Chapter 1

Turning restraint reduction planning into restraint reduction actions

We have aimed to provide a practical and useful guide to action rather than a systematic academic literature review. We point to useful research where this summarises important aspects of practice and include more in the references. Research regarding practice leadership and reducing restrictive practices is limited, but there are studies on the use of data to inform practice and on specific interventions for reducing the restrictiveness of physical or mechanical restraints, eg fixed time release procedures.

Avoiding the slippery slope

The main areas of restrictive practices are physical and mechanical restraints, seclusion and medication use (for details see Paley-Wakefield, 2013 and Allen, 2011). We also include a host of what are sometimes referred to as ‘minor’ restrictions, for example, where staff control access to rooms, personal belongings or daily activities. However, such restrictions may seem far from ‘minor’ to the people who are experiencing them.

Staff who learn to rely upon minor restrictive practices risk the potential of these accumulating, as a ‘slippery slope’ (McDonnell et al, 2014). This accumulation may become part of very restrictive, organisational cultures leading to ‘corrupted cultures of care’ described by Paterson et al (2013). Whilst research evidence to support this idea is limited,
experienced practitioners will be aware of settings where high levels of restrictive practice are sadly still found, such as people spending long periods in isolation or in restraint. In such settings people have limited ways of expressing frustration and unhappiness and are likely to have limited support for their wellbeing.

How we have set out the guide

The format used for this guide is based upon the three stage prevention approach (Allen, 2002; Department of Health, 2014):

- proactive working or primary prevention
- reactive responses or secondary prevention
- tertiary prevention or restrictive responses

These are described in Chapters 3, 4 and 5 respectively. Although we present these as three separate stages, this is not necessarily a graded approach. The level of restrictive response does not have to increase with the severity of the behaviour. We wholeheartedly agree with LaVigna and Willis (2016) that non-restrictive reactive responses can, and should, be used as the first resort at any time in a behavioural crisis. For example, de-escalation can sometimes still be used even if harmful behaviour has already commenced; rather than always seeking physical control.

Within the three prevention stages where relevant we usually describe:

- the key concepts underpinning practice – ie the overarching ideas
- the practice leadership and management needed to support individual restraint reduction
- using data to inform the appropriate use of specific interventions and monitor the rate of individual restraint reduction
- some specific approaches/interventions for reducing restrictions on an individual basis
Leadership, data use and specific interventions were described by Deveau and McGill (2007) as key organisational strategies that support restraint reduction. We believe that these are also the essential strategies of restraint reduction for the individual.

Leadership of day to day practice is needed to create a sense of direction, to guide the staff team towards achieving important outcomes for the person they support. Practice leaders use data. Data is needed to demonstrate how far the team have travelled and whether they are travelling in the right direction, or not. Without data, all we have is opinion and differing opinions (without leadership) do not support motivated, committed teams. Or stronger opinions may lead practice in the wrong direction.

Practice examples and other useful information

In this book there are links, indicated in the text, to sites where you can download complementary resources.

We have included examples based upon real people's lives to illustrate the guidance. These real life examples have had key aspects altered to ensure that particular individuals cannot be identified. These examples may appear very familiar because the factors associated with restricted environments and staff practices are present in the lives of many people needing support from staff.

There is a comprehensive case study available to download and use. The case study summarised in Chapter 7 is written up in some detail in order to demonstrate the multiple components and level of creative thinking needed and to underline the team approach required. The plan can be downloaded as a Word document in case you want to use the template for designing your own plans.
Practice leadership

Current ideas regarding practice leadership have been developed from work by Professor Jim Mansell, Professor Julie Beadle-Brown, Roy Deveau and Professor Peter McGill at the Tizard Centre, by Professor Kathy Lowe and Dr Edwin Jones at Abertawe Bro Morgannwg University Health Board, by Dr Sandy Toogood at Bangor University and by practitioners at United Response (a voluntary organisation that provides support for people with learning disabilities).

Jim Mansell first referred to practice leadership (Mansell et al, 1994) when describing the problems of maintaining support in community services for people with behaviours of concern who were moving out of long stay hospitals. One of the main barriers to maintaining care in smaller community homes was the difficulty of getting area and service managers to act as practice leaders rather than administrators. This problem continues.

Descriptions of practice leadership have been developed in the context of providing Active Support. Active Support changes the style of support from ‘caring for’ to ‘working with’; it promotes independence and supports people to take an active part in their own lives. (For more information, visit www.bild.org.uk/capbs/pbsinformation)

The principles of practice leadership for managers include:

- focusing upon the quality of life of service users and how well staff support this
- allocating and organising staff to deliver support when and how service users need and want it
- coaching staff to deliver better support by spending time with them, providing feedback and modelling good practice
- reviewing the quality of support for service users to engage in meaningful activities and relationships, with individual staff in regular supervision and with staff teams in regular team meetings (Mansell et al, 2004)
Deveau and McGill (2016) explored the wider aspects of practice leadership through interviews with service managers who were good practice leaders. The attitudes and behaviours of the good practice leaders are summarised in a practice paper by Roy Deveau (2015). These include knowing what’s going on in their services, and shaping staff behaviour to develop and implement behaviour support and care plans. Good practice leaders also recognised that staff involvement (ownership) is needed for good and sustained implementation of care plans and that effective leadership and management needs an understanding of both informal and formal aspects of organisational culture.

Practice leaders need to be good at ‘translating’ formal regulation, policy and expert advice into day to day staff practice with the people they support. They also need to be ‘present’ in services to influence practice. If managers and other professionals work offsite they need to ‘find’ onsite staff to act as practice leaders, eg to champion their advice and supervise staff practice.

The common organisational practice of extending the number of separate services and administrative demands of service managers may impact negatively upon their ability to provide practice leadership. Where managers or supervisors fail to provide practice leadership the practices of direct contact staff teams are essentially left to chance. Some organisations have realised that they need to develop and support staff, who are present in services, to lead good practice. Those organisations that fail to take the leadership of practice seriously are taking a risk. Those staff with strong personalities are likely to become unofficial practice leaders and may lead the service in the wrong direction.

United Response have developed a free user friendly resource describing the vital characteristics for good practice leadership (United Response, 2016; available at www.unitedresponse.org.uk/practice-leadership).