



Organisational strategies to reduce the use of restrictive practices in services for people with intellectual and other disabilities and behaviour described as challenging or concerning: a postal survey of current experiences of putting policy into practice – summary

A joint BILD/Tizard Centre survey

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Introduction

Revised government policy regarding the use of restrictive interventions *Positive and Proactive Care: reducing the need for restrictive interventions* (Department of Health, 2014) and professional guidance on best practice (Allen, 2011; BILD, 2014) has promoted the reduction of restrictive practices (RP) as a major aim for organisations and professionals providing services for people with intellectual disabilities (ID) and behaviour that may be described as challenging. Other groups that may experience RP are people with mental health problems and children living away from their families. This provides significant pressure on organisations and practitioners to meet this policy/best practice guidance which are subject to monitoring by service commissioners, professionals and CQC inspectors. BILD has played a major role as a campaigning and training organisation and through its provision of an accreditation scheme for providers and purchasers of training in the management of challenging behaviour, based upon a Positive Behaviour Support (PBS) framework. Policy and best practice guidance is specific upon a number of practices that organisations need to provide to reduce RP, eg strategic and practice leadership, data use

to inform practice and a variety of other service practices, eg providing post incident review or debriefing for staff. This study is a more extensive follow-up to a small scale study conducted in 2015 and examines the experiences of organisations in implementing new policy and best professional practice guidance in reducing the use of RP.

The research

Method

A single point in time survey was completed by coaches trained, by BILD, in Positive Behaviour Support or attendees at a BILD PBS conference (May 2016, Liverpool). Ethical approval was given by the Tizard Centre, University of Kent. Surveys were distributed via email attachment, post or completed via Survey Monkey hosted by BILD. Participants could choose to remain anonymous, unless they wanted to receive an individual summary of the results. The majority provided their names and addresses. A reminder and further questionnaire were sent after four weeks to non-responders. This provided no further response.

The questionnaire

The questionnaire was a shorter version of a survey conducted in 2015 and details of this are available on the BILD website at <http://bit.ly/2g3fmBc>

The survey collected demographic information and information in three areas:

- leadership – strategic/top level and frontline
- use of data to inform practice
- staffing and service issues, especially frontline staff's contribution to reducing RP and access to/use of post incident review or debriefing following incidents of RP

Participants

Three hundred potential participants who were registered with BILD as a PBS coach were contacted by email and invited to complete a questionnaire either via Survey Monkey or by requesting the questionnaire as an email attachment or by post. Attendees at the BILD PBS conference (May 2016, Liverpool) were also invited to participate.

The total of 40 respondents comprised 20 who submitted complete questionnaires via Survey Monkey and 20 completed physical questionnaires via email attachment or post. The response rate was low, with under 10% of the PBS coaches invited participating. The low response rate means these results cannot be regarded as representative of all such organisations.

Of the participants, 50% were male, 95% gave their ethnic background as 'white' and one participant identified themselves as disabled. Twenty three participants (57.5%) worked for a charity/housing association, 12.5% worked in the NHS, 17.5% in private sector organisations and 5% worked for social services. The 40 participants worked for 30 different organisations. Seven participants worked for the same large organisation in a range of different contexts e.g. senior support worker working with 38 students and a PBS lead whose remit covered

over 1,000 individuals. Overall, the participants tended to be employed in relatively senior positions in their organisations and were well qualified (see Table 1). Sixty five percent of participants had been working in services for people with learning disabilities for more than 10 years, this increased to 92.5% for over five years. Thirty percent had been working in their current organisation for over 10 years, this increased to 65% for over five years.

Thirty three participants noted how many service users or students were supported by their organisations, around 24,000 in total. Six participant's organisations supported 1,000 or more service users (the highest number recorded 7,000 supported by a Health and Social Care Trust) and 16 participants worked with 100 or less service users, the smallest being group homes for one individual.

Table 1: Employment and qualification categories of participants

Broad employment categories	N	Service(s) supported	N	Qualifications categories	N
Senior teacher	2	Hospital LD or MH	4	Degree Master	12
Assistant manager/psychologist	3	A&T Hospital	2	Degree Bachelor	12
Behaviour nurse therapist/practitioner	4	Hospital forensic	1	PhD psychology	2
CEO	1	Community home, 1 person	13	Registered nurse LD	5
Senior clinical/leadership post, e.g. clinical team leader, clinical director, consultant clinical psychologist	11	Community home, small groups	17	Diploma	7
Front line manager, e.g. service manager	7	Day services	8	Post grad cert.	3
PBS leader, e.g. PBS team leaders, practice development lead PBS & PCAS	6	Community service families/foster care	6	PGCE	3
Residential or senior support worker	3	Residential school	9	CQSW	3
		FE college	8	NVQ levels 5 4 3	14
		Day school	5		
Total	37		73		61

Note: services and qualifications sum to more than total participants because of multiple qualifications and service contexts supported.

Results

Overall views and types of data collected

Table 2 shows that leadership at all levels, using data, informal staff culture and training in behavioural management were felt to be very important. Less certainty was shown regarding the importance of individual staff debriefing and team meetings focussed upon reducing RP.

Table 2: How overall important various factors are to achieving reductions in RP

	Very important	Somewhat important	Not sure	Not really important	Not important
Strategic senior level leadership	34	5	1		
Frontline practice leadership	39	1			
Using data of RP to inform practice	35	5			
Service staff team informal culture	32	6	2		
Individual staff debrief	29	11			
Team meetings focused upon reducing RP	27	11	1		
Staff training in behaviour management	34	5		1	

Organisations collected data upon the following (frequency in brackets): full immobilisation on the floor (20) immobilisation whilst sitting/standing (25) held whilst being escorted (35) seclusion (17) length of time restraint applied (28) PRN medication use (31).

Leadership and management

We adapted a questionnaire by Colton (2004) on readiness of organisational leadership to reduce RP. Participants responded to six statements using a four point scale from:

- no action/no discussion
- little action
- intermittent/inconsistent action
- consistent action

Around a third of participants felt their organisation's leadership had taken little or no action to commit to or act upon recent policy and best practice. Participants working in provider organisations in four sectors (NHS, charitable/housing associations, private & social services) differed in the perceived level of action taken. Adding together scores for no action and little action into (limited action) and for intermittent action and consistent action into (reasonable action) regarding the six statements gave the following results. Overall, three respondents felt their organisations demonstrated limited action for all six statements and 18 that their organisations demonstrated reasonable action for all six statements. Of the four provider sectors: 43% of charitable/housing associations, 20% of NHS, 71% of private and no social services organisations scored reasonable leadership action for all six statements. No charitable/housing associations, 20% of NHS, 14% of private and 50% social service organisations scored limited leadership action for all six statements. For the five NHS respondents 60% scored five or six statements as leadership showing little/no action to reduce RP. Although the sample from some sectors is very small these results suggest that the leadership in some organisations are not committed to meeting policy or best practice guidance, in the view of some of their staff.

Data use to inform practice

Participants responded to a list of nine statements regarding data use within their organisations to indicate 'what is generally true in your organisation', using a five point scale from:

- never or very rarely true
- rarely true
- sometimes true
- often true
- very often or always true

A majority (75%) felt data collected upon physical restraints and PRN medication use was an accurate reflection of its usage and 60% felt data on episodes of seclusion was also an accurate reflection of its usage. Two items sought to examine organisations' perceived responsiveness to consistently high or a sudden increase in the use of RP in services. Sixty percent felt a formal management review would be held if RP was consistently high and 65%

if RP suddenly increased. This leaves a substantial minority of organisations in which management action in these circumstances would not generally be undertaken.

The authors have for several years called for organisations that include planned RP as part of an individual Behaviour Support Plan (BSP) should also include how they plan to reduce RP. These results showed only 43% of organisations having such RP reduction in BSPs being generally true.

Of twelve additional comments on data use, five suggested that changes have been recently made or are underway and an additional two that these changes were not yet focussed upon frontline practice, eg:

“As a frontline clinician I don’t know what happens to this information... certainly not shared with staff.”

“Changes to our support plans are currently underway to detail more specific strategies for reducing restraint...”

Also that changing data use changes may lead to rather different short term results, eg:

“Hard to know if reporting reflects usage... surge in reporting after PBS training which when investigated was due to better understanding of threshold for reporting than actual increase in incidents.... but we were alarmed for a while.”

“Newly developed PBS plans have been introduced... early data collection has identified a vast reduction in RPI, it is too early to state the longer term impact of this approach.”

Staffing issues

The survey covered several areas regarding frontline staff practice, especially debriefing or post incident review. Participants responded to nine statements on staffing issues and 18 statements specifically on debriefing (DB) on a five point scale from strongly disagree to strongly agree.

Responses to three statements showed little consensus on whether: lack of frontline staff, high turnover or lack of time for frontline teams to discuss RP has an impact upon reducing RP. For example, 50% of respondents disagreed, 25% were unsure and 25% agreed that high staff turnover had an impact upon RP reduction.

Two items examined the influence of informal staff culture upon reducing RP. More than half of respondents felt that informal staff cultures did not have a detrimental influence upon reducing RP. However, one third to one quarter felt informal staff cultures were a detrimental influence for trying to reduce RP. More positively and providing the strongest results in this section, three quarters of respondents agreed that: in some services frontline staff are great at coming up with good ideas for reducing RP, that the registered manager focussing upon practice issues (being practice leaders rather than administrators) is the most important

influence and that a core of frontline staff acting as a team of practice leaders can provide good examples of reducing RP.

Debriefing or post incident review

This survey focused upon debriefing (DB) because of a lack of research in this area in the learning disability sector and the smaller study results showed a marked lack of consensus regarding DB.

In this survey two items regarding the purpose of DB showed widespread agreement, ie that the purpose of DB is to learn lessons and improve BSPs and also to provide emotional support.

A range of practical issues were widely seen as getting in the way of DB taking place e.g. time constraints being the main impediment, with 68% agreeing that lack of time was a major reason. Results were more balanced between agreement and disagreement over the influence of shift patterns and poor availability of a manager to conduct DB, with a quarter of respondents reporting they were 'not sure'.

Three items sought participant's views on staff attitudes to DB, ie staff 'reluctance' to attend DB, staff seeing DB as purely an administrative process or to apportion blame. A quarter of participants responded 'not sure' to all three items. Broadly equal proportions of participants agreed and disagreed that staff 'reluctance' had an impact on whether DB took place, more disagreed than agreed that staff feel DB is to apportion blame for RP or just an administrative process. Two other items examined whether staff see individual or team focussed DB as useful/positive. Just under one half of participants felt staff see individual DB and/or team meetings focussed upon reducing RP as positive/useful, with around 35% recording 'not sure' to both of these statements.

Three items examined views regarding leadership commitment to DB, 50% to 60% agreed that senior and frontline leadership were committed to DB and that DB is an organisational priority, 20-25% disagreed and the remainder were 'not sure'. Other items sought to examine whether commitment to DB was reflected in actual practices. Perhaps reflecting the range of perceived leadership commitment, only 50% of respondents agreed that their organisation had a clear policy/criteria for when DB should take place, 50% disagreed that their organisations monitored whether DB took place when it should and 45% disagreed that their organisations had invested resources in training to facilitate DB.

Nine of 13 additional comments on DB acknowledged that improvement was needed in DB practice and systems or that only recently had DB received attention within their organisation, eg:

"DB has only started to have focus over past 12 months... people blame short staffing or time constraints... some also refuse"

“Identified as something we need to improve...”

“We are just in the process of strengthening our DB process which is weak at the moment.”

Successful implementation of DB may need extensive focus upon data collection and the sharing of data, eg:

“DB is included on incident forms and on manager’s part 2 response which is sent to social services and QA manager... Ensures DB is held with staff and clients.”

A lack of training for organisations in DB was mentioned by two participants, eg:

“... further training in DB is needed ... but we are finding it hard to access.”

References

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Colton, D (2004) *Checklist for Assessing your Organization’s Readiness for Reducing Seclusion and Restraint*. Download from: <http://bit.ly/2geFagf>

Department of Health (2014) *Positive and Proactive Care: reducing the need for restrictive interventions*. London: Department of Health

Participants who would like a copy of the full results should contact s.leitch@bild.org.uk

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