that we needed to follow a Best-Interest decision making process. We needed to: "consider whether it is the least restrictive option, in terms of the person's rights and freedoms, by which to meet the person's need" (Ch. 5 Mental Capacity Act 2005 Code of practice). We established a criteria to apply to any restriction that was part of someone's planned support, in order to decide whether the restriction was ethical and justifiable. We were also clear, though, that an intervention in an emergency to prevent immediate harm was part of our duty of care and may be outside of these criteria. Applying the criteria to restrictions meant that the least restrictive intervention was employed in order to achieve a legitimate aim. At Southdown, for any restriction to be part of someone's support it must:

1.   Be necessary in order to avoid significant harm to the person.
2.   Take account of the emotional effect of the restriction on the person.
3.   Be proportionate-the issue is important enough to justify the restriction and there is no alternative.
4.   Be the least restrictive option-no more than necessary.
5.   Be imposed for no longer than necessary.
6.   Balance the interests of the individual and those of others.
7.   Be within the context of a warm, person centred, adult to adult approach.

We had started our review of the extent of restrictive practices in each of our services shortly before the publication of *Positive and Proactive Care* and had decided that as well as reviewing the use of physical, chemical, mechanical restraint and clinical holding we wanted to identify other restrictions which may impact on someone's quality of life. Following the launch of *Positive and Proactive Care* we reviewed our planned approach and were confident that we were achieving and exceeding its requirements. We were reassured that identifying other restrictions was in line with the overall aim of *Positive and Proactive Care*, as well as being the right thing to do. We also thought that our review would ensure that any 'low level' restrictions didn't develop into greater restrictions, institutional practice and the erosion of people's status and human rights.

Restrictive practice reviews took place in each of our services, led by me (Behaviour Support Manager), in most cases at staff team meetings between late 2013 and early 2014. As an introduction to these team sessions I:

•   explained why we were completing the review of restrictions
•   explained that restrictions were not necessarily a bad thing and were, in some cases, an important part of someone's support-especially in relation to safety
•   encouraged staff to be completely honest when discussing their practice.

Having covered physical restraint, clinical holding, chemical restraint and the use of devices that may be used as mechanical restraint, teams discussed a list of potential restrictions, typical of those that people with learning disabilities living in services, might experience. My judgement is that all but one of the 33 staff teams were open and honest about their current practice and identified where there were restrictions on the following:

•   Food (access to and/or choice of and/or quantities being restricted)

- Alcohol
- Cigarettes
- What to wear
- Choice and timings of activities/going out/getting up and bed times
- Access to spaces within service
- Privacy
- Access to money and/or ability to spend it
- Movement during personal care (restraint)
- Locked front/back doors
- Locked cupboards in someone's own room/flat (person has no key)
- Contact with people

These reviews did raise anxiety amongst some staff teams, and some Managers at all levels, partly due to there being a lack of awareness, at that stage, of the PBS strategy, and the values that sit behind it, and partly due to the services not being used to that level of scrutiny. Some staff teams were very defensive about the strategies they had adopted and were very resistant to any notion that change may be required.

We found a surprising lack of understanding of the Mental Capacity Act and found that staff would often cite their "duty of care" as reasons behind a restrictive practice they had adopted.

Following each service's review a *Summary of Restrictive Interventions* was produced. Managers and Area Managers were asked to comment on why each restriction was necessary and how it had been agreed or authorised. From mid 2014 we held internal case conferences for each of our services. The internal case conferences were chaired by the Director of Learning Disability Services and attended by core members of the PBS team, the Area Manager, Service Manager and an 'independent' practice development trainer from within the organisation. Each case conference took approximately 45 minutes and the 'leading from the top' approach ensured that everyone was clear about the importance of this strategy and that the values were held at every level of the organisation. At the case conferences we applied our criteria for restriction (as above) to all restrictions in place and a decision was made as to whether the restriction either:

- Was reasonable—It met our criteria so was approved as part of someone's planned support
- Had been removed following the initial review or was removed at the case conference
- Didn't meet our criteria, meaning that a reduction strategy was needed

A few practice examples from the case conferences:

Locks: Throughout the process we found a surprising number of locks on wardrobe doors that restricted clients access to their clothes. The restrictive practice reviews established that these were often in place for very historical reasons for example a client had in the past (10 years ago) been known to take their clothes out of their wardrobe and on occasions damage them. At the internal case conferences we identified that these locks did not meet our criteria for restriction and were therefore required to be removed. This was met with anxiety from the manager and the staff. However, after implementing the removal of the restriction, the historical

behaviour of the client had not re-emerged and staff began to see the positives of the approach. We found that by the time of the next internal case conference that the manager had begun to remove other restrictions to client's personal possessions.

Food: We found a significant number of the restrictions related to food and these were often the most emotive discussion points throughout the process. One example related to a 75 year old client who had a history of high cholesterol. The staff team described how he loved ice-cream and would often ask for it. The staff felt that it was their duty of care to ensure that his cholesterol remained low and therefore restricted the ice-cream to just once a week. The internal case conference established that the client had a healthy BMI and his cholesterol levels were very well controlled by other areas of his diet and there were no other health issues that would preclude eating ice-cream on a daily basis. This restriction did not meet our criteria for the restriction to be an agreed part of the persons support plan and was therefore removed.

Personal Care: We identified instances where a degree of force (more than benign) was being used to perform aspects of personal care, particularly to cut people's fingernails or to shave. The restrictive practice reviews established that in a number of examples this was a long standing practice which the team thought was part of their duty of care, persevering despite the person's resistance. At the internal case conferences we identified that this use of force usually did not meet our criteria and required that alternative, less invasive and restrictive options or de-sensitisation techniques were introduced, as necessary.

Following the internal case conferences we produced restriction reduction strategy documents for each service. We then arranged training for managers of services with high numbers of restrictions that didn't meet our criteria to support them to consider, with their teams, the need to review practice involving restrictions. We also put 'restriction reduction' on the agenda of managers' meetings to discuss the issue both theoretically, in the context of *Positive and Proactive*, and in the practical reduction of restrictions. In addition we expanded the emphasis put on restriction reduction in the PBS training that all staff complete, including in update training for longer serving staff. This contributed to a drip, drip approach to raising awareness of the need to review and consider all practice and specifically to reduce restrictions. Restrictions that didn't meet the criteria formed the agenda of a second round of internal case conferences for each service which were held in early 2015 with restriction reduction strategies being driven forward. These will be reviewed quarterly until the restriction is removed or reduced to a point where it is reasonable, that is it meets our criteria. These reasonable restrictions will be reviewed annually.

Before we started this process it was widely understood in our organisation that physical restraint should only be used as a last resort, when there was no alternative and to keep people safe. However attitudes towards chemical and mechanical restraint were not as shared.

Agreement around what constituted good practice around restrictions on food, use of spaces, timings and choice of activities etc. was even less consistent. There was a range of cultures and attitudes towards restriction and this range was represented within each type and/or size of service.

In the majority of services the values of person centred working, positive behaviour support and the approach to restrictions is in line with our stated values, policy and themes covered in training

courses. In these services staff and managers are aware of the need to minimise restrictions, could explain why those in place are necessary, could describe what they have done to try to resolve an issue before resorting (as a last resort) to a restriction and recognised the need to get approval before employing a restriction. Some managers had already reduced or removed restrictions or were thinking about how to since doing the initial review. Some services could describe the less restrictive intervention of teaching service users that they have tried as an alternative to employing a restriction.

However, there were a minority of services where some staff and managers seemed not to recognise that a restriction may not be appropriate and appeared to have "jumped ahead" to employing a restriction to manage a situation. There were examples of managers who had sought to justify a restriction without attempting to question the need for it, consider an alternative, reduce it or remove it. The predominant culture (in relation to restrictive practice) in these services appeared to be quite old fashioned; there were some features of institutional practice and a cultural tendency to over-restrict. In some services challenging behaviour was being managed by the use of restrictions, apparently without having tried less restrictive alternatives. This means that the level of challenging behaviour may have been being managed or contained by inappropriate restrictions. **In some services the same restriction was in place for all the people living there.**

The initial aim of this piece of work was to gather information around actual practice, some of which may be institutional and no longer considered appropriate, which would lead to changes in practice and so to improvements in people's quality of life. Whilst we have achieved that aim, the process has also contributed to a much broader shift in understanding at all levels of the organisation.

Eighteen months into this process, one of the most gratifying outcomes we have noticed is a real shift in attitudes to restriction and have noticed that this seems to have broadened into refocussing staff on the values that underpin high quality care and support. We have also found that staff are now more likely to question their colleagues, managers and themselves as to whether an approach is appropriate, necessary or the only option. Centrally we have had more enquiries around whether a specific action or intervention may be a restriction and if it is, is it reasonable-does it meet our criteria. Long serving staff talk about this whole process as being a breath of fresh air and an opportunity, or rather a requirement, to question established practices and arrangements.

The process has also challenged our previously held perception that having an established staff and management team in each service led to higher quality services. We have in fact found that the services where we saw the most shift in culture and practices was where there was a change in the Manager. **The strategy to give managers the opportunity to transfer to a different service, as part of professional development and in an attempt to refresh ideas and cultures, has resulted in a significant shift in the managers' ability to address the issue of restrictions in a new post, some describing being more able to think more objectively about restrictions that they weren't involved in establishing. This has been a critical part of the process.**

The changes have not been easy or comfortable for some staff, especially those who have been in post for some time and those in positions of authority, as practice that they have been involved

in or overseen is now being questioned and changed. **We have needed to balance supporting people to change with the expectation that change needs to happen.**

Overall, the process has been complex involving numerous aspects, considerable planning, commitment, time and leadership from the top. We needed to emphasise that this was an organisational approach and ensure that senior managers understood what we wanted to achieve and were on board. We stressed the importance of the process and the internal case conferences, at which attendance by managers at all levels was mandatory. We took a strategic, bespoke approach with different services, planning where to push forward and where to move more slowly, ensuring that key people were where they needed to be before continuing. We ensured that managers felt safe to raise any issues in case conferences, especially if they had concerns around removing a restriction and around our duty of care and we made it explicit that any risk was being shared at the most senior level. We invested considerable time in repeating the key messages at every opportunity and in following the message through into all areas of our work. We have also put effort into working with our training department to make sure there is congruency in the messages that staff hear and being very clear about what those messages need to be.

On a final note, we would once again echo the comments in the Family Mosaic report, *No Going Back - Is institutionalisation being recreated in modern care and support settings? (2010):*

"*This review highlights the warning signs providers should look for. It suggests ways of combating any return to the past. These will only be effective if all commissioners and providers of care and support accept that the institutionalised culture is possible in their service. We would argue that if providers don't believe this has ever happened in their services, it just may be that they haven't looked hard enough".*

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