**Relevant guidance: Safeguarding and complaints in relation to Restrictive Practices for Transforming Care cases**

For use alongside safeguarding precedent letter

**Restrictive practices**

* DH guidance [‘Proactive and Positive Care; Reducing the Need for Restrictive Interventions.’](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf) cover physical restraint, chemical restraint, mechanical restraint, and seclusion. This guidance is for adults. Equivalent guidance for children is currently out for consultation. Relevant sections are highlighted below

**RESTRAINT**

**Prone restraint**

Paragraph 70 “People must not be deliberately restrained in a way that impacts on their airway, breathing or circulation The mouth and/or nose must never be covered and techniques should not incur pressure to the neck region, rib cage and/or abdomen. There must be no planned or intentional restraint of a person in a prone/face down position on any surface, not just the floor.”

**Pain compliance techniques**. Paragraph 58, 69 & 75

Summary: “If restrictive intervention is used it must not include the deliberate application of pain.” [Paras 58, 69, 75]

 Paragraph 58 “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.

• Restrictive interventions should never be used to punish or for the sole intention of inflicting pain, suffering or humiliation…..continues.”

Paragraph 69. “Staff must not cause deliberate pain to a person in an attempt to force compliance with their instructions. Where there is an immediate risk to life, in accordance with NICE guidelines, recognised techniques that cause pain as a stimulus may be used as an intervention to mitigate that risk. These techniques must be used proportionately and only in the most exceptional circumstances and never for longer than is necessary to mitigate that immediate risk to life. These techniques should only be used by trained staff having due regard for the safety and dignity of patients. The use of these techniques must be embedded in local policies.”

Paragraph 75. “Staff must not use physical restraint or breakaway techniques that involve the use of pain, including holds where movement by the individual induces pain, other than for the purpose of an immediate rescue in a life-threatening situation.”

**Injury or psychological trauma during restraint**

Paragraph 60 “There is considerable concern and controversy surrounding potential harm to individuals caused by restrictive interventions. In some instances, they have caused serious physical and psychological trauma, and even death”

**Inappropriate/excessive use of restraint**

Paragraph 58 “Restrictive interventions should only ever be used as a last resort”

**SECLUSION & LONG TERM SEGREGATION**

**Seclusion/long term segregation outside of MHA (unless in prison).** Paragraph 88, 90 & 91

**Seclusion/long term segregation not following MHA.** Paragraphs 88, 90 & 91

Paragraph 88. “Only people detained under the MHA should be considered for seclusion. If an emergency situation arises involving an informal patient and, as a last resort, seclusion is necessary to protect others from risk of injury or harm, then it should be used for the shortest possible period to manage the emergency situation and an assessment for detention under the MHA should be undertaken immediately. The MHA Code of Practice lays down clear procedures for the use of seclusion including its initiation, ongoing implementation and review and termination.”

Paragraph 90. “Long-term segregation refers to a situation where a person is prevented from mixing freely with other people who use a service. This form of restrictive intervention should rarely be used and only ever for hospital patients who present an almost continuous risk of serious harm to others and for whom it is agreed that they benefit from a period of intensive care and support in a discrete area that minimises their contact with other users of the service.”

Paragraph 91. “Long-term segregation must never take place outside of hospital settings and should never be used with people who are not detained under the MHA. As such it must only ever be undertaken in conjunction with the safeguards for its use in the MHA Code of Practice. The does not apply to the segregation of prisoners within prison establishments.”

**MEDICATION**

**Regular use of intramuscular injections of rapid tranquilising medication**

Paragraph 86. “The use of medication to manage acutely disturbed behaviour must be a very short-term strategy designed solely to reduce immediate risk; this is distinct from treating any underlying mental illness. The associated term ‘rapid tranquillisation’ refers to intramuscular injections and oral medication. Oral medication should always be considered first. Where rapid tranquillisation in the form of an intramuscular injection is required, the prescriber should indicate the preferred injection site having taken full account of the need to avoid face down restraint.”

**MECHANICAL RESTRAINTS**

Mechanical restraints should never be a first line means of managing disturbed behaviour. The use of mechanical restraint to manage extreme violence directed towards others should be exceptional, and seldom used in this or other contexts outside of high secure settings

80. It is recognised that following rigorous assessment there may be exceptional circumstances where mechanical restraints need to be used to limit self-injurious behaviour of extremely high frequency and intensity. This contingency is most notably encountered with small numbers of people who have severe cognitive impairments, where devices such as arm splints or cushioned helmets may be required to safeguard a person from the hazardous consequences of their behaviour. Wherever mechanical restraint is used as a planned contingency it must be identified within a broad ranging, robust behaviour support plan which aims to bring about the circumstances where continued use of mechanical restraint will no longer be required.

81. There may be occasions when the use of restraint (including handcuffs) is needed for security purposes, for example when transferring prisoners into a healthcare setting. Guidance for prison and NHS staff to develop local procedures was agreed in a concordat36 between the National Offender Management Service (NOMS) and the NHS Counter Fraud and Security Service (now NHS Protect), which forms part of the National Security Framework. Further guidance of transferring prisoners into a secure mental health setting is provided in the Mental Health Act 1983 Code of Practice11. 82. There may be occasions where restraint (including handcuffs) is used for security purposes for transferring restricted patients in secure settings to nonsecure settings. The use of restraint in these circumstances should form part of individual risk assessments to take account of dignity and respect and the physical and mental condition of the individual.

The [MHA Code of Practice 1983](https://www.combined.nhs.uk/media/1084/mha-code-of-practice-2015.pdf) set out clear information about the use of restrictive practices – see 26.69 – 26.160.

Other MHA relevant clauses in general regarding restrictive practice include:

* *Any restrictions should be the minimum necessary to safely provide the care or treatment required having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the person’s rights and freedom of action (1.5)*
* *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. (26.47)*

* *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. (26.47)*
* *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. (26.62)*