

# 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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# Executive summary

The 21st century requires fundamental changes in how health and social care professionals deliver care. One of these changes involves 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 professionals 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, or require the use of restrictive practices. It is encouraging to note the increasing number of examples of established positive practice in this area; however numerous investigations and reports which have shown historical failures and the need for ongoing reform must be acknowledged.

In the current world of health and social care, professionals are ready to embrace new ways of thinking and the creation of a new culture which uses new language. A greater emphasis on early intervention enables an understanding of why a person might behave in a certain way.

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 therapeutic, ethical and lawful.

This document was developed by a multi-disciplinary group based in Northern Ireland, involving the Royal College of Nursing, the Royal College of Psychiatrists, the Northern Ireland Association of Social Workers and the College of Occupational Therapists. It is designed to assist health and social care professionals who may be involved in practices where people in their care may be restricted in some way, particularly during the period of the local review of mental health legislation and implementation of capacity legislation.

The *Three Steps to Positive Practice* is a process to guide professional practice and therefore also helpful to health and social care professionals in Scotland, England and Wales. There are some differences in the legislation across the four countries and it is imperative that health and social care professionals are aware of and understand the legislation that is relevant to their work. Health and social care professionals should also ensure that 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.



*Three Steps to Positive Practice* is a framework designed to help you as a health and social care professional to think about culture and practices and guide professional, ethical and legal decision making when considering the use of potentially restrictive practices. *Three Steps to Positive Practice* is a continuous and cyclical process which requires a health and social care professional to:

- **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; and,
- **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.

# Introduction

*Three Steps to Positive Practice* should be used 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.

*Three Steps to Positive Practice* provides guidance on the new way of thinking which will support health and social care professionals to act differently. With an emphasis on a proactive, evidence based and rights based approach to practice, all health and social care professionals can ensure that wherever they are providing care, treatment and support, they are practising in the best interests of service users, and in accordance with legislation and the requirements of their professional codes of conduct. 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. This understanding is vitally important in decision making processes around the use of potentially restrictive practices.

This is not a document that tells you how to implement or when to implement a restrictive practice, nor will this document contain a “list” of restrictive practices – that would be an impossible task.

This document will be of use to any health and social care professional who works in services where individuals may be subject to restrictive practices, regardless of specialty. The principles and values discussed in the examples used can be translated and applied in the different contexts and environments in which you practise.

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

Historically, health and social care professionals 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 professionals 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 (CQC) 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 restraint rather than positive behaviour support and managing the environment to remove or contain 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 the governance arrangements in each Health and Social Care (HSC) Trust to monitor the use of restrictive practices.

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

Bed (cot) sides; use of lap belts on wheelchair/commodes/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 door, which restrict free movement within the ward. (RQIA, 2014)

A survey undertaken in March 2016 by the Royal College of Nursing, Northern Ireland (RCN NI), 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 professionals are clear about what restrictive practices are or what makes a practice potentially restrictive.

Some professionals demonstrate a deep and clear understanding of the term, and the need for an evidence based and rights based approach to the use of restrictive practices.

### What is your current 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”

However, others have indicated a very narrow understanding, or even no understanding of the term.

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

“A measure taken to ensure a patient’s safety when they are at risk if endangering themselves, i.e. a patient at risk of falls who is confused may be sitting in a chair and their table used as a device to stop them getting up independently”;

“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”.

The lack of a shared understanding of what makes a practice potentially restrictive contributes to health and social care professionals routinely implementing practices that they do not realise are restrictive and very possibly unlawful. For example, monitoring of Deprivation of Liberty Safeguards in England in 2014/15 by CQC demonstrated a continued lack of understanding in the use of the safeguards and failure to report appropriately to the regulator. Staff training and awareness of the safeguards varied across providers, as did the existence and implementation of policies and processes. CQC reported examples where some providers were potentially unlawfully depriving people of their liberty, despite the fact that the safeguards were introduced in 2009 as part of the Mental Capacity Act (2005).

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 in a position 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 professionals 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.

# What makes a practice restrictive?

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

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

Put very simply restrictive practice means actions that stop a person from doing something that 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 preventing a person from having something they want.

Some practices can be easily identified as restrictive, like physically restraining a person, or locking doors to keep a person confined to a certain area. Other restrictive practices can be more subtle, such as only allowing a person a certain amount of time watching television every day. There are also times when certain types of care, support or treatment could be considered a restrictive practice; for example, prescription of certain medications not designed to restrict, but which have restrictive side effects, like sleeping tablets.

It is important to recognise 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 the one place, restrictions necessary for one person could impact negatively on their fellow tenants.

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 professionals must consider all of 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 in order 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 a particular person one day might not be needed to keep them safe the next day.

When restrictive practices are 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 professionals must ensure that the care, treatment and support they provide is safe, effective, person-centred and provided within legal, ethical and professional accountability structures.

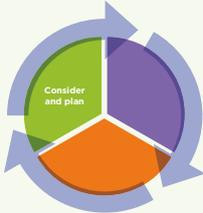
All health and social care professionals should be able to identify whether the purpose of the proposed restriction is the protection of the person or the protection of others and clarify whether the legal framework under which the care is being provided gives authority for the proposed restriction.

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 be the **most effective and therapeutic** intervention possible with regards to reducing behaviours associated with risk and/or their impact. 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. 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.

# Three steps to positive practice

The *Three Steps to Positive Practice* are 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 three steps are intended to assist health and social care professionals 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><b>STEP 1</b> <b>Consider and plan</b></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"> <li>• limit the person’s movement, daily activity or function;</li> <li>• result in the loss of objects or activities that the person values; or,</li> <li>• require the person to engage in a behaviour that he/she would not engage in given freedom of choice?</li> </ul> <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><b>STEP 2</b> <b>Implement the safeguards</b></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 that 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 p.12), 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><b>STEP 3</b> <b>Review and reflect</b></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 that 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>

# Outlining a rights based approach

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

A rights based approach is twofold.

In the first instance we are referring to the rights of individuals which are enshrined in the European Convention on Human Rights which was incorporated into UK law by the Human Rights Act (1998).

The Human Rights Act puts legal duties on public authorities (national and local) to respect the human rights set out in the Convention in their decisions and actions. This helps public officials deliver better services, and empowers every person to ensure they are treated fairly, and if necessary, to hold officials to account.

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

There are however some differences in how the Human Rights articles operate.

Some rights are known as absolute rights, for example Article 3, (freedom from torture and inhumane or degrading treatment or punishment). Everyone is entitled to the full operation of this right and it cannot be interfered with under any circumstances.

Limited rights are rights that can be interfered with in explicit and finite circumstances, for example Article 5 (right not to be deprived of liberty, except in certain legal circumstances).

There are also some articles known as qualified rights, where interference may be justified in order to balance the rights of the person and the needs of the wider community or interest of the state. These rights include Article 8 (right to private and family life) and Article 9 (freedom of thought, conscience and religion).

The Articles which most frequently require consideration in relation to health and social care provision are:

Article	What it says	How might this right be breached in practice
3	<p><b>Prohibition of torture</b></p> <p>A person has the absolute right not to be tortured or subjected to treatment or punishment which is inhumane or degrading.</p>	<p>Measures used to control behaviours which in reality 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>
5	<p><b>Right to liberty and security</b></p> <p>A person has the right not to be deprived of their liberty – ‘arrested or detained’ – except in limited cases specified in the article (e.g. where they are suspected or convicted of committing a crime) and provided there is a proper legal basis in UK law.</p>	<p>Measures used to prevent behaviours perceived to be a risk to self or others, for example: improper or inappropriate admission/detention to psychiatric care; use of chairs with straps; use of ‘time-out’ or seclusion.</p>
8	<p><b>Right to respect for private and family life</b></p> <p>A person has the right to respect for their private and family life, their home and their correspondence. This right can be restricted only in specified circumstances.</p>	<p>Measures which prevent participation in family, social and 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; use of restrictive clothing to limit perceived self-harm or inappropriate touch.</p>
14	<p><b>Prohibition of discrimination</b></p> <p>In the application of the Convention rights, a person has the right not to be treated differently because of their race, religion, sex, political views or any other personal status, unless this can be justified objectively. Everyone must have equal access to Convention rights, whatever their status.</p>	<p>Reducing access to services or opportunities available because of perception of risk or lack of resources to allow for suitable adaptation and support, for example: a reduced school day; exclusion from social clubs.</p>

Secondly, when we talk about a rights based approach, we mean core principles and values which should shape practices and services and put the person at the centre of the delivery of health and social care.

*Three Steps to Positive Practice* uses core principles and values commonly and collectively known as FREDA – Fairness, Respect, Equality, Dignity and Autonomy which form a rights based approach to underpin the articles of the Human Rights Act.

Core principle	What it means	What this means for health and social care staff
<b>Fairness</b>	Ensuring that people who use services have access to fair processes for getting their views heard and for decision-making about 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.
<b>Respect</b>	Ensuring that people who use services are valued as individuals. They must be listened to, and what is important to them must be viewed as important by health and social care staff, even if this conflicts with 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, sexual orientation.
<b>Equality</b>	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.	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.
<b>Dignity</b>	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.	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, avoiding the use of wheelchairs for individuals who are independently mobile.
<b>Autonomy</b>	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.	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, based on clear, sufficient, and relevant information; for example, co-production of personal safety plans.

Health and social care professionals may be familiar with and use alternative core principles and values known as PANEL: participation; accountability; non-discrimination; equality and empowerment; and, legality, in ensuring a rights based approach to care and treatment.

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

- treated with dignity and respect
- 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.

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.”

RCN position statement, 2012

# Decision making

When designing/agreeing or delivering care, treatment or support which may be potentially restrictive, each individual health and social care professional must consider several areas relevant to their professional practice and their decision making.

## 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.

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

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 professionals lead teams of other staff, they must ensure that all team members understand how to apply their practice legally and ethically.

This is particularly important around the areas of capacity and consent, and essential for health and social care professionals working with children and young people, who must understand the laws around capacity, and child and parental consent, including giving and refusing 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, for example, guidance issued by the General Medical Council in relation to 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”.

You must work on the presumption that every adult patient has the capacity to make decisions about their care, and to decide whether to agree to, or refuse, an examination, investigation or treatment. You must only regard a patient as lacking capacity once it is clear that, having been given all appropriate help and support, they cannot understand, retain, use or weigh up the information needed to make that decision, or communicate their wishes.

*Consent: patients and doctors making decisions together*  
General Medical Council, 2008

The requirement to presume that an adult is capable of independently making decisions about any aspect of their care, treatment and/or support has been protected within relevant UK laws. 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 do so. England, Wales and Northern Ireland legislation 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 he or she has capacity to make decisions in any matter. Country specific legislation provide guidance where a lack of capacity to make decisions independently has been established, and health and social care professionals must ensure that their practice in this area meets legislative, ethical and regulatory requirements.

The relevant legislation also provide for a person to make what health and social care professionals 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 professionals 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 taken into account.

## 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. A health or social care professional who does not respect these principles may be liable both to legal action by the person in their care and action by their regulatory body.

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.

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 a number of options. Others may be able to make decisions at certain times but not others, because fluctuations in their condition impair their ability to understand,

retain or weigh up information, or communicate their wishes.

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 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.

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 age under 18 years.

Young people aged 16-17 are entitled to provide consent for their own medical treatment in the same way as adults. Scottish legislation provides a legal basis for a young person under the age of 16 years to consent on his or her own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending them, they are capable of understanding the nature and possible consequences of the procedure or treatment. These provisions need to be considered in conjunction with the rights of those with parental responsibility and human rights law.

In other circumstances, current case law is based on the view that persons aged under 16 years, may be competent to make decisions about their care and treatment when provided with sufficient information in a suitable format. This is sometimes referred to as "Gillick" competence.

These young people can consent or refuse care, treatment and/or interventions, however, refusal to provide consent can be over-ridden by a person with parental responsibility or a court in certain circumstances.

Lucy is seven years old, has a diagnosis of autism and attends a special school. Lucy often ran about the classroom, climbed on furniture and was disruptive. For short periods during the day, Lucy's teacher used a chair with high sides and a lap strap to keep Lucy sitting in one place. The teacher says this helped to keep Lucy focused on curriculum-based table top activities and believed that Lucy "likes the chair", despite that fact that she sometimes protested when strapped into the chair. Lucy's parents agreed with the teacher's actions, which was deemed to be consent.

Lucy's CAMHS practitioner visited Lucy at school to complete an observation as part of an assessment process for ADHD. They noticed that Lucy seemed anxious and that she was more likely to move into the chair when a particular classroom assistant guided her towards the chair. She seemed to watch this person very closely, as if seeking their approval. The CAMHS practitioner was concerned that consent for the use of the chair with the lap strap had been provided on behalf of Lucy by her parents, that there was no therapeutic benefit for Lucy in the use of the chair and that in certain situations, Lucy was demonstrating compliance rather than consent to sitting in the chair.

The CAMHS practitioner arranged a multiagency meeting to review the risk assessment in relation to the use of the chair and to discuss what other types of calming activities and classroom-based approaches might help Lucy co-operate. The group reached an agreement that the use of mechanical restraint was not the least restrictive, most effective way of approaching her behavioural difficulties, and not clearly in her best interests. Lucy was diagnosed with ADHD. Treatment for this, alongside regular advice and guidance from the CAMHS practitioner and occupational therapist for her teacher on how to adapt activities and the environment (for example, use of schedules, visual cues, reducing distractions) to maximise Lucy's classroom performance, led to marked improvements in his concentration for specific activities. Lucy was more relaxed and focused during the school day and she was able to learn a range of new skills over the months ahead.

This plan supported Lucy's Article 5 and Article 8 Human Rights and the application of the FREDA principles and values.

## 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 professionals have a duty to ensure that any decision taken in the "best interests" of or to "benefit" the person who lacks capacity. Most organisations will have established protocols which health and social care professionals must adhere to when making decisions about the care, treatment

and/or support proposed for a person who lacks capacity. In applying the principles of best interests or benefit when considering the use of any restrictive practice, health and social care professionals 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 professionals to consider less restrictive alternatives in circumstances when acting in a person's best interests might include implementing restrictive practices. There are complex situations where it will be appropriate to seek a legal opinion.

You are personally responsible for making sure that you promote and protect the best interests of your service users. You must respect and take account of these factors when providing care or a service...

You are responsible for your professional conduct, any care or advice you provide, and any failure to act...

You must be able to justify your decisions if asked to.

*HCPC Standards of conduct, performance and ethics (2008)*

Health and social care professionals 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.

## Advocacy

Advocacy in all its forms seeks to ensure that people, particularly those who are most vulnerable in society, are able to 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, for whatever reason, 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 professional 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 include 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.

# Positive practice

When we talk about positive practice we mean person centred, ethically driven practice which seeks to effectively and safely meet the needs of the person, delivered within professional and legal accountability structures.

This includes applying positive and proactive evidence based interventions in 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 professionals 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 often influence health and social care professionals' decision making in practice. In the current world of health and social care, professionals must embrace new 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 aims to find the meaning behind a person's behaviour. That is, PBS aims to understand why a person is behaving in a particular way and how that behaviour results in their needs being met (often referred to as the function of the behaviour). PBS then tries to find other (often more socially appropriate) ways to help the person achieve what they want or need, which in turn is less challenging for carers and health and social professionals. Positive behaviour support uses the techniques of applied behaviour analysis, guided by a strong values base, delivered in person centred ways.

Primarily this approach is about increasing a person's quality of life with a secondary aim of decreasing the frequency and severity of their behaviours that are described as challenging. It is a comprehensive approach to assessment, planning and intervention that focuses on addressing the person's needs, their home environment and overall quality of life. It could include changing factors such as staff attitudes, physical factors such as reducing noise levels or ensuring increased choices for the person. PBS-based approaches which enhance quality of life and reduce behaviours that challenge carers and health and social care staff can in turn lead to a reduction in the use of restrictive practices.

Michael is a seven years old and has a learning disability and Fragile X syndrome. Michael was referred to a community paediatric service for assessment of a “behavioural difficulty” which his mum described as being “unpredictable when outside and running off with no safety awareness, particularly road safety awareness”. Despite Michael having no mobility problems or concerns, Michael’s mum insisted that he used a wheelchair anytime he went outside the family home, at school and at the short breaks facility he sometimes stayed at, so he couldn’t “run off”. Michael’s mum reported that she had always used a buggy when outside with Michael, which progressed to using a wheelchair as he got older. Mum felt it was the best way to ensure Michael’s safety, even when he was at the park, or out shopping with her.

Staff undertaking the assessment were concerned that always using the wheelchair was potentially impacting Michael’s developmental progress, independence and quality of life. He had not been given the opportunity to develop skills to walk with supervision, develop road safety awareness and, ultimately develop skills to walk outside independently. The use of the wheelchair was a way of keeping Michael safe in the short term, but staff were concerned that this could have a detrimental impact on Michael’s opportunities in the medium to longer term, in areas such as accessing education, employment and social opportunities.

Using a **positive behaviour support** approach, the clinician clarified with Michael’s physiotherapist and occupational therapist that he did not need the wheelchair for mobility reasons. The clinician then undertook a comprehensive assessment of Michael’s behaviours. Having identified why Michael often “unpredictably ran off” when outside (the function of the behaviour), the clinician worked with Michael, his family, and staff from his school and short breaks facility to implement a skills building programme. This programme was designed to teach Michael to walk while outside under the supervision of adults (primary aim), with an overall goal being that he would eventually learn to walk outside independently and develop road safety awareness skills (secondary aim). The clinician also talked with Michael, his family and staff working with him about the importance of positive risk taking in a systematic, planned way to ensure that he could achieve his full developmental potential and his quality of life.

Michael no longer requires a wheelchair in any setting and can go for a walk with the supervision of one adult. He has learned how to cross the road using pedestrian traffic lights with 1:1 supervision. He is now working towards going out as part of a group without 1:1 supervision.

The FREDA principles underpin this **evidence based and outcomes focused** model of care and treatment. It also promotes Michael’s Articles 5 and 8 Human Rights.

## Positive and proactive approaches

All too often, restrictive practices are introduced as a way of managing risk without engaging the people who use 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 professionals who start from a point of no restriction or least 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, professional practice in the 21st century.

“Least restrictive, most effective” is the ethos of a hospital ward for people with a learning disability who may present with behaviours that challenge carers, staff and services. This embedded culture started with a review of literature to provide a robust evidence base and to deliver a patient centred service that upholds patients' human rights. The team engaged multi-disciplinary endorsement to support the required change in culture and practice. Leadership, and belief in the delivery of positive outcomes for patients and staff, were essential in the development of this model of care and treatment.

Least restrictive, most effective involves:

- patient involvement – weekly multi-disciplinary team meetings, weekly therapeutic 1:1 with named nurse, joint decision making and patient forums
- individual assessment – no blanket restrictions
- decisions made based on the level of risk and not the behaviour, with consideration of any impact on the patient's human rights
- consideration of positive risk taking

- proportionality – the level of restriction is proportionate to the level of risk;
- consideration of any alternatives to the restriction
- clear rationale for the restriction
- regular documented review.

Staff also ensure that families/carers are involved where they wish to be and that the opportunity for independent advocacy is made available. The implementation of therapeutic activity programmes and a commitment to transparency and involvement of patients in decision making has led to a reduction in the use of physical interventions and a reduction in the number of safeguarding referrals.

The FREDA principles are clearly expressed in this proactive model of care and treatment. Least restrictive, most effective has received several commendations including a “Highly Commended” award at the national Strengthening the Commitment: Sharing Success conference in June 2015.

Patients have told staff that they feel like they are treated as individuals and “just like everyone else”.

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 is fundamental to positive approaches which places the person at the centre of service provision and builds delivery of services around their individual needs.

A community children's nursing team realised that some older children with autism in their locality were sleeping in specialist beds with extra high sides designed to keep the children in bed. These beds had been recommended many years previously, often because the child might get out of bed during the night and there was a perceived risk that the child may and fall or injure themselves. In some cases, the beds had been recommended to ensure that the child remained in bed and was safe throughout the night so that other family members could sleep. In many cases the use of the specialist bed was not reviewed and it became clear that as the children grew up, the use of this type of bed had become overly restrictive. These beds prevented the child from learning how to sleep in their own bed for the whole night and in some cases, how to use the toilet independently.

The nursing team worked with the occupational therapy team to ensure that

the use of the specialist beds was reviewed and in many cases the beds were deemed to no longer be necessary. Short programmes of therapeutic work to help with sleep and toileting concerns were instigated. The children can now sleep safely in standard beds for the whole night. A new protocol is in place to ensure that therapeutic programmes to address any concerns are implemented as the first line response to concerns. Therapists work collaboratively and closely with the child and family to agree and implement individualised **evidence based interventions**, which are regularly monitored and reviewed. This **early intervention** protocol reduces the need for the use of restrictive practices in the longer term.

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

The occupational therapy department in a large hospital received six separate requests on the same day from one ward asking for "Specialised seating for restraint of 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 in the hospital were only considering one 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.

The occupational therapist worked with ward staff to complete holistic and comprehensive risk assessments for each of the identified patients. In five of the six situations, the occupational therapist was able to recommend alternative strategies to mechanically restraining the patient which would 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.

The occupational therapist 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".

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

There are a number of principles and models which support the delivery of positive and proactive care, for example:

### 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, but 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.

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

Social workers' safeguarding duty incorporates the need to, "recognise the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people. This includes, recognising that service users have the right to take positive risks and helping them to identify and manage potential and actual risks to themselves and others."

*Standards of Conduct and Practice for Social Workers*  
Northern Ireland Social Care Council 2015

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

Lily is 14 and has a mild intellectual disability. One day Lily and her friend were in the toilets in the youth club and engaged in what was termed "sexually inappropriate behaviour". Lily was deemed to be the instigator of this behaviour. As a consequence of this one incident Lily was prevented from participating in activities with her friends and peers and was closely supervised continually outside her own home. This had a very noticeable negative impact on Lily's mental health and social development. A year later a mental health nurse became aware of this situation. A comprehensive risk assessment had not previously been carried out so the nurse completed one. This demonstrated that the risk of the behaviour recurring was low. Lily agreed to attend some therapeutic sessions about healthy relationships and sexual development. It was agreed that opportunities for Lily to be with her friends and peers contributed to her learning about relationships and behaviour, whereas isolation during adolescence increased risks of not learning about relationships and sexuality.

This example of **positive risk taking** supports the FREDA principles of Equality, Dignity and Autonomy and Lily's right to a private and family life (HR Article 8).

### Recovery based approaches

The recovery model emphasises and supports a person's potential for recovery. The recovery 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, and 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; and,
- 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. The recovery model compliments the use of evidence based interventions, with the FREDA core values clearly embedded in its ethos.

Where children and young people are concerned, recent developments in Child and Adolescent Mental Health Services have been based on 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.

Anna has schizophrenia. Having been a hospital inpatient for several years, Anna moved into a supported living facility. After moving into her own home, Anna frequently experienced relapses and had to be detained in hospital. At these times Anna would drink heavily, not take her prescribed medication and neglect her health and personal hygiene. In order to support Anna to remain physically and mentally healthy she agreed to co-produce a Wellness **Recovery** Action Plan (WRAP) with her social worker. 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. The number of hospital admissions significantly reduced.

This **recovery approach** promoted the FREDA principles of Respect, Dignity and Autonomy. This approach also promoted Anna's right to a private and family life (HR 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".

## A normalised and embedded culture of reviewing and reducing restrictive practices

To support health and social care professionals in thinking and acting differently in any use of a potentially restrictive practice, a culture of

reviewing, reducing and/or removing restrictive interventions will be a normal everyday process. Evidence demonstrates that when practices which have negative implications are replaced with more positive practices which build and/or retain strengths, there are much more beneficial outcomes for people who use services, carers and staff.

A supported living facility is home to four service users with a learning disability and overlapping mental ill health or physical disability who had previously lived in long stay hospital wards. Now each person lives in their own apartment, with their own front door and keys to their apartment. Staff are available to provide care and support over a 24 hour period. Staff working in this service are knowledgeable about each individual's likes/dislikes, wishes, and preferred daily routines and are very vocal about upholding each person's human rights.

For one service user in particular, Thomas, there is evidence of an improving quality of life as a result of the regular review and reduction in the use of restrictive practices. Whilst in hospital Thomas had required supervision of three members of staff at all times and was prone to aggressive behaviours. This always resulted in the use of physical restraint and the frequent use of seclusion. Similar practices continued when Thomas first moved to his new home. However, over time in this less restrictive environment, with a **change in staff practice and approach**, the implementation

of therapeutic programme of care and support, and **regular review** of the levels of restriction, a gradual reduction in the levels of supervision was achieved and aggressive behaviour significantly lessened. Thomas has developed skills that his family never thought he was capable of, such as going to the local shop for the newspaper, and calmly enjoying communal spaces with the people who live next to him. The replacement of negative approaches with rights based therapeutic care and support plainly demonstrates the application of the FREDA principles, particularly Respect, Equality and Autonomy.

Thomas' relatives commented that: "this place is proof of what can be achieved when the environment, care and support are correct. My son 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".

Any intervention or plan must either have a time limited lifespan, or be part of a stepped approach which is contextual and evolving, and which incorporate 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 had been a patient in a dementia ward for more than a year. Initially Mr Brown had been very distressed and experienced what is known as “behavioural and psychological symptoms of dementia”. This resulted in some extremely aggressive and destructive behaviour. A multi-disciplinary team made the decision 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. 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. There was no evidence 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 a range of therapeutic

approaches, there was 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.

An inspection by the HSC regulator highlighted that this level of restriction was not appropriate and required urgent review. Mr Brown was no longer aggressive or agitated. The multidisciplinary team agreed that mechanical restraint was no longer necessary. Subsequently staff now ensure that all alternatives to any level of restriction are considered before agreeing the use of a restrictive practice. Patients who are subject to restrictive interventions have the actual restrictive practice **reviewed regularly** throughout the day, to ensure that it remains appropriate and proportionate. Additionally, all restrictive practices are reviewed formally on at least a weekly basis by the multidisciplinary team.

These actions are more clearly person-centred. The consideration of any impact on any patient’s human rights is more closely examined, and staff can now explain how any restrictive intervention may impact on any of the human rights articles. The supporting FREDA principles are now more clearly evidenced in care and treatment plans.

# Conclusion

This document, and the challenge facing all health and social care professionals, 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 health and social care professional can ask questions, bring a different perspective and do things differently.

***Three Steps to Positive Practice*** 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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