Scottish Patient Safety Programme Mental Health

Least Restrictive Practice Evidence Scan 2021

Evidence and Evaluation for Improvement Team (EEvIT)

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Contents

INTRODUCTION

This paper outlines key considerations from a scoping review of published evidence related to **least restrictive practice**, based on guiding questions shared with EEvIT, undertaken in April 2021.

This scoping review and summary was commissioned by the Scottish Patient Safety Programme for Mental Health (SPSPMH) co-design group as part of their work to understand the current system and inform new and updated improvement resources. The guiding questions devised by the co-design group are:-

- *What are the most common restrictions used against patients in mental health/learning disabilities/specialist inpatient services?*

- *What are the most common factors that contribute to restrictive practice in mental health/learning disabilities/specialist inpatient services?*

- *In what ways does the use of restrictive practice impact any protected groups who use mental health/learning disabilities/specialist inpatient services?*

- *What standards, guidelines or best practice exist in the UK or internationally to inform an intent to provide services that are least restrictive in mental health/learning disabilities/specialist inpatient services?*

- *What initiatives have taken place that have reduced the use of restrictive practice in mental health/learning disabilities/specialist inpatient services?*

- *How is restrictive practice being measured in the UK or internationally in mental health /learning disabilities/specialist inpatient services?*

The scoping review represented a rapid summary and search which was not intended to be exhaustive or represent an appraisal of quality. It tries to give a sense of some of the key considerations from the literature as related to the guiding questions.

After consultation with the co-design group, an update based on selected key documents was completed in September 2021 to explore further considerations related to trauma-informed practice and equality.

We hope this is useful and we would welcome any feedback. Please send your feedback to his.mhportfolio@nhs.scot.

EVIDENCE SCAN - CONSIDERATIONS

Example considerations include:

- **Opportunity and challenge:** The most recent review of evidence reported that whilst there was a clear opportunity to reduce restrictive practice, as well as a range of reduction interventions which in general appeared to have a positive impact, there was an overall lack of high-quality evaluation and research about the specific components applied. This was relevant even where interventions were evidence-based, as they were often applied potentially inconsistently or other interventions were developed *ad hoc* locally – and for this reason it is challenging to know in detail what works in a 'transferable' way to apply to other settings.

- **Common restrictions**: While the literature did not contain detail of the most common restrictions used, previous analysis suggested adult inpatients in the UK may be more likely to experience more coercive measures, more seclusion, more likely ordered verbally by a nurse, than other countries. However, more recent research examining Welsh data reported much lower rates of seclusion.

- **Common factors**: there are many factors which may contribute to increased restrictive practice, some related to the person in hospital such as demographic profile, some behavioural precursors and others external to the person such as bed occupancy, admission levels, different policies, training and ward culture. Overarching factors such as time pressures and feelings of mistrust and fear were also highlighted. Research relating to children found that restraint was more likely to be used earlier in admission, and later in the day.

- **Impacts on protected groups**: The demographic profile of people – for example age, gender and diagnosis was found to influence restrictive practice. The impact of witnessing restrictive practice was reported in relation to staff and patients.

- **Standards/Guidelines/Best Practice:** A number of relevant guidelines and practice documents make reference to *reducing* restrictive practice, including NICE Clinical Guidelines and Mental Welfare Commission for Scotland good practice frameworks.

- **Initiatives**: There are some evidence-based violence and aggression reduction intervention programmes which have reported success in reducing incidents in inpatient settings such as *Safewards* (Bowers, 2014). There are also some quality improvement reports available which report successful initiatives such as *Six Core Strategies* (NASMHPD, 2008), the six strategies being: *1) Leadership in organisational culture change 2) Using data to inform practice 3) Workforce development 4) Inclusion of families and peers 5) Specific reduction interventions (using risk assessment, trauma assessment, crisis planning, sensory modulation and customer services) 6) Rigorous debriefing*).
  There are also some prevention-focused measurement tools which have been developed such as the *Feelings Thermometer*. It is unclear how generalizable these results would be to other settings. Relational programme interventions at a ward and organisational level appear to be required to make the most difference.

- **Measurement:** There appears to be a lack of systematically collected national data on restraint to inform research. It has been suggested there would be a need to monitor potential intended and unintended effects of improvement in reducing restrictive practice interventions.

UPDATE - CONSIDERATIONS

Example considerations include:

- **NICE guideline update:** The current guideline is in the process of being updated and trauma informed care and considerations related to protected characteristics were among the main reasons for the update.

- **Gap in data availability:** There is a recognised gap in the data available to explore potential variation in restrictive practice according to protected characteristics in Scotland, and a new recommendation for a national agency to record and publish national data on restraint.

- **Essential to provide therapeutic environment as well as reduce restrictive practice:**
New training standards applicable to England emphasise that reducing the use of restrictive practices should not be considered in isolation, it is also essential to provide a therapeutic environment where treatment and recovery can take place.

EVIDENCE SCAN

Original questions and related literature

The guiding questions given to EEvIT by the programme are set out below, alongside selected findings from the considered papers.

Question 1: What are the most common restrictions used against patients in mental health/learning disabilities/specialist inpatient services?

Differences in UK practice vs. other countries

A 2010 analysis[1] of data from 10 countries reported that on average, when coercive practice was compared to the other countries analysed, the UK:

- Typically used more coercive measures per patient: two or more measures were frequently applied (the UK being one of four countries to do so, the other six typically used a single measure)
- Typically used more seclusion than the 'average pattern' (UK 30% vs. 8% average) with more similarly matched usage of forced medication (UK 43% vs. 56% average) and restraint (26% vs. 36% average).
- Was the only country where nurses were more likely than doctors to order coercive measures.
- Was the only country, other than Italy, where a verbally expressed coercive practice order was sufficient (and verbal expression used in 28% of orders). In all other countries, a written coercive practice order was necessary.

A more recent analysis[12] which compared restraint data from four countries found that patient related restraint data are similar between countries (in terms of patients exposed to restraint and number of restraints), but that type and length of restraint still vary significantly.

- For example, the use of seclusion varied from 2% in Wales, 29% in Ireland, 49% in Germany to 79% in the Netherlands.

Question 2: What are the most common factors that contribute to restrictive practice in mental health/learning disabilities/specialist inpatient services?

A combination of personal and environmental factors

A 2020 systematic review[3] and narrative synthesis of physical restraint of children and adolescents in mental health inpatient services found:

• a combination of personal factors (such as age, gender, diagnosis, and history) and environmental factors (such as organisational factors, a child or adolescent's admission status, longer length of stay, miscommunication, and mistrust of staff and children) potentially led to experiencing restraint.

• physical restraint is generally more likely to be used earlier in an admission (cited dosReis et al., 2010; Furre et al., 2016; Leidy et al., 2006), in the afternoons or evening

• little is known about children and young people's experiences of restraint and more research about this and contributing factors to restraint is needed.

A 2016[2] comparison of restraint data from four different countries found that variation in the duration and type of restrictive practice are as a result of:

- Different types of restraint culture, specialties, ward types
- Bed occupancy, admission levels
- Demographic profiles of patients
- And potentially, different policies and training may also contribute.

Staff attitudes to coercive measures

A 2020 systematic review[4] of the influence of nurse attitudes and characteristics on the use of coercive measures in acute mental health services found that nurses' attitudes have changed over the last three decades from a therapeutic to a safety paradigm.

- Nurses viewed coercive measures as undesirable but at times necessary, for instance if a person is behaving aggressively.
- The literature on association between staff characteristics and coercive measures was weak and inconclusive.
- Staffing levels were highlighted to be associated with coercive measures (fewer staff = increase in usage).
- One 2019 study showed that patients who were secluded felt vulnerable, neglected and abused, however, nurses felt that seclusion was a 'softer' approach than physical restraint.

Staff decision making about release from seclusion

A 2018[5] integrative review examined the factors that influenced staff to release people from seclusion. Findings included:

- A lack of evidence in this area.
- The main influencing theme was maintaining safety.
- Subthemes included risk assessment (dependent upon interaction and control), the attitude and experience of staff, and the acuity of the environment.
- People were expected by staff to behave in a compliant way, be released and then to reflect, but were not routinely involved in the decision making
- There is not an established decision making tool and support from experienced staff is essential to promote timely release.

Question 3: In what ways does the use of restrictive practice impact any protected groups who use mental health/learning disabilities/specialist inpatient services?

The experience of physical restraint for women

A 2017[6] article examined data from an ethnographic study related to 'the experiences of physical restraint of women with intellectual disabilities who lived in locked wards and their staff'. The authors argue that sometimes restraint is used with women to encourage passivity and relational or therapeutic measures could be used instead. The women shared information about their experiences in the context of previous violence and many reported that being restrained worsened the situation. More information about **when** and **why** individuals are being restrained was important to these women. They suggested that good relationships between staff and individuals can reduce potential restraint situations, and that staff should talk to people about their reasons for anger before restraining them.

Admission to intensive unit

A 2018[7] paper used statistical analysis on two thousand medical records in a South London NHS mental health trust to determine the demographic, clinical and behavioural predictors of the requirement to use an intensive care unit or to use seclusion techniques. Whilst recent behavioural precursors such as restraint or shouting were involved in determining admission to the PICU, age and sex also contributed to the risk of transfer to PICU.

The authors found that people transferred to psychiatric intensive care unit were significantly more likely to be younger, have a diagnosis of bipolar disorder and to be originally admitted under a section order. Being female with a less recent admission was linked with a lower likelihood of transfer to the unit from the ward.

Views of treatment and length of stay

A 2016 prospective study[8] analysed the use of coercive measures during involuntary psychiatric admission by considering two outcomes (patient views after treatment and length of stay) using data gathered for a different purpose from 2030 people, 770 who experienced one or more coercive measure. The authors found:

• Forced medication had a significant impact on patient disapproval of treatment.

• All coercive measures were associated with longer hospital stay

• In particular, seclusion added about 25 days to the average admission, not fully explained by people who experienced seclusion being more unwell.

Human Rights-based care

A 2019 narrative review [9] examined coercive practices in mental healthcare and ethical considerations. The authors note there is a lack of research and systematically collected data in this area and argue that coercion is embedded in mental healthcare and does not align with human rights based care. They suggested that 'tinkering' is not enough and that transformational change which upholds human rights in the culture of psychiatry is required.

Psychological Impact

A 2021 systematic mapping review[10] of non-pharmacological interventions
to reduce restrictive practices in adult mental health inpatient settings noted that the impact of restrictive practice on the 'psychological and physical welfare' of staff and patients 'should not be underestimated'.

Question 4: What standards, guidelines or best practice exist in the UK or international to inform an intent to provide services that are least restrictive in mental health/learning disabilities/specialist inpatient services?

NICE Guidance

2015 NICE guidance exists relating to the short-term management of violence and aggression in adults young people and children in mental health, health and community settings. The guideline aims to 'safeguard both staff and people who use services by helping to prevent violent situations and providing guidance to manage them safely when they occur.' The guideline states restrictive intervention reduction programmes should be in place at all settings which use restrictive interventions. See sections 1.2 to 1.3

2015 NICE Guidance exists relating to prevention and interventions for people with learning disabilities whose behaviour challenges. Section 1.9.4 states that any restrictive intervention should be linked to a restrictive intervention reduction programme as part of longer term behaviour management.

Rights and Risks

The Mental Welfare Commission for Scotland has produced a good practice guide on rights, risks and it's to freedom. Which aims to support care staff to think about the use of restraint and consider the impact of their actions on the people they are caring for, recognising that staff normally want to do their best for those people. It notes that environmental, organisational, institutional pressures, poor support and training can have a negative impact on maintaining sufficient attention on the rights and needs of individuals.

Good Practice

The Mental Welfare Commission for Scotland has also produced a good practice guide for seclusion - written in the understanding that in most cases behavioural support plans would negate the need to use such restrictive practice: therefore it should only be used in the context of a policy where there is a risk of serious harm to others, as an option for managing extremely difficult behaviour.

Reducing Restrictive Practice Collaborative

The Royal College of Psychiatrists ran a Reducing Restrictive Practice Collaborative over 18 months. It focused on peer-to-peer learning between inpatient wards across England, with the aim of reducing restrictive practices by one third on all participating wards. It established a number of ideas for changing practice and learning from the collaborative is available.

Reducing Restrictive Practices Framework

The Welsh Government developed a consultation document containing a Reducing Restrictive Practices Framework to 'promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings'.

Reducing Restrictive Practices Checklist

The (UK based) Restraint Reduction Network has produced a checklist which is an organisational self-assessment tool to prevent and minimise negative consequences of restrictive practice. It centres around 6 strategies: leadership and governance, performance management, learning and development, personalised support, customer involvement, and continuous improvement.

International variation in policy and procedure

A recent study[11] of survey data from 17 European countries including England and Wales (but not Scotland) found variation in policy and procedure across countries.

• The authors described 'an alarming lack of clarity on matters of procedure and policy pertaining to violence management in mental health services'.

• They reported best practice in violence management will combine regulatory, professional, patient-representative and legal obligations to the benefit of patients and staff.

Question 5: What initiatives have taken place that have reduced the use of restrictive practice in mental health/learning disabilities/specialist inpatient services?

Reviews of interventions

A 2021 systematic mapping review[10] of non-pharmacological interventions
to reduce restrictive practices in adult mental health inpatient settings looked at data from 150 interventions, 109 of which had been evaluated. Studies appeared to be diverse and as a result of diverse designs and scant detail in reporting it was difficult to identify which components of the interventions were most effective even

in established programmes like *Safewards* (Bowers, 2014), *Six Core Strategies* (NASMHPD, 2008) and *No Force First* (Recovery Innovations, Inc., 2006).

The most common strategy was staff training, and the most common intervention was seclusion and restraint reduction. Whilst the authors concluded that the most successful interventions were more likely to include a cluster of behaviour change techniques that are frequently used to reduce restrictive practice including :-

- setting goals for staff to work towards, such as reducing how often they use a restrictive practice and educating staff
- changing the environment to prevent incidents
- giving staff feedback about incidents.

A 2020 review[12] of 23 randomised primary studies suggested that there is a benefit to staff training (the related evidence was graded as moderate), shared decision-making interventions (the related evidence was also graded moderate) and integrated care interventions (the related evidence was graded as low) to reduce coercive treatment.

A 2019 review[13] which explored interventions to reduce seclusion and mechanical restraint in adult psychiatric units found that in general, findings were mixed for most single interventions. Programmes (with multiple interventions) showed mainly positive outcomes relating to seclusion and mechanical restraint use, but the optimum components would require more evaluation. Involving patients in planning was seen as key to reduce the feeling that practice was coercive. The authors suggested that change initiatives should focus on :

- psychiatric adult unit work place culture

- supporting nursing staff to evaluate the applicability of different interventions to their unit

A 2017 review[14] compared the effectiveness of strategies to prevent and de-escalate aggressive behaviours in patients in psychiatric acute care including seclusion and restraint reduction interventions. The authors reported that the evidence available was very limited. They found that more research is required, but two preventative strategies consistent with the *Six Core Strategies* principles may have a positive impact on behaviour and use of seclusion and restraint:

- risk assessment, and
- multimodal interventions.

Programme Interventions

A 2019 non randomised controlled trial [15]of the outcome of a restraint reduction programme, which aimed to minimise the use of physical restraint in acute mental health services found that reductions in the use of physical restraint are possible using a *Six Core Strategies* model or similar.

The Improvement Model

A 2016 quality improvement report[2] [Bell 2016] from the Mental Health Service in NHS Fife detailed the outcome of a quality improvement initiative to reduce restraint on an acute admissions ward, using improvement methodology centred on a data collection tool and patient involvement, where a 50% reduction in restraint was reported. As a result, staff were beginning to use the same approach in other wards.

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[2] Bell A, Gallacher N. Succeeding in Sustained Reduction in the use of Restraint using the Improvement Model. BMJ Qual Improv Rep. 2016 Jun 6;5(1):u211050.w4430.

Staff interventions

Improve knowledge and attitudes relating to least restrictive practice via nurse psychoeducation

A 2019 randomised controlled study[16] examined the effect of psychoeducation given to psychiatry nurses in Turkey and found that there was a positive effect on the level of knowledge and attitude to (reducing) physical restraint.

Recovery focused care

A 2017 review [Lim et al] of the literature examined 33 studies to understand how recovery-focussed care can be used by nurses to reduce the risk of aggression. The authors found that four components were important:

- *"seeing the person and not just their presenting behaviour*
- *interact, don't react*
- *coproduction to achieve identified goals*
- *equipping the consumer as an active manager of their recovery".*

Process Interventions

Staff Debriefing

A 2020 review[17] examined immediate staff debriefing following seclusion or restraint in an inpatient mental health setting and declared it was an important intervention, both to reduce future episodes of seclusion and restraint use, and to support the emotional and psychological wellbeing of staff after being involved in or witnessing a distressing event.

Increasing frequency of nurse assessment/surveillance to reduce mechanical restraint

A 2020 QI project[18] to reduce duration of mechanical restraints by increasing the frequency of registered nurse assessment/surveillance found a 30% reduction in duration of episodes, achieved via 3 Plan- Do- study – Act cycles.

Early intervention scale (feelings thermometer) for children/adolescents

A 2016 project[19] to implement a nurse-led early intervention scale for seclusion / restraint reduction among children and adolescents in residential psychiatric care supported individuals to identify a feeling and staff to offer options depending on the feelings identified from 7 escalation levels: (0) Cool, (1)Warm, (2) Hot, (3) Simmering, (4) Steaming, (5) Boiling Over, and (6) On Fire! A simple before/after calculation noted 129 restraint/ seclusion episodes in the 6 weeks prior to implementation, and 91 during the 6 weeks post implementation representing a 29% reduction.

Question 6: How is restrictive practice being measured in the UK or internationally in mental health /learning disabilities/specialist inpatient services?

Monitoring types of restrictive practice is important

A national analysis[20] of seclusion data from Dutch hospitals over 5 years (2008-2013) was analysed after a national improvement target to reduce seclusion each year by 10% was set in 2006. There was variation in the site performance, with change occurring in half of the hospitals involved. Analysis of the data raised the issue that reduction in restrictive practice (seclusion) potentially led to an increase in another coercive practice measure (forced medication). However, longer term analysis showed that on balance the decrease was greater overall. The authors recommend following the American "six-core strategy plan to reduce seclusion and

restraint", alongside quantitative and qualitative research and feedback. There is a need to carefully measure unintended consequences of reducing restrictive practice if focusing on a particular area.

Potential insights from staff and patient views on how to improve practice

33 qualitative articles summary exploring staff and patient experiences did not appear directly linked to the questions posed and are not included in this summary, but are likely to contain valuable insights.

For example, relevant to the implementation of improvement interventions aimed at reducing restrictive practice, a UK qualitative study[21] of inpatient and staff suggestions for reducing physical restraint identified four common areas: **improving communication and relationships; staffing factors; environment and space; and activities and distraction**. A review[22] of staff and patient views to improve seclusion suggested a common need for **improved communication and increased contact between staff and patients before, during and after the event**.

These articles and others contain a wealth of insight from both staff and patient perspectives and would likely contain valuable information related to perceptions of potential initiatives including challenges around engagement for staff:

> *[New initiatives to reduce restraint] flies in the face of the pressures that people are under, because sometimes I was hoping to see a member of staff and I'd have to wait and wait and wait (Patient 13, lived experience and eyewitness)[3]*

> *…it's difficult to point fingers when you're working short- staffed… you've got lots of paperwork to do… [Implementing initiatives to reduce restraint] quite often involves time… and that's the aspect that we don't have a lot of. I'm not saying that we couldn't find half an hour here, or 20 minutes here, but 90% of my colleagues don't have a break in their shifts… 90% of us every single shift work over our hours… it's difficult to persuade people that are already feeling they're giving a lot, to give a bit more… (Staff member 3, lived experience and eyewitness)[3]*

EVIDENCE SCAN - UPDATE

EEvIT examined the 2019 surveillance of violence and aggression: short-term management in mental health, health and community settings (NICE guideline NG10) and was also alerted to the publication of the Scottish Mental Welfare Commission in September 2021.

NICE guideline update

The 2015 NICE guideline is in the process of being updated and trauma informed care and equality considerations were one of the main reasons for update. As part of their routine guidance surveillance processes, NICE considered new published evidence and gathered feedback from topic experts and stakeholders about the 2015 guideline and looked at new evidence that had been published. Initially, the decision was not to update the guidance based on the new published evidence, but a number of consultation comments cited further evidence and the guideline will now be updated (this is still in progress.)

The main reasons for proposing an update to the current guidance included:

A change in perspective from reactive to proactive	There were many comments that the guideline did not address prevention and longer-term care
Trauma-informed care and support	Suggestions included considering trauma-informed care within the guideline in particular the British Institute of Learning Disabilities Restraint Reduction Network Standards which emphasise the importance of trauma-informed care and support
Pharmacological methods for rapid tranquilisation	There were multiple comments about variation in the drugs and practice that can be used or should not be used for rapid tranquilisation. An example of development required is providing more information in respect of rapid tranquilisation in pregnant women.
Post-incident debrief and formal review	Whilst use of this is contained in the guideline, another NICE guideline on post-traumatic stress disorder recommends not using psychologically focused debriefing techniques).
Equality considerations	The Human Rights Framework for Restraint was published after the guidance was written, and the guideline does not fully meet the recommendations. This has prompted further considerations about: • the age of the service user being considered with other factors when undertaking manual restraint • Comments relating to disproportionate use of some restraint mechanisms on particular population groups with protected characteristics was also noted during consultation, and these will be addressed The Human rights framework for restraint: principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions (Equalities and Human Rights Commission, 2019) states:

	'Children are developing physically and psychologically which makes them particularly vulnerable to harm. The potentially serious impact of restraint on them will require weighty justification' *'The disproportionate use of restraint on an identifiable section of the population without justification is evidence that unnecessary and discriminatory restraint may be occurring. Example: A prison segregates black prisoners twice as often as white prisoners. This indicates that the segregation of a black prisoner may be due to discrimination rather than necessity, in which case it would be unlawful.'*
Restraint positions	The guideline update process will reconsider evidence relating to restraint positions
The Use of Force Act 2018	This act (subsequent to the original guideline) states a policy must be published about mental health staff use of force in mental health settings
Deprivation of liberty safeguards	These new safeguards will replace current deprivation of liberty legislation

Gap in data availability

There is a recognised gap in the data available to explore potential variation in restrictive practice according to protected characteristics in Scotland, and a recommendation for a national agency to record and publish national data on restraint. In September 2021 the Mental Welfare Commission for Scotland published a Call to Action around Racial Inequality and Mental Health in Scotland. It cites a briefing paper by UK mental health charity Mind into racism and mental health from 2020, which reported higher rates of restraints for people who are black in England. However, there is a lack of available data on the use of restraint in Scotland and it is therefore not possible to stratify data by protected characteristics. As a result of this gap, one of the commission's recommendations is to 'mandate an appropriate agency to record and publish national data on restraint, stratified by protected characteristics by September 2022'.

The Human rights framework for restraint: principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions (Equalities and Human Rights Commission, 2019) provides an example:

To know whether discrimination is occurring, public bodies should collect and analyse data on their use of restraint, to identify if restraint is being used disproportionately against people with particular protected characteristics under the Equality Act 2010, or who share other identifiable group characteristics, for example, women, ethnic minorities, or people with particular impairments such as learning disabilities. Example: A review of monitoring data at a mental health unit shows that ethnic minority women are more likely to be restrained than white women or men. The hospital is concerned that this might be a result of discriminatory attitudes and decides to investigate the cause of this disparity'

Essential to provide therapeutic environment as well as reduce restrictive practice

The Care Quality Commission in England now expects Health and social care staff training in England to be compliant with the Restraint Reduction Network training standards (Restraint Reduction Network, 2020). Training in restrictive practices in England will need to be certified as complying with these standards, which are due to be reviewed before early 2023.

The standards are applicable across education, health and care settings and aim to:

- *'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.'* (Restraint Reduction Network, 2020)

The standards emphasise that reducing the use of restrictive practices should not be considered in isolation and it is also essential to provide a therapeutic environment where treatment and recovery can take place:

'*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.' (Restraint Reduction Network, 2020)

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