

# Physical Intervention and Restraint



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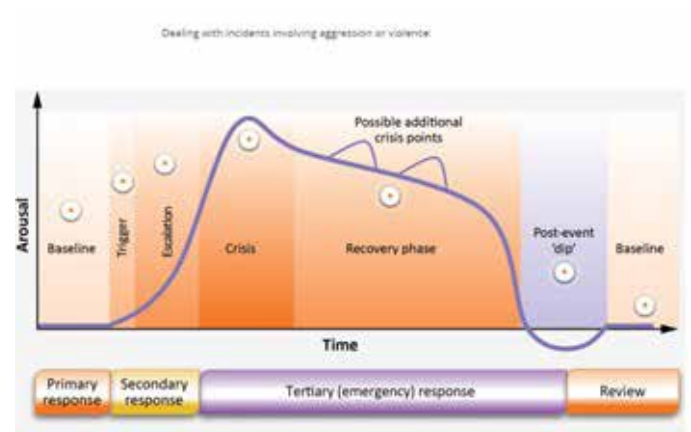


Fig 1

## Safe and therapeutic responses to behavioural disturbance

### Individualised assessments

2.1 People suffering from a mental disorder or emotional behavioural support should be assessed for immediate and potential risks of behavioural disturbance. This is usually carried out by the placement teams, Approved Mental Health Practitioner, social services or as part of a dynamic risk assessment by Lilac Alliance staff. Staff should be alert to risks that may not be immediately apparent, such as self-neglect. Assessments should take account of the person's history of such behaviours, their history of experiencing personal trauma, their presenting mental and physical state and their current social circumstances.

2.2 While previous history is an important factor in assessing current risk, staff should not assume that a previous history of behavioural disturbance means that a person will necessarily behave in the same way in the future.

2.3 Care should be taken to ensure that negative and stigmatising judgements about certain diagnoses, behaviours or personal characteristics do not detract from certain risks of that of the patient.

2.4 Lilac Alliance considers the accuracy of assessments of risks as part of routine audit arrangements and put training in place to learn from any inappropriate risk judgements.

2.5 Cultural awareness is particularly important in understanding behaviour and responding appropriately; assessments should be carried out in a way that takes account of any cultural issues.

2.6 Assessments of behavioural presentation are important in understanding an individual's needs. These should take account of the individual's social and physical environment and the broader context against which behavioural disturbance occurs. There may be times where an individual feels angry for reasons not associated with their mental disorder and this may be expressed as behavioural disturbance. Assessments should seek to understand behaviour in its broader context and not presume it to be a manifestation of a mental disorder.

2.7 The results of the assessment should guide the development and implementation of effective, personalised and enduring systems of support that meet an individual's needs, promote recovery and enhance quality of life during their journey in our transport.

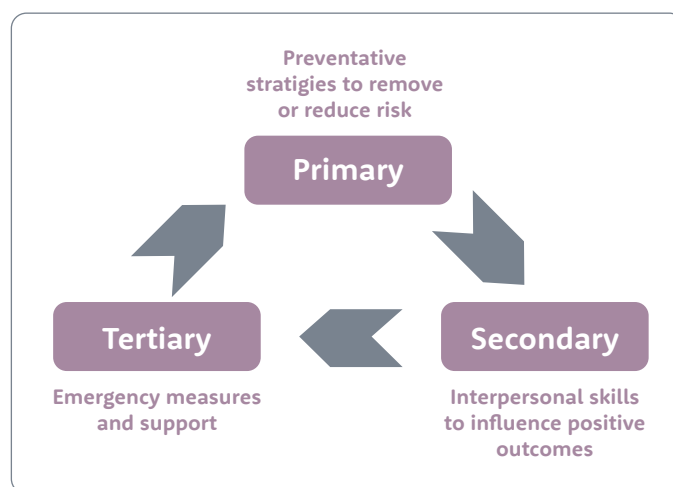
2.8 Factors which may contribute to behavioural disturbances include:

- poorly treated symptoms of mental disorder
- unmet social, emotional or health needs
- excessive stimulation, noise and general disruption
- excessive heating, overcrowding and restricted access
- boredom, lack of constructive things to do, insufficient environmental stimulation
- lack of clear communication by staff with patients
- the excessive or unreasonable application of demands and rules
- lack of positive social interaction
- restricted or unpredictable access to preferred items and activities
- patients feeling that others (whether staff, friends and/or families) are not concerned with their subjective anxieties and concerns
- exposure to situations that mirror past traumatic experiences
- a sense of personal disempowerment
- emotional distress, eg following bereavement
- frustrations associated with being in a restricted and controlling environment

- antagonism, aggression or provocation on the part of others
- inconsistent care
- difficulties with communication
- the influence of alcohol or drugs
- a state of confusion
- physical illness.

Primary, secondary and tertiary strategies

3.1 Staff should ideally have access to children, young people and vulnerable adults who are assessed as being liable to present with behavioural disturbance, a care or treatment plan which includes primary preventative strategies, secondary preventative strategies and tertiary strategies. Certain placements such a care or treatment plan is referred to as a positive behaviour support plan.



3.2 These individualised care plans, should be available and kept up to date, and include the following elements:

- Primary preventative strategies improve as a result of post incident debriefing and these always aim to enhance a patient's quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbances
- Secondary preventative strategies focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to encourage the patient to be calm. Staff will use their interpersonal skills to aid this process.
- Tertiary measures is when the patient has reached crisis point and restrictive interventions need to be implemented to save life, prevent assault or destruction of property. (the least amount of force will be applied at all times)
- Debrief will always follow Tertiary step.

## Positive & Restrictive interventions

4.1 Positive intervention is a deliberate act to support someone:

- at their request to assist in walking (due to varying conditions)
- prevent them from falling
- getting in and out the vehicle

4.2 Restrictive interventions are deliberate acts on the part of other person(s) that restrict a patient'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 patient or others.

Restrictive interventions should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation.

Where a person restricts a patient's movement, or uses (or threatens to use) force then that should:

- be used for no longer than necessary to prevent harm to the person or to others
- be a proportionate response to that harm, and
- be the least restrictive option.

4.3 Where risk assessments identify that restrictive interventions may be needed, their implementation should be planned in advance and recorded as tertiary strategies.

In such cases, emergency management of the situation and the use of restrictive interventions should be based on clinical judgement with that setting, which takes account of relevant best practice guidance (such as those published by the National Institute for Health and Care Excellence, BILD and Restraint Reduction Network) and all available knowledge of the patient's circumstances.

4.4 The most common reasons for needing to consider the use of restrictive interventions are:

- physical assault by the patient
- dangerous, threatening or destructive behaviour
- self-harm or risk of physical injury by accident
- extreme and prolonged over-activity that is likely to lead to physical exhaustion, or
- attempts to escape or abscond (where the patient is detained under the Act or deprived of their liberty under the MCA).

4.5 Restrictive interventions should be used in a way that minimises any risk to the patient's health and safety and that causes the minimum interference to their autonomy, privacy and dignity, while being sufficient to protect the patient and other people. The patient's freedom should be contained or limited for no longer than is necessary. Unless there are cogent reasons for doing so, staff must not cause deliberate pain to a patient in an attempt to force compliance with their instructions (for example, to mitigate an immediate risk to life).

4.6 The choice and nature of restrictive intervention will depend on various factors, but should be guided by:

- the patient's wishes and feelings, if known (eg by an advance statement)
- what is necessary to meet the needs of the individual based on a current assessment and their history

- the patient's age and any individual physical or emotional vulnerabilities that increase the risk of trauma arising from specific forms of restrictive intervention
- whether a particular form of restrictive intervention would be likely to cause distress, humiliation or fear
- obligations to others affected by the behavioural disturbance
- responsibilities to protect other patients, visitors and staff, and
- the availability of resources in the environment of care.

4.7 Where an individual has a history of abuse, restrictive interventions of any nature can trigger responses to previous traumatic experiences. Responses may be extreme and may include symptoms such as flashbacks, hallucinations, dissociation, aggression, self-injury and depression. Where patients have an identified history of trauma it will be particularly useful to obtain their recorded wishes about restrictive interventions. Patients' preferences in terms of the gender of staff carrying out such interventions should be sought and respected.

4.8 Lilac Alliance should work with local services to establish clear local protocols about the circumstances when, very exceptionally, the police may be called to manage patient behaviour within our vehicles or when we are helping in a health or care setting.

4.9 Staff should be alert to the risk of any respiratory or cardiac distress and continue to monitor the patient's physical and psychological wellbeing.

Respecting human rights

4.10 Any use of restrictive interventions must be compliant with the Human Rights Act 1998 (HRA), which gives effect in the UK to certain rights and freedoms guaranteed under the European Convention on Human Rights (ECHR).

4.11 Lilac Alliance and their staff should help all patients to understand the legal authority for any proposed action and their rights (especially their right to leave a hospital if they are not detained there).

4.12 No restrictive intervention should be used unless it is medically necessary to do so in all the circumstances of the case. Action that is not medically necessary may well breach a patient's rights under article 3, which prohibits inhuman or degrading treatment.

Article 8 of the ECHR protects the right to respect for private and family life. A restrictive intervention that does not meet the minimum level of severity for article 3 may nevertheless breach a patient's article 8 rights if it has a sufficiently adverse effect on the patient's private life, including their moral and physical integrity.

4.13 Restrictions that alone, or in combination, deprive a patient of their liberty without lawful authority will breach article 5 of the ECHR (the right to liberty). However, the precise scope of the term 'deprivation of liberty' is not fixed and develops over time in accordance with European Court of Human Rights case law and UK case law on article 5.

4.14 Unless a patient is detained under the Act or is subject to a deprivation of liberty authorisation or Court of Protection order under the MCA, Lilac Alliance and their staff must be careful to ensure that the use of restrictive interventions does not impose restrictions which amount to a deprivation of liberty.

4.15 Examples of restrictions that could indicate there is a deprivation of liberty include:

- informal patients being told that they will be detained under the Act if they do not comply with requests of staff, or
- informal patients being kept in circumstances amounting to seclusion without their consent. Children and young people under 18

### Restrictive intervention Young Persons

4.16 In the case of children and young people under the age of 18, the use of restrictive interventions may require modification to take account of their developmental status. The legal context within which restrictive interventions are used with children and young people is different from adults.

4.17 Lilac Alliance should ensure that staff involved in the care of children and young people who exhibit behavioural disturbance are able to employ a variety of skills and strategies that enable them to provide appropriate help and support. In most cases restrictive interventions will only be used if they form part of the positive behaviour support plan (or equivalent) and have therefore been developed with input from the child or young person and their family.

4.18 Staff should always ensure that restrictive interventions are used only after having due regard to the individual's age and having taken full account of their physical, emotional and psychological maturity.

4.19 When antipsychotic medication is used to sedate a child or young person, special consideration should be given to risks relating to their developing central nervous system, looking out for possible sign/symptoms of adverse reactions.

4.20 The size and physical vulnerability of children and young people should be taken into account when considering physical restraint. Physical restraint should be used with caution when it involves children and young people because in most cases their musculoskeletal systems are immature which elevates the risk of injury.

4.21 In our provision services where 'time-away' processes are used, this is different and not classed as seclusion. Time-away is a specific behaviour change strategy which should be delivered as part of a behavioural programme. Time-away might include:

- preventing a child or young person from being involved in activities which reinforce a behaviour of concern until the behaviour stops;
- asking them to leave an activity and return when they feel ready to be involved and stop the behaviour;
- or accompanying the child or young person to another setting and preventing them from engaging in the activity they were participating in for a set period of time.

Restrictive interventions must only be used with great caution on children and young people who are not detained under the Act. A person with parental responsibility can consent to the use of restrictive interventions where a child lacks competence or a young person lacks the capacity to consent, but only if the decision falls within the 'scope of parental responsibility' For young people aged 16 or 17 who are not detained under the Act and who lack capacity to consent to the proposed interventions, the use of restrictive interventions in the young person's best interests will not be unlawful if they meet the requirements in section 6 of the MCA and do not amount to a deprivation of liberty.

4.22 Staff having care of children and young people should be aware that under section 3(5) of the Children Act 1989 they may do 'what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare'. Whether an intervention is reasonable or not will

depend, among other things, upon the urgency and gravity of what is required. This might allow action to be taken to prevent a child from harming him/herself, however it would not allow restrictive interventions that are not proportionate and would not authorise actions that amounted to a deprivation of liberty.

### Procedures for the safe use of restrictive interventions

Physical restraint refers to any direct physical contact where the intention is to prevent, restrict, or subdue movement of the body (or part of the body) of another person.

5.1 Any initial attempt to manage an acute behavioural disturbance should, as far as the situation allows, be non-restrictive. Where possible, the patient should be asked to stop the behaviour. An individual's communication needs should be taken into account including those arising from sensory impairments, learning disability, autism spectrum disorders, or an individual for whom English is not their first language. Where possible, an explanation should be given of the consequences of refusing the request from staff to stop the behaviour. The explanation should be provided calmly and every attempt should be made to avoid the explanation being perceived by the patient as a threat.

5.2 The nature and manner of application of any restrictive intervention, the reason(s) for its use and the consequences or outcome, is recorded in an open and transparent manner.

5.3 Staff only use methods of restrictive interventions for which they have received training. Training records will record precisely the techniques for which a member of staff has received training.

5.4 Verbal de-escalation should continue throughout a restrictive intervention. Negotiations should focus on establishing rapport, demonstrating concern, helping the patient to relax, and reducing the patient's level of agitation.

5.5 Where a behavioural disturbance occurs and a restrictive intervention has been used, family members should be informed in accordance with any prior agreements with a young person.

5.6 no one should not be deliberately restrained in a way that impacts on their airway, breathing or circulation. The mouth and/or nose should never be covered and there should be no pressure to the neck region, rib cage and/or abdomen. Unless there are cogent reasons for doing so, there must be no planned or intentional restraint of a person in a prone position (whereby they are forcibly laid on their front) on any surface, not just the floor.

5.7 Full account should be taken of the individual's age, physical and emotional maturity, health status, cognitive functioning and any disability or sensory impairment, which may confer additional risks to the individual's health, safety and wellbeing in the face of exposure to physical restraint. Throughout any period of physical restraint:

- a member of staff should monitor the individual's airway and physical condition to minimise the potential of harm or injury. Observations, including vital clinical indicators such as pulse, respiration and complexion (with special attention for pallor/dyscolouration), should be conducted and recorded. Staff should be trained so that they are competent to interpret these vital signs

5.8 Where physical restraint has been used, staff should record the decision and the reasons for it, including details about how the intervention was implemented and the patient's response. This recording needs to be as detailed as possible. To be completed on the Physical Intervention.

5.9 If an individual is not detained under the Act, but physical restraint of any form is necessary, consideration should be given to the reasons why and the staff involved in the incident need to ensure they can justify the reasons for that restraint.

## Post Incident Support / Debrief

8.1 After incidents, the patient/young person and the staff involved should be given emotional support and basic first aid for any injuries as soon as possible. Immediate action should be taken to secure medical help for injuries that require other than basic first aid. All injuries should be recorded and reported. If necessary, this needs to be reported to the Health and Safety Executive.

8.2 The manager should ensure that appropriate lessons are learned from instances where restraint has had to be used. This will involve de-briefing and post-incident review and monitoring of the use of restraint and restrictive intervention. The process should consider individual plans and wider policies.

8.3 As soon as possible after the use of restraint the member of staff involved should be debriefed by the Senior or other appropriate manager, to allow for reflection and the manager to deal with the emotions raised by the incident. This improves staff learning and contributes to professional development.

8.4 Whenever restraint has been used, staff and adult and young people 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 augmentative communication.

8.5 If there is a pattern of persistent use of restraint, the reviewer should consider this information and bring it to the attention of the senior management team. This information can be used to either link into training or to potentially put personal development plan in place.

- Seated De-escalation
- Rationale
- Purpose
- Environment
- Approach
- Trouble Drills
- Upper and Lower Rest Position and Reinforced Holds
- Securing the Legs
- Lost Holds
- De-escalation
- Principles and Current Guidance Relating to Prone Restraint
- Relocation to the Floor and Back to Standing
- Stop and Rest
- Modified Recovery
- Doorways
- Stairs

## Training And Development

1. Lilac Alliance Positive/Restrictive intervention training is in line with the outcomes identified in the Restraint Reduction Network (RRN) training standards.
2. Staff will receive full training on their initial Induction before they start work.
3. Staff will receive ongoing mandatory training in line with their occupational role.
4. All staff will receive mandatory update training on an annual basis.
6. Staff will be notified of their update refresher course with 4 weeks prior notice.
7. Staff will complete their update training two months before their training is due to expire. This will ensure that all staff will be within date.

**Lilac Alliance policy concerning the use of Conflict Management and its implementation will be kept under ongoing review in order to ensure consistency with current national policy, best practice guidance and evidence. All occasions of Physical Intervention will be reviewed by the Transport Planners and or Management by way of reading the detailed reports and viewing CCTV footage.**

**Restrictive interventions should never be employed to deliberately punish or humiliate, and staff should not cause deliberate pain to a person in an attempt to force compliance with their instructions except in the most exceptional circumstances to mitigate an immediate risk to life.**

01/06/2026