

Three steps to positive practice

A rights-based approach when considering and reviewing the use of restrictive interventions

ADVICE AND INFORMATION



Acknowledgements

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1. Executive summary

The 21st century requires fundamental changes in how health and social care professionals and support staff deliver care. One of these changes requires embedding the delivery of care, treatment and services in a rights-based approach, which places the person at the centre of all we do. The challenge for health and social care staff is to positively manage risk and deliver care whilst navigating the complex legal and ethical processes which must guide practice.

This is particularly important in services, settings and situations where people may be subject to restrictive practices. Restrictive practices are sometimes necessary and could form part of health and social care delivery. In this context, it is essential that any use of restrictive practice is used in a therapeutic context and is ethical and lawful. It is evident that many teams and agencies have developed positive practice in this area, however, this is not embedded comprehensively across the health and social care system. Numerous investigations and reports have exposed significant and repeated failures, which in some circumstances have had devastating outcomes for people. These investigations and reports clearly highlight the need for continuing reform.

In the current world of health and social care, staff must continue to build on evolved ways of thinking, use more positive language, and embed cultures of practice that deliver different, more enabling services. People must be supported to make their own decisions and to be involved in designing what their care, treatment and support looks like, or ‘best interests’ determinations made about care and treatment for those unable to make their own decisions. This will assist in ensuring any use of restrictive practice impinges as little as possible on people’s rights, and is the least restriction required to keep the person, or others, safe.

This can be achieved by using the *Three Steps to Positive Practice* framework, which has been developed by a multidisciplinary group based in Northern Ireland, involving the Royal College of Nursing, the Royal College of Psychiatrists, the British Association of Social Workers Northern Ireland, and the Royal College of Occupational Therapists. The framework is designed to assist health and social care staff who may be involved in practices where people in their care may be restricted in some way and guide professional decision-making when restrictive practices are being considered as part of care and support provision.



Three Steps to Positive Practice is a framework designed to help the health and social care workforce think about culture and practices, and guide professional, ethical and legal decision-making when considering the use of potentially restrictive practices. It is a continuous and cyclical process which requires health and social care staff to action the three points below.

- **Consider and plan** – consider if the planned intervention is a restrictive practice using the definition, consider other less restrictive measures, and consider if the planned intervention is therapeutic in its intention.
- **Implement the safeguards** – use a rights-based approach within professional accountability and legal frameworks to ensure that any restrictive practice is used only when deemed to be in the person’s best interests.
- **Review and reflect** – ensure that a regular and timely review of the use of a restrictive practice is built into a therapeutic plan to meet the person’s needs, including reduction and/or removal of the restrictive practice as soon as is possible, and appropriate use of professional reflection support systems that consider the impact of the use of restrictive practices.

The framework should be used at the points of assessment, implementation, evaluation and review, and in situations where the use of restrictive practices has been in place for some time or are associated with a particular environment.

It provides guidance to support health and social care staff, irrespective of their roles, to have the courage to act differently. With an emphasis on a proactive, evidence-based and rights-based approach to practice, all health and social care staff can ensure that wherever they are providing care, treatment and support, they are practising in the best interests of those in their care, and in accordance with legislation and the requirements of their professional codes of conduct, behaviours and standards.

In daily practice, the emphasis must include an understanding of why a person might behave in a way that presents a perceived or actual risk, and/or in a way that challenges carers and staff, with the understanding of a distressed reaction as an unmet need.

Positive practice means that real or perceived risks, or behaviours that challenge staff, do not overshadow an understanding of why the individual is behaving in that way, what is causing their distress and what their underlying needs are. Risk assessment and needs assessment should be complementary of each other, and restrictive practices must enable the individual’s safety and therapeutic needs to be prioritised. This understanding is vitally important in decision-making processes around the use of potentially restrictive practices.

The *Three Steps to Positive Practice* framework is not a document that describes how to implement or when to implement a restrictive practice, nor will it contain a ‘list’ of restrictive practices, as that would be an impossible task. This document will be of use to all health and social care staff who work in services where individuals may be subject to restrictive practices, regardless of setting or specialty.

The principles and values discussed in the examples highlighted in this document can be translated and applied in the different contexts and environments in which they practise. This publication will be helpful to health and social care staff across the UK, although there are some differences in the legislation across the four countries.

It is imperative that health and social care professionals and any staff involved in the delivery of treatment, care and support are aware of and understand the legislation that is relevant to their work. Staff should also ensure they keep up to date with changes and developments in legislation and guidance regarding restrictive interventions and a rights-based approach in a health and social care context. One such example is the phased implementation of the Mental Capacity Act (Northern Ireland) 2016, which is the first phase in respect of deprivation of liberty in Northern Ireland, with future implementation phases planned.

A range of useful guidance documents have been published which focus on the whole arena of restrictive interventions. This publication provides a reference to those documents rather than repeating their content.

2. Introduction

Historically, health and social care staff have understood practices to be restrictive if they fell within the categories of physical or mechanical restraint, with some also including chemical restraint in their understanding of the term. Many health and social care staff only recognise the most obvious forms of restraint as being restrictive.

Reports from health and social care regulators describe variance in understanding of the term “restrictive practice”, across both hospital and community settings, and the range of services for children, adults and older people.

The Care Quality Commission inspection findings post-Winterbourne View described confusion and concern among staff in the awareness and use of restrictive practices. This resulted in an over-reliance by some providers on physical and/or chemical restraint, rather than positive behaviour support, and managing the environment to remove or reduce the triggers which could cause someone to behave in a way which could be seen as challenging.

A report by the Northern Ireland Regulation and Quality Improvement Authority (RQIA) in 2014 in relation to the use of restrictive practices noted a similar uncertainty. Staff described a lack of understanding of restrictive practices, inconsistency in the use of restrictive practices, and an absence of robust and up to date guidance. There was also little understanding of any governance arrangements in each health and social care trust to monitor the use of restrictive practices.

Can you list the restrictive practices you use or have used in the past?

Bed (cot) sides; use of lap belts on wheelchair/commodore/other harness/restrictive equipment; use of “when required/prn” medication; locking doors (including the use of baffle locks) e.g., ward doors, bedroom doors, kitchen doors, which restrict free movement within the ward (RQIA, 2014).

A survey in March 2016 by the Royal College of Nursing, Northern Ireland, on behalf of a multi-disciplinary working group, showed similar results.

The variance in understanding of the term “restrictive practice” means that not all health and social care staff are clear about what restrictive practices are or what makes a practice potentially restrictive. Some staff demonstrate a very narrow understanding of the term “restrictive intervention”, or even no understanding of the term.

What is your understanding of the term “restrictive intervention”?

“I am not familiar with the term restrictive intervention.”

“I have no idea what it means.”

“Using physical force to restrain an individual who may be endangering themselves or others.”

However, it is noted that some staff demonstrate a deeper understanding of the term, and the need for an evidence-based and rights-based approach to the use of restrictive practices.

What is your understanding of the term “restrictive intervention”?

“Any practice which interferes with the liberty, and free choice of self-determination of any person.”

“Any intervention: physical, emotional psychological, mechanical or pharmacological which restricts or prevents an individual or group of individuals from undertaking a specified range of activities that are time-limited; utilised as a last resort and which are intended to be withdrawn at the earliest opportunity.”

“Any intervention which impacts on an individual’s freedom to make his/her own decisions or restricts his/her freedom of movement.”

“Any type of intervention (mechanical, physical, environmental or social) which is used to intentionally or unintentionally limit someone’s liberty.”

The lack of a shared understanding of what makes a practice potentially restrictive contributes to health and social care staff routinely implementing practices that they do not realise are restrictive and are possibly unlawful. For example, Care Quality Commission monitoring of Deprivation of Liberty Safeguards (DoLS) in England in 2020/21, as part of their oversight of the use of the Mental Health Act (MHA) (2005), demonstrated continued confusion around people’s legal rights under the MHA, the Mental Capacity Act, and the DoLS, with some services making subjective interpretations of guidelines to deprive someone of their liberty. Potentially some people may have been or are still unlawfully deprived of their liberty.

If staff using restrictive practices are unclear about what restrictive practices are, or are unable to identify practice as being restrictive, it is unlikely that they will be able to develop and implement less restrictive practices/strategies. Nor will they be able to ensure that necessary safeguards are in place whilst the restrictive practices are being used. In some cases, this has meant that staff are making potentially unlawful decisions by imposing unnecessary or disproportionate restrictions on a person’s liberty. These restrictions are often implemented without a rationale, or an evidence base for their use, and without consideration of the impact on an individual’s human rights, and without appropriate safeguards in place. Additionally, they are often seen as long-term solutions and are not subject to regular review, meaning that consideration is not given to reducing the level of any restriction.

3. What makes a practice restrictive?

Restrictive practices can be difficult to define and even more impossible to list, simply because they are not always obvious or the practices may be justified in the context of keeping someone 'safe'.

Definition of restrictive practice

Restrictive practices are those that limit a person's movement, day to day activity or function.

Put simply, restrictive practice means any actions or measures that stop a person from doing something they want to do or doing it in the way they want to do it. Restrictive practices can also mean actions that make a person do something they do not want to do or prevent a person from having something they want.

Some practices can be easily identified as restrictive, like physically restraining a person, locking doors to keep someone confined to a certain area, or the use of medication that intends to sedate an individual. Other restrictive practices can be more subtle, such as only allowing someone to watch television for a certain amount of time every day, imposing a 'bedtime', or having rigidly set mealtimes. There are also times when certain types of care, support or treatment could become a potentially restrictive practice; for example, prescription of certain medications that are not designed to restrict, but which can cause adverse sedation, like sleeping tablets.

It should also be noted that restrictive practices can be psychological. Attempting to exert control or force compliance by what is said or how it is said, and/or the use of body language and nonverbal methods of communication, are equally restrictive.

In some cases, the person will be restricted because of restrictions placed on others. This includes cases where the person's family is not allowed to have contact with them for safeguarding reasons. In other situations, where a group of individuals live in one place, restrictions that are necessary for one person could impact negatively on their fellow residents.

Restrictive practices may also involve control and/or abuse of a person's financial matters, a type of restrictive practice that is often unrecognised as such.

Health and social care staff must consider all the above possibilities in determining if a practice is potentially restrictive.

It is recognised that there are occasions when the use of restrictive practice is unavoidable to keep the person and/or others safe from harm. Restrictive practices are not inherently wrong, harmful or illegal. They can help to keep people safe and create opportunities for them to learn new skills. What might be restrictive for one person might not be restrictive for another, and what might be necessary for someone one day might not be needed to keep them safe the next day.

When restrictive practices are used as part of a comprehensive therapeutic plan that is outcomes focused and fully embraces a person's rights, and when there is no other way to keep people safe, then they can and often should be used.

In these situations, health and social care staff must ensure that the care, treatment and support they provide is safe, effective, person-centred, and provided within legal, ethical, and professional accountability structures.

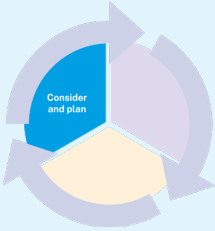
All health and social care staff should be able to identify whether the purpose of the proposed restriction is the protection of the person or the protection of others, and clarify whether the legal framework under which the care is being provided, gives authority for the proposed restriction, for example, mental health legislation.

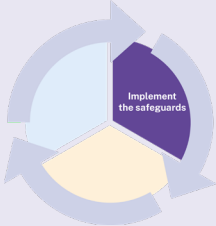
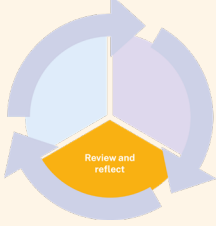
The use of any restrictive practice must be a necessity, used only as a last resort, the least restrictive measure possible, proportionate to the risk and/or type of behaviour, regularly reviewed and used for the shortest length of time possible. It should facilitate the most effective and therapeutic intervention possible with regards to reducing behaviours associated with risk and/or harmful outcomes. The need to use a restrictive practice must be agreed by a multi-disciplinary team, with input from the person and/or their representative. Before implementation, there must be a pre-determined plan to regularly review the use of a restrictive practice with the aim of reducing or removing the restriction.

In some cases, the supporting legal framework or regional/organisational policies require certain professionals to be involved, e.g., the medical officer and social worker in respect of the Mental Health (Northern Ireland) Order, 1986. Any use of restrictive practices should be supported by a framework of robust guidance, assessment, training, supervision, record keeping and governance, and always used in accordance with the requirements of legislation.

4. Three steps to positive practice

Three Steps to Positive Practice is designed to encourage careful consideration and reflection on the use of any potentially restrictive practice, before it is implemented, and throughout the entire timeline when the restrictive practice may be in use. The three step process is applicable at the points of assessment, implementation, evaluation and review, and in situations where the use of restrictive practices have been in place for some time, or are associated with a particular environment. The steps are intended to assist health and social care staff to ensure that the decisions they make and the actions they take are consistent with legal, ethical and professional accountability frameworks, every time a decision is made or an action is taken.

| | | |
|--|--|--|
| <p>Step 1: Consider and plan</p>  | <p>Has a multi-disciplinary discussion around how to keep the person (or others) safe resulted in recommending a potentially restrictive practice?</p> <p>Does the proposed intervention or the way in which care is being delivered:</p> <ul style="list-style-type: none"> • limit the person’s movement, daily activity or function • result in the loss of objects or activities that the person values • require the person to engage in a behaviour that he/she would not engage in given freedom of choice? <p>If you answer yes to any of these questions, then the proposed intervention is potentially restrictive.</p> | <p>You must ensure that a multi-disciplinary discussion has taken place before you proceed. The plan must be discussed with the person and/or their representative, including advocates. Decisions must be clearly documented and communicated to all parties.</p> <p>Remember that some decisions may require a legal opinion.</p> |
| | <p>What other less restrictive options have been considered?</p> | <p>You must ensure that other, less restrictive options, starting from the point of no restriction or least restriction have been discussed. A clear rationale must be documented to evidence why they are not appropriate at this time.</p> |
| | <p>How will the proposed intervention reduce risk, and build or retain the person’s skills and the opportunities available to them?</p> | <p>You must ensure that the proposed intervention is the best and only approach to reducing an identified risk and achieving therapeutic benefit. You must ensure that the proposed intervention is a positive and evidence-based therapeutic approach which clearly articulates how the intervention will reduce the identified risk. The intervention must also support the person’s ability to develop and retain skills and learn through experiences.</p> |

| | | |
|--|--|---|
| <p>Step 2: Implement the safeguards</p>  | <p>Is this proposed intervention considered to be in the person’s best interests?</p> | <p>You must consider the areas of capacity and consent when deciding if the proposed intervention is in the person’s best interests. You must ask questions if you are not satisfied that the evidence confirms that the implementation of the proposed intervention will be in the person’s best interests.</p> <p>Documentation must clearly record the formal discussions and processes involved in reaching a multi-disciplinary agreement.</p> |
| | <p>How do I ensure I am using a rights-based approach?</p> | <p>You must ensure that the plan is fully considerate of human rights and the FREDA principles (see page 15), and can be implemented under an appropriate legal framework. You must support the person and their representatives to understand their rights and provide information on how they can raise any objections or complaints.</p> |
| | <p>What professional accountability frameworks must be considered?</p> | <p>You must ensure that the decisions you make are ethical and fully considerate of your individual professional responsibilities, and your organisation’s accountability and governance structures.</p> |
| <p>Step 3: Review and reflect</p>  | <p>Has a regular and timely review of the intervention been planned?</p> | <p>You must ensure that a pre-determined timeframe for review of the intervention has been agreed before the intervention is implemented.</p> |
| | <p>Is there a plan to ensure that the intervention will be for the shortest length of time possible?</p> | <p>You must ensure there is a positive therapeutic care plan that includes a planned reduction of the restrictive practice. The review must re-consider steps 1 and 2.</p> |
| | <p>Are there mechanisms available to you as an individual and to your team to enable reflection about the impact of using restrictive interventions?</p> | <p>You must recognise that the use of restrictive interventions, especially restraint, can have a negative emotional impact. It is important that opportunities for supportive discussion and reflection are made available to you and your colleagues.</p> |

5. Outlining a rights-based approach

A rights-based approach allows health and social care staff to formulate their decision-making based on certain values, principles, and the law, whilst ensuring that the person and their wishes and needs are at the centre of that decision-making process.

This approach is twofold. Firstly, a rights-based approach to health and social care means ensuring that the fundamental rights of individuals enshrined in law, known as “human rights” (detailed below), are upheld and influence decision-making about health and social care delivery. Secondly, rights-based practice is shaped by the core principles and values that put the person receiving the service at the centre of decision-making about that service, known as the FREDA principles (set out on page 15).

A rights-based approach means that when health and social care staff put in place measures which infringe on an individual’s human rights, they must ensure that these are necessary and proportionate to any potential harms should the restrictive measures not be in place. They must also ensure that the appropriate legal frameworks and procedural safeguards underpin all agreed interventions.

Human rights

Human rights are about our basic needs as human beings. They capture the core rights we are all entitled to so that we develop our potential and live our lives in dignity. They apply to everyone, adults and children, with no exceptions for any individual or groups of people.

The application of human rights is particularly relevant to rights-based health and social care provision. These rights are realised through the European Convention on Human Rights (ECHR), which were incorporated into UK law in the Human Rights Act (1998).

There are some differences in how the ECHR Articles operate. Some rights are known as absolute rights, for example, Article 3 – “No-one shall be subjected to torture or inhumane or degrading treatment or punishment.” Everyone is entitled to the full operation of this right, and it cannot be interfered with under any circumstance.

Limited rights are rights that can be interfered with in explicit and finite circumstances, for example, Article 5 – the “Right to liberty and security.” No-one can be deprived of their liberty, except in certain legal circumstances.

There are also some rights known as qualified rights, where interference may be justified to balance the rights of the person and the needs of the wider community, or in the interests of the state. These rights include Article 8 – “Right to respect for private and family life,” and Article 9 – “Freedom of thought, conscience and religion.”

The United Nations Convention on the Rights of the Child (UNCRC) and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) are international treaties, ratified by the UK, which set out the fundamental human rights of children and of people with disabilities. They aim to ensure that children and disabled people enjoy the same human rights as everyone else, and that they can participate fully in society by receiving the same opportunities as others. The ratification of these conventions ensures that the full enjoyment of human rights by children and by disabled people are promoted and protected, safeguarding full equality under the law.

| Specific Article | | | |
|--|-------------|--------------|--------------|
| What it says | ECHR | UNCRC | UNCPD |
| <p>Right to life The right to life is protected by law.</p> | 2 | 6 | 10 |
| <p>How might this right be breached in practice? Measures or actions that lead to death through negligence, severe malnutrition, decisions about life saving health care treatment, end of life/assisted suicide.</p> | | | |
| <p>Prohibition of torture The right not to be tortured or treated in an inhumane or degrading way.</p> | 3 | 37 | 15 |
| <p>How might this right be breached in practice? Measures used to control behaviours which are shaming and humiliating, for example, not being allowed to have a meal or being made to stand outside as a means of managing a perceived 'bad behaviour'.</p> | | | |
| <p>Right to liberty and security The right not to be deprived of liberty "arrested or detained" – except where there is proper legal basis.</p> | 5 | 37 | 14 |
| <p>How might this right be breached in practice? Measures used to prevent behaviours perceived to be a risk to self or others, for example, deprivation of liberty without the appropriate legal authorisation; improper or inappropriate admission/detention to inpatient care; use of chairs with straps; use of seclusion or "time-out" interventions.</p> | | | |
| <p>Right to respect for private and family life The right to family, relationships, wellbeing, privacy, correspondence, and home, including seeing family and being heard.</p> | 8 | 16 | 22 23 |
| <p>How might this right be breached in practice? Measures which prevent participation in family, social, or recreational activities, for example, structural adaptations to accommodation which separate/isolate the person from others they live with; preventing or limiting contact with family or friends; and use of restrictive clothing to limit perceived inappropriate touch or self-harm.</p> | | | |
| <p>Prohibition of discrimination The right not to be treated differently because of race, religion, sex, political views, or any other personal status, unless this can be justified objectively.</p> | 14 | 2 | 5 |
| <p>How might this right be breached in practice? Reducing access to services or opportunities available because of a perception of risk or lack of resources to allow for suitable adaptation and support, for example, a reduced school day; exclusion from social clubs; and inaccessibility to buildings, premises, transport etc.</p> | | | |

FREDA principles

A rights-based approach also means practice and services shaped by a set of core values and principles that put the person at the centre of the delivery of health and social care. This can be achieved by applying the FREDA principles which underpin the Articles in the human rights frameworks.

The FREDA principles are the basis of good health and social care which should be used mutually and individually to inform decision-making, supported by inclusive communication strategies. They are a useful guide for health and social care staff to ensure that everyone they are providing care, treatment, support and/or services for is:

- treated with respect and dignity
- provided with care which best suits their individual needs
- able to live free from abuse, neglect, or discrimination
- able to lead as fulfilling a life as possible
- able to participate in the choices and decisions made about their lives.

| Core principle | What it means | What this means for health and social care staff |
|-----------------|--|--|
| Fairness | Ensuring that people who use services have access to fair processes for getting their views heard and being actively involved in decision-making about their care and treatment. | Health and social care staff must ensure that people in their care are provided with any practicable help to understand the information about the decision to be made and to communicate their views and raise objections; for example, enabling access to independent advocacy. |
| Respect | Ensuring that people who use services are valued as individuals. Their values and beliefs must be understood and embraced. What is important to them must be viewed as important by health and social care staff, even if this conflicts with their staff's own views. | Health and social care staff must consider and support the views, wishes and feelings (as far as is practicable) of people in their care and facilitate those whenever possible, including for example, different lifestyles, religious observances and sexual orientation. |

| | | |
|------------------------|---|---|
| <p>Equality</p> | <p>Ensuring that people who use services do not experience discrimination and are not treated differently regardless of their age, disability, gender, race, religion and belief, sexual orientation, gender identity and pregnancy and maternity status.</p> | <p>Health and social care staff must promote equality and non-discrimination by actively removing any potential barriers to accessing services or opportunities, and enable maximum participation; for example, support to attend appointments. Organisations and individual health and social care staff must be aware of their legal obligations to make reasonable adjustments to service provision that ensures equitable access for disabled people.</p> |
| <p>Dignity</p> | <p>Ensuring that people who use services are always treated with compassion and in a way that values them as a human being and supports their self-respect.</p> | <p>Health and social care staff must ensure that the provision and delivery of care and support is provided in an individualised and holistic manner, which promotes and protects the person's self-esteem and self-respect; for example, ensuring that bathroom doors are closed during personal care tasks, and avoiding the use of wheelchairs for individuals who are independently mobile.</p> |
| <p>Autonomy</p> | <p>Ensuring that people who use services can exercise the maximum amount of choice and control possible – in their individual care and treatment, in service development and in their relationships with others.</p> | <p>Health and social care staff must ensure that people in their care have the opportunities and support to participate in making choices about what happens to them, what they do each day, choosing food, clothing activity etc., based on clear, sufficient, and relevant information, for example, co-production of personal safety plans.</p> |

The RCN believes that a human rights-based approach is essential, both in developing health policies and services and in individual practice, and that nurses have a particular obligation to “safeguard and actively promote people’s health rights at all times and in all places” (International Council of Nurses, 2011).

Human rights and nursing - RCN position statement:
rcn.org.uk/professional-development/publications/pub-004249

6. Decision-making

When health and social care staff are involved in the design or delivery of care, treatment or support that includes potentially restrictive practice, they must consider all relevant legal and professional frameworks as part of their decision-making and be able to justify their decisions and actions. Issues of capacity and consent, and best interests considerations will be most pertinent. This is the case whether they are acting individually or as part of a team.

Professional accountability

Professional accountability means being personally answerable to the law of the land for all actions or omissions (including what is written or is not written, what advice/information/communication is given or is not given), while fulfilling a contract as a health and social care employee. As a professional and/or a registrant, health and social care staff are also accountable to their registering body.

Health and social care staff must act first and foremost to care for and safeguard those in their care.

What is good medical practice?

Good medical practice describes what it means to be a good doctor. As a good doctor you will:

- make the care of your patient your first concern.

General Medical Council:

[gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice)

Health and social care staff must display a personal commitment to the standards of practice and behaviours set out in their relevant codes of practice and standards. They must show professionalism and integrity and work within professional, ethical and legal frameworks.

As a social care worker, you must be accountable for the quality of your work and take responsibility for maintaining and improving your knowledge and skills.

Standards of Conduct and Practice for Social Care Workers:

[niscc.info/app/uploads/2020/10/Social-Care-Workers.pdf](https://www.niscc.info/app/uploads/2020/10/Social-Care-Workers.pdf)

The values and competencies required of health and social care staff dictate an understanding of current relevant legislation which must be applied in all areas of practice. Where health and social care staff lead teams of other staff, they must ensure that all team members understand how to apply their practice legally and ethically.

4.2.1 - Your actions are based on a set of logical professional reasons, which are themselves informed by professional knowledge, skills and experience, and published resources.

4.2.1.1 - You are able to explain and record your professional rationale for anything you do for/with or in relation to those who access the service.

4.2.1.2 - You use national guidelines, current policy, research and best available evidence to underpin and inform your reasoning, rationale and practice.

4.2.1.3 - Your practice is shaped or structured according to recognised theories, frameworks and concepts that are applicable to occupational therapy.

Professional standards for occupational therapy practice, conduct and ethics, Royal College of Occupational Therapists, 2021: rcot.co.uk/publications/professional-standards-occupational-therapy-practice-conduct-and-ethics

This is particularly important around the areas of capacity and consent, and essential for health and social care staff working with children and young people. The laws around capacity, and child and parental consent must be clearly understood, including knowing who can give or decline to consent for the implementation of any treatment or restrictive practice.

Capacity to make decisions about care, treatment and support

Professional guidance for health and social care staff regarding consent advises that all adults are presumed to have the ability to independently make decisions about any aspect of their care, treatment and/or support. The ability to make decisions independently is often referred to as “having capacity”.

The seven principles of decision-making and consent

“Doctors must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements.”

General Medical Council, 2020 (principle five):

gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent/the-seven-principles-of-decision-making-and-consent

The requirement to presume that a person aged 16 and over is capable of independently making decisions about any aspect of their care, treatment and/or support has been protected within relevant UK laws.

Who assesses capacity?

The starting point for all interventions is the presumption that a person has the capacity to make their own decisions and can provide or withhold the necessary consent. However, it is important to identify when someone lacks capacity and cannot give meaningful consent.

All health and social care staff should consider this when planning and delivering care and take appropriate action if they have a reasonable belief that someone lacks capacity, following the required legislative and best practice processes. Reasonable belief and the lawful actions that can be taken in relation to care, treatment or support are governed by relevant capacity legislation.

In some situations, a more formal assessment of capacity must take place, and should be documented, usually by the person recommending the intervention, or who has a significant role in delivering the intervention.

Proceeding with some interventions, or in some situations, will require health and social care staff to follow legislatively mandated processes. They must act in accordance with the relevant capacity legislation for the jurisdiction they are working in. To note, undertaking a formal assessment of capacity is not confined to medical practitioners. Relevant capacity legislation and supporting codes of practice set out the range of professionals who can undertake formal assessment of capacity, once suitably qualified to do so.

In Scotland, legislation which provides safeguards in relation to capacity to make decisions independently requires the person to be encouraged to use any skills they have to do so. Legislation in England, Wales and Northern Ireland explicitly requires that all appropriate help and support is provided to a person to enable the individual to make independent decisions about matters affecting them, before concluding that an individual is unable to do so. Whether the person has a particular condition is irrelevant to the question of whether they have capacity to make decisions in any matter.

Appropriate help and support to make a decision about a matter

1(4) - The person is not to be treated as unable to make a decision for himself or herself about the matter unless all practicable help and support to enable the person to make a decision about the matter have been given without success.

Mental Capacity Act (Northern Ireland), 2016.

Practicable help and support could include:

- providing information in an easy-to-read or pictorial format
- using the persons preferred language and/or communication system e.g., having an interpreter available, using Makaton
- seeking assistance from close family or carers
- seeking expert advice and support from professional speech and language services
- ensuring that communication aids, such as a hearing aid, are in working order and are used
- assessing the environment for noise levels, comfort, distractions
- having conversations at the time of day when the person is feeling their best
- returning to the conversation later if a person gets agitated or disengaged
- avoiding times when medications that may affect a person's ability to engage have been administered.

This is not a definitive list; the key is an individualised approach that best supports a person's ability to make decisions independently and therefore provide or withhold consent to care and treatment. Where a person lacks capacity, any decision to provide care, treatment and/or support must be in the person's best interests.

Country specific legislation provides guidance where a lack of capacity to make decisions independently has been established; health and social care staff must ensure their practice in this area meets the legislative, ethical and regulatory requirements.

The relevant legislation also provides for a person to make what health and social care staff might consider to be an "unwise decision", or as described in Scottish legislation, "acting as no prudent person would act". Making unwise decisions does not amount to a "lack of capacity" to make decisions.

Capacity should be reviewed at appropriate intervals, for example, if it appears that the person's understanding of their situation has changed, or there are changes in the restrictions that health and social care staff consider may be necessary.

It is important to recognise the concept of emerging capacity in children and young people. Cognitive and emotional skills are acquired differentially throughout adolescent development. Whilst decision-making is primarily dependent on information retention and processing, emotional maturity is needed to make balanced, unwavering decisions, and to cope with the consequences of those decisions. It is important to assess the child's maturity and understanding on an individual basis, and to remember that the severity of the consequences of the decision should be considered.

Consent

It is a general legal and ethical principle that informed and valid consent must be obtained before commencing an examination, starting treatment or physical investigation, or providing care. These principles reflect the rights of a person to determine what happens to their own bodies or what shapes the care and support they receive and is fundamental to good practice. Health or social care staff who do not respect these principles may be liable both to legal action by the person in their care and action by their regulatory body.

- An adult who is capable of making a decision must freely give consent before any medical treatment or care is given.
- Consent is only valid if the patient has sufficient information about the benefits and risks of treatment to make an informed choice.
- Consent may be communicated verbally or in writing or may be inferred from the patient's actions.
- Consent may be withdrawn at any time before the treatment has been given.
- The person providing care or treatment must ensure that consent has been given e.g., a nurse must ensure that consent has been given before administering medication and a health care assistant must ensure that consent has been given before washing a patient or taking blood.

RCN, Consent in Northern Ireland, 2022:

[rcn.org.uk/Log-In?returnUrl=https%3a%2f%2fwww.rcn.org.uk%2fclinical-topics%2fConsent-in-Northern-Ireland](https://www.rcn.org.uk/clinical-topics/Consent-in-Northern-Ireland)

A person who has capacity is able to provide or withhold consent for examination, treatment and/or care. If an adult makes a voluntary and appropriately informed decision to refuse care, treatment and/or support, this decision must be respected.

3.5.1 - Before any person is provided with any intervention or treatment, or undergoes any investigation, it is necessary to obtain that person's informed consent. The fact that a person has given their consent is not sufficient.

Consent is only valid if it is properly 'informed', meaning that all relevant information has been given to the person in a way that they understand. The process of providing information will depend, in each case, on an assessment of the information relevant to that person's decision at that point in time. Obtaining informed consent is a continuing requirement and may need repetition if there is repeated intervention or any change in the intervention offered; it is not a one-off event. Unless restricted by mental health and/or mental capacity legislation, it is the overriding right of any individual to decide for themselves whether or not to accept occupational therapy.

Royal College of Occupational Therapists, Professional standards for occupational therapy practice, conduct and ethics, 2021: rcot.co.uk/publications/professional-standards-occupational-therapy-practice-conduct-and-ethics

Health and social care staff must be aware that a person's ability to make decisions may depend on the nature and severity of their condition, or the difficulty or complexity of the decision. Some people will always be able to make simple decisions but may have difficulty if the decision is complex or involves several options. Others may be able to make decisions at certain times but not on all occasions, because fluctuations in their condition impair their ability to understand, retain or weigh up information, or communicate their wishes.

The importance of communicating with a person in a way that supports their understanding and facilitates their ability to provide or withhold consent and participate as fully as possible in decision-making processes cannot be underestimated. The ability to understand and express a decision effectively is central to all of the FREDA principles, and more specifically fairness, equality and autonomy.

People with speech, language and/or communication needs will require support to understand and make decisions in many circumstances. This is because communication difficulties can affect the way people understand, think, and talk about decisions. Expert advice and support can be provided by speech and language therapy services and may be a vital component of decision-making processes and outcomes, including assessing capacity to consent and best interests decision-making.

Miss Colgan: Practicable help and support to make a decision; informed decision-making; respecting a person's right to provide or withhold consent

Miss Colgan is a 44-year-old and has an intellectual disability. She experiences very heavy and painful periods. Treatment has done little to alleviate her symptoms and a hysterectomy has been suggested to eradicate her symptoms. Miss Colgan's sister informs medical staff that she is giving her permission for the surgery. However, medical and nursing staff understand that no one can consent to the surgery on behalf of Miss Colgan. If Miss Colgan lacks the capacity to provide informed consent for the surgery, then a best interests decision-making process must be followed.

The nursing staff consider what reasonable adjustments must be made and what practicable help and support can be provided to Miss Colgan. A speech and language therapist and a registered learning disability nurse assist the team and provide pictorial information to support the discussion with Miss Colgan about her medical condition, the proposed surgery, what might happen if she refuses the surgery, and what the alternative treatment would be. Miss Colgan's sister is also involved in the discussion.

At the end of the discussion, everyone involved is satisfied that Miss Colgan has understood the information and has retained it long enough to allow her to weigh up and appreciate what she has been told. Miss Colgan informs the medical team that she did not want to have a hysterectomy but consents to the lesser radical endometrial ablation procedure.

This approach supported the successful application of all the FREDA principles and values, and Miss Colgan's right to provide or withhold consent for treatment.

For consent to be valid, it must be given voluntarily and freely, without pressure or undue influence, by an appropriately informed person who has the capacity to consent to the intervention in question.

It is important to note that there may be a requirement for consent to be obtained more than once where multiple interventions may be required. Capacity to consent must always be considered according to the specific time, situation, and decision to be made.

As with capacity, the person's ability to consent to an intervention should be reviewed at appropriate intervals, for example, if it appears that the person's understanding of their situation has changed, or there are changes in the restrictions that are considered necessary.

Adults (people aged 18 and over) must provide consent on their own behalf. No-one can give or withhold consent on behalf of another adult unless special legal provision for particular purposes has been made for this.

The law permits young people aged 16 to 17 to consent to their own medical treatment in the same way as adults. Legal advice should be sought in certain circumstances where a person of this age is refusing treatment, particularly a treatment that could save their life or prevent a serious deterioration in their health.

Children and young people under the age of 16 are not automatically presumed to be legally competent to make decisions about their health or social care. However, the courts have stated that a child under 16 will be competent to give valid consent to a particular intervention if he/she has "sufficient understanding and intelligence to enable him or her to understand fully what is proposed" (sometimes known as "Gillick competence").

In other words, there is no specific age when a child becomes competent to consent to treatment; it depends both on the child's stage of development and on the seriousness and complexity of the treatment being proposed. The health and social care staff must decide whether the child is competent in understanding the nature and purpose of the treatment and the consequences of having it or not having it. The child must be able to understand, retain, use, and weigh this information, and communicate their decision to others.

The legal framework for the treatment of 16 to 17-year-olds who lack the capacity to consent differs across the UK.

If a child under the age of 16 is not competent to give consent, a person with 'parental responsibility' can consent to the treatment taking place. This will generally, but not always, be the child's parent.

If a child under 16 refuses treatment, even when they are deemed to be competent, health and social care staff should consider how to proceed in the child's best interests. This might require multi-professional discussion, further opinions, advocacy, child protection considerations and legal advice.

The courts have confirmed that those with parental responsibility cannot consent to deprivation of liberty for those aged over 16. Relevant mental health legislation and capacity legislation will make provision for the possibility of detention/deprivation of liberty and/or treatment for a mental disorder and its complications without the consent of the adult, or a young person aged under 18.

Best interests

There are circumstances where a person who, despite being provided with all practicable help and support, is unable to independently make decisions about his or her care, treatment and/or support. This is often referred to as “lacking capacity”. In these circumstances, health and social care staff have a duty to ensure that any decision taken is in the “best interests” of or to “benefit” the person who lacks capacity.

Best interests’ decisions must be based on consideration of a range of possible and available options. It is not realistic to agree a best interests decision without having articulated this range of options, weighing them up to inform that decision.

Best interests in this situation must consider what decision the person would make for themselves, if they had the capacity to do so, with consideration of previously known wishes and feelings, and their beliefs and values. Whilst relatives/carers or others who know the person may be able to articulate these views on behalf of the person, the focus must be on what the person would want to happen.

Health and social care staff, and the person making the final decision regarding care and treatment and potentially restrictive interventions, must ensure that the view articulated reflects the wishes and feelings of the person in their care, in so far as they are reasonably ascertainable, and not the inherent wishes of the relative/carer/other involved parties. Health and social care staff must also consider that what may appear to be in a person’s best interests from a clinical point of view may not be what is in the person’s overall best interests.

George: Agreement to covertly administer medicines using a best interests determination process and the Three Steps to Positive Practice framework

George is an elderly gentleman, living at home with his wife. He was diagnosed with Parkinson’s Disease nine years ago. Domiciliary carers attend George in the morning to help with personal care tasks and breakfast. They also administer his morning medication and leave his medications prepared for the rest of the day, which his wife gives to him at the prescribed times.

More recently, George has developed a Parkinson’s dementia where he forgets that he has Parkinson’s Disease and is prescribed essential medications to manage the associated physical symptoms. George doesn’t understand why the carers attend him in the morning and believes that both the carers and his wife are “trying to drug him”. He is refusing to take his medication, which is making the physical symptoms of Parkinson’s Disease worse, as George’s left arm and head are shaking considerably, his swallow appears to be compromised because he has experienced some choking, and he has fallen three times in the last 24 hours.

The carers meet with the service manager, GP, district nurse and George’s son, who is attending on behalf of his father and the rest of the family. They discuss the situation in respect of George refusing to take his medication and whether they should be administered without his knowledge and consent, known as covert administration of medication (consider and plan).

Covertly administering medication is openly acknowledged as a significant impingement of George's human rights and his right to determine what happens to him in respect of medical treatment. However, George currently doesn't have the capacity to understand that the medication he has been prescribed lessens the symptoms of his condition, and that without medication, he is at risk of serious harm from choking and falling, both of which could have fatal consequences.

George's son provides what he determines would be his father's opinion if he was able to articulate this himself. He reports that his father has been "almost regimental" in taking his medicine at the right time, grateful that the medication has helped to manage his symptoms and improve his quality of life. George's son believes that George would want to take his medication if he was in the position to weigh up and appreciate the consequences of not taking it.

Having sought the specialist advice of George's consultant neurologist, the group agree that although Article 8 Human Rights are interfered with, in this situation it would be in George's best interests to have medication administered covertly, so his quality of life improves, and the risk of serious harm is reduced. The covert administration will be limited to only medicines agreed at this meeting as essential. George will be openly offered other prescribed medication and if he refuses, his decision will be respected. The group determines that the appropriate legal and professional registration processes and requirements have been followed (implement the safeguards).

The agreed care plan specifies that any intention to covertly administer medicines must be reviewed every time medication is due to be administered; covert methods must only be used when it is anticipated that George will refuse his medication, with a weekly formal review for the next four weeks (review and reflect).

Most organisations will have established protocols which health and social care staff must adhere to when making decisions about the care, treatment and/or support proposed for a person who lacks capacity, underpinned by legislative requirements.

In applying the principles of best interests or benefit when considering the use of any restrictive practice, health and social care staff must take into account all less restrictive alternatives to the intervention being proposed. Relevant UK laws also provide legislative safeguards and a requirement for health and social care staff to consider less restrictive alternatives in circumstances when acting in a person's best interests might include implementing restrictive practices. This may require exploration with the multi or inter-disciplinary team. In some limited circumstances, a legal opinion or court determination may be required. This may be because there are significant disagreements as to whether proposed interventions can be implemented within the relevant legal frameworks, or the situation may be so complex that a legal determination is required to protect those involved.

Miss AB: Best interests' decision within the correct legal framework

Miss AB is a 36-year-old and has been diagnosed with Asperger syndrome. Until recently, she had been detained under the Mental Health Act 1983 and was discharged under a Guardianship Order to a supported living placement. The Guardianship Order provides the legal authority for Miss AB to live in supported accommodation where support is available to her day and night.

Broadly at liberty to do as she pleases within her own property, Miss AB is free to leave her accommodation, but leaving and returning is always seen by a member of the supervisory staff because of the location of the property. Miss AB is required to reside at the property and if she fails to return, the police will be notified.

There is extensive support available to Miss AB should she need it. As she has a track record of not being able to look after her accommodation, staff will enter Miss AB's property to inspect, clean, or do any repairs. Staff have access to her property whenever they feel is necessary, however, they will often wait for Miss AB to leave her flat to avoid causing her any distress.

The question in front of the Court of Protection was whether care arrangements amount to deprivation of liberty, rather than, as contended by the Local Authority, that the voluntary nature of the support, the freedom to come and go as Miss AB pleases and her freedom of action when she leaves her accommodation, indicate a lack of continuous control and supervision. This distinction and the legal view were essential to ensure that Miss AB's rights were protected, and that staff involved in her care and treatment were operating in accordance with the appropriate legal authority. The judge acknowledged that what made this case difficult was that both approaches are inherently reasonable. The presence of a Guardianship Order with a condition of residence does not itself amount to a deprivation of liberty, though it must be recognised that it is a significant restriction of liberty.

The Court of Protection agreed that it is in Miss AB's best interests to receive a package of care and support in accordance with her assessed needs, and the terms of the Guardianship Order. After careful consideration, the judge concluded that care arrangements did amount to a deprivation of liberty. The judge stated that the question of supervision and control must be viewed in the context of the prescribed condition of residence. So, whilst Miss AB may be free to leave her property, she is always subject to state control requiring her return should she be otherwise unwilling to do so. The fact that Miss AB generally willingly returns does not itself negate this point. Again, whilst the supervision of her coming and going from her property is not intrusive, it is the fact that all her movements are known and noted. Moreover, while she is free to do as she pleases in the community, there will inevitably be some obligation to restrain or control those movements should they become seriously detrimental to her welfare. That control could lawfully be implemented without recourse to the court. Therefore, with this clarity, both Miss AB and the staff involved require the safeguard of formal authorisation of deprivation of liberty.

England and Wales Court of Protection Decisions, 2020:
[bailii.org/ew/cases/EWCOP/2020/39.html](https://www.bailii.org/ew/cases/EWCOP/2020/39.html)

Staff support

Even when a decision to implement a restrictive intervention is considered lawful, ethical and in a person's best interests, staff involved can find the implementation of restrictive practices morally and emotionally challenging. In an ever-increasing busy health and social care sector, it can be all too easy to side-line the impact of staff using restrictive interventions, especially as the intensity of the restriction increases. Over time, this can have increasingly negative impacts such as 'compassion fatigue' or stress.

Three Steps to Positive Practice has included "reflection" as a supportive mechanism for staff within the framework and must be considered as important and essential as every other part of the process. Using the framework will provide health and social care staff with assurances that levels of restriction are subject to robust review and only used when there is no lesser safe alternative. Organisations must ensure that opportunities for supportive discussions and reflection for individuals and teams are provided as standard, with other pastoral type support available where an individual member of staff might require additional support.

Advocacy

Advocacy in all its forms seeks to ensure that people, particularly those who are most vulnerable in society, can have their voice heard on issues that are important to them, defend and safeguard their rights, and have their views and wishes genuinely considered when decisions are being made about their lives.

For those unable to articulate their views about their care and treatment, advocacy is an important method by which a person can be considered and protected in what may be quite complex decision-making about how they live their lives and how their care is provided.

A relative or carer can be an advocate in these situations; someone close to the person who can represent what the person would decide if they were able to make the decisions themselves. In some cases, a health and social care member of staff might be best placed to be an advocate for a person who has no-one else to support them in understanding what is being proposed about their care and treatment.

There are also advocacy services where an external organisation can provide a person with expertise in representing the views of those who cannot do so independently, to help in decision-making processes.

Relevant legislation also includes requirements for independent advocates to be made available to represent those who have been assessed as lacking the capacity to make decisions about serious interventions.

Health and social care staff should ensure that advocacy services are made available to all people in their care, including children and young people. In some situations, they are obliged by law to do so, and therefore must be aware of the legal requirements and circumstances for informal and formal independent advocacy arrangements.

Review

The frequency for review of the use of restrictive practices will be agreed on an individual basis and in the context of changing presentation, assessed risk of harm to the person or others, changing circumstances and/or any fluctuation in capacity to consent to interventions.

For example:

- the presentation of a person with delirium who is subject to restrictive practices, such as close observation or deprivation of liberty, may change day to day, meaning that any restrictive practice should be reviewed on a daily basis
- a person with advanced dementia who requires to be deprived of liberty is unlikely to present significantly differently day to day, meaning that the intervals between review periods will likely be longer
- the requirement for the use of arm splints to manage the risk of a person causing harm to themselves will be assessed and reviewed at every use, possibly multiple times per day, with the shortest interval possible between review to allow the mechanical restraint intervention to end
- the use of Rapid Tranquillisation will be reviewed after every use as part of an incident review with the intention of mitigating recurring use
- the use of physical restraint will be reviewed after every restraint event with the intention of mitigating recurring use.

Three Steps to Positive Practice requires an agreed timeframe for review of any restrictive practice, before the intervention is initiated.

It is essential that restrictive practices are reviewed with appropriate regularity and to ensure that they remain necessary and the most appropriate way of preventing harm. When restrictions are used for longer than necessary, they become counter-therapeutic and impact negatively on the person's quality of life.

7. Positive practice

When we talk about positive practice, we mean person centred, ethically driven practice which seeks to meet the needs of the person effectively and safely – leading to positive outcomes and an improved quality of life. This must be delivered within professional and legal accountability structures.

Positive and proactive evidence-based interventions must be the least restrictive, most therapeutic way to promote best quality of life and maximise self-determination, with the opportunity for learning through experience. All of this must be delivered within a framework of a rights-based approach.

Evidence-based, therapeutic care

Health and social care staff have a duty to always do what is best for the people they care for and support. Doing what has always been done, bowing to resource pressures, or making life easy for staff or carers cannot get in the way of this. Unfortunately, these factors can often influence a health and social care staff's decision-making in practice. Moving forward, staff must embrace ways of thinking and acting about how restrictive practices are used. This involves concentrating on the creation of a culture where safe, effective, and person-centred practice is informed by best available evidence with a strong emphasis on outcomes-focused, therapeutic interventions.

One example of an outcomes focused, therapeutic and evidenced-based approach is the model of Positive Behaviour Support (PBS). PBS is an empirically validated, evidence-based approach, which is mainly used when people with intellectual disabilities present behaviours of concern. It aims to improve a person's quality of life and that of the people around them, and combines the principles of behavioural science with the values of participation and personalisation.

PBS aims to understand why the behaviours are happening or what a behaviour means, so that the person's needs can be met in better ways. This might mean changing the individual's environment or the system of support around them, such as training for the staff team who is supporting the person. It is also about ensuring they lead a meaningful and interesting life and can learn new skills.

PBS should lead to a reduction in behaviours associated with potential harms and a reduction in restrictive practices. The approach requires regular review to make sure this is happening.

Michael: Positive practice, increasing skill and opportunity, and improving quality of life

Michael is a seven-year-old and has been attending his local community paediatric service from an early age because of global developmental delay. At a review appointment, Michael's mum mentioned that he was unpredictable when out in public and would often run off. This was a concern for her because Michael had no awareness of danger. Michael's mum reported that she always used a buggy for outings and had recently purchased a wheelchair.

The paediatrician completed an assessment and consulted with a physiotherapist and occupational therapist. They agreed that there were no concerns about Michael's physical ability to walk. The occupational therapist felt that it would be useful to follow the *Three Steps to Positive Practice* framework, because the wheelchair could be a potentially restrictive practice, impacting Michael's Articles 5 and 14 Human Rights. They all agreed that the wheelchair significantly limits Michael's ability to move independently and felt that a formal multidisciplinary discussion was required. Although Michael is unable to communicate with words, it was evident that he did not like being strapped into the wheelchair, and would often try to get out.

The paediatrician and her colleagues met with Michael's mum and invited Michael's social worker from the Children with Disability team to attend. They agreed that the wheelchair was reducing immediate risk, but that there might be less restrictive ways of achieving this (consider and plan). Everyone agreed that the wheelchair was not giving Michael the opportunity to develop new skills to safely negotiate public spaces. They discussed how this could have detrimental consequences in the longer term, such as limiting Michael's exercise tolerance and physical strength, as well as reducing his educational and social opportunities, impacting his Article 8 Human Rights.

Everyone agreed that there should be a focussed attempt to teach Michael the key skills he needed to walk safely in public (implement the safeguards). The occupational therapist completed further assessment and established that Michael did not like noisy and busy environments. A care plan was agreed (consider and plan). The social worker was able to arrange short breaks to make sure that Michael did not have to go to busy shopping environments with his parents (a short-term measure). It was agreed that Michael's parents, support workers and teachers would all use the same approach to teach Michael how to walk safely. This included practicing in parks, using social stories and building in opportunities for highly preferred activities, such as walking locally to feed the ducks in the pond (consider and plan).

The paediatrician arranged for a review to take place in three months' time (review and reflect). At this point, Michael was able to walk around the local park without using his wheelchair. The group agreed that the next step would be to introduce short walks in quieter public roads (consider and plan). Michael's teacher joined the meeting and recommended that this concept was introduced by creating naturally occurring opportunities for Michael to walk short distances to highly preferred activities e.g., from his house to the park. It was also agreed that Michael would take part in 'The Daily Mile' at school with a small group of pupils, to allow opportunities for social learning, thereby promoting Michael's Article 8 Human Rights (implement the safeguards). Michael's occupational therapist also recommended various approaches to minimise the impact of Michael's aversion to background noise (consider and plan). The group agreed to meet in another six months time (review and reflect).

This approach clearly demonstrates the benefits of the *Three Steps to Positive Practice* framework including consideration of whether an approach might be restrictive and considering how to improve a person's quality of life and increase their skills and opportunities.

Positive and proactive approaches

All too often, restrictive practices are introduced as a way of managing risk without engaging with the people who use the services and their representatives in decision-making, and without considering what therapeutic options might lead to better outcomes and an improved quality of life for the person. Similarly, blanket restrictions may have evolved without a rationale for their use or may have been introduced in response to a particular situation but have become custom and practice.

Health and social care staff who start from a point of no restriction or the least amount of restriction possible, and who understand the implications any level of restriction has in terms of a person's human rights and quality of life, will be able to fully embrace, influence and lead the change in culture required for ethical, legal and professional practice.

Recognising interventions as restrictive - introducing a positive and proactive approach to minimising use of restrictive practices

A registered nurse in a busy paediatric department ran a clinic where children regularly needed to have blood samples taken. He noticed that many of the children were frightened of this procedure and were reluctant to co-operate. Often, without access to certain blood tests, their treatment could not be optimised.

The nurse decided to undertake a quality improvement project to improve the success rate in obtaining blood samples from children. He realised that many of the children who had long-term conditions, had aversive or traumatic experiences of having their blood taken as a young child, usually involving physical restraint – sometimes referred to as clinical holding.

Recognising the need to reduce these restrictive practices, the registered nurse decided to use the *Three Steps to Positive Practice* framework as part of the quality improvement approach. He focussed on ensuring that other less restrictive options were always considered before resorting to physical restraint, which impacts on Articles 5, 8 and 14 Human Rights (consider and plan).

The nurse implemented a positive and proactive approach to reduce the risk of children being traumatised by blood-taking procedures, and to build their skills in relation to co-operating with medical tests. His quality improvement project centred on implementing a no holding approach when children were having planned blood tests in the department (implement the safeguards).

The nurse was able to introduce a range of simple measures to help children co-operate with having their blood taken. This included some environmental changes to the clinical room, the use of social stories and videos to show children what was happening, and some simple desensitisation techniques e.g., parents practicing some aspects of the procedure at home (such as putting on local anaesthetic cream) (consider and plan).

As a result, the nurse quickly demonstrated increased success in being able to obtain blood samples and increased parent and child satisfaction in relation to clinic visits (review and reflect). Ultimately, this led to safer and more effective care because the child's treatment could be refined based on their blood results (implement the safeguards).

This project demonstrates the importance of identifying practices that are restrictive and changing the culture and language of health care environments to ensure these are reduced. It shows the value of positive approaches, as children are now given a sense of control over their own bodies and participation in their care and treatment. It supports all of the FREDA principles and Human Rights Articles 3, 5, 8 and 14.

Claire: Recognising interventions as restrictive – reducing levels of restriction and increasing opportunities, autonomy and independence

Claire is a young woman with an intellectual disability and visual impairment. She has recently transitioned into adult day care services. Her existing care plan had been developed when her care was overseen by children's services and contained advice about the use of a specialised seat with lap belts. Staff at the day centre continued to follow the care plan provided and Claire continued to be mechanically restrained. However, an occupational therapist in the adult service team noted that there had been no recent review of the care plan and no information about why the belts were on the chair or why they were considered necessary (review and reflect).

The occupational therapist reviewed the use of the chair at home with Claire's mum, observing how Claire used the specialist chair without straps. Claire was able to get in and out of the chair independently and safely to retrieve items around her room. At mealtimes the occupational therapist noted that the chair ensured that Claire was in a good upright position for eating.

The occupational therapist decided that a specialised chair was required but thought that the use of a chair in this current manner could be considered a restrictive practice. She used the *Three Steps to Positive Practice* framework to discuss the use of a specialised chair with Claire, her mum, and staff from the day care centre. It was agreed that using the chair with belts and straps would restrict Claire's movement activity and amount to restrictive practice (consider and plan).

The discussion focused on whether the use of belts and straps were necessary to keep Claire safe. Both Claire's mum and the staff involved identified what the actual risks to Claire were and other more appropriate, less restrictive ways of managing these risks, for example, keeping all of Claire's preferred items close to where she is sitting. It was agreed that belts and straps would not be necessary or appropriate on Claire's new specialised chair for use at the day centre (consider and plan). An appropriate chair was acquired for trial without belts and straps. A managed/stepped approach was used to familiarise Claire with the new chair, and a new care plan addressed the need to promote Claire's human rights, particularly Articles 5 and 8, underpinned by FREDA principles (implement the safeguards).

A planned review (review and reflect) evidenced that this new approach had greatly improved Claire's quality of life. Claire was noted as being less frequently agitated, and her mum reported that she appeared more content. Claire now manages her meals independently and her modified diet has been changed from Level 5 – moist/mashed to Level 6 – soft and bite size.

Claire now has significantly increased opportunities, independence, and autonomy, promoting her Human Rights Articles 5 and 8.

There is a growing body of evidence which supports a reduction in the use of restrictive practices and an emphasis on using a proactive approach to positively reduce the need for restrictive practices. It is widely evidenced that early intervention is key in reducing the likelihood of the use of restrictive practices.

Person centred care that embraces partnership working with the person, including, where appropriate, meaningful engagement with family members, is fundamental to positive approaches. It places the person at the centre of service provision and builds delivery of services around their individual needs.

Lisa: Use of the Three Steps to Positive Practice framework to reduce the use of restrictive practices

Lisa is a young woman who has been referred to occupational therapy as part of a transition to adult services. Living at home, Lisa sleeps in a built-up cot bed and has other restrictive interventions. The need for specialist equipment had prevented Lisa from being able to access short break provision. Following discussions with the occupational therapist and Lisa's community nurse, the family agreed that the use of the bed should be reviewed. This review did initially cause some anxiety for Lisa's family as her mum was in poor health at the time, and any further sleep disruption would have been difficult (review and reflect).

It was agreed that a short break would be planned to enable the equipment to be reviewed. The use of a low bed, staff supervision and telecare (implement the safeguards) could monitor Lisa's requirements during the night and give a clearer picture of any actual risk still relevant (consider and plan).

It was soon made clear that the risks over the years, since the prescription of the bed, had reduced and that the use of an ordinary bed presented very few risks to Lisa.

A planned and phased approach was agreed with the family to introduce the changes at home with regular review of the outcomes and the remaining restrictions being scaled back as appropriate (implement the safeguards).

The review of restrictive practice has improved Lisa's dignity, quality of life and access to appropriate services. These approaches support the FREDA principles of Respect, Dignity and Autonomy. They also promote Human Rights Articles 3, 5 and 8.

Supporting and embedding positive and proactive approaches that provide alternative strategies to the use of restrictive practices

The occupational therapy department within a large hospital received six separate requests on one day from one ward asking for "specialised seating for a patient with dementia who is at risk of falling when mobilising". The lead occupational therapist was concerned that staff who work in the dementia assessment and treatment ward considered mechanical restraint as the only solution to what may be perceived risks of falling, as opposed to actual risks, and that a comprehensive risk assessment process may not have been followed (review and reflect).

The occupational therapist worked with ward staff to complete holistic and comprehensive risk assessments for each of the identified patients (consider and plan). In five of the six situations, the occupational therapist recommended alternative strategies to mechanically restraining the patient, which would help reduce the risk of falls. These strategies were person centred, evidence-based and therapeutic, and took account of available resources, including support from the patients' families who wanted to be involved in caring for their relative (implement the safeguards).

The occupational therapy also worked with ward staff to change attitudes and beliefs, and improve awareness and skills around how to reduce risks when caring for patients with dementia. The ward staff developed their own mission statement which focuses on proactive approaches to care. Staff actively encourage the use of positive language when discussing patients' care and when developing care plans, and avoid terminology with negative connotations, such as "restraint", "wanderer", and "challenging" (review and reflect).

These approaches support the FREDA principles of Respect, Dignity and Autonomy. They also promote Human Rights Articles 3, 5 and 8.

It is important to consider practices that at first glance do not appear to be restrictive and are not intended to be restrictive, but meet the definition for restrictive practice and impinge on people's human rights. Some of these practices are so prevalent that national and international campaigns have been developed to highlight the issues, raise awareness, and provide resources to support actions aiming to eliminate or reduce such practice.

Examples include:

#EndPjParalysis: the revolutionary movement helping frail older people – this is a campaign that aims to address older people being kept in beds in hospital, contributing to increased immobility and leading to deconditioning, loss of functional ability and cognitive impairment.

Stay Up Late's #NoBedtimes – this campaign challenges institutional culture in residential settings.

Stopping over medication of people with a learning disability, autism or both (STOMP) – this national project aims to stop the overuse of psychotropic medicines which people with a learning disability, autism or both are more likely to be given, than other people.

There are a number of principles and models which support the delivery of positive and proactive care and the ethos of the above campaigns. These include the following:

Positive risk taking

Building skills and promoting strengths and independence often requires everyone involved to take positive risks. This is not about ignoring potential risk, it is about allowing opportunities for people to learn and find ways of coping with adversity and learning from challenging situations.

It is about sharing responsibility for positive change with a collaborative approach to decision-making and the development of carefully constructed ‘person centred safety plans’. It prevents professionals from becoming risk averse or paternalistic.

Occupational therapists need to embrace risk in occupational therapy, as taking risks can be intrinsic to a service user’s progress, e.g., learning a new skill, participating in a chosen activity or returning home after a stay in hospital.

As a practitioner, it is your role, as far as possible, to enable people to overcome the barriers that prevent them from doing the activities that matter to them; to take opportunities and not to see risk as another barrier.

Royal College of Occupational Therapists (2018), Embracing risk; enabling choice; Guidance for occupational therapists: rcot.co.uk/sites/default/files/RCOT%20Embracing%20Risk%20FINAL%20WEB_0.pdf

Positive risk management is about shared investment in positive outcomes, and ensures that risks are managed in the most therapeutic, least restrictive manner possible, promoting personal autonomy whilst enabling people to stay safe.

Safeguarding responsibilities require social workers to “promote the autonomy of service users while safeguarding them as far as possible from danger or harm”. This includes recognising that people have the right to take positive risks and helping them to identify and manage potential and actual risks to themselves and others.

Northern Ireland Social Care Council, Standards of Conduct and Practice for Social Workers (2019): nisc.info/app/uploads/2020/09/standards-of-conduct-and-practice-for-social-workers-2019.pdf

A positive risk-taking approach entitles service users to the FREDA core values and principles in the delivery of care, treatment and support.

Alice: Positive risk taking

Alice is a 14-year-old and has Down Syndrome. A psychologist was asked to visit Alice, after she had become sad and withdrawn. The psychologist established that Alice was socially isolated – she didn’t have a friendship group and didn’t take part in any regular recreational activities.

Alice’s records stated that she had been involved in an incident of ‘sexually inappropriate behaviour’ two years ago. This incident involved Alice kissing another girl in a school toilet, causing the other child, who didn’t communicate with words, to be upset.

A risk strategy meeting which took place at the time decided that Alice would not attend a forthcoming school trip, and that she would be supervised by an adult when she was with other pupils. This had not been reviewed in the two-year period since the incident happened. Alice stopped attending her drama group because she felt like she was ‘in trouble’ and had become anxious around her peers.

The psychologist completed a comprehensive risk assessment (consider and plan), which hadn't been done previously and indicated that any future risk was low. Alice agreed to attend one-to-one therapeutic sessions about healthy relationships and sexual development (implement the safeguards). A further multi-agency meeting was arranged (review and reflect). The psychologist used the *Three Steps to Positive Practice* framework to shape decision-making at the meeting. Everyone agreed that the initial measures hadn't been the least restrictive option and hadn't demonstrated therapeutic benefit. The plan hadn't given Alice opportunities to build her skills because she needed to be with her friends and peers to learn about friendships and boundaries.

Working closely with Alice's social worker, the psychologist was able to demonstrate positive outcomes over the coming months (review and reflect). Alice was able to take part in after school activities and make new friends. Within several months, there were clear improvements in Alice's mood.

This scenario demonstrates the importance of positive risk taking and seeking to ensure that risks are managed in a way that gives people opportunities to learn and develop autonomy and enjoy an improved quality of life. It supports the FREDA principles of Equality, Dignity and Autonomy and Alice's right to a private and family life (Human Rights Article 8).

Recovery-based approaches

The recovery model emphasises and supports a person's potential for recovery. The model was originally designed to empower people who experience mental ill health to be actively involved in and take control of their individual journey through their illness. Recovery does not necessarily only mean 'clinical recovery' (usually defined in terms of symptoms and treatment response) – it also means 'social recovery' – building a life beyond illness without necessarily eliminating the symptoms of illness. Recovery is understood as being deeply personal.

Recovery principles focus on:

- health, strengths, wellness, and encouragement of self-management
- building a meaningful and satisfactory life, and an identity separate from illness and/or disability, which is based on hope and opportunity
- a clear association with social inclusion.

What is advantageous about this model is that it can be used across the wider health and social care environment, including physical ill health and disability.

Recent developments in Child and Adolescent Mental Health Services have included the Thrive model. This model is needs-led, integrated and collaborative in its approach, from early intervention through to high-intensity support. It is focused on proactive approaches to deliver better long-term outcomes for children and young people, which is fundamental to positive practice.

Again, the focus for children and young people should be about 'real life', positive outcomes fuelled by a strong sense of hope.

The recovery model compliments the use of evidence-based interventions, with the FREDA principle core values clearly embedded in its ethos.

Anna: Evidence-based intervention

Anna has schizophrenia. Having been a hospital inpatient for several years, Anna moved into a supported living facility. After moving into her own home, she frequently experienced relapses. At these times, Anna would drink heavily, she wouldn't take her medication, and she would neglect her health and personal hygiene, resulting in her being detained in hospital.

To help support Anna in being physically and mentally healthy, she agreed to co-produce a Wellness Recovery Action Plan (WRAP) with her social worker (consider and plan). This plan helped Anna to identify relapse triggers and easily access the best sources of support in the community when necessary. This approach meant that Anna was able to make positive choices about her health care and to stay at home, even when she experienced a relapse.

With Anna fully engaged in the WRAP process and detail, she was able to agree with the social worker what level of restriction might be appropriate at any time to successfully support her physical and mental health. The social worker used the *Three Steps to Positive Practice* framework to ensure that the least restrictive approach was always used, and that Anna's rights were protected throughout (implement the safeguards).

This recovery approach promoted the FREDA principles of Respect, Dignity and Autonomy. It also promoted Anna's right to a private and family life (Human Rights Article 8). Anna told her social worker: "I love my new home and not having to go back into hospital so often. I know I can lift the phone when I need help" (review and reflect).

As a result of this planning and process, the number of times Anna was subject to detention in hospital were significantly reduced.

A normalised and embedded culture of reviewing and reducing restrictive practices

To support health and social care staff in thinking and acting differently in any restrictive practice, a culture of reviewing, reducing and/or removing restrictive interventions must be a normal everyday process. Evidence demonstrates that when practices, which have negative effects/outcomes are replaced with more positive practices, which build and/or retain strengths, there are much more beneficial outcomes for people who use services, as well as their carers and staff.

Thomas: A normalised and embedded culture of reviewing and reducing restrictive practices

A supported living facility is home to four service users with intellectual disability and overlapping mental ill health or physical disability. Having previously lived in long stay hospital wards, each individual now lives in their own apartment. Staff provide care and support over a 24-hour period, and are knowledgeable about every person's likes/dislikes, wishes, and preferred daily routines. They are very vocal about upholding everyone's human rights.

For one service user in particular, Thomas, there is evidence of an improving quality of life because of the regular review and the steady planned reduction in the use of restrictive practices (review and reflect). Whilst in hospital, Thomas had always required supervision of three members of staff and was prone to aggressive behaviour. This resulted in the use of physical restraint and the frequent use of seclusion.

Similar practices continued when Thomas first moved into his new home. However, over time in this less restrictive environment, with a change in staff practice and approach, including the use of the *Three Steps to Positive Practice* framework when developing and agreeing the implementation of therapeutic programme of care and support (consider and plan), and a regular review of the levels of restriction (review and reflect), a gradual reduction in the levels of supervision required was achieved, and aggressive behaviour was significantly reduced.

Thomas developed skills that his family never thought he would be capable of achieving, such as going to the local shop to buy a newspaper, and calmly enjoying communal spaces with the people who live next door to him. The replacement of negative approaches with rights-based therapeutic care and support (implement the safeguards) plainly demonstrates the application of the FREDA principles, particularly Respect, Equality and Autonomy, and promotion of Human Rights Articles 5, 8 and 14.

A relative of Thomas said: "This place is proof of what can be achieved when the environment, care and support are correct. Thomas has evolved into a much happier, more out-going person, and has achieved a level of independence we never thought possible. We are overwhelmed with the progress Thomas has made since coming to live here. There has been a significant reduction in periods when he is unsettled, which we consider to be because of the environment in which he now lives, and how he is cared for and supported by staff" (review and reflect).

Joe: Therapeutic responsiveness supported by consistent use of the Three Steps to Positive Practice framework

Joe has autism. Sensitive to sound and touch, he often has difficulty regulating the amount of sensory information he experiences every day, and at times, Joe becomes overwhelmed and demonstrates this through his destruction of his surroundings.

In previous environments, this was responded to by physically restraining Joe every time an incident happened. However, the team at his new home use a different approach, routinely using the *Three Steps to Positive Practice* framework. They understand that Joe is communicating his distress to his sensitivity through his behaviours (consider and plan), and are aware of the impact of his sensory sensitivities. They have considered this in his care plan.

To limit Joe's exposure to his distress triggers, staff ensure that he has access to meaningful activities every day, and help him to manage the amount and type of sound and touch he experiences (implement the safeguards). They also provide regular opportunities for therapeutic sensory input to help him to better regulate his responses.

The team leader set out a regular review schedule for the care plan. At first it was daily, but as Joe responded to the therapeutic interventions, the reviews quickly moved to weekly, bi-weekly, and then monthly (review and reflect). This consistent use of the cyclical *Three Steps to Positive Practice* framework process ensures that Joe's needs are being met, enables the care plan to be therapeutically responsive to any change in Joe's needs, and ensures that more restrictive interventions can be avoided.

Any intervention or plan must either have a time limited lifespan or be part of a stepped approach, which is contextual and evolving, and incorporates a range of strategies as opposed to being a singular solution. An outcomes-focused approach which ensures that any restrictive practice has a precise and evident justification, must allow for consideration of the reduction or removal of restrictive methods once the desired outcome has been achieved.

Mr Brown: The importance of a planned review to support the reduction or removal of a restrictive practice

Mr Brown had been a patient in a dementia ward for more than a year. Initially he had been very distressed and experienced what is known as “behavioural and psychological symptoms of dementia”. This resulted in some aggressive and destructive behaviour.

A multi-disciplinary team decided that Mr Brown should be physically restrained in a specially designed chair when he experienced these periods of extreme agitation. Bed rails were also used when Mr Brown was in bed. Care plans stated that the belt on the chair restraining Mr Brown should be released when he was “settled or sleeping”.

The use of the restrictive practice was to be reviewed on a monthly basis. Six weeks ago, a new ward sister reviewed Mr Brown’s care plan (review and reflect) and noted that there was no record of any discussion and decision-making about the impact of this restrictive practice on Mr Brown’s human rights, whether this intervention was deemed to be in his best interests or consideration of the FREDA core principles.

Furthermore, there was no evidence to suggest that the actual use of restraint as the least restrictive measure available to keep Mr Brown safe had been reviewed. The practice of keeping Mr Brown restrained with a belt in a chair continued every day as normal practice, and on most days for an extended period of time, despite records demonstrating that he was often settled or sleeping. Additionally, due to the absence of any other therapeutic approach, there was a lack of evidence to support the use of the chair, belt, and bedrails as the least restrictive, and the most effective evidenced-based treatment option.

The ward sister initiated an urgent review (review and reflect) and introduced the use of the *Three Steps to Positive Practice* framework to multi-disciplinary team discussions and decision-making around any use of restrictive practices. In Mr Brown’s case, consistent use of lesser restrictive interventions, such as appropriate pain relief, art therapy, music therapy and massage, led the multidisciplinary team to agree that mechanical restraint was no longer necessary, and the use of regularly prescribed sedative medication could be reduced (consider and plan).

Subsequently, staff now ensure that all alternatives to any level of restriction are considered before agreeing the use of a restrictive practice (consider and plan). Patients who are subject to restrictive interventions have the actual restrictive practice reviewed regularly throughout the day, to ensure that it remains appropriate, proportionate, and in the patient’s best interests (review and reflect). Additionally, all restrictive practices are reviewed formally on at least a weekly basis by the multidisciplinary team, using the *Three Steps to Positive Practice* framework. These actions are more clearly person centred. The consideration of any impact on a patient’s human rights is more closely examined, and staff can now explain how any restrictive intervention may impact on any human rights. The supporting FREDA principles are now more clearly evidenced in care and treatment plans (implement the safeguards).

8. Conclusion

The challenge facing all health and social care staff, is about changing the culture and practices of the services you work in. Whilst radical change is often needed, this is about evolution rather than revolution.

Every individual member of the health and social care team, irrespective of their position, can ask questions, can bring a different perspective, and do things differently.

The *Three Steps to Positive Practice* framework will help structure your thinking as decisions are made, which can have a major impact on the lives of people who use services, ensuring that humanity and compassion remain central to the care and support provided. It is your responsibility to do so, every time.

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RCN quality assurance

Publication

This is an RCN practice guidance. Practice guidance are evidence-based consensus documents, used to guide decisions about appropriate care of an individual, family or population in a specific context.

Description

There are an increasing number of people with criminal justice setting who have multiple and complex health care needs. From time-to-time these people require attention in NHS settings outside of prison/police custody. This guidance is aimed at nursing staff working in NHS settings and gives further support and advice to provide optimum care to this group of patients.

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The Nine Quality Standards

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Evaluation

The authors would value any feedback you have about this publication. Please contact publicationsfeedback@rcn.org.uk clearly stating which publication you are commenting on.

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