

Thematic review of the use of restraint, prolonged seclusion and segregation for people with mental health problems, learning disabilities and/or autism

Terms of Reference

26 November 2018

Background

The Secretary of State has asked the Care Quality Commission (CQC) to review and to make recommendations about the use of restrictive interventions in settings that provide inpatient and residential care for people with or who might have mental health problems, learning disabilities and/or autism.

Appendix 1 defines the restrictive interventions that the review will focus on. In brief, restraint is the use or threatened use of force to secure the doing of an act which the person resists, or which restricts a person's liberty; whether or not they are resisting. The force used might be physical (for example holding the person), mechanical (for example by the use of restraining belts) or chemical (by the use of sedating medication). Seclusion or segregation are where staff prevent a person from leaving a designated room or rooms. Seclusion may be viewed as the management of immediate violence, whereas segregation is the management of a longer-term threat of violence.

Settings and groups

For the purposes of this review, the settings in which people with mental health problems, learning disabilities and/or autism might be subject to these restrictive interventions can be divided into four groups.

Group 1 (early focus, in-depth consideration of both segregation/prolonged seclusion and restraint)

- Specialist NHS and independent sector wards for people of all ages with learning disabilities and/or autism. These include assessment and treatment units and low and medium secure wards for people with learning disabilities and/or autism.
- Specialist NHS and independent child and adolescent mental health wards.

Group 2 (later focus, in-depth consideration of segregation/prolonged seclusion only)

- NHS and independent sector mental health rehabilitation wards.
- NHS and independent sector low secure mental health wards.

Group 3 (later focus, exploratory work to identify and describe whether and how restrictive interventions are used in these settings)

- Residential care homes designated for the care of people with learning disabilities and/or autism.
- Children’s residential services that are jointly registered with CQC and Ofsted. These services provide care for young people with very complex needs – such as severe learning disabilities and physical health needs. This aspect of the review will be undertaken in close collaboration with Ofsted.
- The 14 secure children’s homes in England (these are children’s homes which provide a locked environment and restrict a child or young person’s liberty). These homes are registered with Ofsted and are not also registered with CQC. Therefore, this aspect of the work will be undertaken in close collaboration with Ofsted.

Group 4 (currently out of scope – though CQC/DHSC may extend the scope to explore one or more of these settings if CQC finds evidence of misuse of these restrictive interventions and CQC has the authority to visit/inspect that setting).

- Medium secure or high secure mental health wards (there are significant safeguards in place already for people in these settings) – secure units that admit children and young people or that are specifically designated for the care of people with learning disabilities would be considered in group 1.
- Mental health admission wards for working age adults or for older people with mental health problems (CQC’s inspection teams rarely encounter problems with segregation/prolonged seclusion in these settings).
- Residential care homes designated for any other groups of clients (for example, care homes for older people).
- Any other non-health or non-social care setting (although CQC has some involvement in the inspection of, for example, immigration detention centres, it is not the principal regulator/inspectorate for these settings).

Methods

The work will be undertaken in two stages.

Stage 1 will focus on the settings of greatest concern (group 1 above) and consider all forms of restrictive intervention.

Stage 2 will focus on the use of restrictive interventions in a wider group of settings (groups 2 and 3 above).

CQC will use the following methods:

- **Review of literature and guidance** to determine what is already known and to ensure that CQC's assessment of the use of restrictive interventions is underpinned by a full knowledge of best practice in the care of people with challenging behaviour. CQC will supplement the literature review with a call for evidence and invitation for submissions from interested parties, providers, academics and groups that speak on behalf of people using these services. CQC will also seek submissions from those with lived experience (see below).
- **Collation and further analysis of the various sources of data and other information about the use of restrictive interventions in settings of interest.**
- **Bespoke information requests of providers** to identify settings in which segregation or prolonged seclusion are being used and to determine how many people are subject to these practices.
- **Visits to providers to assess actual practice against what is known to be best practice.** CQC will visit every location in group 1 where it identifies that a person is subject to segregation/prolonged seclusion. In addition, CQC will visit a purposive sample of other group 1 services to examine the more commonly used forms of restrictive interventions (such as physical and chemical restraint). It will visit a purposive sample of group 2 services where it identifies that a person is subject to segregation/ prolonged seclusion. CQC will also undertake visits to a purposive sample of group 3 services to explore how and what restrictive interventions are used in these settings. The sampling would take account of characteristics such as the managing sector (to ensure a mix of NHS and independent sector units), the patient type, whether the unit admitted men or women and reported frequency of use of restraint. CQC will also ensure that the sample includes sites where evidence suggests there is good practice that the system might learn from.
- **Interviews with people who have been subject to segregation/prolonged seclusion and with families and carers.**
- **Interviews with commissioners and other parties to the wider system.**
- **Co-production and engagement with people with lived experience.** CQC will involve those with lived experience – as either a service user or a carer - in the governance of the review (for example, as members of advisory groups) and in all elements of the work – including as experts by experience on site visits. CQC will invite people with lived experience to make verbal or written submissions about their experience. The literature review will also examine information in the public domain about people's lived experience.

Questions/key lines of enquiry

The element of the review that considers segregation and prolonged seclusion will assess these practices from the viewpoint of the person affected and will consider care and the pathway of care from that perspective. It will address the following questions:

- How many people with mental health problems, learning disabilities and/or autism are subject to segregation or prolonged seclusion in the settings that are the focus of this review?
- What is the pathway that the person has followed to end up in segregation/ prolonged seclusion?
- What is the quality of care and treatment provided to the person?
- Are all appropriate safeguards in place to protect the person's rights and to protect the person from abuse?
- What has been the impact of segregation/prolonged seclusion on people who are subject to it and on their families?
- What impact has there been on other patients/residents and staff?
- What role has 'the wider system', including commissioning and the actions of other providers, played in the person ending up in segregation/ prolonged seclusion or in prolonging the time that they are in this situation?

The element of the review that considers the use of all forms of restraint will involve an in-depth assessment of the physical, therapeutic and social environment in which such practices occur. The site visits will be guided by assessment tools informed by the literature and guidance on best practice in managing aggression, violence and behaviours that challenge. The factors that contribute to the environment include:

- The quality of the physical environment of the wards/settings.
- The number, professional background, knowledge, training and competence of staff.
- The extent to which services apply best practice interventions to anticipate and de-escalate challenging behaviour (for example through the application of the principles that underpin positive behaviour support).
- The social and therapeutic milieu and the extent to which it promotes engagement, empowerment, recovery and 'normalisation'.
- The quality of leadership and the extent to which this fosters a culture of 'no force first'.

Timing, reporting and links with related work

CQC will produce an interim report of its findings in May 2019 and will publish the full findings of the review – with recommendations – by March 2020.

The CQC review team will work closely with those leading other related work and with key national stakeholders to ensure that any learning emerging from the thematic is fed into and informs their work 'real-time'. These interested parties include:

1. Those leading NHS England and NHS Improvement's programme of work to reduce the use of restrictive interventions. This includes the quality improvement work involving NHS trusts managed through the mental health safety improvement programme.
2. Those at NHS England who are undertaking the serious incident investigation of the care of a young woman who has been held in long term segregation.
3. Those implementing the recommendations from the review of the Mental Health Act – including consideration of any new mental health legislation.
4. Those leading the work to oversee the implementation of the long-term plan for mental health and for learning disabilities.
5. Ofsted – with respect to practices affecting children and adolescents in other settings where restrictions of this type might apply.
6. Officials at the Department for Education and the Ministry of Housing, Communities and Local Government.

Appendix 1: Types of restrictive intervention and the principles that should underpin their use¹

Restraint

The Mental Capacity Act 2005 (MCA) defines restraint as when someone “uses, or threatens to use force to secure the doing of an act which the person resists, OR restricts a person’s liberty whether or not they are resisting”.

Physical restraint: 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.

Prone restraint: (a type of physical restraint) holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is face down or has their face to the side. It includes being placed on a mattress face down while in holds; administration of depot medication while in holds prone, and being placed prone onto any surface.

Chemical restraint: the use of medication which is prescribed and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.

Mechanical restraint: the use of a device (e.g. 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.

Seclusion and long term segregation

Both seclusion and segregation are ways to manage the threat or actual use of violence. Seclusion may be viewed as the management of immediate violence, whereas segregation is the management of a longer term threat of violence. According to the MHA 1983 Code of Practice (2015) the difference between the two practices is that patients in seclusion are alone, whereas patients subject to long-term segregation should continue to have contact with and receive therapeutic interventions from staff.

Seclusion: The MHA Code of Practice defines this as ‘the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient 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’. The following practices should be recorded as seclusion:

- staff lock a person in a seclusion room,
- staff lock a person in a bedroom,

¹ Taken from CQC’s brief guide on restraint - https://www.cqc.org.uk/sites/default/files/20180322_900803_briefguide-restraint_physical_mechanical_v1.pdf

- staff place a person in a room and prevent them from leaving either by locking the door, holding it shut or by standing in the doorway,
- a patient asks to be isolated from others and then staff prevent them from leaving the area in which they are isolated.

The following practice should not be recorded as seclusion:

- staff restrain a person in any situation other than those described above,
- staff tell/ask a person to go to a particular area but that person is free to leave that area.

There is no time limit on seclusion. A patient could be in seclusion for an hour, a day, a month or longer. The use of prolonged seclusion should be reviewed periodically and as with other restrictive interventions used only where considered strictly necessary.

Long-term segregation: The Mental Health Act Code of Practice defines this as ‘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 representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward on a long-term basis’.