Restraint Reduction Network

Ethical training standards to protect human rights and minimise restrictive practices

Restraint Reduction Network (RRN) **Training Standards**

First edition

James Ridley
Sarah Leitch

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Foreword



You may not know us, but we want to tell you about something very personal that shattered our lives and changed our family forever.

This is a photo of our son Seni with his grandmother. Everything you need to know about him is here in this beautiful picture. He was our baby and a gentle giant. He hated bullying and was always looking out for the less able and vulnerable people in society.

Seni was just 23 years old – an IT graduate – when he died in hospital on 3 September 2010. He died because of prolonged restraint, when he was held down by 11 police officers while he was a patient in a mental health hospital.

Seni had never had any mental health issues before, but over that bank holiday weekend in 2010 he seemed agitated and his behaviour became odd. We took him to A&E and, after an assessment, we were told to take him to Bethlem Royal Hospital. We took him there, to what we thought would be the best place for him to get help.

Seni agreed to stay overnight at the hospital as a voluntary patient. We were asked to leave him at the end of visiting hours, and we did so reluctantly. Shortly afterwards, he became agitated when he was stopped from leaving the hospital because he wanted to come home. The hospital staff 'sectioned' him and called the police who came and agreed to take Seni to a seclusion room in the hospital. He was co-operative until he stopped at the threshold of the seclusion room. As soon as he stopped, the police officers pushed him inside and forced him face down to the floor.

The police officers held Seni face down, shackled his hands with two sets of handcuffs and put his legs in two sets of restraints. They held him down like that over a period of some 45 minutes altogether, in a restraint they knew was dangerous, until he went limp. And even then, instead of treating him as a medical emergency, they simply walked away: they believed he was faking it! They left our son on the floor of a locked room, all but dead. All of this happened in the presence of hospital staff including nurses and a doctor who stood by and looked on, unable or unwilling to intervene. Seni never regained consciousness and died four days later. That is how we lost our beloved son.

At the inquest into his death, the jury found Seni died as a result of excessive, disproportionate and unreasonable restraint and force. To this day, we struggle to comprehend that our son died as he did, simply because those who were responsible for his care – police officers and medical staff alike – failed in their duty to treat him with the respect that he deserved as a human being.

In a signed statement after these events, one doctor described how the officers treated our son: 'I felt like it wasn't a human being that they were trying to restrain … it was like trying to contain an animal … after they had tied him up with the straps it seemed like when a hunter has tied the animal … it was an uneasy feeling that I had that it was not a human being that they were restraining'. That is how he was seen and treated at that point: as an animal, rather than a petrified young man, terrified at the prospect of being put in a padded seclusion room.

We don't want anyone else to go through this. We have been fighting for over eight years to get answers and justice for Seni. Now, through initiatives in his name – such as Seni's Law, a parliamentary bill with cross party support designed to open up the system to greater transparency and accountability to stop the disproportionate use of force and restraint – we feel that our son may not have died in vain. If we can make sure this never happens to anyone else, that would be an amazing legacy for Seni.

That is why we are really pleased to see the publication of these new standards, but this must be just the beginning. There is so much more to do in view of the increasing number of deaths in the context of restraint. In addition to health, education and social care services, we need to get law enforcement agencies involved in these standards concerning the use of restraint. We need to ensure these standards are not just implemented, but also regulated. And we need to make sure that the use of force and restraint is not just reduced but prevented altogether when dealing with vulnerable individuals who may find themselves in Seni's position in the future.

Aji and Conrad Lewis

"The NHS welcomes the publication of the Restraint Reduction Network Training Standards. These Standards have been written to focus on ensuring training promotes human rights and supports cultural change necessary to reduce reliance on restrictive practices (rather than purely focus on technical skills). Certification of compliance with these Standards will be a requirement in NHS commissioned and CQC regulated services from April 2020"

(Professor Tim Kendall, National Clinical Director for Mental Health, NHS England 2019)

"CQC has been concerned about the use of restrictive practices for some time so we are pleased to see the launch of the new Restraint Reduction Network Training Standards. The Standards will support staff in health and social care services to understand and apply the principles of minimising use of force with the aim of promoting human rights and person centred care of the people they are caring for"

(Dr Paul Lelliott, Deputy Chief Inspector at CQC 2019)

Introduction

Background

The Restraint Reduction Network welcomes the increased focus on restraint reduction across the NHS and adult social care in the UK. There is growing recognition among professional bodies and government departments (and arm's length bodies) that whilst the use of any kind of restraint may on rare occasions be necessary to keep people safe, it is also traumatic and must be minimised in therapeutic settings. The number of organisations endorsing these standards is testament to this.

The UK has many excellent education, health and social care services that provide person centred therapeutic care. However, there have also been too many shocking scandals exposing the unnecessary and inappropriate use of restrictive interventions on people with mental health conditions, dementia, learning disabilities, and autistic people. Such scandals include Winterbourne View, exposed by the BBC *Panorama* programme, the recent cases of people like Bethany, who was secluded for years resulting in the Secretary of State ordering a serious incident review, and the tragic case of Seni, highlighted within the Foreword, who was restrained by police in a mental health service. (Whilst this case is unusual as it involved the police, it has been highlighted because of its tragic nature, and the fact that it resulted in the Mental Health Units (Use of Force) Act 2018.)

Restraint by its nature restricts a person's liberty, but the frightening, overwhelming and traumatising nature of this experience can amount to degrading treatment, which is never lawful. *'Physical restraint can be humiliating, terrifying and even life-threatening. It should only be used as the last resort, when there is no other way of de-escalating a situation where someone may harm themselves or others'* (Campbell, 2018).

It is therefore vital that all services sufficiently understand and apply the principles of restraint reduction. However, minimising the use of restrictive practices and interventions is only one part of ensuring that vulnerable adults and children have a good quality of life. Providing therapeutic environments where treatment and recovery can take place is essential. As well as a safe comfortable environment to live in, people also need choice, control, supportive relationships, interesting things to do and learn, and opportunities to be involved in community activities. These are fundamental elements of good quality preventative support and these are the same things we would want for ourselves and our own families.

When the *Training Standards* refer to restraint reduction or minimisation it is in the context of a shared commitment and belief that the use of all restrictive interventions and practices should be minimised.

Why are the *Restraint Reduction Network Training Standards* required?

Providing high quality evidence based support to vulnerable adults and children in all settings, across education, health and social care, is a highly skilled activity. The workforce do an important and challenging job (that requires balancing risk, welfare, and safety) and sometimes require specialist training to understand and meet the needs of the people they are supporting so people are less likely to become distressed, but they also need training in how to support people when they are distressed.

Typically, restrictive interventions are used by staff, carers or family members with the intention of averting harm, minimising the potential for pain or injury and to keep people safe.

There are a number of organisations providing training in supporting people in crisis, and there is a range in the quality of their provision. The lack of quality assurance and oversight of such training programmes leads to a concern that staff may be trained to use a range of restrictive interventions that may not necessarily be appropriate or properly risk assessed for use. These concerns have been highlighted on many occasions through service reviews, and by training commissioners, families and staff who have been through training. The *Training Standards* aim to address these concerns.

Poor quality training focuses primarily on reactive approaches such as physical restraint and places insufficient emphasis on human rights, meeting needs, prevention, de-escalation and recovery. Most importantly, it fails to sufficiently explain the traumatic nature of restraint.

If training places insufficient emphasis on restraint prevention and de-escalation, staff will understandably be more likely to use restrictive interventions as a first resort, rather than last resort, resulting in an over reliance on restrictive interventions.

Whilst there is some great practice across education, health and social care, there are still too many services that focus on management of behaviour or risk rather than on prevention and better meeting needs. A positive and proactive approach is vital to anticipate potential triggers for behaviour that challenges, and minimise the likelihood of, or avoid the need to use, restraint (DHSC, DfE 2019).

An over reliance on restrictive practices in services can create toxic culture characterised by the cycle of trauma for both staff and patients (Paterson, 2013). To be in the position of being restrained or to be part of a team that is implementing a restraint is likely to be traumatising. It is also important to remember that many of the people who come to be in a position where they are restrained may already have a history of trauma and this experience can be re-traumatising. Sensitivity to this is crucial as, if not recognised, the situation could quickly escalate.

In addition, restraints may be employed against some degree of active (physical) resistance. This can result in potentially damaging stresses being imposed upon systems and structures such as the respiratory system, heart, joints and muscles (Aiken et al, 2011). Any restrictive intervention must be based on an assessment that intervention is likely to cause less harm than not intervening. Training that includes restrictive interventions is potentially dangerous and distressing for everyone involved and therefore quality standards are essential.

Eliminating inappropriate use of restraint is particularly vital in relation to children, who are still developing both physically and emotionally and for whom any potentially traumatic experience at this formative stage in their development could be very damaging and have long term consequences to their welfare. Where use of restraint is necessary to safeguard children, young people and others from harm, it should be consistent with clear values and sound ethical principles, comply with the relevant legal requirements and case law and be consistent with obligations under the European Convention on Human Rights, the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities (DHSC, DfE 2019).

Aims of the *Training Standards*

The *Training Standards* will provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings.

These standards will ensure that training is directly related and proportional to the needs of populations and individual people. They will also ensure that training is delivered by competent and experienced training professionals who can evidence knowledge and skills that go far beyond the application of physical restraint or other restrictive interventions.

In addition to improving training and practice, the *Training Standards* will:

- protect people's fundamental human rights and promote person centred, best interest and therapeutic approaches to supporting people when they are distressed
- improve the quality of life of those being restrained and those supporting them
- reduce reliance on restrictive practices by promoting positive culture and practice that focuses on prevention, de-escalation and reflective practice
- increase understanding of the root causes of behaviour and recognition that many behaviours are the result of distress due to unmet needs
- where required, focus on the safest and most dignified use of restrictive interventions including physical restraint

Who are the *Training Standards* for?

This document provides cross sector quality standards that can be applied to training provision where restrictive interventions are included in the curriculum. To understand what is meant by the term restraint or restrictive intervention these standards recommend reference to the Equality and Human Rights Commission (EHRC) *Human Rights Framework for Restraint* (2019). The terms restraint and restrictive intervention are used in these standards to mean the same thing.

> *'Restraint' is an act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently. This may or may not involve the use of force. Restraint does not require the use of physical force, or resistance by the person being restrained, and may include indirect acts of interference for example removing someone's walking frame to prevent them moving around.* (EHRC, 2019)

It is important that the standards are applied consistently to services:

- across education, health and social care
- across children and adult services
- across the UK and internationally
- for all populations, including people with mental health conditions, dementia, learning disabilities and autistic people in order to consistently minimise the risk of physical and psychological harm to all people in all settings in all nations in the British Isles

The *Training Standards* support the human rights of all populations and may be useful to the private security industry, but are not specifically designed for training providers outside of education, health and social care sectors.

Staff must have face to face training in preventative/primary strategies and secondary strategies before they are taught to use restrictive interventions. In some organisations it may be more appropriate that a different training provider manages the face to face training in a preventative model such as Safewards.

The *Training Standards* can apply to all training providers, including:

- commercial training providers who deliver training to a range of organisations
- in-service training providers who develop their own training and only deliver within their organisation

(Service providers who develop and deliver their own training but also sell or deliver training to other organisations will be considered commercial)

The *Training Standards* will be mandatory for all training with a restrictive intervention component that is delivered to NHS commissioned services for people with mental health conditions, learning disabilities, autistic people and people living with dementia in England. Implementation will be via commissioning requirements and inspection frameworks from April 2020. This includes services in the independent, private and voluntary sectors. Other UK countries may benefit from following the principles and standards, albeit within a devolved legislative context, where country specific legislation applies.

Health Education England (HEE) welcomes the fact that the Restraint Reduction Network has delivered training standards suitable for use within mental health and learning disability NHS commissioned units. It is our sincere hope that the use of the *Training Standards* in an accredited certification scheme will reduce the number of occasions restraint is required and help to make those occasions that restraint is unavoidable safer and dignified.

The standards apply across the lifespan. However, it will be vital that a developmental perspective is taken and that the fragility of some individuals is given proper consideration – for example, pre-pubescent young people, people with severe eating disorders, and those who are living with dementia and at end of life who often have significant weight loss.

Whilst the *Training Standards* focus on training, and support training providers, it is important to recognise the significant responsibilities of service providers in ensuring these principles are applied in practice and a positive culture of care and support is promoted. Training alone is not human rights based nor is it sufficient to facilitate cultural change. Therefore the *Training Standards* complement new guidance for service providers in minimising restrictive interventions: *Towards Safer Services*. There is an important role for the regulator in ensuring services implement the *Training Standards*.

The implementation, embedding and maintenance of the *Training Standards* will also be viewed by regulators and inspectors, as well as concerned family members, to be indicative of an organisation committed to best practice and characterised by therapeutic care and support.

The *Training Standards* may also be useful to support:

- commissioners of training
- commissioners of services
- regulators of services
- individuals who have lived experience of services
- families, carers and advocates

For more information on (UKAS accredited) certification of compliance with the *Training Standards* (including a list of certified training organisations), please visit the Restraint Reduction Network website. Only certified training organisations will be licensed to use the Restraint Reduction Network certified™ logo.

How have the *Training Standards* been developed?

The Restraint Reduction Network was initially established to bring together those passionate about reducing reliance on restrictive practices across education, health and social care. The Restraint Reduction Network is a registered charity and is free to join. All members pledge their commitment to reduce reliance on restrictive practices. The Restraint Reduction Network steering group includes representation from government departments, professional bodies and regulators, as well as charitable organisations and representatives who have lived experiences of restraint.

The Restraint Reduction Network started to develop training standards in 2017. In 2018 there was increased focus on restraint reduction within government departments and arm's length bodies. This included a significant cultural change programme within the NHS. As part of this programme of work Health Education England were asked to ensure quality standards were in place for training and that training was certificated as complying with the *Training Standards*. Rather than reinventing the wheel, Health Education England (on behalf of the NHS) commissioned the Restraint Reduction Network to develop the *Training Standards* for training in the prevention and use of restrictive interventions to support best practice in supporting people (across the lifespan) who may become distressed and meet the requirements of training within the Mental Health Units (Use of Force) Act 2018.

Health Education England has worked with the Restraint Reduction Network and the United Kingdom Accreditation Service to develop a process for certifying training with a view to all providers of NHS funded mental health, learning disability and autism services being required to use accredited training services. In addition, local authority commissioners intend to make UKAS accredited training services a requirement of social care contracts. *For more information on (UKAS accredited) certification of compliance with the standards please visit the Restraint Reduction Network website.*

The *Training Standards* are evidence based and informed by government policy, guidance and the consensus views of professionals and experts in the field.

A wide range of critical readers have contributed to the development of the *Training Standards* including representatives from a number of professional bodies, government departments and arm's length bodies. (For more details please see Acknowledgements.)

The standards will be updated at least every three years and will reflect the burgeoning knowledge base and developments in research, policy and practice. (This version will be reviewed by 2022 – feedback can be sent to RRN@bild.org.uk)

This edition considers physical, mechanical and environmental restraint. The next edition will increase the focus on social restraint, chemical restraint, seclusion and segregation, and consider a wider range of settings including mainstream schools, criminal justice services and accident and emergency services. Changes and adaptations to this version will be announced on the website.

How to use the *Training Standards*

The first part of this document is a rights based framework, in which all training must be delivered. Training providers seeking certification for their programmes will need to use the framework when designing their curriculum.

The curriculum standards focus on the fundamental principles across all settings and populations. These include prevention, de-escalation, reactive strategies and recovery.

There are specific standards to ensure that trainers have the appropriate levels of expertise, experience and competence.

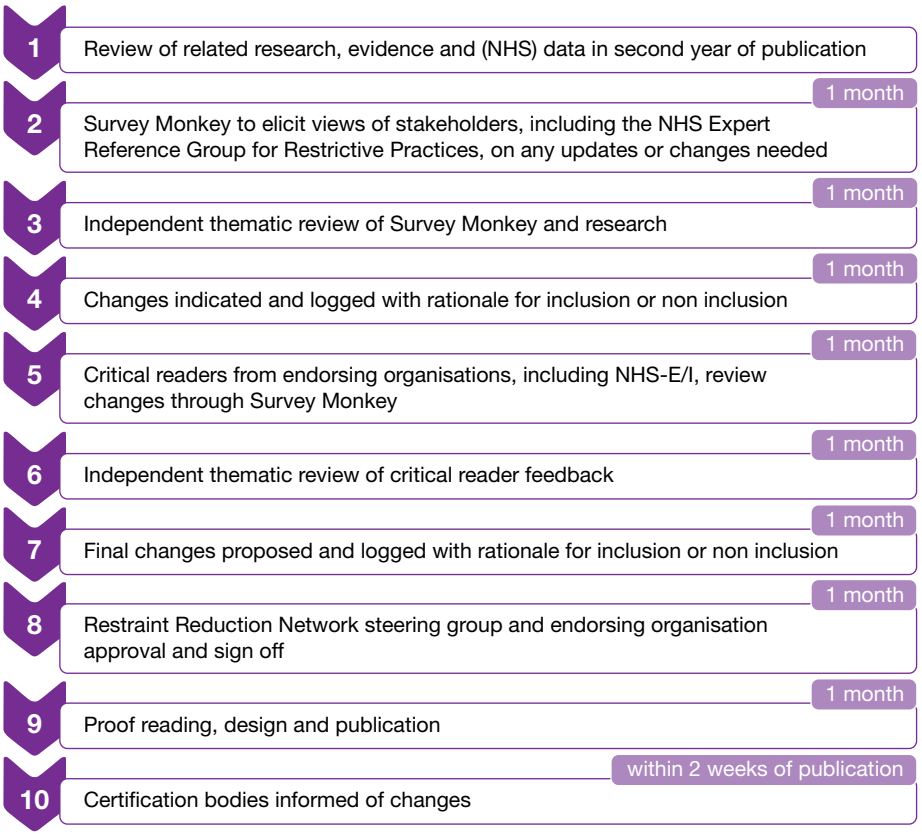
There are also a number of appendices which document any specific considerations or adaptations to the standards that should be taken into account for different populations or settings. The appendices will be subject to a continuous review timetable, therefore the most up to date versions will be available online.

Any text in **bold** or regular text font is a requirement of the standard and is therefore mandatory, and *any text in italics offers extra explanation or guidance.*

Reviewing and updating the *Training Standards*

The review process will be facilitated by the Restraint Reduction Network Director with support and scrutiny from the Trustees of the Restraint Reduction Network who represent professional bodies, arm's length bodies and people with lived experience.

The *Training Standards* will be updated within three years and a review of research will start in the second year and will follow the process set out below. Ongoing public feedback will be gathered through email and consultation on the Restraint Reduction Network website. Feedback will also be sought from all certification bodies and certified training providers. The appendices will be updated as part of an ongoing process over the three years – through small expert reference task and finish groups.



A rights based framework for training

This section covers the overall context and framework of law and values within which any training in the use of restrictive interventions must be provided.

Contents

A human rights approach to restrictive interventions

The relationship between legislative frameworks involved in restrictive interventions

Being person centred to respect and protect human rights

A human rights approach to restrictive interventions

Training must be provided with clear reference to supporting an overall human rights based approach, focused on the minimisation of the use of restrictive interventions, and ensuring any use of restrictive interventions and other restrictive practices is rights-respecting.

Human rights apply to any person receiving care and treatment, and these rights must be at the centre of decision-making. The Human Rights Act 1998 applies to all public authorities, and all training must be informed by the legal duties of staff to respect and protect these human rights. Training must also make clear that human rights apply to the person's family and carers, and others receiving treatment (eg patients on a ward) and staff involved in the person's care and support.

The training must support the reduction of the use of restrictive interventions and ensure consideration of alternative responses to distress or behaviours of concern, including a focus on prevention and secondary responses such as de-escalation.

Any use of lawful restrictive intervention must be rights-respecting. This means it must not cause harm, including unintended harm, which amounts to degrading treatment, which is never lawful (see Article 3). All reasonable steps must be taken to protect a person's right to life, including stopping the use of an intervention or intervening to protect a person from themselves or others; failure to protect life is likely to be unlawful (see Article 2). Importantly, a human rights approach also means involving the person in decision making and taking the least restrictive option (see Article 8).

Training must make it clear that some human rights cannot be interfered with (whether by restrictive intervention or otherwise) and some can be restricted by professionals, but this can only occur when the correct balancing exercise has been undertaken. This balancing exercise, which is required by the law, is an important tool to ensure the proper consideration of the rights of all people involved in restrictive interventions, including staff.

Restrictive practices, including physical restraint, can be characterised as an exercise of power over another individual. In order to ensure this power is never abused, comprehensive safeguards must always be in place. It is essential that such safeguards eliminate any risk of discrimination, harassment or victimisation.

Organisations must ensure that no individual is exposed to any restrictive practice because of their age, mental health status, mental capacity, physical impairment, race/ethnicity, religion and belief, gender (including transgender), HIV/AIDS status, sexual orientation, political opinion, socio-economic background, spent convictions, or on any other grounds which are irrelevant to a decision-making process leading up to any application.

The following will also be important in supporting a rights based approach:

- understanding which human rights cannot, and which can, be lawfully interfered with by staff, including in situations where restrictive interventions are used
- understanding the positive obligation of staff to take action to protect human rights, including safeguarding against serious harm arising from the use of restrictive interventions
- respecting people's right to autonomy (see Article 8) by assuming capacity and ensuring involvement in care decisions, including ascertaining current/previous/future views on the use of restrictive interventions as set out in the Mental Capacity Act 2005, Adults with Incapacity (Scotland) Act 2000 and the Mental Capacity Act (Northern Ireland) 2016*
- using restraint as a last or emergency response
- treating distress or behaviours of concern as communicative acts and exploring what this means for the person to help avoid the use of restrictive interventions
- identifying the risks associated with restrictive interventions including, but not limited to, children who are developing physically and psychologically
- understanding the impact of trauma (historic or otherwise) on an individual's mental and physical health and therefore their experience of restrictive interventions – this will be especially important in determining whether an intervention risks being degrading
- considering the impact of restrictive interventions on an individual's physical and mental health, their development and/or recovery, including how this may affect those with sensory processing differences, eg autistic people
- commitment to co-production with individuals with lived experience in the planning, development and delivery of care and treatment
- commitment to ensuring people's needs to participate in decisions are met, eg access to interpreters, appropriate information, advocates, etc
- avoiding blanket policies or standardised responses that do not allow consideration of the person's situation
- demonstration of processes and practices to avoid or minimise the use of restrictive interventions

*NB: The working date for full implementation of this Act is 2020. (RCN 05/09/2018)

Training organisations must show how they have embedded a rights based approach within their curriculum. One example is the 'PANEL' framework (Donald, 2012; BIHR, 2013) which supports using a rights based approach:

- **P**articipation
- **A**ccountability
- **N**on-discrimination
- **E**mpowerment
- **L**egality

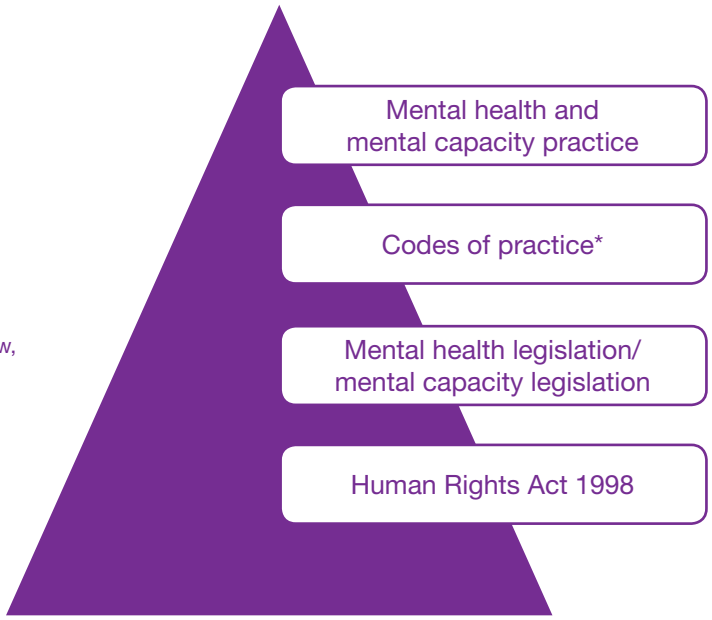
See also BIHR's guide *The Difference It Makes: Putting Human Rights at the Heart of Health and Social Care* (2013) which explains the benefits of using a rights based approach, using PANEL (available at BIHR).

The relationship between legislative frameworks involved in restrictive interventions

Training must ensure that the relationship between the Human Rights Act and other legal frameworks relevant to the use of restrictive interventions is understood and those laws are applied in a way that is compatible with the person's rights.

Training must make clear reference to how the Human Rights Act 1998 and other key legislation work together in practice. Essentially, other legislation should be interpreted and applied in a way that is compatible with people's human rights. Figure 1 (BIHR, 2016) illustrates how the Human Rights Act operates as a foundation for other law, policy, guidance and practice.

Figure 1: **The Human Rights Act 1998 as a foundation for other law, guidance and practice**



* This can be for any codes of practice. The HRA is the foundation, then the next levels up – the law, the codes of practice, the practical decision-making and service delivery – sit on top of that foundation. The same process could be applied to any other statute, eg Mental Health Act, Care Act, statutory guidance etc

The following legislative frameworks must be included in training, as they may provide legal authority to interfere with a person's rights when restrictive interventions are being used in situations, or may otherwise be relevant:

- Mental Health Act 1983 (amended 2007)
- The Children's Act 1989 (as amended) and the Children and Families Act 2014
- Criminal Law Act 1995
- Criminal Justice Act 1995
- Adults with Incapacity (Scotland) Act 2000
- Mental Health (Care and Treatment) (Scotland) Act 2003
- Mental Capacity Act 2005 (including Deprivation of Liberty Safeguards (DOLS) or its equivalents)
- Equality Act 2010
- The Care Act 2014
- Mental Health Act Code of Practice 2015, Chapter 26
- Mental Capacity Act (Northern Ireland) 2016*.

*NB: The working date for full implementation of this Act is 2020. (RCN 05/09/2018)

Training must also include relevant devolved legislation and/or legislation focused on specific groups of people.

Being person centred to respect and protect human rights

Training must be person centred, focusing on the human rights of the person involved in the use of the restrictive intervention, preventing unlawful breaches of rights, and taking positive steps to protect rights.

A person's wishes and feelings must be respected. Human rights law, together with mental capacity law, starts from the presumption that people have the capacity to make decisions about their own care and treatment. Where there are doubts about a person's capacity to make a specific decision, a mental capacity assessment must be conducted, and if needed a substituted decision can be made following a best interests assessment. However, the rights of that person to have their wishes and feelings considered during this process remain central and this process must be clearly recorded in their care plan. Even where a Mental Capacity Act assessment finds a person does not have capacity to make a specific decision (eg about treatment or refusal of treatment), the law requires respect for their right to autonomy (see Article 8). This means ensuring participation and involvement as far as possible, which may include providing specific support, eg interpreters, information in specific formats, etc. This will be important when staff are deciding whether or not to use a restrictive intervention, determining the least restrictive option, and how to make interventions. Training must make it clear that compliance with the Human Rights Act 1998 means both:

- refraining from taking action which unlawfully breaches rights, eg not using restrictive interventions that cause serious harm and safety risks (Article 3), and
- taking positive steps to protect rights, eg using proportionate restrictive measures (Article 8) to protect someone in care from taking their own life (Article 2)

The Human Rights Act 1998 sets out 16 rights ('Articles') which belong to all people in the UK in all situations. Training is expected to cover those Articles likely to be relevant to the use of restrictive interventions, for example:

Rights which cannot be lawfully restricted (including by use of restrictive interventions):

- The right to life (Article 2): in health and care settings this right is absolute; any restrictive intervention that compromises this right will not be lawful
- The right to not be treated in an inhuman or degrading way (Article 3): the use of some restrictive interventions may breach this right, including where serious physical or mental harm results either deliberately (abuse) or where it is not intended (neglect). The focus is primarily on the impact on the individual rather than the intentions of staff

Rights which can be lawfully restricted (including by use of restrictive interventions):

- The right to liberty (Article 5): whether this right can be restricted will depend on the legal basis for the action (see standard 1.2) and ensuring that the safeguards in the right have been met (eg knowing why liberty is being restricted and being able to challenge the decision)
- The right to respect for private and family life (Article 8): this ensures a person's physical and mental wellbeing and their personal autonomy, including involvement in care and treatment decisions. Restrictive interventions can significantly interfere with this right; this will only be permissible if actions are: (1) permitted by a legislative framework; (2) for a legitimate aim set out in the right way (usually protecting the person or others); and (3) proportionate (ie least restrictive option)

Rights of children:

- The United Nations Convention on the Rights of the Child (UNCRC) ensures all children have the right to be heard and protected from harm and provides guidance for best interests test
- Children and young people with learning disabilities and/or autism, and mental health difficulties whose behaviour challenges have the same human rights as all children and young people and require additional help to overcome the difficulties their behaviour may present (DHSC, DfE 2019)

Rights of people with disabilities:

- The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) Article 12 ensures equal opportunities of people with disabilities to exercise their legal capacity and rights to liberty as well as freedom from degrading treatment and exploitation

Non-discrimination:

- The right to not be discriminated against in relation to the above human rights (Article 14): this could include use of restrictive interventions which restrict liberty for discriminatory reasons, eg on the basis of ethnicity, age or other status, and any combination of these characteristics. The Equality Act also protects against discrimination on the basis of one (not a combination) of nine protected characteristics (all also covered by human rights law). Additionally, the Equality Act also sets out the public sector equality duty on services to consider how their policies and decisions affect people who may be discriminated against due to one of the nine protected characteristics (EHRC).

Training must make reference to contexts in which the use of a restrictive intervention may or may not be a lawful restriction on a person's human rights. For example:

- The right to liberty may be restricted if permitted by law for the purposes of mental health/capacity care (Article 5, Schedule 1, Human Rights Act 1998). The Mental Capacity Act 2005 can provide authority for restraint under Section 6, where (a) a person lacks capacity and (b) it is reasonably believed to be necessary and proportionate to protect them from harm. Additionally, Chapter 26 of the *Mental Health Act Code of Practice* (England and Wales) sets out guidance related to the use of restrictive practices for people detained under the Mental Health Act 1983 (Department of Health, 2015). (See also Mental Health (Care and Treatment) (Scotland) Act 2003; *The Mental Health Act 1983 Code of Practice for Wales* (Welsh Assembly Government, 2016a); Adults with Incapacity (Scotland) Act 2000; Mental Capacity Act (Northern Ireland) 2016*

*NB: The working date for full implementation of this Act is 2020. (RCN 05/09/2018)

Opportunities for discussion and analysis of scenarios related to the use of restrictive interventions in a range of settings must be provided in any training, and the potential impact of this on a person's human rights must be explored. Examples covering various service models and the relationship between human rights, mental health and mental capacity law can be found in the British Institute of Human Rights (BIHR) *Practitioner Toolkit Series* (BIHR, 2016b), BIHR Practitioner Toolkits.

Training standards

The next four sections cover the process from engagement with an organisation to development of the curriculum, its delivery and the cycle of feedback afterwards. Figure 2 (on page 35) displays this process.

Training providers must show that they have a process which meets the standards and they must be able to provide evidence needed at all the different stages.

Section 1: Standards 1.1–1.8

These standards cover the part of the process that needs to be completed before a curriculum is developed.

Section 2: Standards 2.1–2.15

These standards cover what must be included in the curriculum.

Section 3: Standards 3.1–3.6

These standards relate to post-delivery processes.

Section 4: Standards 4.1–4.7

These standards relate to trainers.

Section 1

Standards supporting pre-delivery processes

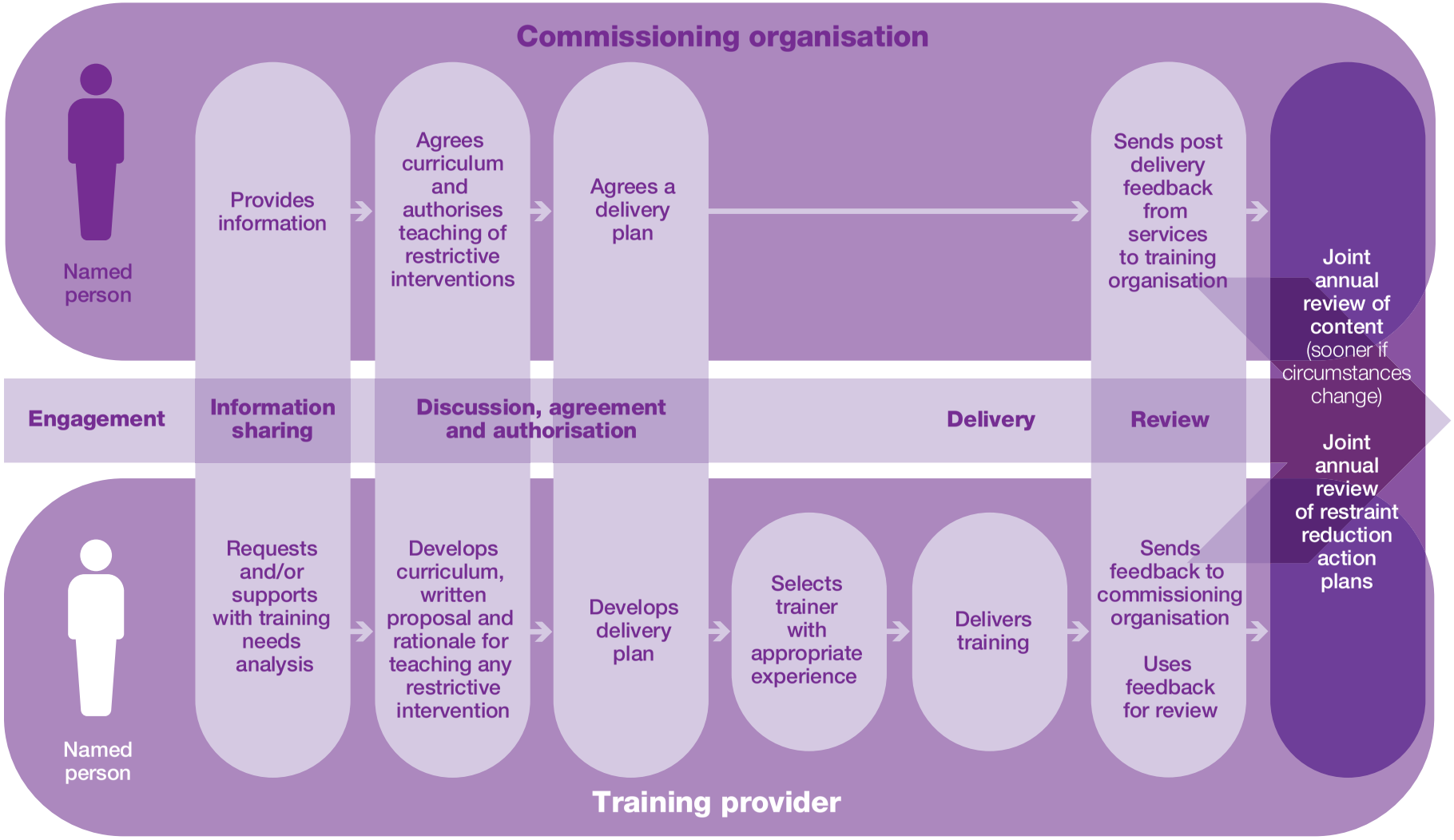
Standards 1.1–1.8 cover the part of the process that needs to be completed before a curriculum is developed and authorised.

Alongside these standards, please refer to Figure 2 (on page 35), which depicts the process for the commissioning, development, delivery and review of training with a restrictive intervention component.

Standards

Standard 1.1:	**Training needs analysis**
Standard 1.2:	**Developing and authorising the content of the training curriculum**
Standard 1.3:	**Independent risk assessment of techniques**
Standard 1.4:	**Committing to the reduction of use of all restrictive interventions and practices**
Standard 1.5:	**Involving people with lived experience**
Standard 1.6:	**Agreeing delivery plans**
Standard 1.7:	**Providing accessible information**
Standard 1.8:	**Responding to concerns and complaints**

Figure 2: Process for the commissioning, development, delivery and review of training with a restrictive intervention component



Introduction

Before developing and delivering any training, a good training provider engages with the organisation or service that needs training and finds out as much information as possible about the needs and characteristics of the staff and the people they support. This means they are confident that the training they provide is appropriate, proportional, meets identified needs, and any elevated risks are highlighted and adjustments made where needed.

Figure 2 illustrates the process for the development, delivery and review of training. It shows how the commissioning organisation and the training provider should work together to ensure all training is safe and designed to meet the needs of the people being supported by the commissioning organisation and the people who are receiving the training. Both parties must be responsible for ensuring the training is developed and delivered within a framework that is person centred and minimises the use of restrictive practices and that there is evidence that the training is monitored, reviewed at a minimum annually and adjusted where needed.

In the commissioning organisation the named person responsible for restraint reduction is usually the restrictive practices reduction lead or the lead trainer. In the training organisation this is the person who engages with the commissioning organisation and is responsible for developing the written proposal and agreeing the curriculum with the named person in the commissioning organisation. Both people are responsible for the annual review of the curriculum.

Where training is both developed and delivered in-house, the same process of development, delivery and review must be followed although there may only be one named person.

Standard 1.1

The curriculum must be based on a training needs analysis (TNA) which must be completed by the commissioning organisation before the curriculum is developed and delivered.

1.1.1 **As part of the commissioning process the training provider must request a training needs analysis (TNA) from the commissioning organisation.**

The TNA must include the current needs and risks posed to everyone based on current evidence and the past two years of incident data. It must be authorised by someone in the commissioning organisation who holds responsibility for restrictive intervention governance and reduction.

The TNA must consider the training needs and risks posed to all staff who may come into regular contact with distressed people or challenging situations including clinicians, teachers, and direct support staff.

In some cases the training provider will need to support the commissioning organisation to complete the TNA as part of the commissioning process or may need to request extra information. A TNA checklist can be found here RRN Training Standards – materials to download

1.1.2 **The data that training providers request and receive from the commissioning organisation must be managed in line with the Data Protection Act 2018 (the UK implementation of the General Data Protection Regulation (GDPR)). Any data relating to specific individuals must be in an anonymised form.**

1.1.3 **As part of the agreement to provide any training in physical restraint and before commencing the training, both the training provider and the trainer who delivers the programme must satisfy themselves that the commissioning organisation has the appropriate level of immediate life support training (including required refresher training). This should be in accordance with the guidelines of the UK Resuscitation Council for immediate life support** (see Resuscitation Council (UK)).

In some cases this training will be provided by the training provider as part of the content of training and in other cases another provider will have delivered this.

1.1.4 **The training provider must ensure that the curriculum takes account of elevated risks to populations and individuals.**

The training provider must ensure any and all restrictive interventions take into account any known factors that may cause an elevated risk of harm at population and service level, and that arrangements are in place to ensure that any known risks are considered at the individual level.

Therefore agreement must be reached between the training commissioner and the training provider about how the information needed to support this process is transferred from one to the other. An anonymised summary of information must be received as part of the TNA. This should include any population or person-specific characteristics for people who are likely to be in receipt of restrictive interventions by the staff undergoing training. As a minimum, this information must include:

- range of age, gender identity, cultural heritage, diagnosis
- any known sensory processing issues that may elevate the risk of harm to a person if a restrictive intervention is used
- any known physical characteristics or health problems that may elevate the risk of harm to a person if a restrictive intervention is used
- any known emotional or psychological characteristics or current and potential issues and problems that may elevate the risk of harm to a person if a restrictive intervention is used. This should include, if known, reference to any past trauma
- any known developmental issues that may elevate the risk of harm to a person if a restrictive intervention is used

A good practice checklist for personalised wellbeing risk assessments for use by commissioning organisations can be found at: RRN Training Standards – materials to download

1.1.5 **The training provider must receive the TNA from the commissioning organisation in sufficient time so that training can be tailored appropriately and all the requirements in standards (section 1) can be met. Please note that it could take up to one month to complete all these activities, before training is delivered.**

Standard 1.2

A named person in the training provider organisation must develop a written proposal for a curriculum including the rationale for teaching specific restrictive interventions.

1.2.1 **The training provider (a named person) must develop a written proposal for the curriculum that covers both theory and practical elements.**

If restrictive interventions are being taught, participants must have completed a minimum of two days' training (12 hours) in the underpinning theory, including training in preventative and secondary strategies, as specified in standards 2.1–2.15, prior to participating in a practical, physical skills training session. The majority of these two days must be face to face to ensure that discussion and demonstration can take place, and blended learning could be considered for some elements where it enhances understanding. Training providers must be able to evidence that the training methods they choose are effective in supporting learning and cultural change. Participants must not be taught to use restrictive interventions unless they have received prior training in primary preventative strategies.

In some cases, training that covers primary preventative strategies (see standard 2.5) have been covered on separate training courses, for example, Safewards or Positive Behaviour Support. In this case the underpinning theory requirement can be reduced to a minimum of one day (6 hours) but must include all elements of theory specified in standards 2.1 to 2.15 with the exception of standard 2.5.

If this is the case as part of the agreed delivery programme the training provider must clarify with the commissioner that this training will be provided to any staff before they attend training with a restrictive intervention component. This should be clearly documented in the agreement to provide training.

In some cases training may be delivered as part of a modular programme.

1.2.2 **The proposal must be based on information in the TNA provided by the commissioning organisation.**

The written proposal must include as a minimum:

- who the training is intended for
- aims, objectives and learning
- outcomes for each programme
- training methods*
- timings
- assessment methods
- rationale that justifies the inclusion of each restrictive intervention in the programme. This may be in any format but must include the following as a minimum (RRN Training Standards):
  - name and description of restrictive intervention (diagram or photo)
  - rationale for use (why and in what situation)
  - how the intervention will be taught to staff and how competence will be tested
  - general safety issues for staff during teaching and practice
  - any person specific safety issues for staff during teaching and practice (where information has been provided, and adjustments need to be made)
  - any issues that may compromise the fidelity of the technique between the taught version in the classroom and its application in practice. This must include a description of how any identified issues may compromise both safety and effectiveness
  - general safety guidelines, supporting those restrictive interventions authorised for use at population level
  - person centred safety guidelines, supporting personalised restrictive interventions
  - a statement that the restrictive intervention must be used as taught and not modified, unless authorised by the training provider

* If simulated role play is proposed as part of the curriculum the level of force must be justifiable, appropriately risk assessed and training ratios reflected accordingly

1.2.3 **If the TNA identifies specific staff groups whose job role means there is only ever a small risk of them being involved in challenging situations (for example administrative staff or maintenance staff) they may only require a short course that covers de-escalation and breakaway skills.**

In this case a one-day programme could be developed and delivered, where the breakaway training does not have a restrictive component (ie the techniques do not use physical restraint).

The shorter programme must be framed in a human rights framework and must as a minimum meet all the standards, with the exception of the content described in standards 2.4, 2.5, 2.7, 2.8. 2.9, 2.10 and 2.12.

The programme must include enough time for demonstrating, practising, and assessing participants as competent to use general de-escalation and other secondary strategies as set out in 2.6 as well as the non-restrictive breakaway skills. It should ensure that participants are given an understanding of why people may be upset and distressed. It must also make reference to the recording and reporting requirements if an incident should occur.

The ratio for teaching theory, de-escalation and breakaway skills is a maximum of 1 trainer to 18 participants unless there is an element of physical restraint in any of the techniques. If the TNA indicates that techniques that have an element of physical restraint are needed, participants will have to complete a full programme that meets all standards.

The definition of physical restraint used by these standards is found in standard 2.8.6: '**Physical restraint** is any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person (Department of Health, 2014). Physical restraint can also called manual restraint, physical intervention and restrictive physical intervention.'

1.2.4 **In the case of direct support staff members who are at risk because of a crisis situation and have not yet received full training, they could attend a one-day programme as described in standard 1.2.3 as an interim to learn non-restrictive breakaway skills as above.**

This programme must only ever be delivered to a minority of staff in exceptional circumstances and must never be the default course. The following criteria must be applied:

- All participants must complete a full programme that complies with all the standards within one month of completing the emergency programme
- The TNA and written proposal must indicate the date of the full programme
- Certificates of attendance for participants who attend emergency programmes must also indicate the date by which a full programme must be completed
- The training is not transferable to other settings

1.2.5 **The training provider must also provide a 'training information sheet' that must be made available to participants in advance.**

It must include:

- an overview of the theory training
- an overview of the practical training, including the length of the session
- a brief description of the nature of the training sessions, and any specific physical requirements – for example, most techniques are passively practised in a standing or occasionally seated position, or there is a requirement for learners to be able to move from a kneeling to standing position during one procedure
- any specific requirements in terms of suitable clothing or footwear
- how to find out any more information prior to the training taking place

Standard 1.3

Training providers must ensure that each physical restraint technique that is included in the curriculum is holistically risk assessed.

The risk assessment must include:

- trainability, complexity, effectiveness, and fragility of the technique
- risk factors to people including moving/manual handling risks physical/physiological risks, psychological risks (risk of causing or retriggering trauma) and risks to dignity

Risk assessment must consider evidence from injuries that have previously occurred in training this technique and any injuries or harm from its application in real life.

Factors that cause elevated risk must be identified. A risk assessment tool is provided. Alternatively, training providers may use their own tool that covers the required criteria.

1.3.1 **The training provider must ensure that the commissioning organisation receives a current risk assessment for each physical restraint being taught.**

1.3.2 **The training provider must identify the appropriate person or persons with relevant experience to assess risk in each area of the risk assessment.**

Different clinicians are likely to be needed to contribute to different aspects of each risk assessment (for example an expert in biomechanics would be involved in assessing biomechanical risks). The whole final risk assessment must be independently reviewed by an external person with significant experience of providing training in restrictive practices for the population the restraint is intended for use with. An external person could potentially be someone with lived experience or be a peer reviewer from another provider of certified training.

1.3.3 **The risk assessment for each physical restraint must be reviewed every two years minimum, and any time that an adaptation is made to it, or a risk assessment is requested in the context of an investigation. Records of reviews must be documented.**

1.3.4 **The risk assessment for each physical restraint must ensure the suitability of the physical restraint for the population it is intended for.**

The risk assessment for each physical restraint must record any potential of risk in the following areas:

- psychological or emotional harm, as well as reference to potential risk factors such as prior trauma experiences
- risks to dignity
- trainability and complexity of the technique, including the level of skills, coordination and fitness required to carry out the technique correctly
- the fragility of the technique – that is the extent to which risks may be elevated and safety compromised by any margin of error in application
- physical harm, as well as reference to any general potential risk factors such as illness, impairment or injury, or issues specific to a named individual which may elevate risk
- restricted breathing, as well as reference to any general potential risk factors such as obesity, positioning and intoxication or issues specific to a named individual which may elevate risk
- circulation, as well as reference to any general potential risk factors such as limb position and bodyweight being used to hold someone, or issues specific to a named individual which may elevate risk
- joint functioning, as well as reference to any general potential risk factors such as the hyperextension and hyperflexion of joints, and the unauthorised adaptation of techniques or issues specific to a named individual which may elevate risk

Safety guidance accompanying risk assessments must:

- ensure that any physical restraint avoids vulnerable parts of the body (such as neck, chest and sexual areas)
- emphasise the need to minimise absolutely the time any individual is subject to any form of restraint
- include recommendations on the level and type of observation that accompanies any application and post-application monitoring period. These may include personalised protocols in the event that an individual's personal characteristics and/or personal history elevate risks
- describe the signs of distress which should be actively monitored for. These may include personalised protocols in the event that an individual's personal characteristics and/or personal history elevate risks
- describe those aftercare arrangements that are required to maximise recovery and minimise any potential traumatising effects of any restraint

1.3.5 **All trainers must have access to authorised information about the risks or elevated risks for any restrictive interventions they are teaching.**

This may include anonymised information, as well as risk assessments supporting the use of restrictive interventions at both population level and person centred level (standard 1.1.4).

1.3.6 **Training providers must ensure that all physical restraint included in the curriculum complies with guidance relevant to country, setting and population** (see appendices 17–20)**. Evidence must be provided throughout the self assessment process to show that the training covers any specific adaptations to the standards or special considerations.**

1.3.7 **These standards do not support the use of pain to gain compliance. Training providers must not include the teaching of any restrictive intervention that uses pain to force an individual to comply** (see also appendices 21A and 21B)**.**

Standard 1.4

Training must be provided within the context of an explicit commitment to the reduction of all restrictive practices.

1.4.1 **Training providers must be clear in all their communications with any commissioning organisation, ensuring that training is provided within the context of reduction** (see glossary).

1.4.2 **Training providers must use feedback from training programmes as part of both a continuous review and the annual review process.**

1.4.3 **Training providers must review the rationale and continuing need for specific interventions to be included in the programme with the commissioning organisation at a minimum annually and each time the TNA is reviewed.**

1.4.4 **Training providers must have a restraint reduction plan which details measurable outcomes and actions that support the reduction of the use of restrictive practices.**

The plan must be updated at least annually and shared with commissioning organisations or published via Restraint Reduction Network membership. *Restraint reduction resources, including six core strategies and self-assessment tools, are available at* RRN Training Standards – materials to download

Standard 1.5

Training providers must ensure that people with lived experience are involved in the development and delivery of training which involves the use of restrictive interventions.

1.5.1 **Training providers must ensure that the views and experiences of people with lived experience of being in receipt of restrictive interventions should both inform and be explicit in training content.**

Co-production of materials and training with people who have lived experiences may include the use of monologues, video diaries or other forms to support discussion and interaction with participants. It is recognised that access to the views and experiences of people with lived experience may be through the training provider or in direct partnership with commissioners of training who may have developed opportunities and networks which support participation.

1.5.2 **Training providers must ensure that any direct engagement with people with lived experiences is managed sensitively and safely and is viewed in the context of a professional relationship.**

People with lived experience involved in the training must also receive adequate recompense. People with lived experience must be acknowledged as subject matter experts who are able to enrich and enhance training programmes, and play a valuable role in supporting restraint reduction measures.

1.5.3 **Training providers must ensure proper consideration and planning is given to any co-produced training sessions, if any sessions are to be co-produced and/or co-delivered with a person with lived experience. Sharing lived experiences can be an emotionally intensive experience for both the person with lived experience and the participants. The appropriate support arrangements must be in place.**

Standard 1.6

The training provider must agree delivery arrangements with the commissioning organisation before delivery takes place.

1.6.1 **Plans for competency testing and refresher programmes must be agreed with the commissioning organisation in advance and be part of the agreed delivery plan.**

Refresher training must take place as a minimum annually and must include competence testing for minimum content requirements (see standard 3.1.1). Refresher training must have an annual core content and an additional rolling programme of remaining content (see standard 3.1). Refresher or update cycles may in some circumstances be increased in frequency if individual or service circumstances change.

1.6.2 **Training providers must specify and agree the requirements for the training venue with the commissioning organisation as part of the delivery plan.**

1.6.3 **The training provider must describe the physical fitness level required for each programme it is commissioned to deliver as part of the delivery plan.** (See also standard 1.2.3 on the training information sheet.)

1.6.4 **The training provider must agree in advance with the commissioning organisation before any training is developed and delivered how the information needed for record keeping will be held and shared, in line with GDPR data protection rules and legislation.**

1.6.5 **The ratio of trainers to participants when teaching people theory and practical skills must be part of the agreed delivery plan.**

When teaching and assessing competence in practical (eg physical) skills with a restrictive component, the ratio (of trainers to participants) must not be more than **1:12** in line with first aid that also requires competency testing. The participant cohort size cannot be more than 18. A minimum of two trainers will be required if the cohort size is above 12.

Training organisations must evidence that they considered all relevant risks when planning training (and the ratio of trainer to participant is adjusted accordingly) including:

- the risk assessment for each physical restraint technique being taught. Training providers must be able to evidence low risk across all appropriate risk domains where one trainer is used (or that a second trainer is always in place where risks are identified as higher, eg complexity of technique or use of simulation). The certification process will be particularly rigorous in reviewing this
- the training needs analysis (and that this has not identified any elevated risks to people being supported by the service or the staff)
- a risk assessment for the training delivery that takes into account additional hazards (eg the environment)
- if resistance based simulations (or role plays) are being used, a second trainer must be present with one trainer having the responsibility for ensuring safety (see also standard 2.8.11)

Training providers should take into consideration the likely gender balance of participants and trainers.

1.6.6 **Training providers must request in advance any information about reasonable adjustments that need to be made so that participants with additional support needs can maximise their participation in the training event.**

This information must be received at least two weeks before the delivery date. If participants are added to the programme nearer the time, training providers must request that the commissioning organisation also include any information about additional support needs for those participants.

1.6.7 **All training providers and any trainers who are employed by them must as part of the commissioning process provide evidence of both professional indemnity and public liability insurance.**

Standard 1.7

The training provider must provide accessible information about the content of the training programme.

1.7.1 **Accessible information must be available to everyone who will be directly or indirectly impacted by the training. The information must:**

- be available to the commissioning organisation to disseminate and also readily available for any individual or representative of an individual who makes a request
- be in a format that best suits people's communication requirements and needs
- cover both the theory and practical aspects of the training. All restrictive interventions that are to be taught must be described, alongside potential risks and the rationale for their inclusion in the programme

Standard 1.8

The training provider must have a policy for responding to concerns and complaints.

1.8.1 **The training provider must have a policy that clearly describes how questions, concerns and complaints will be processed and dealt with. The policy must be:**

- available on request
- publicly available, eg through the training organisation's website
- presented in an accessible information sheet (see standard 1.2.3) which should contain the training organisation's contact information

The policy must include:

- a time frame for acknowledgment of the complaint to the complainant
- details of how an investigation will take place to determine if the complaint is justified or not
- a process for a root cause analysis of the complaint, and corrective actions
- details of the closure of the complaint and feedback to the complainant

Section 2

Standards supporting curriculum content

Standards 2.1–2.15 describe areas that the curriculum must cover.

Standards

Standard 2.1:	**Placing the curriculum within a rights based framework**
Standard 2.2:	**Duty of candour and duty of care**
Standard 2.3:	**Attitudes and attributions**
Standard 2.4:	**Considered decision making**
Standard 2.5:	**Primary and preventative strategies**
Standard 2.6:	**Teaching secondary strategies**
Standard 2.7:	**Teaching non-restrictive tertiary strategies**
Standard 2.8:	**Teaching restrictive tertiary strategies**
Standard 2.8.A:	**Use of mechanical restraint**
Standard 2.9:	**Factors that contribute to risk and elevated risk**
Standard 2.10:	**Emergency procedures**
Standard 2.11:	**Identifying the range of restrictive practices**
Standard 2.12:	**Use of data to inform minimisation**
Standard 2.13:	**Post-incident support, review and learning**
Standard 2.14:	**Trauma informed care and support**
Standard 2.15:	**Restraint reduction theory**

Introduction

Well-designed training programmes can influence learning, and behaviour change programmes that teach people to restrain may inadvertently reinforce the use of restrictive practices. A good training programme will teach the restrictive interventions as only one small part of a whole range of person centred working practices that aim to prevent and minimise distress and crisis rather than the primary focus being on management.

Standard 2.1

Training content must support a person centred and rights based approach.

Training providers must reference the rights based framework found at the front of these standards when developing this part of the curriculum.

*Figure 3 illustrates how training must consider the rights and needs of people who are being trained **and** the rights and needs of people who are being supported and may be in receipt of restrictive interventions. These rights and needs include universal human rights and are also person specific, setting specific and country specific.*

2.1.1 **Training content must ensure participants understand the importance of adopting a person centred approach at all times.**

Understanding could be checked by the trainer through developing exercises such as case studies or questions for participants to work through.

2.1.2 **Training content must ensure participants understand the legislation that supports individual rights.**

Understanding could be checked by the trainer through developing exercises such as case studies or questions for participants to work through. Reference in training must be made to:

- the Human Rights Act 1998
- the Equality Act 2010
- the Mental Capacity Act 2005, Adults with Incapacity (Scotland) Act 2000, and the Mental Capacity Act (Northern Ireland) 2016*
- where relevant, the Mental Health Act 1983 and the Mental Health (Care and Treatment) (Scotland) Act 2003

*NB: The working date for full implementation of this Act is 2020. (RCN 05/09/2018)

2.1.3 **Training providers and trainers must be aware of current Health and Safety Executive guidance around work based violence.**

Training content must be congruent with the guidance and it must also be referred to in training content.

2.1.4 **Training content must include an overview of relevant legislation, regulations and guidance designed to uphold human and individual rights as they relate to specific populations, settings and nations** (see Appendices 1–20).

Standard 2.2

Training content must cover duty of candour and duty of care in all settings.

2.2.1 **Training content must:**

- explore participants' obligations related to duty of candour and duty of care
- include a definition of both duties (for example Care Quality Commission (Regulation 20), 2015) and reference to guidance from the appropriate specific professional bodies for the participants
- explore how both duties relate to practice through examples and show how they contribute to a culture of safety for everyone
- explore where reflective practice can support both duties
- reference and direct participants to the commissioning organisation's whistle-blowing policy and procedures

Understanding could be checked by the trainer through developing exercises such as case studies or questions for participants to work through.

Figure 3: **Diagram demonstrating the layers of guidance and legislation to be considered when developing a training syllabus that has a restrictive intervention component**



Standard 2.3

Training content must cover how attitudes to and attributions of distress or concerning behaviours can impact directly on responses to the people being supported.

2.3.1 **Training content must cover:**

- how a range of factors can affect staffs' conscious and unconscious responses to the people they support
- how the language used to describe people, behaviours and restrictive interventions can negatively influence personal and service responses
- how negative attitudes and attributions can contribute to discrimination, power imbalances and the perpetuation of a culture of control
- how staff perceptions of authority and control and team relationships can impact on responses to the people they support (entrenched team cultures – 'the way that things are done here' – or influential team members can impact on the behaviour and practice of others). Please also refer to standard 2.10.

Standard 2.4

Training content must cover the use of decision making in response to distress or behaviours of concern.

2.4.1 **Training content must:**

- define the concept of least restriction and this principle must be reinforced through the whole programme
- explore the impact of staff decision making and choices in relation to the use or non-use of any strategies or interventions. This must cover when, where and how to replace, reduce or release those that they have selected. The decision must be safe, lawful and effective
- include discussion about the influences of team culture or relationships with other staff or authority figures as impact factors on staff decision-making processes or the ability to challenge other people's decisions
- cover advanced directives and consent. It is vital that the person themselves is involved in discussions and decisions about what happens and when, and that directives should take into account preferences and wishes of the person
- draw a direct link between decision making and accountability
- refer to organisational protocols and guidance for calling the police to assist in crisis situations. The rationale for police involvement must be explored in detail

Over reliance on police involvement is not likely to contribute to a culture of therapeutic treatment. Please refer to the memorandum of understanding drawn up by the College of Policing, available at Protocol for Police and Mental Health Staff

Figure 4 supports standards 2.5 to 2.8, illustrating the purpose of primary, secondary and tertiary strategies and when they should be used.

Standard 2.5

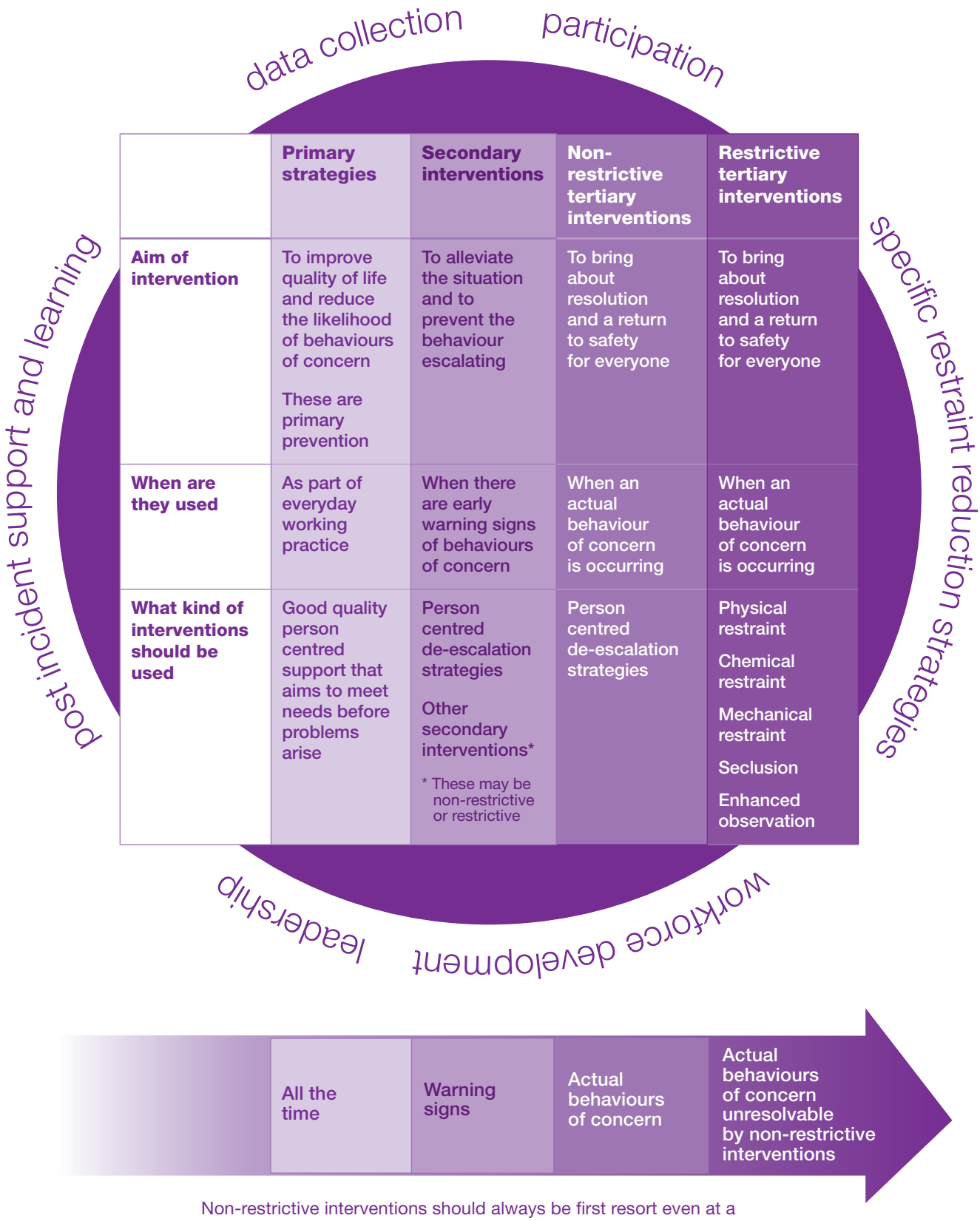
The curriculum must give proportional time (no less than one day or six hours) to exploring primary strategies and preventative approaches (unless the commissioning organisation already provides an evidence based model of preventative training to all staff).*

2.5.1 **Training content must:**

- reference evidence-based frameworks, for example Positive Behaviour Support, Safewards, Recovery models etc for understanding the root causes of distress and the communicative function of behaviours of concern, meeting needs, and creating supportive environments
- support participants' understanding of the potential causes and vulnerabilities associated with the risk of developing distressed behaviours or behaviours that are concerning for the specific populations being supported. *Potential causes and vulnerabilities may include (but are not restricted to) communication difficulties, sensory differences, physical and mental health problems, social exclusion and lack of social relationships, and history of trauma and abuse (Hastings, 2013)*
- include activities and discussion relating to creating cultures of support and developing primary strategies designed to proactively meet people's needs so they are less likely to develop distress or behaviours of concern. *Primary strategies aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of harmful behavioural disturbances (Department of Health, 2015, 26.19–26.22); these strategies may also be referred to as proactive strategies* (see Figure 4)
- explore the impact of the environment and factors that have a negative impact both on the people being supported and staff. The relationship between enhancing quality of life and reduction of restrictive practices must be emphasised
- refer to the role of relationships within the context of meeting need and preventing the development of behaviours of concern. It must also explore what constitutes healthy and helpful therapeutic relationships

* examples of frameworks may include Positive Behaviour Support, Safewards, No Force First, the Recovery model, and/or specific strategies such as Safety Huddles.

Figure 4: **Minimisation matrix showing the different types of interventions and when they should be used within a restraint reduction framework** (NASMHPD, 2008)



	Primary strategies	Secondary interventions	Non-restrictive tertiary interventions	Restrictive tertiary interventions
Aim of intervention	To improve quality of life and reduce the likelihood of behaviours of concern These are primary prevention	To alleviate the situation and to prevent the behaviour escalating	To bring about resolution and a return to safety for everyone	To bring about resolution and a return to safety for everyone
When are they used	As part of everyday working practice	When there are early warning signs of behaviours of concern	When an actual behaviour of concern is occurring	When an actual behaviour of concern is occurring
What kind of interventions should be used	Good quality person centred support that aims to meet needs before problems arise	Person centred de-escalation strategies Other secondary interventions* * These may be non-restrictive or restrictive	Person centred de-escalation strategies	Physical restraint Chemical restraint Mechanical restraint Seclusion Enhanced observation

Non-restrictive interventions should always be first resort even at a tertiary stage when an actual behaviour of concern is occurring

- include identifying triggers or events that may increase the likelihood that people will become distressed. Participants must be encouraged to think about the individual people they support and how these personalised triggers can be both identified and managed. Participants must also be encouraged to reflect on their own personal triggers and responses to those triggers

Standard 2.6

The curriculum must give proportional time (typically at least three hours) to covering the use of secondary strategies which alleviate the situation and prevent distress or behaviours of concern from escalating.

2.6.1 **Training content must:**

- cover a definition and examples of secondary strategies and when they should be considered for use. Secondary strategies may be non-restrictive or restrictive and examples should be given of both (see Figure 4)
- refer to any evidence-based frameworks or models that are used by the commissioning organisation
- include enough time for demonstrating, practising, and assessing participants as competent to use general de-escalation and other secondary strategies
- emphasise the importance of developing person centred, individualised de-escalation techniques and secondary strategies. Participants must be encouraged to relate the use of secondary strategies directly to the people they support
- refer to the importance of keeping records of successful secondary strategies, in line with organisational systems, and how this information can be used to inform reduction plans

Standard 2.7

The curriculum must give proportional time to covering the use of non-restrictive tertiary strategies.

2.7.1 **Training content must cover a definition of tertiary strategies (see glossary) and examples of both non-restrictive and restrictive tertiary strategies and when they should be considered for use** (see Figure 4, p59).

Tertiary strategies are used to bring potentially unsafe situations under control. Tertiary strategies do not aim to prevent the situation from occurring again in the future but are used for the exclusive aim of bringing about a safe and timely resolution.

2.7.2 **The curriculum must allow time for discussion and consideration of the safe use of non-restrictive tertiary strategies when there is an actual behaviour of concern occurring. Some interventions used at the secondary stage (early warning stage) can also be used when someone is in distress or there is a risk of harm occurring.**

The interventions may need adapting as the risk presented at this time is greater. These are referred to as non-restrictive tertiary strategies and should always be considered for use before a restrictive intervention is applied. The primary aim is to bring about safe and timely resolution in the least restrictive way.

2.7.3 **The curriculum must have time factored in for demonstration and practice for each strategy and time factored in for each participant to have an assessment of competence in the safe use of each strategy.**

2.7.4 **The trainer must refer to the importance of recording the use of non-restrictive tertiary strategies and how successful the de-escalation attempt was. This information will help support the minimisation plan.**

2.7.5 **Training content must cover any non-restrictive breakaway or disengagement techniques as identified by the Training Needs Analysis.**

These are techniques that are used to breakaway/disengage from any unwanted physical contact for example a grab or a hair pull. Breakaway techniques may be completely non-restrictive, or have a restrictive component included. Breakaway techniques may also be used to assist another person to disengage from unwanted physical contact.

Training content must draw attention to potential communicative function of the unwanted physical contact, particularly if the person is unable to verbalise their distress or make themselves understood clearly. The curriculum must have time factored in for demonstration and practice for each technique, and time factored in for each participant to have an assessment of competence in the safe use of each technique.

Standard 2.8

Teaching the use of restrictive interventions (may include physical restraint, physical restraint to facilitate seclusion or long term segregation, clinical holding, or mechanical restraint).

The following restrictive interventions are covered by these standards:

- *physical restraint*
- *physical restraint used to facilitate seclusion*
- *physical restraint used to facilitate long term segregation*
- *physical restraint used to facilitate rapid tranquilisation*
- *mechanical restraint*
- *clinical holding*

2.8.1 **Training in the use of restrictive interventions must only be provided within the context of an explicit commitment to reduction of the use of all restrictive interventions** (see standard 1.4) **and the provision of person centred support.**

2.8.2 **Training content should refer to any elevated risks identified in the TNA** (see standard 1.1).

Any restrictive interventions which are to be taught to training participants must have been assessed as suitable for the needs of that population. Where TNAs have highlighted elevated risks to individuals or populations, training must reflect any additional safeguards, limitations or restrictions. There must not be blanket training of any restrictive intervention techniques (see Appendix 10 for emergency admission services).

2.8.3 **Training content must define the type of restrictive intervention being taught, and this must include a definition of the purpose of the intervention and the context in which it is to be used.**

Reference must be made to terminology used in local policy documents, as well as authorised procedure. If breakaway/ disengagement techniques are taught that have a restrictive component the restrictive element must be highlighted. Breakaway techniques are used to breakaway/disengage from unwanted physical contact and may also be used to assist another person to disengage from unwanted physical contact. Training content must also draw attention to potential communicative function of the unwanted physical contact particularly if the person is unable to verbalise their distress or make themselves understood clearly.

2.8.4 **Training content must be clear that restricting someone's movement for clinical or personal care purposes is a form of physical restraint and should be recorded as such. This is sometimes referred to as clinical holding.**

Training must refer to the use of person centred approaches and less restrictive alternatives to the use of clinical holding or holding for personal care that can decrease the traumatic impact of the experience.

2.8.5 **The trainer facilitating the session must be competent to safely teach and manage those training sessions covering the use of specific restrictive interventions. In addition to meeting the criteria in** standard 3, **trainers must have been formally assessed to be competent to deliver those specific interventions by the training provider.**

Clinical experience of participating in certain procedures such as rapid tranquilisation and long term segregation would also enhance their understanding.

2.8.6 **Training must cover the specific circumstances in which the restrictive intervention under consideration may lawfully be used.**

As a minimum the following must be covered:

- an overarching definition of restraint/restrictive intervention must be discussed in training so delegates gain a clear understanding of when any intervention becomes restrictive and is categorised as a restraint. These standards recommend reference to the Equality and Human Rights Commission (EHRC) *Human Rights Framework for Restraint* (2019):

  > *'Restraint' is an act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently. This may or may not involve the use of force. Restraint does not require the use of physical force, or resistance by the person being restrained, and may include indirect acts of interference for example removing someone's walking frame to prevent them moving around.* (EHRC, 2019)

- the legislation and guidance that legitimises the use of the specific restrictive intervention being taught, as well as the rationale, legislation and guidance relating to any clinical or statutory function that the intervention (eg physical restraint) is being used to support (eg rapid tranquilisation or detention under the MHA 1983 or the Mental Health (Care and Treatment) (Scotland) Act 2003)
- any national or service specific guidance that applies to the specific restrictive intervention being used
- relevant sections of the local organisational policy along with procedures relating to the use of the specific restrictive intervention
- that the intervention under consideration must only be considered when all other available and appropriate methods of primary and secondary prevention and non-restrictive tertiary interventions have been explored and found ineffective
- that the intervention must only be used for its intended and agreed purpose
- that it must be the least restrictive option available
- that it must employ the minimum amount of force for the minimum amount of time
- that it must never be used as a threat or as punishment, or in a way that curtails the rights and freedoms of the individual

- that if it is used as a planned intervention, it must be accompanied by the consent of the individual, or based on a best interests decision (Mental Capacity Act 2005) or in consultation with relevant others (Adults with Incapacity (Scotland) Act 2000; Mental Capacity Act (Northern Ireland) 2016* unless the person is detained under the Mental Health Act 1983, or the Mental Health (Care and Treatment) (Scotland) Act 2003

*NB: The working date for full implementation of this Act is 2020. (RCN 05/09/2018)

Physical restraint is any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person (Department of Health, 2014). Physical restraint can also be called manual restraint, physical intervention and restrictive physical intervention.

Seclusion involves 'the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving' (Department of Health (2015) Mental Health Act 1983 Code of Practice Section 26.103).

NB the Equality and Human Rights Commission (EHRC) *Human Rights Framework for Restraint* (2019) refers to enforced isolation:

> Example: Isolation may be enforced by locking a door or using a door the person cannot open themselves, or otherwise preventing them from leaving an area, for example by the use or threat of force. Enforced isolation is therefore restraint, but it may be described as seclusion, segregation, separation, time out or solitary confinement (EHRC, 2019).

Rapid tranquilisation refers to 'the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. This may provide an important opportunity for a thorough psychiatric examination to take place' (Department of Health (2015) Mental Health Act 1983 Code of Practice Section 26.91).

Long term segregation (LTS) involves 'a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis' (Department of Health (2015) Mental Health Act 1983 Code of Practice Section 26.150).

Mechanical restraint involves 'the use of a device (eg belt or cuff) to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control' (CQC, 2015b).

Clinical holding involves 'immobilisation, which may be by splinting, or by using limited force. It may be a method of helping children (and adults), with their permission, to manage a painful procedure quickly or effectively' (RCN, 2010).

2.8.7 **The training content must cover all of the risks that are associated with the use of the specific intervention under consideration, before any practical component is delivered. Training must cover the safeguards in place to manage any risks that may arise as well as the planned contingencies in place in the event of a medical emergency developing** (see standard 2.10).

As a minimum it must cover:

- general risks associated with the specific intervention (standard 1.3)
- specific risks associated with the use of the intervention under consideration on any individuals
- warning signs to look out for, which reveal distress, pain or a deterioration in any individual medical condition (refer to standard 2.10)
- action to be taken in the event that warning signs are detected (see standard 2.10)

2.8.8 **Before delivering the practical components of the programme the trainer must highlight those risks that are potentially present within the training environment and during training practice** (see standard 1.3)**.**

These include:

- general safety issues for staff during teaching and practice
- person specific safety issues for staff during teaching and practice

2.8.9 **The training session must allow enough time for demonstration and practice for each technique and time factored in for each participant to have an assessment of competence in the safe use of each restrictive intervention that has been approved** (see standard 2.6)**.**

2.8.10 **The training session must be structured in such a way as to contextualise the use of the specific restrictive intervention. For example structuring scenarios that integrate the restrictive interventions into operational or clinical situations.**

2.8.11 **Where simulated resistance is used during training sessions the risks it poses must be managed:**

- only trainers must role play resistant service users
- role plays must be directly managed by a separate trainer who should immediately stop the scenario if there is any likelihood of injury

2.8.12 **The training content must emphasise that the application of any restrictive intervention will be within the context of a therapeutic or supportive relationship with that person.**

Training must recognise that the use of restrictive interventions can traumatise people and damage relationships. It must explore how relationships can be maintained during and after the use of any restrictive interventions.

2.8.13 **The training content must emphasise the need to comply with reporting requirements and participate in any review processes designed to learn from experience and reduce the need for future restrictive interventions.**

Standard 2.8.A

Teaching the use of mechanical restraint.

Due to the highly restrictive nature of some mechanical restraints, additional training standards are required to complement standard 2.8.

2.8.A.1 **Training providers must ensure that any form of mechanical restraint that they are requested to teach the use of has been agreed at a board level. There must be clear documentation as to how this has been deemed the least restrictive option for that person and why alternative approaches would not be suitable for them (CQC, 2016). Training content must explicitly cover this point.**

2.8.A.2 **Mechanical restraint must only be considered for use in exceptional circumstances in specific settings and under specific circumstances. Training content must clearly identify what these are and refer to organisational policy and protocol for their use.**

2.8.A.3 **Training content must refer to specific legislation and guidance on the use of mechanical restraint. This must include:**

- ***Brief Guide: Restraint (Physical and Mechanical)* (CQC, 2015)**
- ***MHA 1983 Code of Practice* (Department of Health, 2015), and the *MHA 1983 Code of Practice for Wales* (Welsh Assembly Government, 2016a)**
- ***NICE guidance NG10* (NICE, 2015a)**

2.8.A.4 **Training content must refer to the *Mental Health Act Code of Practice* (Department of Health, 2015, 26.8026.81, 26.82), and the *Mental Health Act 1983 Code of Practice for Wales* (Welsh Assembly Government, 2016a) which specifies requirements for safety reviews and observation protocols.**

2.8.A.5 **Training content must refer to any other general and specific safety guidance around the use of the specific mechanical restraint.**

2.8.A.6 **If appropriate, training must cover the protocol for the use and recording of mechanical restraint such as splints or cat paws which sometimes are used in services for people with learning disabilities and autistic people who have self injurious behaviours.**

The principle of least restrictive intervention must apply. The function of the self injury for the person must be identified and alternative ways of meeting the person's needs must be implemented. The clinical team, family, carers and advocates would need to be in agreement about the parameters of the use of the device (*MHA 1983 Code of Practice*, Department of Health, 2015, 26.87).

2.8.A.7 **Training must cover protocols for the use and recording of mechanical restraint in services for older people and people with disabilities. Belts and straps in chairs etc must be used lawfully for intended purpose only and not used to restrict liberty for the convenience of staff.**

Standard 2.9

Training must cover the factors that contribute to risk and elevated levels of risk in the application of restrictive interventions.

2.9.1 **Training content must make clear that *all* restrictive interventions contain an element of risk even when in accordance with training approved techniques and guidance.**

Training content must cover:

- physical, psychological or emotional risks
- factors that may elevate risk – these may include:
  - personal factors – of both the person being restrained and the people who are carrying out the restraint
  - environmental factors
  - service factors that may include, among other things, inadequate policies, poor leadership, lack of appropriate training and supervision, inadequate staffing levels, negative team or organisational cultures, power imbalances, and lack of opportunity or encouragement for reflective practice
  - the types of restrictive interventions being used as well as how long they are applied for and how they are applied

2.9.2 **Training content must make clear that staff have a responsibility for the safety of those individuals on whom they are applying restrictive interventions.**

Training content must cover participant responsibilities for ensuring:

- restrictive interventions are only ever used as a last resort, and always in line with policy and guidance
- any and all general safeguards are implemented
- any and all person centred safeguards are implemented
- active monitoring of the person is undertaken (see standard 1.3.4)
- emergency procedures are implemented immediately in the event that relevant warning signs are detected (see standard 2.10)

2.9.3 **Training content must make clear that staff have a responsibility for their own safety and that of their colleagues involved in applying restrictive interventions, as well as for others involved in the incident.**

This would include organisational policies in place that are designed to keep staff safe. These include lone working procedures, safe systems of work and any guidelines relating to personal safety.

Standard 2.10

Training in restrictive interventions must include contingencies to reduce the likelihood of medical emergencies arising; and the provisions to manage any that do.

2.10.1 **Training should include arrangements for monitoring a person's health status whilst under restraint, including: the integrity of their airway; their breathing and circulation; any deformity of limbs; and complications associated with any pre-existing medical condition or injury. (In some service settings local arrangements may include discrete monitoring of pulse and respiration, the use of pulse oximetry etc.)**

This requires participants to be trained to recognise warning signs which indicate some form of medical emergency may be emerging; and especially signs and symptoms which may be associated with conditions of particular concern, including asphyxiation, cardiac arrest, cerebral vascular accident and myocardial infarction, and fractures.

2.10.2 **Training must be explicit that if, whilst attempting to manage a behavioural crisis, a medical emergency arises, participants have a clear responsibility to take immediate action to ensure the patient's safety.**

Examples of medical emergencies include a person experiencing breathing difficulties or some form of cardiac or circulatory event, as well as injury to limbs or joints, including fractures or dislocations.

2.10.3 **Training must include consideration and reflection on how social and human factors, including high levels of expressed emotion, can influence the objectivity of interpretations of a patient's condition and associated decision making in emergency situations.**

2.10.4 **It must be made clear to training participants that any/all staff involved in a restraint have a responsibility immediately to raise any concerns they have about the patient's health status.**

2.10.5 **Training must include recognition of the need, in some instances, immediately to discontinue the use of restrictive holds (albeit possibly whilst retaining an ability to recommence them, in a modified form, based on the person's presentation).**

This must also include consideration of the degree of urgency with which restrictive interventions should cease in a medical emergency; arrangements, in accordance with local policies and procedures, for immediately summoning emergency medical assistance; and how the person should be supported until assistance arrives.

2.10.6 **Training must include recognition of situations where staff involved in restraining a patient need to instigate immediate life support measures, based on training that is compliant with the guidelines of the UK Resuscitation Council.**

Training content must take full account of the available resources and environment within which care is provided. In particular, in accordance with any organisational policies and procedures, this should include arrangements for summoning assistance of colleagues with more advanced life support expertise; and the availability and use of emergency medical devices that may be required for immediate life support, such as Automated External Defibrillators (AEDs).

2.10.7 **Training must cover measures required to prevent postural/positional asphyxia developing; as well as how to recognise when it may be occurring.**

Training must include identification of factors such as obesity and stature, pre-existing medical conditions, pressure to the chest or abdomen, obstructing a person's airway etc, that increase the likelihood of postural/positional asphyxia developing; and steps that should be taken to reduce the risks, including vigilant monitoring, avoidance of specific holds.

This must also include recognition of signs that positional asphyxia may be developing and in particular: monitoring the content of a person's speech; vocalisations that might indicate a blockage of the airway; discolouration (cyanosis) of the lips, hands or face; increased panic/resistance; and/or a person suddenly becoming more tranquil.

2.10.8 **Training content must cover procedures for recording and reporting medical emergencies associated with situations where restrictive interventions have been used. Relevant organisational policies in support of Health and Safety obligations must be referenced and clarified.**

Standard 2.11

The curriculum must identify the full range of restrictive interventions and restrictive practices and their application.

2.11.1 **Training content must identify and prompt discussion about all forms of restrictive interventions, including seclusion, rapid tranquilisation, chemical restraint, mechanical restraint, clinical holding, physical restraint and psychological restraint.**

This must include:

- definitions of key terms
- reference to blanket restrictions
- identification of other restrictive practices imposed by staff on people, such as dietary restrictions, lack of choice, restricting access to activities and personal items and locked doors
- restrictive intervention and practices that may be used covertly, such as not identifying opportunities or options, or influencing people's choices, eg 'you don't want to go out this afternoon do you?', or secreting medication in preferred food

Training content must also include discussion about how blanket restrictions and unnecessary service led restrictive practices can be identified and challenged. The use of all restrictions should be discussed in relation to human rights.

2.11.2 **Training content must define coercion and trainers must allow time for discussion about how, if unchecked or unregulated, restrictive interventions can become coercive and potentially harmful (physically, emotionally and psychologically).**

Standard 2.12

The curriculum must cover the requirements for recording and analysing data from restrictive interventions and occurrences of distress or concerning behaviour.

2.12.1 **Training content must cover:**

- the regulatory and organisational requirements for recording the use of any restrictive interventions and injuries associated with the use of restrictive interventions. It is recommended that an independent review should take place if any injuries occur during the use of any restrictive interventions
- the importance of accurate and objective recording. Activities that enable participants to practice and reflect on elements of good recording must be used. Different types of data collection tools and their uses must be covered
- the use and analysis of data to support restraint reduction. Analysis should support the identification of trends such as frequency and seriousness of different types of restraint over time and across different areas of the provider's work. Analysis of data must be used to inform individual and organisational restraint reduction plans. Analysis of data can help identify patterns that inform preventative working – by highlighting the conditions in which incidents are more or less likely to occur it should be possible to develop primary strategies that meet people's needs before behaviours of concern arise. Reference should be made to *Towards Safer Services* (DoH, in development) and *Restrictive Interventions in Inpatient Intellectual Disability Services: How to Record, Monitor and Regulate* (Chester et al, 2018, available at: University of Kent Academic Repository)

Standard 2.13

The curriculum must include reference to the importance of required procedures that are related to post-incident review.

2.13.1 **Training content must include reference to the need for, and the understanding of, the purpose of both components of post-incident review for individuals and staff.**

With reference to a review of current available evidence, these standards support a clear separation of these two components (Baker, 2017). Best practice and review of the limited evidence base suggest there are two main components of post-incident review, each with a distinct purpose:

1. Post-incident support – attention to physical and emotional wellbeing of the individuals involved
2. Post-incident reflection and learning review

Post-incident review requirements for staff, service users, carers and others involved in incidents where restrictive physical interventions are used are outlined in NICE guidance NG10 and QS154 (NICE, 2015a, 2017b).

2.13.2 **Training content must cover the need for post-incident support.**

This is the support that is immediately offered to an individual who has been involved in an incident. It should be available after any incident where a restrictive intervention has been used and after any incident that may have had an impact on the individuals involved. It should be available and proactively offered to all individuals who have been involved in the incident or who have witnessed the incident. The support should include assessment and treatment of any medical needs and provision of immediate emotional support. The trainer should discuss the importance of staff seeking and accepting this support.

2.13.3 **The training content must indicate what future options for emotional support are available through the commissioning organisation. The training must identify how participants and individuals who use services can access this either within the service or independently of the service. (NB: This should have been identified as part of the TNA and overall commissioning.)**

This may include individual and/or group supervision/ debriefing and individual psychological therapy delivered by a trained professional.

2.13.4 **Training content must also cover the second component of a post-incident review: a reflective and learning review. The training content must cover the essential elements of the learning and reflective review which should be triggered by the use of any planned or unplanned restrictive intervention or any other event specified in organisational policy.**

The review should examine the factors that led to the restrictive intervention being used and consider if:

- future incidents could be either avoided or the impact could be minimised – this might mean the service or environment could be altered to better meet the needs of the person or that the staff could respond differently to the person
- personalised triggers can be identified and either minimised or avoided in the future and/or the person could be supported to learn coping or alternative skills
- the risk assessment and support plan need to be reviewed
- a less restrictive approach could be used in the future

Reflective reviews should be led by experienced facilitators and should be a learning and reflection forum and not about blaming individuals. There should be clear actions taken forward from the review. Views of the individuals who were involved in the incident should be part of the review process using whatever method is most appropriate and supportive to them. There should be recognition that some individuals may be distressed by recalling the incident.

Standard 2.14

The curriculum must have content that enables participants to understand the meaning of 'trauma' and how it can impact on people's experience of restrictive interventions.

2.14.1 **Training content must cover:**

- the definition of 'trauma' including post-traumatic stress disorder (DSM 5) and complex trauma disorder (ICD 11) and the basic principles of trauma informed care
- how trauma may impact on the experience of use of restrictive interventions. This can apply both to people who may be in receipt of the restrictive intervention and to those who apply the restrictive interventions. Experiencing a restrictive intervention such as seclusion or physical restraint is in itself potentially traumatising. The experience could also trigger a trauma memory.
- how a person's trauma history, if it is known, must form part of the personalised wellbeing risk assessments needed for the use of any restrictive interventions. There may be considerations that could lessen the impact of the experience should it become necessary. A person's trauma history may not be known so training should also cover the importance of the recognition of potential symptoms of trauma and how these can sometimes be overshadowed by autism or learning disability, and also the fact that behavioural symptoms could potentially be linked to past trauma. It is possible that people who have care histories may have had multiple traumatic experiences of restraint – it is important that the training considers people's past experiences and how these might impact on any present experience. It would be important for participants to consider the types of restraint that people who have had histories of restraint and/or abuse may find particularly traumatising
- an affirmation that a trauma informed approach must be provided to everyone whether trauma is known or not
- an understanding of trauma through a developmental perspective that applies to all ages not just children

Standard 2.15

The curriculum must contain reference to and explore understanding of restraint reduction theory.

2.15.1 **Training content must include reference to evidence based models of restraint reduction.**

These may be with reference to resources, among others, from the Restraint Reduction Network, the Restrain programme (The Health Foundation), or other population specific programmes. Trainers are recommended to refer to the 'six core strategies' as identified by Huckshorn (NASMHPD, 2008). Other evidence based models include Safewards and No Force First Restraint.

2.15.2 **Training content must make reference to any policy, procedure or commitments which have been made by the commissioning organisation related to restraint reduction.**

Section 3

Standards supporting post-delivery processes

Standards

Standard 3.1: **Competence, assessment and feedback**

Standard 3.2: **Record keeping**

Standard 3.3: **Reporting concerns**

Standard 3.4: **Evaluation**

Standard 3.5: **Quality assurance**

Standard 3.6: **Refresher training**

Introduction

Good training providers will have a range of different processes for monitoring the quality and effectiveness of their training that feed into a cycle of continuous improvement. This is so they can be confident the training they provide is having a positive impact on the quality of life for people who are supported in the organisations they provide training for.

Standard 3.1

Training must include a competence based assessment within each programme, with participants being assessed for both knowledge and skills. It is recognised that such assessments can only assess participants' skills within a training environment.

3.1.1 **Training providers must establish assessment criteria which are consistent with the level of training which has been commissioned.**

The criteria must identify and distinguish between introductory level, refresher training, and train the trainer programmes.

Areas that must be included are:

- values and attitudes, as reflected in the language and behaviour used during the course
- knowledge of appropriate theoretical concepts, approaches and strategies (eg rights based approaches, person centred care, primary, secondary and tertiary strategies)
- the ability to describe a range of primary interventions
- the ability both to describe and demonstrate a range of secondary strategies
- the ability both to describe and demonstrate non-restrictive tertiary strategies
- the ability both to comprehensively describe and demonstrate all component parts of any restrictive interventions and the safety parameters for them that have been taught
- participants should be able to clearly articulate the rationale for the use of these interventions
- knowledge relating to the legal and ethical implications of using restrictive intervention

3.1.2 **The training provider must have assessment methods which take into account any reasonable adjustments that people need.**

(NB: When testing the competence to apply a restrictive intervention any reasonable adjustments must not compromise the safety of the restrictive intervention when it is applied in practice.)

3.1.3 **The curriculum must have time factored in for demonstration and practice of each intervention that has been taught, as well as time factored in for the assessment of competence for each participant.**

3.1.4 **The training provider must allow time within the programme so that the participants can be given verbal feedback about their performance.**

3.1.5 **If participants fail to reach the level of competency required by the training provider, the training provider must agree with the commissioning organisation (service provider) the necessary actions for the participant.**

This may for example involve a personal learning plan, a repetition of the training within six months, a bespoke training programme or a coaching intervention. The training provider must recommend that the participant should not be involved in the direct application of restrictive interventions until they are able to provide evidence of competence.

If a trainer has serious concerns during the programme about a participant's ability to complete the programme successfully they must refer to the identified manager in the commissioning organisation as soon as is practical (also refer to standard 4.6.6).

3.1.6 **The training organisation must provide the commissioning organisation (service provider) with written feedback on the assessed performance of each course participant.**

This must include:

- the areas they have demonstrated competence in
- any identified areas in which they have demonstrated excellence

- if a participant has failed to demonstrate competence in all areas of the curriculum. In this case, feedback must also include:
  - any actions that can be taken to enable them to achieve competence in these areas
  - a recommendation that the participant should not be involved in the direct application of restrictive interventions until they are able to provide evidence of competence for the whole of the curriculum

Standard 3.2

Training records for each programme delivered must be maintained by the training organisation.

3.2.1 **Training providers must ensure that their trainers maintain complete, accurate and up to date records of each course they deliver.**

This must include the following:

General information

- date and title of the course, duration and details of the trainers involved

About the participants

- names of the participants, their employing organisation and service/setting
- confirmation of each participant's fitness to attend the programme

About the programme

- learning aims and objectives of the programme
- brief description of curriculum content
- details of secondary strategies that have been taught
- details of non-restrictive tertiary strategies that have been taught
- details of any restrictive tertiary strategies that have been taught
- date when refresher training due

Assessment information

- assessment records for each participant for each part of the syllabus (with reference to standard 3.1.1) with any reasonable adjustments that have been made
- assessment records must clearly indicate who has successfully completed the programme and demonstrated the required level of competence and who has not
- written feedback for each participant (see standard 3.1.5), including any recommended actions in respect of participants who failed to demonstrate competence
- any concerns related to the conduct or values of any of the participants (please refer to standard 3.1.1)
- evaluation information (please refer to standard 3.4.1)
- health and safety information, details of any injuries or accidents reportable under health and safety legislation occurring during the training, in compliance with Health and Safety Executive *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations* (RIDDOR) (HSE, 2013b)

3.2.2 **Records must be maintained and retained by the training organisation for a period of time that is consistent with legislative requirements.**

3.2.3 **Training providers must have a data storage and destruction policy that is compliant with GDPR regulations.**

Standard 3.3

Training providers must have a policy for dealing with concerns that arise during training.

3.3.1 **Training providers must have a policy that outlines the procedure for handling any concerns about the conduct of participants arising during training sessions. This policy must be available to the trainer before any training is delivered.**

The policy must include:

- examples of behaviours that may constitute a concern or amount to inappropriate conduct
- an outline of the procedure for informing participants how inappropriate conduct will be managed within the context of the training session
- an outline of the informal procedures for resolving matters, where the trainer seeks to address the issue during the training session
- an outline of the procedure for escalating concerns formally to the training commissioner if the concern cannot be resolved informally
- details of any formal record that must be completed by the trainers

Standard 3.4

All training must be evaluated post-delivery using an evidence based framework.

3.4.1 **Training providers must collect evaluation responses for each programme that they run.** The evaluations must inform both the training provider's internal quality assurance processes and a review with the training provider about the effectiveness of the programme. They must also inform the annual review with the commissioning organisation (service provider) and the review of the restrictive intervention reduction plan.

Standard 3.5

Training providers must have internal quality assurance systems and be able to provide evidence that they effectively monitor the quality and consistency of all of their training services. Training providers must be able to evidence that their training services are being consistently delivered and that they routinely adhere to all the training standards. Training providers must use their quality assurance process to identify and action improvement priorities.

3.5.1 **Training providers must be able to demonstrate how their quality assurance cycle supports improvements.**

The quality assurance process for training providers must feed into the annual review with commissioning organisations as well as their own processes that support improvement.

Analysis of evaluation information will assist the training provider to identify priorities and create an action plan.

Areas that must be evaluated:

- ensuring delivery is consistently in line with the *Restraint Reduction Network Training Standards*
- how training programmes are developed and delivered
- the performance of trainers
- the administration of the programmes
- the feedback to the commissioning organisations

There are a number of methods that can be used to gain evaluation information:

- evaluation forms from participants on the training programme
- verbal or written feedback from people who are being supported
- direct observation of training programmes
- verbal or written feedback from managers of staff who have attended the training

- verbal or written feedback from the commissioning organisation about how the training provider has performed during different stages of syllabus development and delivery of the programme
- self-assessment against these standards
- peer review – working with other providers to peer review
- independent reviews of training programmes and impact

Standard 3.6

Training providers must develop refresher training curricula that take into account the current needs of the organisation, service or individuals, using information from an updated TNA (see also standard 1.6.1).

3.6.1 **Training providers must follow the same process for the development of refresher programmes as for the development of the original programme curriculum.**

3.6.2 **Training providers must ask the commissioning organisation to update the information in the TNA and must review the TNA together to check each restrictive intervention is still needed or if the level of restrictiveness can be reduced.**

3.6.3 **The training content of a refresher programme must be based upon an updated TNA agreed with the commissioner/organisation restraint reduction lead.**

Refresher training must have an annual core content (see standard 3.1) and an additional rolling programme of remaining content. The rolling programme may have a different focus each year but all curriculum areas must be covered at least every three years.

Refresher training must include the following:

- revision of key areas of the original syllabus – all curriculum content must be studied/revised over a three year period
- a reassessment of the competence to apply primary/preventative strategies, secondary strategies, and non-restrictive tertiary strategies must take place at least once a year
- an update on relevant legislation or guidance on good practice and organisational policies must take place at least once a year
- further development of skills to apply primary/ preventative strategies must take place at least once a year
- a reassessment of competence to apply any of the taught restrictive tertiary strategies must take place at least once a year
- any additional safety advice or modifications needed relating to the use of tertiary strategies with the individuals in the service or that need to be considered because of changes in the services must be highlighted in every training programme

Refresher training must be a minimum of one day. It is expected that sufficient time is allocated to teaching both theory and physical skills and to competence assessment. Refresher training is likely to be more than one day if there are multiple interventions and/or they are complex or high risk interventions and/or when the TNA has identified areas that need extra support.

Section 4

Trainer standards

Standards

Standard 4.1:	**Quality assurance**
Standard 4.2:	**Training competence**
Standard 4.3:	**Professional competence**
Standard 4.4:	**Delivering relevant content**
Standard 4.5:	**Insurance**
Standard 4.6:	**Safety**
Standard 4.7:	**Professional development**

Introduction

Good restrictive intervention trainers have the potential to change practice, win hearts and minds, and have an important role in supporting a system wide approach to the reduction of the use of unnecessary restrictive practices. They have a range of skills and are confident in their knowledge of all the training content, how it fits within the human rights framework, and best practice for the sector and population they are training in. They are able to assess competency, encourage potential, and appropriately challenge unhelpful attitudes.

For certification purposes there are two kinds of trainers referred to in the *Training Standards*:

Senior trainers who deliver training across multiple organisations and/or deliver train the trainer programmes. They may be employed (or paid) by a commercial training provider, or be employed within a service provider organisation such as an NHS Trust.

Associate trainers who are employed by (and deliver training only within their own) service provider organisation which may be an affiliate organisation linked to the trainer provider (eg NHS Trusts, schools or care homes). They do not deliver train the trainer programmes.

When a standard refers to all trainers it means both senior trainers and associate trainers.

The certification scheme does not certificate providers, curricula or trainers separately. Valid certification only applies when all three are in combination, though the certification scheme trainers are **authorised** to deliver **approved** curricula on behalf of the training provider.

Trainers are **not** authorised under the certification scheme to deliver any other programmes that have not been through the certification process. Trainer certification is not transferable to other organisations.

Standard 4.1

Training providers must have effective internal quality assurance systems that effectively monitor the consistency of delivery and adherence to all the standards across all training services. This includes monitoring all curricula and all trainers delivering their programmes across all services including affiliated satellite services. Training providers should use their quality assurance process to identify improvement priorities.

Quality assurance must include regular observation in situ of training delivery. The training provider must be able to provide evidence that it has been checking its own compliance against its own quality assurance system. This must include evidence that there is checking of the compliance of all quality systems in place that monitor the quality and fidelity of training delivered by associate trainers in satellite organisations.

4.1.1 **Training providers must keep up to date records of both professional and training competence for all trainers.**

4.1.2 **Training providers must keep records of all trainers and all training programmes that are delivered.**

4.1.3 **Training providers must be able to show evidence that they conduct regular quality assurance checks to ensure that accredited authorised curricula are being delivered as intended and that no unauthorised adaptations are being made.**

Standard 4.2

All trainers who are delivering training must be able to demonstrate that they are qualified and competent to train.

4.2.1 **Training providers must be satisfied that trainers they recruit have the capability to train effectively and have appropriate levels of teaching and training skills.**

Training providers must evidence they have robust processes to assess this aspect of the trainers' performance. Training and teaching skills may be assessed through a combination of qualifications, scrutiny of evaluations, peer reviews and formal assessment by the provider.

4.2.2 **All trainers delivering training in restrictive interventions must hold current first aid certification including immediate life support.**

As a minimum requirement this must be the Emergency First Aid at Work one day programme which includes immediate life support. Different premises may require different levels of training.

Standard 4.3

All trainers must be able to evidence that they have the qualifications, experience and competence in supporting people in the sector in which they are delivering training.

4.3.1 **All trainers must be able to evidence that they have a professional qualification (with current up to date registration) or have completed a programme of relevant vocational training, having received a qualification within health, education or social care. Training providers must have mechanisms in place so that they can demonstrate that all trainers are able to evidence professional competence and understanding of the sector in which they are delivering training.**

This may include:

- vocational qualification (health, education or social care)
- social work qualification (Diploma, BSc, BA)
- teaching or education-based qualification
- nursing qualification (with current registration) (NMC)
- other health professional qualification (with current HCPC or equivalent registration)

4.3.2 **All trainers must have been continuously employed in a support or care role within social care, education or a health care environment for a period of not less than two years. Training providers must be satisfied that trainers are able to evidence professional competence and understanding of the needs of the populations and settings in which they are delivering training. This may be evidenced in a number of ways, including a portfolio that shows professional development and competence.**

4.3.3 **All trainers must be able to demonstrate that they have the required level of knowledge and under-pinning values to competently deliver all elements of the curriculum** as specified in Section 2.

This would include:

- a commitment to upholding human rights and to working within a restraint reduction framework
- an appropriate level of knowledge in all areas of the curriculm, not just in demonstrating restrictive intervention techniques
- a commitment to working within the *Restraint Reduction Network Training Standards*

It is the responsibility of the training provider to have mechanisms in place that include criteria for assessment of trainers so they can provide evidence of competence and underpinning values.

When recruiting trainers the training provider must have a robust process for selecting trainers that includes references, previous evaluations and appropriate criminal disclosure checks.

All trainers must have successfully completed a face to face train the trainer programme of a minimum of 30 hours or 5 days in length (which may be an accredited qualification for example a diploma or BTEC). The competence to deliver the whole of the curriculum must be assessed during and at the end of the train the trainer programme.

Training providers must have mechanisms in place to evidence the underpinning values. Trainer competence must be assessed and quality assurance checks completed at a minimum annually by the training organisation and should cover the whole curriculum not just restrictive interventions.

In some circumstances a commissioning organisation will already have a model of preventative working in place, such as Safewards or Positive Behaviour Support, and this training may be delivered by another agency. Staff must receive preventative training before they receive any training in restrictive interventions (see standard 1.2.1). In this circumstance the training programme that is commissioned with a restrictive intervention component may not need to include the content covered in standard 2.5, but the trainer must have the knowledge to teach all the other areas of the curriculum covered in the standards.

4.3.4 **All senior trainers must successfully complete a minimum of two days' refresher training annually.**

4.3.5 **Training providers must specify CPD requirements for all trainers who deliver their programmes.**

CPD hours are not set in these standards. However, trainers must collect a portfolio of evidence to demonstrate to the training provider that they meet the provider requirements and the Restraint Reduction Network standards. Evidence of relevant CPD records of trainers must be kept by the training provider to ensure quality, knowledge and skills are maintained.

Where employing or commissioning organisations make stipulations that professional registration is maintained then this remains the responsibility of the trainer.

Standard 4.4

All trainers must ensure that the delivery of any programme is informed by the training needs analysis (TNA) (see standard 1.1)**.**

4.4.1 **All trainers must familiarise themselves with the TNA that has been agreed between the training provider and the commissioning organisation before they deliver any programme of training.**

The curriculum must reflect the specific needs identified in the TNA.

4.4.2 **A trainer must only teach the restrictive interventions that have been previously identified and agreed between the commissioning organisation and the training provider and highlight any identified person specific risks during training.**

Before delivering any restrictive intervention component the trainer must familiarise themselves with the written rationale for the use of any restrictive intervention and any elevated risks that have been highlighted.

4.4.3 **Before delivering any physical restraint training the trainer must satisfy themselves that the commissioning organisation has the appropriate level of immediate life support training (including required refresher training). This should be in accordance with the guidelines of the UK Resuscitation Council for immediate life support** (see UK Resuscitation Council).

In some cases this training will be provided by the trainer as part of the content of training and in other cases another provider or trainer will have delivered this programme.

Standard 4.5

All trainers must be covered by professional indemnity and public liability insurance.

4.5.1 **Trainers must have appropriate insurance cover for the work they are undertaking.**

Trainers working as consultants for a training provider under a franchise agreement or as self-employed trainers must ensure that they have insurance comparable with that of the training provider for the activities they undertake. Valid insurance documentation should be submitted annually for review to the organisation for which they deliver training.

Standard 4.6

Trainers must manage training sessions safely and professionally.

4.6.1 **Trainers must undertake an environmental risk assessment that has been provided to them by the training provider.**

Before any training occurs, trainers must undertake a formal risk assessment of the training environment to satisfy themselves that the space is free from hazards, provides enough room to move around safely and is suitable and conducive to successful training delivery.

4.6.2 **Trainers must give out information to participants at the start of any programme.**

All trainers must, as a minimum, at the start of any programme, clearly outline:

- training ground rules and safety rules
- the process for reporting any concerns about the conduct of the participants or the trainer
- fire safety requirements, access to toilets and refreshments etc
- timings for the programme
- learning outcomes, topics to be covered and assessment criteria
- the process for managing participants who don't reach the assessment criteria

4.6.3 **Trainers must outline participants' personal responsibilities before teaching any restrictive intervention component.**

This must include:

- guarding against the risk of injury during the training and immediately reporting to the trainers any subsequent injury
- reporting any existing injuries and disabilities that may pose health and safety risks to their own safety and welfare and those of other participants during training
- their responsibility to adhere to safety guidelines issued by the trainer
- reporting all injuries or adverse events in accordance with the commissioning organisation's own reporting policy and statutory guidance *Reporting of Injuries, Diseases and Dangerous Occurrences Regulations* (RIDDOR) to the purchasing organisation, including any injuries sustained during the training

4.6.4 **Trainers must use respectful language and conduct themselves professionally.**

All trainers must adhere to a code of conduct, as specified by the training organisation.

4.6.5 **Trainers must be mindful of the emotional impact of some of the topics on participants and must provide opportunities for individual discussions if needed.**

4.6.6 **Trainers must exclude any participant from the course whom they believe to be unsuitable for training.**

Participants may be unsuitable on grounds of:

- their attitudes, values and beliefs as displayed on the course
- their behaviour towards the trainer and/or other participants
- their time keeping and attendance throughout the course

Any exclusions must be confirmed in writing to the commissioning organisation or the participant's manager if it is an in-house course.

4.6.7 **Before commencing any training event, the trainer must confirm that suitable first aid facilities and equipment are readily accessible at the training venue.**

4.6.8 **Trainers must have the knowledge, means and ability to summon emergency services to the venue should a serious injury occur during a training session.**

Standard 4.7

All trainers will be expected to maintain accurate training records which support an agreed quality assurance system.

4.7.1 **All trainers must be able to demonstrate how they use participant evaluations to improve the programme or further their professional development.**

4.7.2 **All trainers must have at least one peer evaluation per year.**

Trainers must be able to show evidence of having one peer evaluation per year and be able to demonstrate how they have used it to further their professional development.

Appendices

Preface to the appendices

The appendices are included to show that the standards will need to be adapted according to some specific considerations. These relate to:

- which specific population is being supported by staff or carers who are accessing training
- the setting that the staff/carers who are receiving the training provide the support in
- the country that the service or setting is operating in

It is likely that training providers will need to refer to more than one appendix when developing a person centred curriculum for a commissioning organisation.

Please follow the link to the relevant current guidance and legislation on the Restraint Reduction Network website: RRN Training Standards. These appendices will be subject to a continuous review timetable; therefore the most up to date versions will be available online. Please let us know if any relevant guidance or legislation is missing from the website.

New appendices currently in development include:

- Specific considerations for agency staff/flexible staff/bank staff who require certificated training
- Specific considerations for patient/ pupil transport services who require certified training
- Students in work placements who require certificated training

Contents

There is a timetable of review for the appendices and they will be updated to reflect changes in policy and new guidance, but please be advised that you should refer to other more frequently updated sources of sector specific information in addition to these.

The reviews will be informed by experts in each area. Please refer to the online version of this publication for the latest versions of the appendices.

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Examples and checklists

The following templates are available to download at RRN Training Standards – materials to download:

- Sample checklist for a training needs analysis
- Information needed for a personalised wellbeing risk assessment checklist
- Sample template for a written rationale for the inclusion of a restrictive intervention in a curriculum
- Self assessment tool template
- Sample risk assessment template

Appendix 1

Specific considerations and adaptations to the training standards for services supporting people who have acquired brain injury

Type of service

Services for people who have acquired brain injury. Such injuries arise from accidents, assaults, infections, tumours and strokes and can result in physical, cognitive, emotional and behavioural impairments. (This list is not exhaustive.)

Specific considerations when delivering training in this setting:

- Mood swings, stress, frustration and anger are often experienced by individuals with acquired brain injury. These, and the difficulties in understanding, processing and responding to information and events, coupled with the potential loss in insight and impulse control, should not lead to a person being characterised as 'violent' or 'high risk', and routinely managed as such
- An acquired brain injury can lead to changes and impairments which should be considered as risk factors in the context of any physical restraint. These include:
  - issues with memory, including a struggle with the retention of information in both short and long term
  - changes in muscle tone (low tone – hypo; and high tone – hyper)
  - impairments in receiving and processing sensory information, which may manifest in hypo- or hyper-sensitivity to touch, and to pain in particular
  - difficulties with speech and language
  - difficulties with swallowing, which should be treated as a risk to breathing
  - increased risk of epileptic seizures or fits

- The stress associated with the application of a physical restraint technique should be considered as a risk factor in and of itself
- Restrictive interventions may include the use of mechanical restraints/restraint devices in a very limited number of very clearly delineated situations, eg attempting to remove catheters, arterial lines and breathing tubes. The removal of an arterial line is potentially life threatening in a very short period of time, hence why such an extreme form of restraint may be advocated. The use of mechanical interventions is likely to give rise to additional risks, such as potential interference with circulation, and potential damage to nerves
- There is also the risk that such devices begin to be thought of as a means of managing more general behaviours of concern. A clear authorisation process and reduction plan needs to be developed
- These risks are linked to both the application of restraint devices, and the misapplication of devices, so staff will need clear guidance and training on how to apply them safely

Specific adaptations to the standards for this setting:

- Physical restraint plans must:
  - be personalised and reflect the unique impairments of the person
  - have multi-disciplinary input from relevant health professionals
  - contain an explicit rationale for the use of techniques which should be centred on safety and the prevention of harm, not simply behaviour management
  - include explicit monitoring protocols which cover those safety criteria upon which any physical restraint techniques should be relinquished and these should be linked to relevant emergency medical support protocols, eg responses to breathing difficulties or seizures
- Additional risk assessments will be required to cover the application of any mechanical restraints. These should cover the risks arising from their application, and the vulnerability of the individual they are being applied on. It is possible that physical restraint techniques may be included in any application procedure, so any risk assessments should be considered in parallel
- Additional training time will be required to cover the criteria for using devices, the application of them, any contra-indications for fitting, safety monitoring protocols and criteria for release
- Additional time should be spent during training sessions to discuss the local protocols in place for ambulance services to manage the heightened risks involved in the rapid admission/assessment process

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards

Appendix 2

Specific considerations and adaptations to the training standards for services supporting autistic people

Type of service

Services and settings are inclusive of education, residential, social care, and individuals' tenancies working within family home and health or hospital service settings. Children with autism and autistic adults may or may not also have a learning disability and/or mental health diagnosis and may be in generic services as well as specialised settings.

The National Autistic Society (NAS) defines autism as a lifelong developmental disability that affects how people perceive the world and interact with others. Identity first language is in general the preference of autistic adults (though not always), so it is used here but the person's preference should always be ascertained.*

* **Identity-first language** places the disability-related word **first** in a phrase. People who prefer **identity-first language** for themselves often argue that their disability is an important part of who they are, or that they wouldn't be the same person without their disability. However, personal preference should always be identified and used

Specific considerations when delivering training in this setting:

- All autistic people are different and have a range of individual strengths and needs but it is important to consider the following during training

  Autistic people and children with autism:

  - may have some difficulties understanding what's happening around them, or understanding social cues
  - may at times find it difficult to express or communicate their needs
  - may not be able to process or understand instructions and other communications and need extra time and cues – it is important not to perceive this as ignoring instructions, or as rude or non-compliant behaviour

- may at times be very anxious and tense and want to escape from stressful situations or activities
- are likely to have sensory differences, eg an over-sensitivity to noise or touch or a need for stimulation. Sensory sensitivities can lead to extreme levels of stress and anxiety in unfamiliar or over-stimulating environments. Environmental considerations are extremely important when supporting an autistic person and as much information as possible should be gathered about the person's preferences and needs
- may have differences in experiencing levels of pain
- may have a different awareness of personal space and may seem to be unusually intolerant
- are likely to have concomitant health problems that may be undiagnosed
- are vulnerable to the full range of mental health issues experienced by people without autism but may be particularly vulnerable to anxiety related conditions

- It is very likely that a restrictive intervention could be a frightening, painful and traumatising experience and consideration should be made of the individualised support needed during any restrictive intervention and afterwards. It would be especially important to consider the person's individual communication needs and preferences and understand how the environment may impact upon their emotional state. Identification of any comforting object or routines to support recovery should be in the personalised wellbeing risk assessments
- If it is suspected that a person is deliberately seeking sensory stimulation through physical restraint, the advice of a psychologist should be sought so that alternative methods of stimulation can be provided
- In the event that there is to be a planned response to any behaviour of concern that involves a restrictive intervention, it is best practice to ensure that this is supported by the consent of the individual in question or a best interests decision. Such advanced decisions should be recorded in plans that detail the decision making process, the consultation that was undertaken, why it is necessary, how it is the least restrictive intervention, the risk factors that have been identified, the safeguards in place to minimise its use and its physical, psychological impact on the individual, and review mechanisms

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 3

Specific considerations and adaptations to the training standards for services supporting children (including residential schools and children's homes)

Type of setting/service

Services for children including residential child care, respite care, residential special schools, secure children's homes, residential holiday schemes for disabled children and NHS comissioned health services as well as local authority and independent fostering service providers:

- Children are defined by NICE as *'people aged 12 years or under'*
- Young people are defined by NICE as *'people aged between 13 and 17 years'*
- For additional information on Fostering and adoption settings see Appendix 11: Family homes

Below are a number of key principles for policy and practice that are promoted in the guidance *Reducing the Need for Restraint and Restrictive Intervention,* guidance aimed at children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings published by the DHSC and DfE in 2019.

Key principles

Restraint may be necessary to safeguard the individual and/or others from serious injury or harm, and sometimes it will be the only realistic option, for example to prevent a child from running into a busy road.

Specific considerations when delivering training in this setting:

- Promote a positive and proactive approach to behaviour, including de-escalation techniques appropriate to the child or young person, to minimise the likelihood of or avoid the need to use restraint (see examples in all of the case studies in Annex B, HM Government, 2019)
- Use of restraint is based on assessment of risk and to safeguard the individual or others
- Restraint should only be used where it is necessary to prevent risk of serious harm, including injury to the child or young person, other children or young people, to staff, the public or others, if no intervention or a less restrictive intervention were undertaken
- An intervention is in the best interests of the child or young person balanced against respecting the safety and dignity of all concerned, including other children, young people or adults present
- Restraint is not used to punish or with the intention of inflicting pain, suffering or humiliation
- Techniques used to restrain or restrict liberty of movement are reasonable and proportionate to the circumstances, risk and serious-ness of harm; and are applied with the minimum force necessary, for no longer than necessary, by appropriately trained staff
- Use of restraint, reasons for it and consequences of its use, are documented, monitored, open and transparent
- When planning support and reviewing any type of plan which references restraint (such as a behaviour support plan), children and young people, and parents, and where appropriate (for example, where the child or parent/carer wants it), advocates should be involved

Other considerations

Education, Health and Care plans should be developed after suitably wide consultation which may involve the co-ordination of the assessment process where relevant across education, health and care domains. In addition to the child/young person themselves and his or her family, those consulted may include:

- education professionals such as nursery staff, teachers, Special Educational Needs and Disabilities Co-ordinators (SENDCOs) and educational psychologists
- physical health professionals such as GPs, community based paediatricians, paediatric neurologists, specialist community nurses, physiotherapists, occupational therapists, dentists, opticians, speech and language therapists and health visitors
- mental health professionals including clinical psychologists with expertise in learning disability and functional analysis, behavioural therapists, psychiatrists with training in child and adolescent psychiatry/learning disability/autism and specialist nurses
- social care professionals such as social workers, care managers, care staff and support workers

Individualised behaviour support plans should also be formulated after suitably wide consultation. The management of risk in its widest sense should form a key part of any plan (see list of risk factors below, p114). Every behaviour support plan should have an explicit process for supporting a child or young person to avoid crisis and a protocol for escalation

Training programmes should include the use of psychosocial methods and behavioural techniques to avoid or minimise restrictive interventions whenever possible, and an emphasis placed on working in a child/young person centred way with reference to relevant plans

‘Best Practice Guidelines’ relating to physical responses to escalated behaviours of concern: Physical Restraint (are applicable across all groups of children and young persons)

Restrictive interventions (and in particular physical restraint) can be planned or unplanned. Each type of intervention presents a unique set of practical challenges and risks to be recognised and managed.

Planned interventions involve staff following agreed approaches to behaviour that challenges that have been set out in the child or young person’s behaviour support or care plan, and will detail any procedures, strategies or techniques authorised for use as a last resort physical restraint. Planned interventions will be formulated following suitably wide consultation and based on careful assessment of the potential risks (including any particular vulnerabilities, communication difficulties, medical conditions and/or impairments – see list of risk factors below, p114)

Unplanned interventions by contrast are responses for unforeseen and unpredicted behaviours of concern. Such situations require highly skilful responses from staff based on the fullest appraisal of the individual, the behaviour and its likely impacts. Such decisions, known as dynamic risk assessments, will include a judgement about the capacity of the child or young person in that moment to make safe choices. Any physical response (physical restraint) should only ever involve the least restrictive intervention being deployed in the safest way for the minimum amount of time.

The right core values and key principles should be used to underpin the management (including the physical management) of all behaviours of concern, including unforeseen behaviours that challenge, even in those settings and contexts where they cannot be anticipated or responses pre-planned. This is particularly relevant to those services that admit children and young persons with limited, or little or no knowledge of their background.

A core set of such values were presented in the recent document titled *Reducing the Need for Restraint and Restrictive Intervention* (HM Government, 2019). They included:

- upholding all children and young people’s rights – children and young people with learning disabilities, autistic spectrum conditions, and mental health difficulties whose behaviour challenges have the same human rights as all children and young people and require additional help to overcome the difficulties their behaviour may present

- treating all children and young people with learning disabilities, autistic spectrum conditions, and mental health difficulties whose behaviour challenges as full and valued members of the community whose views and preferences matter
- respecting and investing in family carers as partners in the development and provision of support for children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties
- recognising that all professionals and services have a responsibility to work together to coordinate support for children and young people whose behaviour challenges and their families

The same document (HM Government, 2019) also provides a set of key principles that relate specifically to the use of physical restraint. They were drawn up with reference to the Independent Restraint Advisory Panel's review of restraint systems used in secure children's homes but were held to be relevant to all of the settings and services covered in the guidance. The principles hold true across all children's and young person's services where physical restraint may be used:

- Every child or young person deserves to be understood and supported as an individual
- The best interests of children and young people and their safety and welfare should underpin any use of restraint
- The risk of harm to children, young people and staff should be minimised
- The needs and circumstances of individual children and young people, including their age, particular vulnerabilities, learning disability, medical condition or impairments, should be considered and balanced with the needs and circumstances of others. Decisions on whether or not to restrain or intervene with an individual affect others, including staff
- A decision to restrain a child or young person is taken to assure their safety and dignity and that of all concerned, including other children, young people or adults present

When considering whether to use restraint with a child or young person, staff should ask themselves: 'At this moment what is in the best interests of the child and/or those around them, taking account of the risks presented?'

When assessing risk, staff involved should take into account:

- the type of technique used, and how it will likely interact with, and impact on, the child/young person
- the size, age and understanding of the child or young person
- their particular history, vulnerabilities, learning disabilities, medical conditions and impairments
- the relative risks of not intervening
- the child or young person's previously sought views and experiences, and those of parents and carers, on strategies and approaches they considered might de-escalate or calm a situation
- the impact of the restraint on the future relationship with the child or young person (HM Government, 2019)

It must be recognised that any and all restrictive interventions (including physical restraint in particular) carry the risk of inadvertent distress, pain, injury and re-traumatisation. Examples of specific risk factors include:

- communication impairments which may reduce the ability of the child or young person to express their feelings or enter into a two-way problem solving and/or de-escalatory dialogue
- sensory processing or integration disorders which can be significant within the context of understanding and managing triggers, as well as in the context of understanding and managing any physical touch, holding or physical restraint which may be used. Staff should be aware that all forms of sensory stimulation above and beyond physical contact may be distressing so need to be carefully considered
- underdeveloped anatomy, eg bone size, shape and density, which will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques, and the force with which they are applied
- underdeveloped physiology, eg underdeveloped ability to regulate breathing rate and temperature, which may have implications for a child/young person's ability to breathe and how suddenly they can become exhausted
- underdeveloped psychological and emotional capacities which are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one

There is a significant incidence of Adverse Childhood Experiences (ACEs) which may be higher amongst some populations such as 'looked after' children, but nevertheless prevalent across society. Such ACEs can heighten the risk of trauma/re-traumatisation being experienced.

ACEs may mean that some children have attachment disorders or have developed emotional and physical responses to adults that may be unsafe or unhelpful. This may have implications for the use of physical restraint and other restrictive interventions such as seclusion (which may be extremely distressing). If it is suspected that a child or young person is deliberately seeking contact through physical restraint the advice of a psychologist should be sought.

Options for eliminating and/or reducing all forms of risk should be thoroughly explored, and the benefits and drawbacks of each considered and, where possible, recorded in plans (as discussed above).

Organisations should consider when to record occasions where restrictive interventions and physical restraint in particular are used (whether planned or unplanned). Depending on the type of setting or service, this may be a mandatory requirement (HM Government, 2019).

Good practice is to record why restraint was used, by whom, for how long and what the outcomes were in terms of any injuries to a child or young person and/or staff (organisations should refer to national guidelines and organisational policy for local recoding criteria) (HM Government, 2019). NB: this is likely to be supported by information about antecedent or setting conditions as well as behaviour consequences which will be used to support PBS/preventative planning.

After all incidents (including the use of physical restraint), the child or young person as well as the staff involved should be given emotional support and basic first aid for any injuries as soon as possible (HM Government, 2019).

Immediate action should be taken to access medical help for injuries that require more than basic first aid. All injuries should be recorded in accordance with the setting or service's procedures and reported as appropriate to the Health and Safety Executive (HM Government, 2019).

Action taken in respect of post-incident support could include trauma support for children, young people and their families affected by the use of restraint as well as staff (HM Government, 2019).

Organisations should ensure that appropriate lessons are learned from instances where restrictive interventions and physical restraint in particular have had to be used, including any patterns and trends, and consider how use of restraint might be avoided in future. This will usually involve de-briefing and post-incident review and monitoring of the use of procedures, strategies or techniques. The process should consider all types of individual plans that reference behaviour support and crisis management, including behaviour support plans (HM Government, 2019).

Whenever restraint has been used, staff and the child/young person should have separate opportunities to reflect on what happened, and wherever possible a choice as to who helps them with this. Those with cognitive and/or communication impairments may need specific help to engage in this process, for example, use of simplified language, visual imagery or Alternative and Augmented Communication (HM Government, 2019).

Wherever possible, the families of children and young people should have the opportunity to participate in post-incident reviews. Someone appropriate and trusted by the child/young person and their family or, where appropriate, the individual's advocate, could also play a role.

Reviews could involve a facilitated staff team discussion about the warning signs of an impending incident, whether any previously agreed behaviour plans were followed, what de-escalation strategies were used and how effective they were, and what might be done differently in future (HM Government, 2019). The same reflective process should be used to consider the appropriateness, suitability and safety of physical restraint.

If a pattern of persistent use of physical restraint emerges, and if a setting or service considers they do not have sufficient expertise themselves, an expert assessment should be sought, to identify the triggers for the behaviour that leads to use of restraint. The reviewer should consider, with the child or young person, and as appropriate, their parents and/or advocates, revising their individual support plan. Consideration should also be given to improving staff training and development as part of action to address the issue (HM Government, 2019).

Wherever there are security procedures such as search and confiscation that involve physical restraint the physical restraint technique should be considered as a risk factor in and of itself.

Where attendances and responses from the police become a feature of any management of seriously escalated behaviours it can be appropriate to agree joint response protocols. A discussion of the likely risks of any restraint should be considered to ensure such risks can be effectively managed.

Specific adaptations to the standards for this setting:

- Factors such as in-utero exposure to alcohol and/or drugs, pre, peri and post-natal trauma, poor attachment experiences, and complex home circumstances as well as the implications of such experiences on the developing brain will need to be covered during training
- Trainers would typically be expected to discuss the multi-agency and multi-level of support required for children/young persons with complex needs
- Primary preventative strategies should be prioritised. These should include evidence based models such as Positive Behaviour Support (suitable for all settings) and setting specific programmes such as Safewards (healthcare)
- Identification of any comforting routines or anxiety reducing objects to support recovery and help children cope should be in any behaviour support plan and should be flagged as part of initial assessment made at point of referral. The general value of such individualised strategies should be communicated clearly during any training (and be an intrinsic part of any child/young person-centred planning meeting)
- There must be strict limitations on the types of restrictive interventions/physical restraint techniques authorised for use on children/young persons in recognition of underdeveloped anatomy/physiology, psychological/emotional abilities to cope with such experiences, and disparities in size between children and adults
- Staff should be trained to understand the difference between planned and unplanned interventions, and receive training in how to recognise and manage the risks dynamically
- Staff training and supervision of practice should support dynamic risk assessment. Unless the situation is urgent, staff should be advised to seek assistance from appropriately experienced and/or trained staff. If such assistance is not available, any response must still be reasonable and proportionate, and should only ever involve the least restrictive intervention being deployed in the safest way for the minimum amount of time
- Any authorised restriction of liberty, in the form of a physical restraint, should be used for no longer than is absolutely necessary. Quite apart from infringing on human rights, time is a risk factor within the context of any physical restraint
- Risk factors that are specific to the children and young persons within the service must be covered. These may be separate and distinct from those risk factors that relate to adults

- Techniques intended to inflict pain as a means of control must never be used (Equality and Human Rights Commission, 2019; UN Committee on the Rights of the Child, 2006)
- Possible disparities in size/strength and gender differences between adults and children, and the ratio of staff to pupils in the context of any restrictive intervention or physical restraint, should be considered as risk factors
- Trainers should discuss 'intervention creep' as well as the use of euphemisms to disguise or hide restrictive interventions (consciously or unconsciously). Restraint techniques are defined as 'any method of responding to behaviours of concern which involves some degree of direct force to try and limit or restrict movement', but the nature and attendant risk of such techniques should not be obscured by ancillary descriptive terms such as 'embrace', 'prompt', 'guide' or even referred to erroneously under euphemisms such as 'physical support', 'manual handling' or as a 'first aid technique'
- Staff working in healthcare settings such as Child and Adolescent Mental Health Services (CAMHS) should undertake training designed specifically for teams working with physically frail or emotionally fragile children and/or young people. In such settings clinical holding may be necessary and the increased risks associated need to be recognised and managed

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 4

Specific considerations and adaptations to the standards for services supporting people who are deaf and have mental health conditions

Type of service or setting

Specialist mental health services for deaf people. These include inpatient non-secure and secure psychiatric care, emergency and urgent care, community mental health teams, early intervention teams and crisis resolution and home treatment teams, community healthcare, primary care, social care and care provided in people's homes.

Specific considerations when delivering training in this setting:

- Training should emphasise the need to uphold and support the statutory rights of all deaf and hard of hearing service users under the Mental Health Act 1983 (amended 2007), the Mental Health (Care and Treatment) (Scotland) Act 2003, and the Equality Act 2010. The Equality Act 2010 states that deaf people who use British Sign Language (BSL) constitute an officially recognised, minority cultural group in the UK and are a population with 'protected characteristics'. There is a public sector duty to ensure that service provision does not discriminate against treatment
- Training must emphasise the need to ensure effective communication at all times in order to minimise distress, confusion, frustration and any delays in receiving vital treatment. BSL is the first language of 100,000 deaf people in the UK. NB: The *Mental Health Act Code of Practice*, section 14, states that an approved mental health professional involved in the assessment must be responsible for booking and using registered Qualified Interpreters with expertise in mental health interpreting (Department of Health, 2015; see also Welsh Assembly Government, 2016a)

- Training must emphasise that a person centred approach involves optimising and maintaining effective communication channels, providing deaf service users with the means to communicate expressively or receive communication visually
- The trainer must be familiar with the presentation of specific conditions in the service in which they are providing training. This is to ensure that all staff are able to understand the various causes of deafness, any impact on a person's cognitive abilities, and the practicalities of ensuring communication channels are maintained
- It would be a valuable experience for any Qualified Interpreters operating within the unit to attend and/or participate in training courses relating to prevention and management of behaviours of concern, and in particular sessions covering restrictive interventions including physical restraint
- Trainers must actively involve the Qualified Interpreters in the delivery of sessions in order to deepen staff members' understanding of the patient's perspective. For any deaf members of staff, trainers must take time in advance to prepare with any Qualified Interpreter who may be supporting the session. Key terms and concepts must be clarified in advance
- The instruction model used for teaching physical restraint skills in some organisations is: Demonstrate–Participate–Explain. Deaf participants must have the opportunity to observe the demonstration and then receive a further demonstration during which they can concentrate on the qualified interpreter in order to receive an explanation of the demonstration before practising
- Qualified Interpreters must be provided with the flexibility to position themselves effectively to provide a clear visual field to deaf participants in order that they might receive information

Specific adaptations to the standards for this setting:

- Deaf service users can experience a range of mental health conditions which may present in different ways. Therefore an accurate assessment of their needs will be key when considering the use of restrictive practices, planned or unplanned. NB: Additionally, people with mental health conditions who are deaf may also have concomitant diagnoses such as autism or a learning disability

- Additional risk factors to be considered for individuals with mental health conditions, within the context of any restrictive interventions, include the following:
    - The rapid admission of service users is likely to restrict the time available to staff to complete comprehensive individualised assessments (which may include access to suitable interpreter services or staff with BSL fluency) supporting the authorisation of physical restraint techniques
    - A higher incidence of long term physical health conditions may be evidenced in diagnoses of cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculo-skeletal disorders
    - A higher incidence of health neglect and damaging personal habits may be evidenced in patterns of smoking, drinking, substance abuse and poor diet
    - A higher incidence of psychological impairment may be evidenced in unwillingness on the part of service users to co-operate with staff and make decisions in their own best interests. This may be linked to staff decisions to use restrictive practices, as well as how service users respond to them. Therefore it should be considered an organisational risk factor, as well as an individual risk factor
    - In addition to a higher incidence of exposure to traumatising events amongst this population, individuals who are deaf and rely upon BSL may be additionally traumatised where services are not able to support their communication needs. Trauma history may not always be known. If a person displays signs that may indicate past abuse the personalised wellbeing risk assessment should be updated
    - Additional consideration must be given to any evidence of recorded histories of prior exposure to restraints, violence and/or abuse and neglect, particularly among women and girls where gender and gender differences have been a key dynamic. These are linked to increased sensitisation to restrictive interventions such as some physical restraints or seclusion or witnessing a restrictive intervention being used on someone else
    - A greater likelihood that mood stabilisers or anti-psychotics will be prescribed and administered within forensic and high secure settings may be evidenced in side effects including high blood pressure, disturbed heart rhythms, dizziness, confusion or stupor

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 5

Specific considerations and adaptations to the standards for services supporting people who have eating disorders

Type of service

Specialist eating disorder (ED) services provide support to individuals with a range of different mental health disorders that involve disordered eating behaviour and a disordered perception of body image. Behaviours can include restriction of dietary intake, binging, purging (including vomiting and laxative misuse) and excessive exercise, or a combination of these behaviours. The majority of inpatient services provide short term treatment offering a more recovery focused programme, focusing on refeeding, weight maintenance and recovery.

Refeeding may include naso-gastric (NG) tube feeding and may need to be completed with the use of physical interventions.

Specific considerations when delivering training in this setting:

- The individual's age and specific eating disorder pathology will have a bearing on their psychological and emotional resilience. Reduced psychological and emotional reserves are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one. This will have significant implications for implementing trauma informed approaches to managing behaviours of concern

- Eating disorders are also often associated with low weight and can cause serious physical health issues including poor bone health, low energy levels, and interruption to or cessation of menstruation, all of which can impact on internal organs such as the heart. Inpatient treatment is often needed for patients with significant weight loss, chronic or complex conditions and a large part of treatment focuses on controlled refeeding. This will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques
- Training must promote the importance of providing a positive and safe therapeutic environment. For example, specific attention needs to be paid to the use of language and effective communication when working with ED, avoiding the misuse of praise and references to 'lifesaving treatment'
- Ward based trainers are well placed to deliver or support the development of training due to their experience, knowledge and specific skill set gained from working in specialised services. This will help to link clinical practice with training
- If training covers assisting there must be a focus on using the least restrictive interventions

Specific adaptations to the standards for this setting:

- There must be limitations on the types of restrictive interventions/ physical restraint techniques authorised in recognition of under-developed anatomy/physiology and psychological/emotional abilities to cope with such experiences
- Procedures need to account for the space, time and understanding required to justify and support prolonged restraint due to the natural delivery time of NG feed
- More staff may be required in order to safely manage an incident involving treatment resistance
- Physical adjuncts may be required to maintain safety and reduce prolonged restraint
- Possible items used in the management of NG feed restraint may include neck collar protection, cushions or beanbags, as well as the possible use of soft cuffs to reduce physical restraints and the use of bespoke 'feeding sofas'
- Support structures should be in place in order to help staff manage their emotions, anxieties and trauma related concerns when dealing with individuals in psychological and emotional distress, in particular around NG feed restraints

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 6

Specific considerations and adaptations to the training standards for services supporting people who have learning disabilities

Type of service

Services for people with a learning disability are also referred to as intellectual disability services. Services are inclusive of residential, social care, and individual's tenancies working within family home and health or hospital service settings.

People with a learning disability have reduced intellectual ability and may therefore take longer to learn and may need support to develop new skills or understand complicated information. People with a learning disability can also have concomitant mental illness and other neuro-developmental disorders such as autism and ADHD, as well as sensory and communication difficulties.

Specific considerations when delivering training in this setting:

- Interventions aimed at minimising any restrictive practices are more comprehensive when they arise from multi-disciplinary consultation
- Psychosocial interventions include a broad range of therapeutic approaches designed to support the person. They are generally non-pharmacological and aim to identify underlying factors for behaviour, reduce the person's distress and increase their skills. Approaches include communication interventions, applied behaviour analysis, positive behaviour support and cognitive behavioural therapy

- A multi-disciplinary team, care managers and social care providers should ensure that staff are trained in the management of escalating behaviours of concern using a training programme designed specifically for staff working with people with a learning disability. Training programmes should include the use of psychosocial methods and behavioural techniques to avoid or minimise restrictive interventions whenever possible
- The communication needs of people with a learning disability, particularly the needs of people who are unable to communicate through speech, should be taken into account in any assessment
- Underdeveloped psychological and emotional capacities are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one
- People with a learning disability are at significantly increased risk of exposure to events with the potential to result in trauma symptoms, but such symptoms may be less likely to be recognised
- The link between restrictive interventions/physical restraint and security procedures such as search and confiscation should be noted
- Identification of any comforting object or routines to support recovery should be part of individual assessment
- People with a learning disability have an increased incidence of physical health conditions, but such issues may not always be recognised. Any risk assessment for the use of restrictive physical interventions should include a full medical review if one has not been undertaken recently in response to the presentation of behaviours of concern. The presentation of any behaviours of concern and/or distress may be a response to an underlying health problem and should always be investigated fully
- As with people who have mental health conditions, people with learning disabilities are not a homogeneous group and are likely to have suffered a range of adverse psychosocial experiences that may include bullying, abuse, trauma, over-medication and unnecessary use of restrictive practices

Specific adaptations to the standards for this setting:

- There must be limitations on the types of restrictive interventions/physical restraint techniques authorised in recognition of underdeveloped psychological/emotional abilities to cope with such experiences
- There are processes in identifying health or sensory problems early
- There must be a focus on providing strategies and interventions to support communication

In the event there is to be a planned response to any behaviour of concern that involves a restrictive intervention, it is best practice to ensure that this is supported by the consent of the individual in question or a best interests decision. Such advanced decisions should be recorded in plans that detail the decision making process, the consultation that was undertaken, why it is necessary, how it is the least restrictive intervention, the risk factors that have been identified, the safeguards in place to minimise its use and its physical, psychological impact on the individual, and review mechanisms.

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 7

Specific considerations and adaptations to the training standards for services supporting people who have mental health conditions

Type of service

Includes inpatient psychiatric care, emergency and urgent care, secondary mental health care (such as care provided by assertive community teams, community mental health teams, early intervention teams and crisis resolution and home treatment teams), community healthcare, primary care, social care and care provided in people's homes.

Specific considerations when delivering training in this setting:

- People with mental health conditions are not a homogeneous group. They may have a range of mental health conditions that present in different ways – the training provider should be familiar with the presentation of specific conditions in the service in which they are providing training. Additionally people with mental health conditions may have concomitant diagnosis such as autism and a learning disability
- Any behaviour management strategies stand within broader programmes that focus on recovery and care. Use of restrictive interventions will need to be contextualised and positioned within any overall plan and all individualised behaviour management strategies
- Additional risk factors to be considered for individuals with mental health conditions, within the context of any restrictive interventions, include the following:
    - The rapid admission of service users is likely to restrict the time available to staff to complete comprehensive individualised assessments supporting the authorisation of physical restraint techniques
    - A higher incidence of long term physical health conditions may be evidenced in diagnoses of cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders

    - A higher incidence of health neglect and damaging personal habits may be evidenced in patterns of smoking, drinking, substance abuse and poor diet
    - A higher incidence of psychological impairment may be evidenced in unwillingness on the part of service users to co-operate with staff and make decisions in their own best interests. This may be linked to staff decisions to use restrictive practices, as well as how service users respond to them. Therefore it should be considered an organisational risk factor, as well as an individual risk factor
    - A higher incidence of exposure to traumatising events may be evidenced by recorded histories of prior exposure to restraints, violence and/or abuse and neglect, particularly among women and girls where gender and gender differences have been a key dynamic. These are linked to increased sensitisation to restrictive interventions such as some physical restraints or seclusion or witnessing a restrictive intervention being used on someone else. Trauma history may not always be known if a person displays signs that may indicate past abuse. The personalised wellbeing risk assessments should be updated
    - A greater likelihood that mood stabilisers or anti-psychotics will be prescribed and administered within forensic and high secure settings may be evidenced in side effects including high blood pressure, disturbed heart rhythms, dizziness, confusion or stupor. Training should also cover advance decisions and advance statements and the legal obligation attached to both
- The training should consider the legal issue of consent to the use of restrictive interventions and should take into account current legislation and guidance

Specific adaptations to the standards for this setting:

- Community mental health teams should not use physical restraint in community settings. In situations of medium risk, staff should consider using breakaway techniques and de-escalation. In situations of high risk, staff should remove themselves from the situation and, if there is immediate risk to life, contact the police

In the event there is to be a planned response to any behaviour of concern that involves a restrictive intervention, it is best practice to ensure that this is supported by the consent of the individual in question or a best interests decision. Such advanced decisions should be recorded in plans that detail the decision making process, the consultation that was undertaken, why it is necessary, how it is the least restrictive intervention, the risk factors that have been identified, the safeguards in place to minimise its use and its physical, psychological impact on the individual, and review mechanisms.

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 8

Specific considerations and adaptations to the training standards for services supporting older people and people who are living with dementia

Type of service

Specialist dementia services which are designed to offer care and support to older adults experiencing mental health problems and cognitive decline as a result of the changes associated with Alzheimer's disease, vascular dementia, Lewy Body dementia, fronto-temporal dementia and other forms of dementia. People with dementia can also have learning difficulties, as well as concomitant diagnoses including other functional mental health issues as well as autism.

Specific considerations when delivering training in this setting:

- Support provided within older adult/dementia services will aim to continue to promote personal independence whilst ensuring safety of the individual and those around them
- People with dementia can benefit from a high level of input from family carers or family members. They can both help the individual make sense of what is happening around them and provide insight and information that can be invaluable to the care team. The individual can have a complete lack of comprehension and therefore find it impossible to understand and follow instructions from staff. They are in a different reality and the use of restrictive practices including physical or mechanical restraint is likely to be terrifying and dangerous
- Any behaviour management strategies are likely to be supplemented/supported by personalised programmes/plans of care which should reflect the needs and wishes of the individual, as well as considering any advance directives which may have been agreed. Physical restraint will need to be contextualised and positioned within any overall plan and all individualised behaviour management strategies
- Additional risk factors to be considered for older people and people who are living with dementia, within the context of any restrictive interventions, include the following:
    - A rapid admission of a service user is likely to reduce the time available to staff to complete comprehensive individualised assessments supporting the authorisation of physical restraint techniques
    - Where a person has experienced long term mental health difficulties leading into older adulthood, a higher incidence of long term physical health conditions may be evidenced in diagnoses of cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders. Consideration must also be given to 'age-related' health conditions such as arthritis and osteoporosis which may also increase the risks within the areas above or develop in later life

- Where a person is experiencing cognitive decline related to their mental health or potential dementia, the impact can be significant. The development of multiple higher cortical deficits, including those associated with perceiving, understanding, problem solving, remembering, learning and making judgements can be both frightening and disorientating. This may be considered a risk factor in respect to the presentation of behaviours of concern, as well as within the context of any physical restraint technique
- A higher incidence of personal neglect may be evidenced in patterns of personal care, taking of fluids/drinking, poor diet or the refusal of food. This can increase the likelihood of poorer general health and increase the risk of infection and malnutrition
- Difficulties with swallowing, that raise the risk of choking or aspiration, would add to any distress experienced during a restraint
- The development of 'delirium' (a treatable condition which can be over-shadowed by diagnosis such as dementia, as the person can experience memory loss, confusion and/or hallucinations) could give rise to behaviours of concern, as well as compromising the ability of the individual to make sense of what is happening and communicate effectively with those in a position to help
- The potential for a higher incidence of psychological impairment amongst the population with dementia could be manifested in a perceived unwillingness to co-operate with staff. This may lead to staff considering decisions that might need to be made based on best interests. This in turn may be linked to staff decisions to use restrictive practices
- An increased likelihood of a person experiencing 'poly-pharmacy' or the prescribing of more than one medication may be evidenced in side effects including high blood pressure, disturbed heart rhythms, dizziness, confusion or stupor. There is also the complication of drugs interacting with each other

- There is a link between restrictive interventions/physical restraint and security procedures such as search and confiscation

Specific adaptations to the standards for this setting:

- There must be explicit safety guidelines and monitoring protocols developed for all types of restrictive interventions/physical restraint techniques authorised in recognition of the risk factors described above. The process of identifying potential risks and agreeing suitable safeguards will require cross disciplinary collaboration with input potentially being required from dieticians, speech and language therapists, psychologists, physiotherapists, occupational therapists and pharmacists
- Consideration must be given to safety limits within procedures supporting physical restraint, eg the number of staff involved, in recognition of likely disparities in size/strength, as well as the gender mix of teams responding to behaviours of concern
- Where staff may be required to use restrictive practices/restraint techniques as part of personal care, the emphasis must be placed on personalised planning and support, including additional emphasis on therapeutic/clinical holding
- In emergency assessment units, wherein staff may be required to use restrictive practices/restraint techniques as part of the rapid admission/assessment process, additional time should be spent during training sessions to discuss the local protocols in place to manage the heightened risks
- Personalised wellbeing risk assessments should be completed and the training provider should be proactive in acquiring the most current anonymised information available about individual patients

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 9

Specific considerations and adaptations to the training standards for adult acute psychiatric wards and PICUs

(Please also refer to Appendix 7: Services supporting people who have mental health conditions)

Type of setting

Acute services including those referred to as PICUs (Psychiatric Intensive Care Units), are likely to be required to provide rapid assessment and therapeutic psychiatric services for individuals who may be experiencing a mental disorder, an acute episode of mental illness, personality disorder or neurodevelopmental disorders such as learning disability and autism and who present a significant risk of harm to themselves and others including staff and members of the public. Acute services as part of their commissioning may be expected to provide care and support within acute medical areas such as Accident and Emergency. This care could be considered emergency, or unplanned. Individuals accessing a PICU should be detained compulsorily under the appropriate mental health legislative framework, and the clinical and risk profile of the patient usually requires an associated level of security (NAPICU, 2016).

Specific considerations when delivering training in this setting:

- Support provided within acute/PICU services will aim to continue to promote recovery as well as personal independence whilst ensuring protection of the public. However, within a PICU environment this may be superseded by actions which seek to offer stabilisation through psychological, psychosocial or pharmacological means. Both areas will require the provision of appropriate levels of physical, procedural and relational security. Physical restraint will need to be contextualised and positioned within any overall security management strategy
- The rapid admission of service users to acute or PICU services is likely to restrict the time available to staff to complete comprehensive individualised assessments supporting the authorisation of physical restraint techniques. It is recommended that within these circumstances a plan be developed within 48 hours (admission dependent) with a maximum timeframe of seven days. This is an individual risk factor to be considered within the context of any physical restraint technique
- Behaviour management strategies may in some circumstances be accessible and therefore should be utilised to supplement/ support an admission by ensuring that care offered is based on an individual's personalised recovery-oriented programmes/ plans, understanding of a person's trauma journey, recognition of any self-injury reduction programmes, managing emotions programmes and communication development programmes. It may not always be possible to identify internal triggers but review may identify conditions and factors that make people's distress more likely to occur or impact on the severity of distress.
- Restrictive interventions may include the use of mechanical restraints/restraint devices in a very limited number of very clearly delineated situations. These can include the administration of some emergency medical treatments, when the behaviours of concern being presented are likely to seriously jeopardise the individual's safety, eg attempting to remove catheters, arterial lines and breathing tubes. The use of mechanical interventions is likely to give rise to additional risks such as potential interference with circulation, and potential damage to nerves
- There is also the risk that such devices begin to be thought of as a means of managing more general behaviours of concern. A clear authorisation process and reduction plan needs to be developed. These risks are linked to both the application of restraint devices, and the misapplication of devices, so staff will need clear guidance and training on how to apply them safely
- There is a link between restrictive interventions/physical restraint and security procedures such as search and confiscation

Specific adaptations to the standards for this setting:

- There must be explicit safety guidelines and monitoring protocols developed for all types of restrictive interventions/physical restraint techniques authorised in recognition of the risk factors presented by co-morbidities, damaging personal habits, psychological impairment, exposure to prior trauma and the side effects of medication
- There must be consideration given to safety limits within procedures supporting physical restraint, eg the number of staff involved, in recognition of likely disparities in size/strength, as well as the gender mix of teams responding to behaviours of concern
- Additional time should be spent during training sessions to discuss the local protocols in place in emergency assessment to manage the heightened risks involved in the rapid admission/assessment process
- Personalised wellbeing risk assessments should be completed as soon as possible and the training provider should be proactive in acquiring the most current anonymised information available about individual patients. Advice is that this should be developed within the first 48 hours; however, where information is being collated then up to seven days should be seen as a maximum time frame
- Additional risk assessments will be required to cover the application of any mechanical restraints. These should cover the risks arising from their application and the vulnerability of the individual they are being applied on. It is possible that physical restraint techniques may be included in any application procedure, so any risk assessments should be considered in parallel
- Additional training time will be required to cover the criteria for using devices, the application of them, any contra-indications for fitting, safety monitoring protocols and criteria for release

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 10

Specific considerations and adaptations to the training standards for Emergency Departments

Type of setting

Emergency Departments are a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

Emergency Departments often manage patients who may exhibit behaviours of concern. These are often associated with mental health problems, a learning disability, dementia, intoxication (alcohol/drugs) and autism.

Specific considerations when delivering training in this setting:

- Specific training regarding the causes and management of behaviours of concern in a busy Emergency Department environment should be at the core of any training programme. It is important to note that many Emergency Department staff receive only minimal training in the care of patients with mental health problems, learning disability, dementia, or other intellectual impairments. Additionally, patients who are intoxicated through alcohol or substances may also present in Emergency Departments with behaviours of concern

- Organic disease may hide behind a psychiatric disorder and full biological assessment is essential to avoid diagnostic overshadowing (where signs and symptoms are ignored or not fully assessed and are attributed to the primary condition, eg learning disability or mental health problem). Reactive psychiatric symptoms and behavioural responses may occur as a response to pain, fear, infection or chronic disease. This is more common in older adults, paediatrics, immuno-supressed and cancer patients. Recognition of physical deterioration in patients is essential and the relevant NICE guidelines should be included in training (Clinical Guideline CG50) (NICE, 2007). An assessment that considers the potential biological, psychological, pharmacological and social causes of behaviour will help to prioritise appropriate actions. The pharmacological domain should explore street drugs, alcohol, legal highs and over the counter medication as well as prescribed medications

Specific adaptions to the standards for this setting:

- Training must cover supporting patients coming from prison or low (such as psychiatric intensive care), medium or high secure mental health settings, who must arrive with their own staff who should take responsibility for any restrictive interventions. On-site security teams should be alerted at the time of admission of these patients, should support be needed, and this should be reflected in organisational policy. Where possible a separate space aside from the main Emergency Department should be allocated for specific use by this patient group. This space may also be used for other disturbed patients (including intoxicated patients) or those needing psychiatric assessment by the psychiatric liaison team (PLT). The space should be risk assessed, ligature free and not contain any objects that could be used as weapons.

  It is also important to check that the patient is not carrying potential weapons or illicit substances on their person. This can be discreetly performed by replacing outdoor clothing with a hospital gown. NICE guidelines on violent and aggressive behaviours in people with mental health problems (QS154) (NICE, 2017b) should be alluded to in training

- If the on-site security team (or in some cases, the police) are called and physical intervention is considered necessary as a last resort, medical and senior nursing staff must remain present throughout to monitor the patient's physical health and ensure that the least force is utilised for the shortest space of time
- Any form of restrictive intervention must be recorded in the patient's notes, including the duration of the intervention and description of which body part(s) were held. An incident form must also be completed using the organisation's reporting systems detailing all aspects of the event
- Any use of mechanical restraint such as mittens must be prescribed in writing by senior medical staff (Consultant or Senior Registrar) and the care team informed
- Chemical restraint may be given when prescribed by senior medical staff, as per organisational policy, should rapid tranquilisation be considered necessary. Oral medication shall be offered in the first instance where not contra-indicated due to medical condition
- Psychiatric emergencies (including S136 MHA, 1983) and transfers to mental health facilities shall be accompanied by staff and a risk assessment must be in place, as per organisational protocol (see also the Mental Health (Care and Treatment) (Scotland) Act 2003)
- Relationships with psychiatric liaison teams are crucial to the functioning of Emergency Departments and where possible integrated training should take place with both staff teams included

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 11

Specific considerations and adaptations to the training standards for family homes

(Please also refer to Appendix 14: Lone working)

Type of setting

Family homes. The training could be delivered to family members and friends, other carers paid or unpaid, personal assistants, home tutors and other professionals.

Specific considerations when delivering training in this setting:

- Lone working arrangements relating to personal assistants*/carers, home tutors, and other health/social care professionals working in these settings (see Appendix 14: Lone working)
- With regard to restrictive interventions/physical restraint see relevant considerations in Appendix 3: Children's services

* The Health and Safety at Work Act 1974 does not apply to activities classed exclusively as 'domestic services' carried out in 'private households'. Personal care provided within someone's own home may be 'domestic service' and therefore may fall within this dis-application. Clarity would need to be sought.

Specific adaptations to the standards for this setting:

- There must be a strong focus on personal safety and avoidance of any procedures involving restrictive interventions/physical restraint when the behaviours of concern are presented by children or young persons, and when staff are working alone. (See Appendix 14: Lone working)

- With regard to the approval of any restrictive interventions and the specification and authorisation of any physical restraint technique, it is strongly advised that any decisions are made only after full and thorough multidisciplinary consultation, and following a consideration of all the psychological and emotional risks (likely impacted by any developmental trauma or abuse) and any physical risks (likely impacted by immature anatomy and physiology) (see relevant considerations in Appendix 3: Children's services)
- Arrangements for post-incident support and review for all parties must be agreed prior to delivering training, and recording protocols should be manageable for family members. These should be covered within the curriculum

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 12

Specific considerations and adaptations to the training standards for forensic and high secure services

(Please also refer to Appendix 4: Services for people who have mental health conditions)

Type of service

Forensic and high secure mental health services, specifically those providing a therapeutic psychiatric service for individuals with a mental disorder, mental illness, personality disorder or neurodevelopmental disorders such as learning disability and autism and who present a significant risk of harm to themselves and others including staff and members of the public.

Specific considerations when delivering training in this setting:

- Training in high secure services must be delivered in accordance with the NICE-approved Positive and Safe training manual: *Violence Reduction and Management Programme* (West London Mental Health Trust, 2016 – for further information visit Promoting hope and wellbeing together)
- Support provided within forensic/secure services will aim to promote recovery as well as personal independence whilst ensuring protection of the public. This will involve the provision of appropriate levels of physical, procedural and relational security. Physical restraint will need to be contextualised and positioned within any overall security management strategy
- The rapid admission of service users is likely to restrict the time available to staff to complete comprehensive individualised assessments supporting the authorisation of physical restraint techniques. This is an individual risk factor to be considered within the context of any physical restraint technique
- Restrictive interventions may include the use of mechanical restraints/restraint devices in a very limited number of very clearly delineated situations. These can include the administration of some emergency medical treatments, when the behaviours of concern being presented are likely to seriously jeopardise the individual's safety, eg attempting to remove catheters, arterial lines and breathing tubes. The use of mechanical interventions is likely to give rise to additional risks such as potential interference with circulation, and potential damage to nerves
- There is also the risk that such devices begin to be thought of as a means of managing more general behaviours of concern. A clear authorisation process and reduction plan needs to be developed. These risks are linked to both the application of restraint devices, and the misapplication of devices, so staff will need clear guidance and training on how to apply them safely
- There is a link between restrictive interventions/physical restraint and security procedures such as search and confiscation

Specific adaptations to the standards for this setting:

- There must be explicit safety guidelines and monitoring protocols developed for all types of restrictive interventions/physical restraint techniques authorised in recognition of the risk factors presented by co-morbidities, damaging personal habits, psychological impairment, exposure to prior trauma and the side effects of medication
- There must be consideration given to safety limits within procedures supporting physical restraint, eg number of staff involved, in recognition of likely disparities in size/strength, as well as the gender mix of teams responding to behaviours of concern
- Within high secure/forensic settings the appointment of an overall lead (or response 'controller') within the context of any restrictive intervention/physical restraint is recommended
- Additional time must be spent during training sessions to discuss the local protocols in place in emergency assessment units to manage the heightened risks involved in the rapid admission/assessment process
- Personalised wellbeing risk assessments should be completed as soon as possible and the training provider shall be proactive in acquiring the most current anonymised information available about individual patients
- It is expected that information about existing medical conditions can be accessed very quickly. Other information needed to complete the personalised wellbeing risk assessment must be gathered within 48 hours, with seven days being the limit for a completed assessment. When they have received the anonymised information the training provider must advise on any adaptations or contra-indications to the range of techniques that can be used on that person as soon as the information is received. It is expected that the training provider has a protocol for dynamic personalised wellbeing risk assessments which has been agreed with the commissioning organisation
- Additional risk assessments will be required to cover the application of any mechanical restraints. These must cover the risks arising from their application, and the vulnerability of the individual they are being applied on. It is possible that physical restraint techniques may be included in any application procedure so any risk assessments must be considered in parallel
- Additional training time will be required to cover the criteria for using devices, the application of them, any contra-indications for fitting, safety monitoring protocols and criteria for release

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards.

Appendix 13

Specific considerations and adaptations to the training standards for foster care

Type of setting

Foster carers/foster caring. One of a number of care options that offers children a home when they are unable to live with their birth family.

Specific considerations when delivering training in this setting:

- Only behaviour management strategies and policies agreed by local authorities and fostering agencies must be authorised for use
- Distinctions shall be made between caring and supportive touch, and coercive touch; and between caring and supportive holding, and coercive holding
- With regard to restrictive interventions/physical restraint see relevant considerations in Appendix 3: Children's services
- In those settings where an adult may apply a restrictive intervention/physical restraint technique on a child without direct support or supervision the practicalities and limitations of 1:1 practices must be considered. It is vital that there are robust processes and procedures in place so as to ensure that the child's voice can be heard in relation to any safeguarding issues/concerns
- Identification of any comforting object or routines to support recovery and help children cope should be in the personalised wellbeing risk assessments and should be part of initial assessment made at point of referral

Specific adaptations to the standards for this setting:

- There must be a strong focus on personal safety and avoidance of any procedures involving restrictive interventions/physical restraint when the behaviours of concern are presented by children or young persons, and when foster parents/carers are working alone. See Appendix 14: Lone working
- With regard to the approval of any restrictive interventions and the specification and authorisation of any physical restraint technique, it is strongly advised that any decision is made only after full and thorough multi-disciplinary consultation, and following a consideration of all the psychological and emotional risks (likely impacted by any developmental trauma or abuse) and any physical risks (likely impacted by immature anatomy and physiology) (see relevant considerations in Appendix 3: Children's services)
- In the event that a 1:1 intervention is considered, a risk assessment covering this dynamic must be undertaken before any strategy or technique is authorised for use
- Arrangements for post-incident support and review for all parties must be agreed prior to delivering training and recording protocols should be manageable for foster carers. These must be covered within the curriculum

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 14

Specific considerations and adaptations to the training standards for lone working

Type of setting

Lone workers are those who work by themselves without close or direct supervision. This may include those working outside of normal hours, or within satellite locations. Lone workers may include personal assistants, home tutors, social workers, healthcare professionals and mental health workers.

Specific considerations when delivering training in this setting:

- The need for staff to be able to conduct dynamic risk assessments in support of formal risk assessments and agreed safety procedures
- How the assessment and management of risk is impacted by lone working status
- The role of tracking, communication and alarm systems in mitigating against harms

Specific adaptations to the standards for this setting:

- A prohibition on restrictive interventions/ restraint techniques is likely, based on lone working arrangements
- A strong emphasis on responses likely to ensure safety, keeping personal distance, de-escalation and strategic capitulation
- Arrangements for post-incident support and review for all parties should be agreed prior to delivering training and must be covered within the curriculum

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 15

Specific considerations and adaptations to the training standards for schools

Type of setting

This includes local authority maintained schools, academies and free schools, pupil referral units, non-maintained special schools, independent schools and sixth form colleges.

Other settings for which the following may have some relevance include Special Education Units, Special Educational Needs resourced provision, Pupil Referral Units and Early Years providers

Specific considerations when delivering training in this setting:

- Teachers have the power to discipline pupils for misbehaviour and this includes the power to use reasonable force to prevent pupils from hurting themselves or others
- Joint Select Committee on Human Rights stated that use of restraint of children for discipline and good order (where there is not an imminent risk of serious harm) must be prohibited as it contravenes the ECHR
- The use of force cannot be as a punishment – it is always unlawful to use force as a punishment

- In order to minimise risk, and safeguard children against harm, the way in which restrictive interventions, including physical restraint, are authorised and used must be carefully considered. This duty of care cannot be avoided or must not be subverted by misleading terminology. Within schools, and other educational establishments, 'physical restraint' may be referred to as 'physical intervention' or even simply as the 'use of force'. Alternatively, reference may be made to the function of the force, such as its use 'to control pupils or to restrain pupils'. Furthermore, within policy documents reference may be made to specific training systems and even types or levels of physical holds

- For the purpose of these training standards any physical contact undertaken by a staff member, with the intention to *'restrict, or subdue movement of the body (or part of the body) of the student or pupil'* should be seen as amounting to *'physical restraint'* (Department of Education, 2013b)

- Underdeveloped anatomy, eg bone size, shape and density, will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques

- Underdeveloped physiology, eg underdeveloped ability to regulate breathing rate and temperature, will impact on the selection of techniques to be included in any training syllabus

- Underdeveloped psychological and emotional capacities are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one

- There may be children within the school, often those who display behaviours of concern, who may have been exposed to Adverse Childhood Experiences (ACEs). As a result children can be traumatised, and at risk of re-traumatisation. The nature and presence of such prior experiences will have significant implications on how behaviours of concern are managed, in particular with restrictive interventions including physical restraint

- Possible disparities in size/strength and gender differences between adults and children, and the ratio of staff to pupils in the context of any restrictive intervention or physical restraint, should be considered as risk factors

- The link between the use of restrictive interventions/physical restraint and security procedures such as search and confiscation should be considered as a risk factor, ie the removal of personal items and/or weapons is likely to heighten emotions and potentially have an impact on decision making

- In some instances physical restraint may be used in incidents that result in the application of other restrictive interventions such as the use of seclusion/isolation rooms. Schools can adopt a policy which allows disruptive pupils to be placed in an area away from other pupils for a limited period, in what are often referred to as seclusion or isolation rooms. Guidance issued in 2016 by the Department for Education states that *'any use of isolation that prevents a child from leaving a room of their own free will should only be considered in exceptional circumstances. The school must also ensure the health and safety of pupils and any requirements in relation to safeguarding and pupil welfare'* (Department of Education, 2016)
- An increasing number of special schools are using specially constructed PVC tents within classrooms. Such tents are often used as sensory areas, quiet/safe spaces or as alternative teaching locations
- Some tents can be zipped up from the outside to prevent the student from leaving. If a child were enclosed within such a tent by a staff member this would likely constitute a deprivation of liberty and compromise the student's human rights. Such tents should never be used in this way, or threatened as a form of punishment

Specific adaptations to the standards for this setting:

- Trainers should discuss 'intervention creep' as well as the use of euphemisms to disguise or hide restrictive interventions (consciously or unconsciously). For example, a verbal reprimand is permitted within DfE guidelines on behaviour and discipline in schools; however, if the teacher deliberately stands over a child and prevents them leaving the classroom the intervention may become a deprivation of liberty. Likewise the same guidelines state that school based community service punishments may be appropriate if used in line with the school policy; however, time in the 'safe space', 'sensory tent', 'chill out room', 'de-escalation/quiet room' or teacher imposed 'garden time' can be unwarranted punishments or restrictions of liberty by another name
- Any authorised restriction of liberty, in the form of a physical restraint, should be used for no longer than is absolutely necessary. Quite apart from infringing on human rights, time is a risk factor within the context of any physical restraint
- There should be limitations on the types of restrictive interventions/ physical restraint techniques authorised in recognition of under-developed anatomy/physiology, underdeveloped psychological/ emotional abilities to cope with such experiences, and likely disparities in size/strength between children and adults

- The gender of staff and that of pupils needs to be considered, with safeguards in place to avoid traumatising/re-traumatising experiences, as well as avoid any scope for allegations of inappropriate physical contact
- Identification of any comforting object or routines to support recovery and help children cope should be in the personalised wellbeing risk assessments
- Children attending residential special schools in England are protected under the Children Act (1989) through the Residential Special Schools National Minimum Standards (Department for Education, 2013a): *'no school should restrict the liberty of a child as a matter of routine or provide any form of secure accommodation'*

Training providers delivering training in other countries must refer to country specific legislation.

Below are a number of key principles for policy and practice that are promoted in the guidance *Reducing the Need for Restraint and Restrictive Intervention,* guidance aimed at children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings published by the DHSC and DfE in 2019.

Key principles

Restraint may be necessary to safeguard the individual and/or others from serious injury or harm, and sometimes it will be the only realistic option, for example to prevent a child from running into a busy road.

- Promote a positive and proactive approach to behaviour, including de-escalation techniques appropriate to the child or young person, to minimise the likelihood of or avoid the need to use restraint (see examples in all of the case studies in Annex B, HM Government 2019)
- Use of restraint is based on assessment of risk and to safeguard the individual or others
- Restraint should only be used where it is necessary to prevent risk of serious harm, including injury to the child or young person, other children or young people, to staff, the public or others, if no intervention or a less restrictive intervention were undertaken

- An intervention is in the best interests of the child or young person balanced against respecting the safety and dignity of all concerned, including other children, young people or adults present
- Restraint is not used to punish or with the intention of inflicting pain, suffering or humiliation
- Techniques used to restrain or restrict liberty of movement are reasonable and proportionate to the circumstances, risk and seriousness of harm; and are applied with the minimum force necessary, for no longer than necessary, by appropriately trained staff
- Use of restraint, reasons for it and consequences of its use, are documented, monitored, open and transparent
- When planning support and reviewing any type of plan which references restraint (such as a behaviour support plan), children and young people, and parents, and where appropriate (for example, where the child or parent/carer wants it), advocates should be involved

Other considerations

- The use of force cannot be as a punishment – it is always unlawful to use force as a punishment
- In order to minimise risk, and safeguard children against harm, the way in which restrictive interventions, including physical restraint, are authorised and used must be carefully considered. This duty of care cannot be avoided or must not be subverted by misleading terminology. Within schools, and other educational establishments, 'physical restraint' may be referred to as 'physical intervention' or even simply as the 'use of force'. Alternatively, reference may be made to the function of the force, such as its use 'to control pupils or to restrain pupils'. Furthermore, within policy documents reference may be made to specific training systems and even types or levels of physical holds

- For the purpose of these training standards any physical contact undertaken by a staff member, with the intention to 'restrict, or subdue movement of the body (or part of the body) of the student or pupil' should be seen as amounting to 'physical restraint' (Department of Education, 2013b)
- The link between the use of restrictive interventions/physical restraint and security procedures such as search and confiscation should be considered as a risk factor, ie the removal of personal items and/or weapons is likely to heighten emotions and potentially have an impact on decision making
- In some instances physical restraint may be used in incidents that result in the application of other restrictive interventions such as the use of seclusion/isolation rooms. Schools can adopt a policy which allows disruptive pupils to be placed in an area away from other pupils for a limited period, in what are often referred to as seclusion or isolation rooms. Guidance issued in 2016 by the Department for Education states that 'any use of isolation that prevents a child from leaving a room of their own free will should only be considered in exceptional circumstances. The school must also ensure the health and safety of pupils and any requirements in relation to safe-guarding and pupil welfare' (Department of Education, 2016)
- An increasing number of special schools are using specially constructed PVC tents within classrooms. Such tents are often used as sensory areas, quiet/safe spaces or as alternative teaching locations
- Some tents can be zipped up from the outside to prevent the student from leaving. If a child were enclosed within such a tent by a staff member this would likely constitute a deprivation of liberty and compromise the student's human rights. Such tents should never be used in this way, or threatened as a form of punishment
- See 'Best practice guidelines' contained in the section 'Specific considerations when delivering training' in 'Appendix 3 Specific considerations and adaptations to the training standards for services supporting children' for detailed information about general best practice in particular regard to the use of physical restraint

Specific adaptations to the standards for this setting:

- Training providers may need to adapt their delivery model to accommodate school INSET days where appropriate
- Trainers should discuss 'intervention creep' as well as the use of euphemisms to disguise or hide restrictive interventions (consciously or unconsciously). For example, a verbal reprimand is permitted within DfE guidelines on behaviour and discipline in schools; however, if the teacher deliberately stands over a child and prevents them leaving the classroom the intervention may become a deprivation of liberty. Likewise, the same guidelines state that school based community service punishments may be appropriate if used in line with the school policy; however, time in the 'safe space', 'sensory tent', 'chill out room', 'de-escalation/quiet room' or teacher imposed 'garden time' can be unwarranted punishments or restrictions of liberty by another name
- Children attending residential special schools in England are protected under the Children Act (1989) through the Residential Special Schools National Minimum Standards (Department for Education, 2013a): *'no school should restrict the liberty of a child as a matter of routine or provide any form of secure accommodation'*
- Primary preventative strategies should be prioritised. This should include evidence based models such as Positive Behaviour Support (suitable for all settings)
- Identification of any comforting routines or anxiety reducing objects to support recovery and help children cope should be in any behavior support plan and should be flagged as part of initial assessment made at point of referral. The general value of such individualised strategies should be communicated clearly during any training (and be an intrinsic part of any child/young person centred planning meeting)
- There must be strict limitations on the types of restrictive interventions/physical restraint techniques authorised for use on children/young persons in recognition of underdeveloped anatomy/physiology, psychological/emotional abilities to cope with such experiences, and disparities in size between children and adults
- Staff should be trained to understand the difference between planned and unplanned interventions, and receive training in how to recognise and manage the risks dynamically

- Staff training and supervision of practice should support dynamic risk assessment. Unless the situation is urgent, staff should be advised to seek assistance from appropriately experienced and/or trained staff. If such assistance is not available, any response must still be reasonable and proportionate, and should only ever involve the least restrictive intervention being deployed in the safest way for the minimum amount of time
- Any authorised restriction of liberty, in the form of a physical restraint, should be used for no longer than is absolutely necessary. Quite apart from infringing on human rights, time is a risk factor within the context of any physical restraint
- Risk factors that are specific to the children and young persons within the service must be covered. These may be separate and distinct from those risk factors that relate to adults
- Possible disparities in size/strength and gender differences between adults and children, and the ratio of staff to pupils in the context of any restrictive intervention or physical restraint, should be considered as risk factors
- Techniques intended to inflict pain as a means of control must never be used (Equality and Human Rights Commission, 2019, UN Committee on the Rights of the Child, 2006)
- Trainers should discuss 'intervention creep' as well as the use of euphemisms to disguise or hide restrictive interventions (consciously or unconsciously). Restraint techniques are defined as 'any method of responding to behaviours of concern which involves some degree of direct force to try and limit or restrict movement', but the nature and attendant risk of such techniques should not be obscured by ancillary descriptive terms such as 'embrace', 'prompt', 'guide' or even referred to erroneously under euphemisms such as 'physical support', 'manual handling' or as a 'first aid technique'

Training providers delivering training in other countries must refer to country specific legislation.

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 16

Specific considerations and adaptations to the training standards for Tier 4 Child and Adolescent Mental Health Services (CAMHS)

Type of service or setting

Child and Adolescent Mental Health Services (CAMHS) Tier 4 Children's Services deliver specialist inpatient and day-patient care to children who are suffering from severe and/or complex mental health conditions that cannot be adequately treated by community CAMH services. Many of the children and young people who are admitted to these services have experienced unsuccessful treatment regimes in tier 1 to 3 community or other services and may be detained under the Mental Health Act 1983 (Amended 2007) see also the Mental Health (Care and Treatment) (Scotland) Act 2003.

Specific considerations when delivering training in this setting:

- There must be an emphasis on working collaboratively with parents/carers to provide family centred care. To this end, there must be effective communication between service users and their families, health providers and other involved agencies using the Care Planning Approach, so that families and professionals are fully involved in decisions related to treatment as well as any planned responses to behaviours of concern

- Training must emphasise the need for, and value of, investing in a meaningful engagement process with patients and family members in order to enhance the therapeutic alliance between patient and staff
- Training must also consider providing an understanding of how to recognise and respond to those children/ young people who may be affected by being involved in or witnessing physical interventions, especially those with a history of trauma and abuse
- Ward based trainers are well placed to deliver or support the development of training due to their experience, knowledge and specific skill set gained from working in specialised services. This will help to link clinical practice with training
- Underdeveloped and over-developed anatomy, eg bone size, shape and density, underdeveloped physiology, and disparities in size between children and adults will significantly impact on the selection of restrictive interventions, in particular physical restraint techniques
- Underdeveloped psychological and emotional capacities are likely to result in any restrictive intervention being experienced as a hostile, overwhelming and/or traumatising one. This will have significant implications for implementing trauma informed approaches to managing behaviours of concern
- The safety of any restrictive interventions, in particular physical restraint techniques, is contingent upon the impact of such techniques being carefully considered and managed
- The psychological, emotional and physical vulnerabilities linked to the presentation of any of the following should be considered risk factors: psychosis, eating disorders, affective disorders, developmental disorders including autism, neurodevelopmental disorders such as learning disability and autism, attention deficit hyperactivity disorder (ADHD), tic disorders, obsessive compulsive disorders, anxiety and emotional disorders, self-harming behaviours, attachment and emotional regulation disorders, as well as a primary diagnosis of mental illness with co-morbid learning difficulties. In order to manage the risks arising, collaboration with, and input from, allied health professionals is likely to be necessary

Specific adaptations to the standards for this setting:

- There must be limitations on the types of restrictive interventions/physical restraint techniques authorised in recognition of underdeveloped anatomy/physiology, underdeveloped psychological/emotional abilities to cope with such experiences, and likely disparities in size/strength between children and adults
- Support structures should be in place in order to help staff manage their emotions, anxieties and trauma related concerns when dealing with children and adolescents
- Training programmes for this setting must be flexible, and kept under review, in order to ensure they are able to adopt changes in line with clinical evidence-based practices supported by incident data analysis
- Children and young people in these settings should be involved in developing certain aspects of training in relation with primary, secondary and tertiary strategies
- There should be a framework/processes in place to involve children/young people/parents in making decisions on the use of unavoidable restrictive interventions offered by services, and in the use of least restrictive intervention as part of their treatment plans (eg PILRIMP – Patient Inclusion in Least Restrictive Intervention and Management Plan)
- The framework (such as PILRIMP) must be part of the training programme for staff to understand the value of positive engagement with children and young people in order to reduce and to manage their emotions, anxieties and trauma related concerns when using restrictive interventions
- The training provider must provide a list of all restrictive interventions that are taught to staff so that the commissioning organisation can make this information available to children/young people/parents with the information as to why, when and how these restrictive interventions can be used as part of treatment plans
- Photos/leaflets of restrictive interventions techniques must be provided to children/young people/parents as part of an admission pack to help them to manage their emotions, anxieties and trauma related concerns in the use of possible unavoidable restrictive interventions

Specific guidance/legislation relating to delivering training in this setting/service:

- Mental Health Act 2007 and Code of Practice
- Mental Health (Care and Treatment) (Scotland) Act 2003
- *The Mental Health Act 1983 Code of Practice for Wales* (Welsh Assembly Government, 2016a)
- Mental Capacity Act 2005 and Code of Practice
- Adults with Incapacity (Scotland) Act 2000
- Mental Capacity Act (Northern Ireland) 2016*
- Deprivation of Liberty Act 2010
- The Children Act 1989 and Children Act 2004
- Department of Health Guidance for Restrictive Physical Interventions (July 2002)
- United Nations Convention on the Rights of the Child 1989
- Protection of Children Act 1999
- NICE (2015) *Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings*. NICE guideline NG10
- NICE (2004) *The Short-term Physical and Psychological Management and Secondary Prevention of Self-harm in Primary and Secondary Care.* NICE clinical guideline 16
- Royal College of Nursing (2010) *Restrictive Physical Intervention and Therapeutic Holding for Children and Young People. Guidance for Nursing Staff.* London: RCN
- Department of Health and Social Care and Department for Education (2017) *Reducing the Need for Restraint and Restrictive Intervention: Children and Young People with Learning Disabilities, Autistic Spectrum Disorder and Mental Health Difficulties* (Consultation document)
- National Decision-Making Model (NDM), College of Policing

*NB: The working date for full implementation of this Act is 2020. (RCN 05/09/2018)

Appendix 17 Specific considerations and adaptations to the training standards for services in England

Specific adaptations to the standards:

The Department of Health's document *Positive and Proactive Care* (2014) relates to health and social care services where individuals who are known to be at risk of being exposed to restrictive interventions are cared for. Such settings may provide services to people with mental health conditions, autistic spectrum conditions, learning disabilities, dementia and/or personality disorders, older people and detained patients. It is more broadly applicable across general health and social care settings where people using services may on occasion present with behaviour that challenges, but which cannot reasonably be predicted and planned for on an individual basis. This may include homes where individuals employ their own support staff, and community-based primary and secondary care settings. 'Restrictive interventions' are defined within the guidance as: *'deliberate acts on the part of other person(s) that restrict an individual's movement, liberty and/or freedom to act independently in order to:*

- *take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and*
- *end or reduce significantly the danger to the person or others; and*
- *contain or limit the person's freedom for no longer than is necessary.'*

The legal and ethical basis for organisations to allow their staff to use restrictive interventions as a last resort is founded on eight overarching principles:

1. Restrictive interventions shall never be used to punish or for the sole intention of inflicting pain, suffering or humiliation
2. There must be a real possibility of harm to the person or to staff, the public or others if no action is undertaken
3. The nature of techniques used to restrict must be proportionate to the risk of harm and the seriousness of that harm
4. Any action taken to restrict a person's freedom of movement must be the least restrictive option that will meet the need
5. Any restriction must be imposed for no longer than absolutely necessary
6. What is done to people, why and with what consequences must be subject to audit and monitoring and must be open and transparent
7. Restrictive interventions must only ever be used as a last resort
8. The involvement of people who use services, carers and advocates is essential when reviewing plans for restrictive interventions

A panel of experts identified that certain restraint techniques presented an unacceptable risk when used on children and young people (Physical Control in Care Medical Panel, 2008; quoted in Department for Education, 2013b). The techniques in question are:

- the 'seated double embrace' which involves two members of staff forcing a person into a sitting position and leaning them forward, while a third monitors breathing
- the 'double basket-hold' which involves holding a person's arms across their chest and
- the 'nose distraction technique' which involves a sharp upward jab under the nose

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 18 Specific considerations and adaptations to the training standards for services in Northern Ireland

Specific adaptations to the standards:

Physical restraint has been defined within 'health and personal social service settings' as: *'The use of any part of one's body, or mechanical method, to prevent, restrict or subdue movement of any part of another person's body. It can be employed to achieve a number of different outcomes:*

- *to break away or disengage from dangerous or harmful physical contact initiated by a service user*
- *to separate the person from a "trigger", for example, removing one service user who has responded to another with physical aggression*
- *to protect a service user from a dangerous situation – for example, the hazards of a busy road'* (Human Rights Working Group On Restraint And Seclusion, 2005)

Within educational settings the term 'reasonable force' is used, with the following qualification: *'the working definition of "reasonable force" is the minimum force necessary to prevent a pupil from physically harming him/herself or others or seriously damaging property, but used in a manner which attempts to preserve the dignity of all concerned'* (Department of Education Northern Ireland, 2004)

Training content must refer to the Royal College of Nursing guidance: *Three Steps to Positive Practice: A rights based approach when considering and reviewing the use of restrictive interventions* (2017) Royal College of Nursing Three Steps to Positive Practice

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website RRN Training Standards.

Appendix
19 Specific considerations and adaptations to the training standards for services in Scotland

Specific adaptations to the standards:

- The Mental Welfare Commission for Scotland is concerned with ensuring the 'welfare of individuals with mental illness, learning disability and related conditions'. In their good practice guide they define 'restraint' as *'taking place when the planned or unplanned, conscious or unconscious actions of staff prevent a person [or other person] from doing what he or she wishes to do and as a result places limits on his or her freedom. Restraint is defined in relation to the degree of control, consent and intended purpose of the intervention'* (Mental Welfare Commission for Scotland, 2013a)

- In *Holding Safely* (guidance produced for residential child care practitioners, which covers children and young people), 'physical intervention' was defined as *'an action involving using a worker's body, for example blocking the path of a child or any guiding of him or her away from a harmful situation. It includes physical restraint'* (The Scottish Institute for Residential Child Care (SIRCC), 2005, updated 2013)

- In the same document 'physical restraint/restraining a child' was defined as *'an intervention in which staff hold a child to restrict his or her movement and should only be used to prevent harm. We have largely avoided simply using the term restraint and instead have referred to restraining a child as just that – restraining a child. We deliberately chose to change this language to avoid losing sight of the child, who might otherwise be overlooked by the more clinical and depersonalised use of the term "restraint"'* (SIRCC, 2005, updated 2013)

- *Holding Safely* defines certain techniques that should never be used: 'neck holds'; those involving any 'obstruction of the mouth or nose'; and those relying on 'pain compliance'
- *Holding Safely* also defined high risk practices that required strong justification and comprehensive safeguards: 'prone restraint'; 'supine restraint'; 'seated holds' and 'basket holds'
- *Holding Safely* was produced in 2004, when SIRCC were asked by the Scottish Executive to produce guidance on restraining children and young people in residential child care establishments. The *Holding Safely* guidance was originally specifically targeted at the residential child care sector, and not at schools
- In 2013 additional guidance was issued, designed to complement *Holding Safely*. The purpose of this additional guidance was to ensure that the key principles and practice of *Holding Safely* were adopted in all residential child care establishments across Scotland. This included secure care and establishments which provided services for children affected by a disability. The Scottish Executive published its refreshed national guidance, *Included, Engaged and Involved Part 2: A Positive Approach to Preventing and Managing School Exclusions* on 19 June 2017. This refreshed guidance includes information and advice for education authorities on de-escalation and physical intervention

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix 20 Specific considerations and adaptations to the training standards for services in Wales

Specific adaptations to the standards:

The Welsh Assembly Government considers that guidance it issues on restrictive physical intervention policy and practice for professionals who work with children, young people, adults and older people in health, education and social care settings should share a common framework of principles and expectations. The Welsh Assembly Government has therefore elected to use the term 'restrictive physical intervention' to describe direct physical safeguarding action: *'Direct physical contact between persons where reasonable force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behaviour displayed by an individual'* (Welsh Assembly Government, 2005)

Within education settings the term 'use of force' has been used. A distinction is made between its use for 'control', and for 'restraint':

- Control can mean either passive physical contact (eg standing between pupils or blocking a pupil's path) or active physical contact (eg leading a pupil by the hand or arm, or ushering a pupil away by placing a hand in the centre of the back)
- When members of staff use 'restraint' they physically prevent a pupil from continuing what they were doing after they have been told to stop. Restraint techniques are usually used in more extreme circumstances, such as when two pupils are involved in a fight and physical intervention is needed to separate them (Welsh Assembly Government, 2010)

In 2005, the Welsh Assembly Government published the *Framework for Restrictive Physical Intervention Policy and Practice* which stated that, *'Under no circumstances, should any individual ever be restrained in a (prone) face down position.'*

In 2008 this guidance was revised in recognition of the fact that the prone restraint position was used in mental health services across the Welsh NHS. The position is recognised as one of last resort, and one which needs to be carefully managed to ensure the patient's safety. If prone (face down) restraint is used it will need to be justified and documented.

In 2013, the Welsh Assembly Government published further guidance on the use of physical intervention: *Safe and Effective Intervention – Use of Reasonable Force and Searching for Weapons* (097/2013). This guidance does not refer to the use of face down (prone) restraint. However, the guidance recognises that in exceptional circumstances staff have to do whatever is necessary to keep a pupil safe.

In 2016, *Positive Approaches: Reducing Restrictive Practices in Social Care* was published by the Care Council for Wales.

The All Wales NHS Violence and Aggression Training Passport and Information Scheme provides a framework for the delivery of violence and aggression training within the NHS in Wales. It also provides guidance on the development of documentation to ensure the effective assessment and maagement of violence and aggression. The scheme has four modules:

- Module A Induction and awareness raising
- Module B Theory of personal safety and de-escalation
- Module C Breakaway techniques
- Module D Restrictive physical interventions (this has been developed specifically for specialist areas such as mental health services, and is currently being reviewed and revised by the all Wales Proactive Reduction of Restrictive Interventions Clinical Effectiveness (PRRICE) group)

Specific guidance or legislation relating to delivering training in this setting can be found on the Restraint Reduction Network website at RRN Training Standards.

Appendix
21A The use of pain to gain compliance

- The cross sector Restraint Reduction Network steering group does not endorse the use of pain based techniques
- The Restraint Reduction Network is committed to the specification, and implementation, of person centred care planning. This may include the development of individualised behaviour support plans, which may include reactive strategies, providing carefully considered guidance on how to respond to those behaviours of concern that represent a risk to safety. Such plans may include physical restraint as a last resort. In addition to being lawful, such interventions must also be ethical and safe
- The Restraint Reduction Network believes that the planned, or intentional, application of pain to elicit behavioural compliance runs counter to the primary role of staff which is to provide individualised therapeutic care and support. Techniques, which are often referred to as 'pain compliance techniques', are also potentially dangerous and likely to be damaging to the development and maintenance of vital ongoing therapeutic/supportive relationships
- The European Committee for the Prevention of Torture advise that pain must never be used to gain compliance
- The European Commission for Human Rights takes the view that pain inducing restraint must be prohibited on children and many professional codes of practice clearly define that the deliberate application of pain is not acceptable

Appendix
21B The use of pain for escape or rescue purposes

- The Restraint Reduction Network does acknowledge that where there is an immediate risk to life, the NICE Guidelines (NG10) refer to the use of techniques which may cause pain-based stimulus to mitigate the risk to life
- In this case, the training provider must present a clear, written rationale for the inclusion of such techniques in training and the reasons why staff require such training. The rationale must be supported by risk assessments and should include recommended criteria for monitoring, minimising and reducing the use of these techniques
- It must be clear in the rationale which staff need the training. The rationale must be authorised by the most senior official responsible for restraint in the commissioning organisation and must be reviewed with the senior official before any training event that includes the techniques
- Training must cover safety advice, reporting requirements and review arrangements for the use of these techniques

Glossary

Accreditation

The official recognition of a particular status or qualification to provide or perform a particular activity. Training providers can demonstrate compliance with these standards through certification. Contact BILD Association of Certified Training for information regarding certification.

Advance decision

A written statement made by a person aged 18 or over that is legally binding and conveys a person's decision to refuse specific treatments and interventions in the future.

Advance statement

A written statement that conveys a person's preferences, wishes, beliefs and values about their future treatment and care. An advance statement is not legally binding.

Affiliated service providers

These are service provider organisations that deliver certified training services within their own organisations on behalf of the training provider.* Quality assurance and training for the associate trainers who are delivering the approved programmes within the service provider organisation are provided directly by the training provider which will be sampled in the continuous assessment process for certification.

* these may be known as in-house or in-service training models

Behavioural overshadowing

This is when behaviours of concern are attributed to the person's learning disability, mental health, differential diagnosis, age or gender.

Breakaway techniques

These are techniques that are used to breakaway/disengage from any unwanted physical contact for example a grab or a hair pull. Breakaway techniques may be completely non-restrictive. or have a restrictive component included. Breakaway techniques may also be used to assist another person to disengage from unwanted physical contact.

It would be important to assess the communicative function of the physical contact particularly if the person is unable to verbalise their distress or make themselves understood clearly.

Certificated training service

Certificated training services are the combination of approved curriculum and authorised trainers that meet the *Restraint Reduction Network Training Standards*.

Children

People aged 12 years or under.

Coercion

Any action or practice undertaken which is inconsistent with the wishes of the person in question (ie undertaken without the person's informed consent) – also see psychological restraint.

Commissioning organisation

This is an organisation who commissions training – usually a service provider – and in some cases this might be through an in-house provider.

De-escalation

The use of techniques (including verbal and non-verbal communication skills) aimed at preventing potential or actual behaviours of concern from escalating. PRN medication can be used as part of a de-escalation strategy, but PRN medication used alone is not de-escalation. De-escalation techniques can include verbal strategies, such as maintaining a calm tone of voice and not shouting or verbally threatening the person; and non-verbal techniques, including an awareness of self, body stance, eye contact, and personal safety (Cowin et al, 2003; Spencer and Johnson, 2016). Effective de-escalation approaches are personalised and include openness, honesty, support, self-awareness, coherent communication, non-judgemental approaches, and confidence (without arrogance) (Price and Baker, 2012).
They have the aim of preventing escalation and supporting the person to be calm.

Diagnostic overshadowing

This is when symptoms of physical ill health are mistakenly attributed to either a mental health/behavioural problem or as being inherent in the person's learning disabilities.

Distressed behaviours

Distress can result in challenging behaviour of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion (adapted from the definition in Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, 2007). They may also be referred to as challenging behaviours, behaviours that challenge or that can be described as challenging, and distressed behaviours or behavioural disturbances.

There are a wide range of behaviours that are considered to be concerning. These can include verbal or physical aggression, violence and aggression towards others, self-harm, withdrawal, and they can manifest verbally or physically. Distressed behaviours of concern are assumed to have a purpose and communicative meaning for the person.

Duty of candour

The duty of professionals to be open and honest with people when something goes wrong and has the potential to cause harm or distress.

Duty of care

The legal obligation to safeguard others from harm while they are in your care and/or exposed to activities such as training programmes.

Escape and rescue techniques

A set of physical skills to help separate or break away from an aggressor in a safe manner. This may be completed by an individual or in extreme cases supported by another to enable escape/rescue. These techniques are not expected to involve the use of restraint (NICE, 2015).

Fragility

Refers to issues that may compromise the fidelity of the technique between its taught version and application in practice. Fragility issues have implications for both effectiveness and safety. A technique is deemed fragile if small adjustments (movement or pressure) to the procedure are likely to result in intentional, or unintentional injury or severe pain to an individual (Paterson, 2014; Martin et al, 2008).

GDPR

General Data Protection Regulations 2018

Hyperextension

An excessive joint movement in which the angle formed by the bones of a particular joint is opened, or straightened, beyond its normal, healthy, range of motion.

Hyperflexion

Flexion of a limb or part beyond the normal limit.

Incident

Any event that involves the use of a restrictive intervention – restraint, rapid tranquillisation or seclusion (but not observation).

Named person

In the commissioning organisation this should be someone with board level/executive level responsibility as well as a practice restraint reduction lead or the lead trainer. In the training organisation this is the person who engages with the commissioning organisation and is responsible for developing the written proposal and agreeing the curriculum with the named person in the commissioning organisation.

Both people are responsible for the annual review of the curriculum. Where training is both developed and delivered in-house, the same process of development delivery and review should be followed although there may only be one named person.

Pain compliance

Pain compliance is the use of painful stimulus to control or direct a person's actions.

Participant

In these standards a participant is a person who attends a training programme.

Peer review

A systematic interactive process that helps nursing staff and students evaluate their colleagues' practice and engage in constructive dialogue with them, providing feedback to peers based on specific criteria to assist in professional and/or personal growth.

People with lived experience

People with a lived experience of receiving services and experience of having restrictive interventions applied to them. The term can also apply to families and carers.

Personal assistants (PA)

A carer (PA) employed by an individual or a related third party without the involvement of an employment agency or employment business, and working wholly under the direction and control of that individual or related third party in order to meet the individual's own personal care requirements.

Personalised wellbeing risk assessment (PWRA)

A process which supports the gathering of important personal information used to determine the suitability and safety of any restrictive interventions.

Planned and unplanned restrictive intervention

These standards use the term planned restrictive intervention to mean a restrictive intervention that has been agreed and is documented as part of someone's agreed plan. An unplanned restrictive intervention is when a restrictive intervention is used as a response to an unexpected incident. The use of the restrictive intervention should be recorded and reviewed shortly afterwards.

Post-incident review

A review that consists of two separate components:

1. Post-incident support This is the support that is immediately offered to an individual who has been involved in an incident, it should include assessment and treatment of any medical needs and provision of immediate emotional support.

2. Post-incident reflection and learning review This is a non-blaming review where the factors that led to the restrictive intervention being used are examined and actions are agreed that support the prevention of future incidents or the minimisation of impact and less restrictive response in the future.

Primary strategies

These strategies aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of behaviours of concern arising.

PRN (pro re nata)

When needed, PRN refers to the use of medication as part of a strategy to de-escalate or prevent situations that may lead to harm to the person or others.

Reflective practice

The practice of reflecting on one's actions so as to engage in a process of continuous learning. Services and professionals can at times unintentionally provoke situations. Reflective practice helps identify how to better meet needs to prevent crisis.

Refresher training

A programme that the participant attends within a year of attending the original programme. Its aim is primarily to refresh skills learned previously but it should also contain a developmental element.

Restraint minimisation

Assessment, planning and review measures aimed at reducing the intensity and duration of any physical restraint techniques that are used within defined settings, or in relation to a defined population or a specific individual.

Restraint reduction

Assessment, planning and review measures designed to reduce the number of times restraint techniques are used within defined settings, or in relation to a defined population or a specific individual.

Restrictive interventions

Interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, physical restraint, mechanical restraint and rapid tranquilisation and other chemical restraint. Restrictive interventions have the potential to violate the person's human rights.

- **Chemical restraint**

Involves using medication with the intention of restricting someone's movement. This could be regularly prescribed medication – including those to be used as required (PRN) – or illegal drugs.

- **Observation**

A restrictive intervention of varying intensity in which a member of the staff observes and maintains contact with a service user to ensure the service user's safety and the safety of others. There are different levels of observation.

- **Physical restraint**

Any method of responding to behaviours of concern which involves some degree of direct force to try and limit or restrict movement. Physical restraint can also be called manual restraint and restrictive physical intervention.

- **Long term segregation**

Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the person to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a person should not be allowed to mix freely with other patients on the ward or unit on a long term basis.

- **Mechanical restraint**

A method of physical intervention involving the use of authorised equipment, for example handcuffs or restraining belts. Its purpose is to immobilise or restrict movement of part(s) of the body of the person.

- **Rapid tranquilisation**

Use of medication by the parenteral route (usually intramuscular or, exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed.

- **Technological surveillance**

Tagging, pressure pads, closed circuit television, or door alarms, for example, are often used to alert staff that the person is trying to leave or to monitor their movement.

- **Psychological restraint or coercive practice**

This can include constantly telling the person not to do something, or that doing what they want to do is not allowed, or is too dangerous. It may include depriving a person of lifestyle choices by, for example, telling them what time to go to bed or get up. Psychological restraint might also include depriving individuals of equipment or possessions they consider necessary to do what they want to do, for example taking away walking aids, glasses, outdoor clothing, or keeping the person in nightwear with the intention of stopping them from leaving.

- **Seclusion**

If a person is isolated and prevented from leaving a room of their own free will, it meets the criteria for seclusion, even if it is called by a different name. Alternative names in use may be: time out, isolation, chill out, or single separation. There could be a number of methods that prevent someone from leaving a room including a perceived or real threat. In a hospital setting seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the person is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others. Seclusion does not include locking people in their rooms at night in accordance with the High Security Psychiatric Services (Arrangements for Safety and Security) Directions 2013.

Restrictive practices

This is an umbrella term for making someone do something they don't want to do or stopping someone doing something they want to do. In service settings it can be linked to the use of blanket rules which apply to everyone regardless, but may have a tenuous basis for application or are only necessary because of a specific individual risk.

Secondary strategies

These strategies focus on the recognition of an individual's early behavioural signs (physical, emotional, communicative, etc) which can indicate an increase in behavioural disturbance. Strategies are developed to identify how to respond to a person's behaviours or support the person to self-manage. Secondary strategies are likely to include approaches to de-escalation. These may be referred to as reactive strategies, secondary preventative strategies or active interventions. Secondary strategies can be restrictive (such as use of PRN at an early stage) or non-restrictive. Such strategies are designed to be used when staff recognise signs of a developing behavioural disturbance, and are aimed at reducing or removing the underlying causes of the behaviour, including issues such as pain, distress or frustration.

Tertiary strategies

These strategies are used when an actual behaviour of concern is presenting, with the primary aim to bring the incident to an end in a timely and safe manner, with due regard to the individual's rights and dignity. Examples of non-restrictive tertiary strategies include de-escalation, diversion, distraction or strategic capitulation. Examples of restrictive tertiary strategies include restrictive interventions such as physical restraint.

Trainers

There are two kinds of trainers referred to in these standards:

- **Senior trainers**

Senior trainers are authorised under the certification scheme to deliver approved programmes across multiple organisations and/or deliver approved 'Train the Trainer' programmes. Senior trainers may be employed (or paid) by a commercial training provider or be employed within a service provider organisation such as an NHS trust. 20% of senior trainers are subject to direct quality assurance sampling processes through the certification scheme. This status is non transferrable across organisations, employers or other training organisations.

- **Associate trainers**

Associate trainers are authorised by the training provider to deliver approved programme(s) only within their own service or organisation, they are not authorised to deliver any approved 'Train the Trainer' programmes. Associate trainers are likely to be employed by affiliated service provider organisations (eg NHS trusts, schools or care homes who deliver training services on behalf of the training provider and will be expected to meet the requirements as laid out within the *Restraint Reduction Network Training Standards*. This status is non transferrable across organisations, employers or other training organisations. Direct quality assurance for these trainers is the responsibility of the training provider who will be expected to provide evidence of quality assurance monitoring processes as part of the certification of their training services, which will be sampled in the continuous assessment process for certification

Training curriculum

A list of subjects that make up the training programme.

Training needs analysis (TNA)

The first step in the training process. Designed to identify performance gaps that can be remedied by training. It consists of surveillance, investigation, and data analysis (Thomas, 2004)

Training providers

There are two kinds of training provider referred to in these standards:

- **Commercial training organisation**

who are commissioned to provide training to a range of organisations

- **In-house training providers**

who deliver training within their own organisation, for example, an NHS trust or a care organisation

Trauma informed care

An organisational structure and treatment framework that involves understanding, recognising, and responding to the effects of all types of trauma.

Written rationale

Written explanation of the logical reasons or principles for arriving at a decision to include particular restrictive interventions in the training curriculum.

Young people

People aged between 13 and 17 years.

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Restraint Reduction Network

Restraint Reduction Network (RRN) Training Standards

First edition

James Ridley
Sarah Leitch

The Restraint Reduction Network (RRN) welcomes the increased focus on restraint reduction across the NHS and adult social care in the UK. There is growing recognition among professional bodies and government departments (and arm's length bodies) that whilst the use of any kind of restraint may on rare occasions be necessary to keep people safe, it is also traumatic and must be minimised in therapeutic settings.

The RRN is an independent network which brings together committed organisations with a shared vision of reducing reliance on restrictive practices and making a real difference in the lives of people who use services across education, health and social care services.

These standards have been developed with the support of Health Education England and the Royal College of Nursing to provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings.

In addition to improving training and practice, the standards will:

- protect people's fundamental human rights and promote person centred, best interest and therapeutic approaches to supporting people when they are distressed
- improve the quality of life of those being restrained and those supporting them
- reduce reliance on restrictive practices by promoting positive culture and practice that focuses on prevention, de-escalation and reflective practice
- increase understanding of the root causes of behaviour and recognition that many behaviours are the result of distress due to unmet needs
- where required, focus on the safest and most dignified use of restrictive interventions including physical restraint

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