Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Scottish Patient Safety Programme Mental Health

Least Restrictive Practice Evidence Scan 2021: Executive Summary

Evidence and Evaluation for Improvement Team (EEvIT)

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Executive Summary

This paper summarises 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. The full evidence summary can be accessed here.

A rapid scoping review and summary of published evidence related to least restrictive practice was commissioned by the Scottish Patient Safety Programme for Mental Health (SPSPMH) co-design group as part of their work in 2020 to understand the current system and inform new and updated improvement resources.

The scoping review represented a rapid summary and search and 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.

Guiding questions from co-design group, and key considerations from the literature include:-

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

  The literature reviewed did not contain detail of the most common restrictions used in the UK. 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 (though more recent research examining Welsh data reported much lower rates of seclusion).

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

  The literature suggested 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.

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

  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.

  The 2019 Equalities and Human Rights Commission Human rights framework for restraint: principles for the lawful use of physical, chemical, mechanical and coercive restrictive interventions states that children's developmental profile means that they are at a particular risk of harm from restraint, and that disproportionate use of restraint on particular population group is evidence of discrimination, giving an example scenario of black prisoners in a setting being segregated twice as often as white prisoners.

In September 2021 the Mental Welfare Commission for Scotland published a Call to Action around Racial Inequality and Mental Health in Scotland. It cited 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. There is a lack of available data on the use of restraint in Scotland.

- *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?*

  A number of relevant guidelines and practice documents make reference to *reducing* restrictive practice, including NICE Clinical Guidelines from 2015 and Mental Welfare Commission for Scotland good practice framework for seclusion from 2019.
  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. The Human Rights Framework for Restraint was published after the guidance was written, and the guideline does not fully meet the recommendations.
  New training standards applicable to England emphasise that reducing the use of restrictive practices should not be considered in isolation, because it is also essential to provide a therapeutic environment where treatment and recovery can take place.

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

  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.
  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.

  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.

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

  From the literature reviewed, 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. One of the Mental Welfare Commission for Scotland's recommendations is to 'mandate an appropriate agency to record and publish national data on restraint, stratified by protected characteristics by September 2022'.

  References: Please see full evidence scan for references.

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