The Impact of Restrictive Interventions in a Learning Disability Service

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Thesis submitted to the University of Nottingham for the degree of Doctor of Philosophy, September 2019.

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Acknowledgements

There are many people I need to thank for your help, support and guidance throughout the process of undertaking this PhD.

Firstly, I would like to thank my family for your support throughout especially Rob and Stephanie who I have made read every word of it (sorry) and for all the IT help, Rob. You are amazing. I love you very much.

I would like to thank colleagues at De Montfort University for your advice, wisdom, guidance and mutual grumbling.

I would also like to thank the Trust, for allowing me access to your service for this research and especially the individual staff members and patients who were willing to be interviewed. You were all fantastic.

And finally, the wonderful Professor Penny Standen. If I have a fraction of the impact on my students as you have on me I will be happy. You motivate me, support me and make me feel that it is achievable. Thank you! I DEFINITELY could not have done it without you.

Abstract

Recent high profile cases have drawn attention to the use of techniques used to control people with learning disabilities when they display challenging behaviour. These techniques are collectively referred to as restrictive interventions in this work and include physical restraint, medication and seclusion.

The limited research available indicates that young males with learning disability with another diagnosis such as Autism are most likely to be in receipt of restrictive interventions and that restraint and medication are those most likely to be used. It was also identified that there is extensive conflicting and confusing terminology used in documents regarding restrictive interventions. The literature also highlighted that both staff and patients can suffer injuries as a result of using these interventions, additionally there is little research that focuses on the impact that restrictive interventions have on those central to the issue: the staff members and the patients.

This thesis presents research undertaken that explores incidents of violence and aggression and other challenging behaviours in a learning disability service. The research took place in an NHS Trust and focuses specifically on the impact of restrictive interventions used to manage challenging behaviours, examining that impact on the service, the staff and the patients.

The research is in three parts. Part one is a retrospective study of untoward incident documents to establish the number, nature and type of incidents that occur in the learning disability service and the type of restrictive interventions utilised by staff to deal with these incidents. It

establishes who is involved in these incidents with regard to both staff and patients and any trends regarding when incidents happen.

The second and third studies go on to qualitatively explore, using a phenomenological approach, how people feel about being involved in challenging incidents with particular focus on how they feel when restrictive interventions have been utilised. Study two focuses on the staff involved in dealing with challenging behaviours and implementing restrictive interventions and study three focuses on the patients with whom the restrictive interventions are used.

In the quantitative study 312 incidents were recorded during the research period and identified that 248 of these incidents took place in one part if the service, the Assessment and Treatment Service. Of these incidents 123 were dealt with by Heath Care Assistants and staff from the non-professional categories. The largest number of incidents, 180 were classified as patient to staff assaults. The most common intervention utilised was an approach called passive restraint, closely followed by the use of medication and full restraint. De-escalation was only recorded on 5 occasions. However, of the 312 incidents 195 had no intervention recorded. A further interesting finding, that conflicts with much of the literature in this area is that a high proportion of the incidents involved female patients.

Twelve staff were interviewed, six qualified nurses and six health care assistants, three males and three females in each group. Thematic analysis of the interviews produced six themes while the patient interviews produced three themes. The staff themes included staff beliefs about the nature of the patients and the incidents, role conflict, negative impact on staff, negative impact on patients, the significance of the team and preference for aversive techniques.

Three male patients were interviewed and the themes identified from these interviews were them and us, overwhelming negative reactions; and understanding and insight.

Some of the themes from the staff interviews were echoed in the patients interviews, specifically the ‘role conflict’ theme from the staff interviews and the ‘them and us’ theme from the patient interviews, which highlighted the destructive impact the use of restrictive interventions has on the therapeutic relationship. Both staff and patients also highlighted the negative emotional reactions they experience when involved in the use of restrictive interventions, which stay with them over long periods. Despite these negative emotions, staff discussed the significance of good team working and good leadership can have on them while patients showed understanding into why restrictive interventions are used.

In a service that admits people who have been unable to be cared for in any other setting, in the period before staff can get to know them challenging behaviours will inevitably occur. These behaviours will need some sort of restrictive intervention to ensure the patient, staff and other patients are safe. To minimise the use of these techniques and their negative impact the following recommendations should be introduced.

There needs to be improvement in the use of alternatives to restrictive interventions mainly around the use of de-escalation and PBS, debriefing should be introduced for staff and patients with robust training to underpin all of the above especially to HCA’s. In addition, there needs to be an improvement of recording of incidents and a standardisation of language used for restrictive interventions, with more research around the use of restrictive interventions and the impact it has on those central to the issue- the staff and patients.

Chapter 1: Introduction to this thesis.

1:1- Introduction to this chapter:

This thesis presents research undertaken that explores incidents of violence and aggression and other challenging behaviours in a learning disability service. The research focuses specifically on the impact of interventions used to manage challenging behaviours, examining that impact on the service, the staff and the patients. It does this through an analysis of recorded incidents and from interviews with staff and patients to establish peoples' perceptions of how incidents are managed and the impact on them.

This introductory chapter will give a brief outline of the research to be covered in this thesis, an introduction to key terminology and the researcher's background. Included in this thesis following this introductory chapter there will be a literature review, a chapter outlining the methods utilised in the research, chapters outlining the findings, exploration and discussion of the findings, followed by a recommendations for future directions and a concluding chapter. Full references and an appendices section will complete the thesis.

1:2- A brief overview of the research:

This research aims to explore incidents of violence and aggression and other challenging behaviours in an NHS learning disability service. It aims to explore the impact of the interventions utilised for those incidents and is divided into three studies. Study one aims to generate descriptive statistics that demonstrate the impact and burden violence and aggression/ challenging behaviour places on a service provider. This will be done through a retrospective study of documents to establish the number, nature and type of incidents that occur in the learning disability service and the type of interventions utilised by staff to deal with these incidents. It also establishes who is involved in these incidents and any trends regarding when incidents happen.

The second and third studies go on to qualitatively explore how people feel about being involved in these incidents with particular focus on how they feel when Restrictive Interventions (RI's) have been utilised. Study two focuses on the staff involved in dealing with challenging behaviours and implementing RI's and study three focuses on the patients with whom the RI's are used. The two qualitative studies aim to explore the impact challenging behaviours and implementing RI's have on those involved. A more in-depth explanation of what this research entails will be covered later in the method chapter (chapter 3).

Research in the use of restrictive interventions will be explored fully in the literature review (chapter 2) however it is important to point out that of the limited research available to date, much of it is regarding staff, staff training and attitudes and little is concerned with experiences of the patients (Allen, 2001). Additionally, there are many weaknesses and biases noted in some of the research (for example, papers that explore the impact on staff training carried out by the training providers, this is discussed further in the literature review). One of the identified gaps that this thesis aims to address is this lack of research involving people with learning disabilities and what their experiences are of restrictive interventions and the impact they have on them. More research involving people with learning disabilities is vital to strengthen the argument for more robust guidelines and legislation in the future. Additionally, involving people with learning disabilities in research is vital for service development and as a means of empowerment (Northway, 2000) and this research will be fed back to the host NHS Trust for this purpose. Northway, Howarth and Evans (2014) detail that participatory research involving people with learning disabilities can be difficult due to issues of capacity to consent and unintended negative consequences on some participants, however this is no reason to not undertake this research. They go on to suggest that we must identify specific barriers to participation and introduce individual reasonable adjustments that are ethically sound to assist the individual to participate in the research.

1:3- An introduction to key terminology in this thesis:

Before any further discussion it is important to establish the definitions and meanings of some key terms that will be used throughout this research and indeed have already been used above. This section will also explore alternative key terms and give justification for the ones chosen in this thesis.

1:3:i- Learning Disability:

The term learning disability(ies) will be used throughout this research. When used it is referring to a blanket term that includes many different conditions and which can manifest in many ways. Learning disability is defined by the Department of Health (DoH), (2001) as "the presence of a significantly reduced ability to understand new or complex information, learn new skills and a reduced ability to cope independently." It also explains that this will have started before adulthood and with lasting effect.

The World Health Organisation defined learning disabilities as "a condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities. Retardation can occur with or without any other mental or physical condition", (W.H.O. 2010). More recently the W.H.O. have altered this definition to: "A group of etiologically diverse conditions originating during the developmental period, characterised by a significant below average intellectual functioning and adaptive behaviour'" (W.H.O. 2018). This newer definition, along with other changes, has noticeably dropped the word 'retardation' and terminology in this field will be discussed further below.

Having a learning disability is also classified as having an IQ below 70, with profound and multiple learning disability being an IQ below 20, severe learning disability having an IQ between 20 and 34, moderate learning disability an IQ between 35 and 49 and mild learning disabilities an IQ between 50 and 69. It must be acknowledged however that in many cases measuring IQ is extremely difficult in the learning disabled population for a range of reasons, most notably communication difficulties in this group.

Learning disabilities are highly heterogeneous with multiple causes which include genetic conditions such as Downs' Syndrome and Fragile X, birth complications and trauma, other conditions such as Autism and many more. According to Lindsay (1998) in 1998 there were approximately two per cent of the United Kingdom's population who could be described as having a learning disability, which equates to 210,000 people with severe and profound learning disabilities and 1.2 million people with mild to moderate learning disabilities (DoH, 2001). However it must be acknowledged that there is no definitive record of the number of people with learning disabilities in England as no government department collects comprehensive information on the presence of learning disabilities in the population and learning disabilities are not recorded in the decennial Census of the UK population (Hatton et al, 2016). Current estimated prevalence of learning disabilities is 2.5% of the population of England (Hatton et al, 2016).

It is important to note the differences between a learning disability and a learning difficulty. The term learning difficulty is used in educational settings in the UK to include those individuals who have 'specific learning difficulties', such as dyslexia, but who do not have a significant general impairment of intelligence, (British Institute of Learning Disabilities, 2018a). This research is not concerned with people who have learning difficulties. In some cases, most typically in the general media these terms are used interchangeably, which is incorrect and confusing for the general population.

There have been endless debates about the terminology used in the learning disability field and much change in this terminology over recent decades. Mentally deficient, mentally handicapped, mental impairment, mental sub-normality, intellectual disability, developmental disability and mental retardation are just some of the terms used over time, countries and professions. The turnover of such labels has accelerated in recent decades reflecting the increase in pace of social change (Rix, 2006), however, these differences in terminology are confusing for those outside the speciality and it has been argued by the researcher that the speciality would benefit from a more consistent title to refer to this group (Barksby, 2014). It is acknowledged that currently some countries (Ireland, Canada, Australia and New Zealand) are using the term 'Intellectual Disability', and while it is not yet widespread in the USA, the formerly known American Association on Mental Retardation is now known as the American Association on Intellectual and Developmental Disabilities. The term 'retardation' appears to be going out of favour due to negative connotations associated with the word. The term 'intellectual disabilities' can be seen across academic journals and some service providers across the UK, yet these changes seem to be slowly appearing with little wider discussion about the term. Research by Cluley, (2018) involving groups of professionals, lay people and parents found the term 'Intellectual disability' ambiguous and it was met with fear, disbelief and dislike.

While the writer acknowledges these differences in terminology, for the purpose of this thesis the term "learning disability" or if plural "learning disabilities" will be utilised, except if in direct quotation. This term has been chosen over the others as this researcher is a Learning Disability Nurse by profession and at the time of this research 'learning disability' is the chosen term used by the Nursing and Midwifery Council (NMC) as identified in the Standards for Competence for Registered Nurses (NMC,

2014) and in addition, it is still the chosen term utilised by the Department of Health.

1:3:ii- Patients:

The term “patients” will be used when discussing the people with learning disabilities involved in this research as they are patients in a specialist National Health Service (NHS) Trust, Learning Disability Service, however it is acknowledged that most people with learning disabilities are not referred to in this way and this is by no means intended to be derogatory.

1:4- Researchers Preconceptions:

Lofland and Lofland (1995) cited in Bryman (2004) note many research studies emerge out of the researcher’s personal biography and it is acknowledged that this is certainly the case of the research in this thesis. Additionally, when Malterud, (2001) discusses reflexivity he states "a researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions", therefore it is important to acknowledge that the perspective of the researcher shapes the research.

The researcher concerned spent many years working with people with learning disabilities who display challenging behaviours and this involved the implementation of RI’s. It is important to acknowledge this, especially when interviewing staff concerned to demonstrate a non- judgemental position to those staff interviewed and that the researcher will not be negatively judging them. It is also important that the researcher acknowledges this throughout the research process as the researcher is not coming from an entirely neutral position. However, Malterud (2001) explains that preconceptions are not the same as bias as long as it is acknowledged.

The researcher became a learning disability nurse through no desire to be a nurse but a desire to work with people with learning disabilities and a desire to, in some small way, right some of the injustices people with learning disabilities experience. This came about through a chance encounter with a girl with learning disabilities and her mother, which led to the researcher working with the girl for several years (not in a care setting, as a dance teacher). Hearing the battles and injustices her mother faced everyday led to the researcher changing careers. Several years later the researcher was in a position of managing a service for people with learning disabilities who display challenging behaviour, often having to implement restrictive physical interventions and being a trainer for the physical techniques employed in the NHS Trust.

Reflecting on this career journey one day, caused the researcher to question if she was indeed righting those injustices she set out to do or was in actual fact adding to them. Implementing restrictive physical interventions did not feel morally right to the researcher but at the same time, the service catered for people who displayed severe challenging behaviours, which without any intervention would have led to someone getting hurt. This led to a subtle change in direction as the researcher became a lecturer in learning disability nursing, in the hope of influencing the next generation of learning disability nurses. As mentioned, it is important to acknowledge that the researcher has opinions on the use of restrictive interventions and has been involved in the training and implementation of these many times.

1:5- Conclusion of this Chapter:

This chapter has provided a brief overview of the research to be presented in this thesis. It has also given some background information on the terminology to be used throughout and the background of the researcher.

Lack of research and the current call for a different approach to the management of challenging behaviours in learning disability services highlights the timely need for this research. The following chapter presented is the literature review, where an overview of the existing research in this area is explored.

Chapter 2- Literature review.

2:1- Introduction to this chapter:

This literature review will present an overview of the literature on violence and aggression in health services, it will explore how this manifests in learning disability services and what restrictive interventions are. It will look at the literature on the use of restrictive interventions (RI's) in learning disability services.

It will look at violence and aggression in care services and then specifically explore it within learning disability services. It will explore how violence and aggression are managed, what are restrictive interventions and the legislation and training around these. It will explore the nature of incidents, which patients are most likely to display challenging behaviours, staff responses and in which settings these occur. It will explore the literature around staff training and look at what this involved, and how staff and patients feel about the use of restrictive interventions.

2:1:i- Search Strategy:

Bryman (2012) and Ridley (2012) assert that a literature review is a gathering of multiple studies that are evaluated and analysed so that findings can be made. To obtain the literature and research studies required for this literature review an online systematic search was undertaken using a variety of databases. These were: Cumulative Index of Nursing and Allied Health (CINAHL), MEDLINE, Sage, PsycINFO and Elsevier. This ensured access to the widest range of comprehensive papers and is an essential step of the literature review process (Aveyard and Sharpe, 2009). Research papers were also selected from a manual search of journals and Google scholar to ensure all available literature was captured. Additionally, this process was repeated periodically throughout the

duration of undertaking this research in order to capture any new literature that became available.
Consideration was given regarding the search terms used to ensure the full range of relevant research literature was captured. Search terms were manipulated to account for variations of terminology, foci of particular databases and country of origin of the evidence. As the main focus of this literature review is people with learning disabilities this was the predominant key word used. However, it was important that different variations of this term were utilised due to ‘learning disability’ being referred to differently in different parts of the world and in different professions (as discussed in the introductory chapter).

In addition to the focus being on people with learning disabilities, for this literature review the other area of focus is restrictive interventions (RI’s). Consideration was also given to the range of key words used to represent RI’s in order to capture the widest range of relevant research. The key words used, as well as RI’s, included:

- Challenging behaviour
- Restraint
- Control and restraint
- Seclusion
- Chemical restraint
- PRN medication
- Physical restraint
- Physical interventions
- Restrictive practices
- Restrictive physical interventions
- Service user views
- Staff views

The identified key words/ terms were entered into the databases including the use of Boolean operators- this refers to the use of ‘AND’ and ‘OR’ within searches. This method of linking search terms together enables the researcher to manage the wealth of literature available (Freshwater and Bishop, 2004). The same search terms were used in each of the databases and then the results were cross-referenced for duplication.

Gerrish and Lacey (2006) support the approach of utilising inclusion and exclusion criteria in the search for literature and suggest that by doing so the literature found will be most relevant. It was decided that the exclusion criteria were minimal for this search in order to capture the widest possible range of research literature available, however a few were used.

The first exclusion criterion involved the year of publication, with an earliest limit set at 1985. Studies that pre-dated 1985 were excluded on the grounds that health and social care services and their practices have developed so radically over recent years that these were considered to be out of date and contemporary material was judged to be more reliable, relevant and appropriate for this literature review.

World regional restrictions were not utilised in the search process in order to capture the full breadth of research, however no research was found from countries other than western countries so cultural implications did not need to be considered as learning disability services can be very different in culturally different parts of the world.

Several research papers were found on Positive Behaviour Support (PBS) and these were not included in this literature review as, on the whole their focus was on the effectiveness of PBS which is a separate discussion and is not the focus of this literature review or this research. Some aspects of PBS will be discussed in the 'Discussion Chapter' later (chapter 7).

This literature review is not a systematic review or meta-analysis as it was decided to review as much literature on the subject as possible with no restrictions regarding methodology. In addition, for the same reason the journal impact factors and bibliometrics were not considered, although most research included is from journals with respectable impact factors.

The literature obtained from the search above was read, analysed and critiqued. The critiquing process utilised the Holland and Rees (2010) critiquing frameworks to aid this process. Although some issues were identified in some of the literature during the critiquing process this did not automatically exclude them from the literature review. This is due to the paucity of research in some areas, so it was deemed necessary to still include this literature. Any flaws identified in the critiquing process are discussed in the review below. Following the critiquing process, the literature was placed in a matrix and themes were identified that arose from this literature. The matrix identified the content that arose in each paper and content themes were derived from this (the matrix can be found in appendix 1). These content themes became the results and these results are presented below as summary findings. As well as the literature presented in the matrix, additional supporting literature is utilised in this literature review. This supporting literature is in the form of laws and guidance documents as well as literature on research methods that are used to support comments made about the research approaches used.

2:2- Theme 1- Background to Violence and Aggression in Care Services:

The incidence of violence and aggression in the work place is a huge concern particularly in health and social care services. 'Health professionals' and 'health and social care associates' are the second and third most likely groups to experience violence and aggression at work (behind only the protective services, such as the police and prison officers) (Buckley, 2013). Aggression at work is defined as "any work-related action that includes the deliberate use of physical strength or emotional harm" (Drach-Zahavy et al, 2012; p.43); interestingly this definition includes verbal insults (in the emotional harm aspect) and is not only focussed on a physical incident. Government studies show that these incidents of violence and aggression (in healthcare) are on the increase (3.3% rise from 2010/11 to 2011/12, Hampton, 2013) and up 3.89% by 2014/15 (Ford, 2017). The latest NHS survey showed that 15% of NHS staff had experienced violence in the last 12 months, this is the highest figure in five years (Ford, 2018).

The cost (impact) of this violence on healthcare staff is high and includes injury, distress, short-term and long-term stress, sickness absence, lower morale and recruitment and retention problems (House of Commons: Committee of Public Accounts, 2002-3) as well as fear and reduced confidence (Scott, 2008 cited by Inglis and Clifton, 2013; RCN, 2001). This is not to mention the impact on the perpetrators (patients/ service users and in some cases their family members) and the effects on the important therapeutic relationship between staff and patients (Scott, 2008 cited by Inglis and Clifton, 2013; RCN, 2001). In addition front line staff are usually the most at risk of being on the receiving end of this violence and yet are often those with least knowledge and the least training to deal with it (Sofield and Salmond, 2003; Cox, 1987). Some may suggest that there has been an increase in reporting of such incidents over recent years but other evidence from the NHS staff survey suggests that 30% of physical assaults go unreported (Hampton, 2013) so reporting alone cannot account for the increase. It appears that the figures are getting so high the government has decided to stop counting the number of assaults that happen to NHS staff (Ford, 2017). Needless to say, violence and aggression are a common reality in many health and social care environments and should be a cause for concern.

It could be argued that government policies of the past, introduced to address the matter of violence and aggression in health and social care, such as the Zero Tolerance Policy (Health and Safety Executive, 1999) have been ineffectual, they are reactive and do not consider why violence and aggression occur. Farrell and Salmon (2014) argue that zero tolerance policies are deskilling nurses and having a negative impact on staff and patients by placing challenging behaviours outside the nurses' remit so they do not have to address such behaviours. They go on to explain that nurses must reclaim the management of challenging behaviours and see them as something clinical and requiring a nursing response. Although this point is regarding generic health services, the point is applicable to learning disability services, maybe even more so, in that challenging behaviour should be seen as a clinical need requiring a clinical response.

The exclusion of 'offenders' as advocated in the zero tolerance policy (Health and Safety Executive, 1999) is not an appropriate response and in many areas is unenforceable, indeed learning disability services being one such place. The nature of the incident needs to be considered as it differs across the range of health care services: the nature of violence and aggression experienced in an inner-city Emergency Department is very different to that experienced in a care of the older person ward or a mental health service. In some services violence and aggression should be regarded as a symptom of a person's illness or condition or a form of communication (Stansfield and Cheseldine, 1994) and something requiring additional, not less support and service input: this is especially true in services for people with learning disabilities.

The government are now at least starting to acknowledge this issue and a need to do more to protect staff. In October 2018 the government launched a new strategy for violence reduction in the NHS. Sadly, this strategy has a focus on prosecuting the perpetrators, simply rehashing the zero tolerance policy. The strategy includes staff training on how to deal with violence and some of this will focus on those with needs that may contribute to this violence, such as dementia and mental illness. This strategy also has a focus on more accurate recording processes and full investigations into the incidents: a welcomed return to appropriate reporting of incidents to identify patterns of those staff most at risk (Ford, 2018).

2:3- Theme 2- Violence and Aggression in Learning Disability Services:

In the section above the significance of violence and aggression in health services has been discussed. Often in learning disability services the term challenging behaviour is used as a broad term to include violence and aggression but also a wider range of behaviours. This term is discussed below.

2:3:i- Challenging Behaviour:

Some people with learning disabilities display challenging behaviours, although figures vary slightly on just how many, with Emerson and Baines (2010) stating between 10 and 15%, while Lindsay (1998) estimates between five and fifteen per cent, the Michael Report (2008) states 15% and Campbell (2010) states up to 20%. The most commonly quoted figures are between 10 and 15% (Qureshi & Alborz 1992; Kiernan & Qureshi 1993; Emerson et al. 2001). The reason for the variation in this percentage is often dependent on the definition of what one means by challenging behaviour with different service providers having differing understandings of what this means and this will be explored further.

The term challenging behaviour has been debated and has been referred to as complex behaviours, maladaptive behaviours, aberrant behaviour, behaviour disturbance, difficult behaviours, behaviours of concern and simply violence and aggression. Challenging behaviour is an umbrella term, which can include socially unacceptable behaviours, destruction of property, self-injurious behaviours and violence and aggression to others. It also includes any behaviour that impacts on the person's ability to live in the community. This is a crucial point as the main philosophy of learning disability services for many decades has been for people with learning disabilities to live ordinary lives alongside non- learning disabled people. This is evident in the principles of social role valorisation (Gates, 2003), Valuing People (DoH, 2001) and more recently Transforming Care (Department of Health, 2012) (and its subsequent follow up reports, including Transforming Care for People with Learning Disabilities- Next Steps, 2015 and Building the right support, 2015).

Emerson, Barrett, Bell, Cumming, McCool, Toogood and Mansell (1987) describe challenging behaviours as being "of central concern to providers of care for people with learning disabilities". They go on to define them as "culturally abnormal behaviours of such intensity, frequency or duration that the physical safety of the person or others is placed in jeopardy, or behaviour that is likely to seriously limit or delay access to and use of ordinary community facilities". Although this definition was published over 30 years ago, it is established as the seminal definition in learning disability services. Other definitions include an adaption of Emerson et al's stating that challenging behaviour is that which is "of such intensity, frequency or duration as to threaten the quality of life and/ or the physical safety of the individual or others, and which is likely to lead to responses that are restrictive, aversive or result in exclusion" (Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, 2007). The addition of 'threaten the quality of life' is a significant one- an aspect that will be addressed further, later on in this section and one of the principle reasons this research is needed.

Additionally, Sigafoos et al (2003) define challenging behaviour as destructive, harmful, disruptive or otherwise unacceptable behaviours that occur with sufficient frequency and/or severity to be of major concern.

Although there are many definitions and descriptions they all encompass a range of behaviours including:

- Violence and aggression to others
- Self harm/ injury
- Destruction of property
- Socially unacceptable behaviours

It is believed that there is a positive correlation between the severity of the learning disability and the prevalence of behaviours and the likelihood of multiple forms of challenging behaviours exhibited (Rojahn, 1994 cited in Evers and Pilling, 2012). Others argue that there is a correlation between the degree of learning disability and the nature of those behaviours displayed, where aggression is more likely in those with mild learning disabilities and self-injury is more likely in those with severe learning disabilities (Emerson et al, 2001).

Hayes and Hannold (2007) cited in Chan (2012) consider the term challenging behaviour to be disempowering to people with learning disabilities and Chan argues it should be changed to 'behaviours of concern' as this is the reaction it should evoke in staff. He goes on to suggest that staff should respond with sympathy and compassion and argues that challenging behaviour is administrative and not clinical. This is a somewhat controversial point of view, the manifestation of challenging behaviour is indeed a clinical symptom (as discussed shortly) and indeed challenging behaviours are identified as a health need in the Health Equalities Framework (Improving Health and lives: Learning Disability Observatory et al. 2013). The term challenging behaviour, when introduced, was intended to refer to the challenge presented to the service providers and not challenging as a confrontational term, (Stansfield and Cheseldine, 1994).

Whatever the terminology it is important to understand that people with learning disability do not ‘have’ challenging behaviour in the same way that a person can ‘have’ measles but they ‘display’ challenging behaviours as a result of, or as a symptom of something else- a cause and it is important to understand the difference. People with learning disabilities display challenging behaviours for many varied and complex reasons some of which are discussed next.

It is important to acknowledge that medical factors and/ or a medical condition can contribute to incidents of challenging behaviours (Hampton, 2013) across all sectors but this is a particular issue in learning disability services. Felce (1996) states “the prevalence of challenging behaviours (in those with a learning disability) is more likely to be associated with specific syndromes, neurological damage and mental health problems”.

A systematic review by de Winter et al (2011) highlighted motor disorders (such as cerebral palsy), sensory impairments, gastro-intestinal diseases, sleep disorders, pain and the menstrual cycle among other physical conditions that contribute to the manifestation of challenging behaviours in those with learning disabilities.

Behavioural phenotypes are described as “patterns of behaviour that present in syndromes caused by chromosomal or genetic abnormalities” (O’Brien, 2006). Berney (1998) explains how certain behavioural phenotypes are present in many conditions associated with a learning disability, such as Fragile X, Prader- Willi and Lesch- Nyhan to name but a few. Additionally, many conditions associated with learning disability have a predisposition to the manifestation of challenging behaviours. For example, autism is an often cited example of a condition associated with a wide range of behavioural manifestations, including self-injury, aggression, injury to others and socially inappropriate behaviours such as stripping, (Prasher, 1996). Additionally, Gilles de la Tourette's syndrome is associated with verbal outbursts, obsessive/ compulsive behaviour, aggression and self-harm, (Gelbart, 1998). Challenging behaviour is also associated in some people with epilepsy and part of the epilepsy cycle can manifest as challenging behaviour (Deb and Hunter, 1991) particularly in complex partial seizures. Phenylketonuria (Shanley and Starrs, 1993), mental illness (Prosser, 1989), dementia (Ridley and Jones, 2012) physical pain and developmental and aging processes (Thompson and Mathias, 1992) are additional but not an exhaustive list of causes of challenging behaviour in the learning disabled.

The Health Equalities Framework (Improving Health and lives: Learning Disability Observatory et al. 2013) states "mental health problems and challenging behaviours are more prevalent among people with autistic spectrum conditions, Rett syndrome, Cornelia de Lange syndrome, Riley-Day syndrome, Fragile-X syndrome, Prader-Willi syndrome, Velocardiofacial syndrome / 22q11.2 deletion, Williams syndrome, Lesch-Nyhan syndrome, Cri du Chat syndrome and Smith- Magenis syndrome." The above illustrates a breadth of conditions where the person is predisposed, as part of their condition, to display challenging behaviours.

Chan (2012) also explains that challenging behaviours can occur because of:

- Underlying physical, neurological, mental or emotional health issues
- The physiological effects of substances, including alcohol, illegal drugs or medicines
- Breakdown in communication
- An inability to self regulate desire for things
- A lack of appropriate learning opportunities or role models

- The failure of service systems or support networks or other environmental problems
- The effects of relationships with other people

Challenging behaviours serve functions and are often a response to social, biological and environmental conditions (Hastings, 2010). However, for those that exhibit challenging behaviours the cause is often complex with more than one trigger, indeed McGill (2012) cited in McGrath (2013) identified that those behaviours caused by a biological basis are often triggered by environmental stimuli. McGrath (2013) identifies that staff play a part in this too as they can be instrumental in reinforcing behaviours through “a cycle of reciprocal behavioural reinforcement.”

Research shows that once challenging behaviours become established in the person, they tend to be persistent (Kiernan and Alborz, 1996) and that people with learning disabilities are at high risk of adversity, trauma and stress which can cause or result from behaviours that challenge (Sullivan and Knutson, 2000; Allen, 2011.)

Additionally evidence suggests that there is a danger of diagnostic overshadowing and that when a person with learning disabilities displays challenging behaviours those behaviours are attributed simply to their learning disability (Improving Health and lives: Learning Disability Observatory et al., 2013) and no further cause is sought. Mason and Scior (2004) illustrated this in their work with psychiatrists when diagnosing mental ill health. When the cause of that behaviour is a physical condition this often results in conditions being diagnosed at a late stage, often too late for effective treatment. This has led to cases of premature deaths in the learning disabled population and several investigations into this matter, most notably Death by Indifference (Mencap, 2007) and 74 deaths and counting (Mencap, 2012).

Challenging behaviour has been identified as one of the top five health needs for people with learning disabilities by The Health Needs Annual Evidence Update (AEU) for 2010 (NHS Evidence – learning disabilities, 2010). It has been identified as a key element in poor quality of life for people with learning disabilities, as suggested in the definition from Royal College of Psychiatrists et al (2007) above and is a major health issue leading to health inequalities (Emerson and Baines, 2010). The Health Equalities Framework (Improving Health and lives: Learning Disability Observatory et al. 2013) identifies that challenging behaviours lead to:

- Poor physical health (due to the impact of self-harm and undiagnosed health needs)
- Abuse (from carers)
- Inappropriate treatment (including the over use of anti-psychotic drugs and mechanical restraint)
- Social exclusion, deprivation and systematic neglect

Indeed, this is supported by Evers and Pilling (2012), who found that challenging behaviours lead to a reduction in services, limited opportunities and placement in out of area services, all leading to reduced quality of life. Carr (1994) reinforces this explaining that there is a direct negative correlation between challenging behaviour and quality of life and that the higher the frequency of challenging behaviours the lower the quality of life. Importantly the opposite is also true, a reduction in challenging behaviours leads to an improved quality of life.

To sum up, the aetiology of challenging behaviour is complex and multifaceted, with physical, psychological and sociological explanations (Whittington and Ritcher, 2005 cited by Inglis and Clifton, 2013). There are many definitions of challenging behaviour but despite these differences evidence consistently suggests that those who display challenging behaviours are more likely to have a poorer quality of life and include categories of behaviours such as:

- Violence and aggression to others
- Self-harm/ injury
- Destruction of property
- Socially unacceptable behaviours

The term "challenging behaviours" will be utilised throughout this thesis and when used will refer to all behaviours discussed above.

2:3:ii- How challenging behaviours are managed in Learning Disability Services:

Across many services the way that challenging behaviours have been managed over the years is reactive (in that staff wait until the behaviour occurs and then respond to it) and aversive (unpleasant outcomes for the patient). This is true in many areas but especially prevalent in mental health services, learning disability services and services for older people and consists of various forms of restraint, seclusion and high levels of medication to control patients' behaviours. Restraint has taken the form of physical person to person restraint, tying a patient to a wheelchair (Castledine, 2003), using bed sides to prevent a patient getting out of bed (Akid, 2002), locked doors, the use of 'baffle' handles, seclusion, medication (Akid, 2002) and many more.

Within learning disability services, historically people were placed in institutions usually geographically and socially removed from mainstream society (Paterson et al, 2011). In these services incidents of challenging behaviours have been dealt with by utilising such interventions as restraint, seclusion, the use of medication and other restrictive interventions (RI's). While in recent decades these institutions closed and people with learning disabilities became part of mainstream society, for those people that display challenging behaviours these behavioural management practices moved with them and for many years these approaches have been the accepted norm for the management of challenging behaviours. However, in the 1980's and 1990's as learning disability services underwent these radical changes and moved away from institutions to community settings some services questioned these approaches and considered a human rights approach to dealing with challenging behaviours. This saw the development of other approaches such as applied behavioural analysis (ABA) and positive behavioural support (PBS), however this was not across all service providers, many still accepting of the approaches used in the past. Even in services that did adopt ABA and PBS or other more proactive approaches to dealing with challenging behaviours it did not result in the complete removal of RI's. In some cases it could be argued, this is appropriate as the complete removal would leave people (both staff and other patients) vulnerable to injury from the incidents of challenging behaviour and so some interventions were considered necessary.

In recent years the continued use of RI's has come under much scrutiny from professionals and patients within services, questioning the moral and ethical basis of such interventions and the inappropriate and overuse of them. This scrutiny has arisen from a range of high-profile cases that have brought these interventions into question, in mental health services (such as the David 'Rocky' Bennett case), learning disability services, older people services and even in special education (BBC, 2017).

Within learning disability services this scrutiny has come from professionals and also from learning disability communities, the media and wider society. Much of this scrutiny has come about following the Panorama television programme on Winterbourne View in 2011 that brought these practices to the forefront of society's attention. This programme highlighted the misuse and abusive manner in which RI's were used. This was followed by a plethora of further cases of misuse of RI's, the most recent of which was the Whorlton Hall case, again highlighted by the Panorama television programme. While the type of interventions seen in these Panorama programmes (and indeed the reasons they were used) are not representative of all RI's used in learning disability services it, nonetheless, added to the growing scrutiny of the use of RI's.

These calls for changes do not just refer to restraint and seclusion but also to the use of medication to control behaviours (especially without the diagnosis of a mental illness). This practice is wide- spread across learning disability services, with the 2013 Learning Disability Census showing that 68.3% of inpatients had been given anti-psychotic medication in the 28 days leading up to the census and of those 93% had been given the medication on a regular basis (Health and Social Care Information Centre, 2013). One report that contributed to the questioning of the use of medication was that by Tyrer et al (2008). This research compared three groups of patients with learning disabilities who displayed challenging behaviours. One group was given Haloperidol, one was given Risperidone and the third a placebo. The groups were compared at four, twelve and twenty-six week periods for the demonstration of challenging behaviours. All three groups showed a decrease in challenging behaviour but the group given the placebo showed the greatest change. In addition, the quality of life of the two groups on Haloperidol and Risperidone was shown to be reduced during the trial. Following this research, the researchers themselves stated that anti-psychotic medication does not work for people with learning disabilities to control challenging behaviour and it should be used as a last resort. They also advocate a move away from long-term use due to the negative side effects. These findings (and others of a similar nature) have led to a national project called 'Stopping the Over Medication of People with a learning disability' referred to as STOMP. STOMP (2018) claim that people with learning disabilities, autism or both are being prescribed antipsychotic medication, an anti-depressant or both without the appropriate diagnosis for such, which can lead to many severe side effects including organ failure and death.

The presentation of challenging behaviours in people with learning disabilities leads to a reduction in quality of life, health inequalities, increase risk of abuse and the utilisation of RI's. These RI's are aversive and have been utilised for many years as the short-term reactive management of challenging behaviours. The nature of these interventions should have changed over recent years with restraint in the past consisting of tying people to posts or chairs or person-to-person restraints that involve inflicting pain on the individual, whereas interventions that are taught and advocated today do not support this type of approach.

The nature of the restrictive interventions has changed (in most services) and people should no longer be tied to posts or furniture and restraint techniques do not need to use pain compliance to be effective. However, the continued use of all RI's is still professionally, morally and ethically challenging to staff in learning disability services and there has been professional disquiet and campaigning to move away from these practices (Deveau and McDonnell, 2009). There is little research to demonstrate their effectiveness, limited staff training in alternatives and they are often used due to a lack of resources (Powell, Alexander and Karatzias, 2008). Paterson, Wilkinson, Leadbetter, Bradley, Bowie and Martin, (2011) state that corrupt cultures legitimise the use of restraint and seclusion by dehumanising people with learning disabilities. This is sadly a situation known too well in learning disability services, as seen in high profile cases such as Winterbourne (Bubb, 2014), Cornwall (McMillan, 2006) and Sutton and Merton (Healthcare Commission, 2007). When such interventions are given approval this leaves them open to being over used and abused as evidenced in these high profile cases. One example from Cornwall stated that a man was strapped down for 23 hours out of every 24 (McMillan, 2006). Such practices are sadly, said to be commonplace (Allen 2011) and have led to deaths (Paterson, Leadbetter and Bradley, 2009 in Allen, 2009) and injury (Perry, White, Norman, Marston, Auchoybur, 2006) as shall be discussed further later in this chapter.

It has been shown that approximately 50% of people with learning disabilities who display challenging behaviour are subject to physical restraint, (Emerson, 2000; Sturmey, 1999). More recently a study by the Health and Social Care Information Centre in 2013 found that 3254 people with learning disabilities were inpatients in specialist LD provision and of these, 1093 (34.2%) had been restrained at least once in the last three months, 2220 (68.3%) had been given major tranquiliser medication in the last 28 days and of these 2064 (93%) had been given them on a regular basis. This study has been repeated subsequently (see below) and the figures show little change. Table 1 shows the actual figures and percentages of people who had experienced restraint and seclusion in the three-month period leading up to the data collection in three consecutive years. As can be seen the actual figures and percentage figures are consistent across this period. These reports were commissioned following the revelations from Winterbourne View from 'Transforming Care: A national response to Winterbourne View Hospital' report.

TABLE 1:

	2013	2014	2015
One or more restraint	1110 (34%)	1080 (33%)	1030 (34%)
Seclusion	370 (11%)	350 (11%)	380 (13%)

As broached above, the risks associated with restrictive interventions are high resulting in staff and patient injury and patient death as well as the potential for long-term psychological distress as will also be discussed in more detail later. There is little evidence to support the use of restrictive interventions having any long-term effect on challenging behaviours. Evidence suggests that seclusion has no therapeutic value (Paley, 2009 cited in Paley-Wakefield, 2012, Allen, 2011) and there is conclusive evidence that psychotropic medication is ineffective in reducing severely challenging behaviours (Deb, 2009 cited in Allen, 2011 and Tyrer et al 2008). Furthermore, inquiries into restraint related deaths suggest that people with learning disabilities are especially prone to suffering adverse consequences of being restrained due to a number of factors including being overweight (linked to their condition), the nature of the medication they may be on, cardiovascular disorders associated with some conditions in the learning disabled population and neurological issues, to name but a few (Perry, White, Norman, Marston, Auchoybur, 2006). Despite this growing evidence against the use of RI's they continue to be a main response to challenging behaviours in many learning disability services.

Surprisingly, the latest figures show that RI's and particularly restraint are on the increase for patients with learning disabilities. Figures obtained by the BBC File on 4 showed that patients with learning disabilities were restrained 22,000 times in 2017, an increase of almost 50% from 2016 (Adams, 2018). This is despite the latest guidance from the government stating services must look to reduce it. This includes an increase in the use of prone restraint from 2200 in 2016 to 3100 in 2017. Prone restraint is considered the most dangerous type of restraint, explained further below.

2:4- Theme 3- What are Restrictive Interventions?

The term restrictive interventions was used above and this next section will explain fully what is meant by this term. It will also look at the national guidance on restrictive interventions.

2:4:i- Background and Types of Restrictive Interventions:

The manifestation of challenging behaviours and a service’s need to respond to these behaviours has led to the use of physical interventions and restrictive interventions. One problem with the literature in this area is that various terms are used interchangeably to refer to techniques that involve the management of challenging behaviours and techniques that involve stopping the patient from having free movement. These terms include ‘Physical Interventions’, ‘Restrictive Physical Interventions’, ‘Restraint’ and ‘Physical Restraint’ to name but a few. This is confusing and misleading and clear distinctions need to exist, defining the various terms.

To illustrate this point, restraint is defined by the Royal College of Nursing (RCN) (2008) as “stopping a person doing something they appear to want to do” while the Mental Capacity Act (DoH, 2005) defines restraint as “using force or threatening to use force to make someone do something that they are resisting; or restrict a person’s liberty of movement whether they are resisting or not”. Counsel and Care (2002) define it as the intentional restriction of a person’s voluntary movements or behaviour. These definitions imply stopping someone from doing something or restricting movement however, none of the definitions above address how one should do this. None of them are specifically referring to person to person ‘holding’, which is often what is implied when one uses the term ‘restraint’.

Categorisation of techniques that involve stopping the patient from having free movement throw more light on how it may be limited but even here, not all writers use the same categorisation. Watson (2001) cited in Ridley and Jones, (2012) identifies five types of restrictive practice:

- Physical
- Mechanical
- Chemical

- Psychological
- Technological

The ‘physical’ restrictive practice mentioned above usually refer to person to person holding, restricting the patient’s movement. Mechanical restrictive practice may involve things such as leg splints or the use of bed sides or other such devices. Chemical restrictive practice refers to the use of medication to suppress a person’s behaviour. Psychological restrictive practice refers to threats or scaring a person into behaving a certain way (or not behaving a certain way) in order to, for example, get them to stay in one room. Technological restrictive practice could involve turning off electric wheelchairs or locks on doors.

Physical Interventions and Restrictive interventions are broad terms that encapsulate many different approaches with many different interpretations of what this actually means and these shall be explored below. ‘Physical interventions’ is often the broader term used to refer to a range of physical skills staff can be taught to react to challenging behaviours.

Harris, Allen, Cornick, Jefferson and Mills (1997) define physical interventions as “the actions by which one person restricts the movements of another” and go on to divide them into three broad areas, these being:

1. Direct physical contact between a member of staff and a patient, e.g. holding a patient’s arms and legs to prevent them from hitting someone.
2. The use of barriers to limit freedom of movement e.g. locked doors and placing handles beyond the reach of the patient.
3. Materials or equipment that restricts or prevents movement, e.g. strapping into a chair.

The category “direct physical contact” consists of two broad categories of intervention and can include many different approaches adopted by services with different ‘holds’ and actions being taught to staff, including ‘breakaway techniques’ and ‘person to person restraint’. Breakaway techniques are a range of movements staff can be taught to release themselves from grabs and attacks from patients. So if a patient grabs staff by the wrists, by their clothing, the hair etc staff members know techniques to free themselves.

The latter example from Harris et al (1997) above is a form of mechanical restraint in Watson’s (2001) terminology, but other types of restraint (chemical, psychological, technological) are not included in their definition. Another form of restrictive intervention not included in the definition of Harris et al (1997) is seclusion. Seclusion involves locking a person in a room, or at least leaving them in a room which they are unable to leave independently. It may or may not include some form of observation by staff. Sometimes types of seclusion are referred to as ‘time out’, ‘therapeutic isolation’ and ‘quiet time’. Again this variation in terminology is not helpful, indeed Clarke and Elford (2010) argue for the use of plain English and sticking with words that may have negative connotations when dealing with such interventions as a move to less emotive terminology could result in such practices being less open to scrutiny and be seen as less serious than they are. The use of any form of restrictive interventions should be well monitored and recorded, by using softer words it means they can go unmonitored which then may lead to over-use, misuse or abuse of such practices.

As can be seen above from the range of definitions explored, restrictive interventions can take many forms and under each of these types of restrictive interventions there are many different approaches adopted by services with different ‘holds’ and actions being taught to staff. The delivery of training in restrictive interventions is a free market and anyone can create a business to deliver training in this area. This has resulted in a plethora of different approaches being available. These approaches vary in the degree of restriction applied and with that varying degrees of ethical appropriateness.

While it is acknowledged that many services for people with learning disabilities use restrictive interventions that are more ethically appropriate, any use impacts on a person's quality of life even if their use is well justified at the time. However, some are considered more acceptable than others for a variety of reasons.

The techniques vary considerably across the different organisations that deliver training on them, from the least aversive techniques based on balance, leverage and momentum to be effective to the more aversive approaches, those that are based on pain to be effective. The less aversive approaches utilise principles of using the staff member's weight and the weakest part of the patient's grab for effectiveness; while those based on pain include using wrist locks, moving joints against natural positions, pressing of knuckles onto the patient's hand and other painful approaches for effectiveness. In recent years there has been a steady move away from techniques that rely on pain for their effectiveness however they are still in use in some services today. When using release techniques, the idea is that staff members are able to release themselves from the grab and then move away from the perpetrating patient, however the patient still has freedom of movement.

Some services only teach their staff release techniques and the reasons for this vary. It may be the service has patients that can be challenging but this degree of challenge is the easier types of behaviours to deal with such as grabbing of wrists and does not escalate further into physical attacks on others. Alternative reasons for only teaching staff release techniques could be simply the service in question have a no restraint policy or the other reason staff may only be taught release techniques could be if they are lone workers. Community based staff who go into the patients home alone may require release skills but nothing further.

Person to person restraint can take various forms, including prone, supine, seated or walking. Prone restraint is where a person is held down on the floor, face down. Prone restraint can also vary in the number of staff involved (between two and five) and in the different ways that staff will hold the person, some involving 'locks' and others not. 'Locks' refers to the way staff hold the persons limbs. When in a lock, if the person attempts to move or struggles against being held it will result in them experiencing pain. Prone restraint is considered the type of restraint that poses the highest risk. This is for various reasons but in the learning disabled it is considered particularly dangerous due to breathing problems, being overweight, existing heart problems, epilepsy and many other factors that are prevalent in the learning disabled population. There are also various ways that staff can utilise to get the patient to the floor, some of which are more aversive to the patient but all of which involves a degree of risk of injury both to the patient and the staff.

Person to person restraint can also include holding a person on the floor in a supine position (face up) similarly with between two to five members of staff and different methods of holding, again some including locks and others not. This position is slightly less dangerous than prone, however both still pose huge risks both to staff and the patient during the process of getting the person to the floor and once there maintaining that hold.

Other forms of person to person restraint include seated restraint where staff hold a person in a chair while staff remain on their feet, restraint on beds or sofas where all staff and the patient are seated and walking/ escorting restraint- these involve the patient being held by staff, typically two, and being moved from one room to another (usually against their wishes). Again the way staff hold the patient both in seated and walking restraints can involve pain compliance techniques or not.

The new bill, The Mental Health Units (Use of Force) Bill (2018) (to be discussed further later on in this chapter) also has definitions for different types of restrictive interventions and these are somewhat clearer and state that the term “use of force” means

- the use of physical, mechanical or chemical restraint on a patient, or
- the isolation of a patient.

It goes on to define different interventions as such;

- physical restraint means the use of physical contact which is intended to prevent, restrict or subdue movement of any part of the patient’s body;
- mechanical restraint means the use of a device which is intended to prevent, restrict or subdue movement of any part of the patient’s body, and is for the primary purpose of behavioural control;
- chemical restraint means the use of medication which is intended to prevent, restrict or subdue movement of any part of the patient’s body;
- isolation means any seclusion or segregation that is imposed on a patient.

These definitions are somewhat clearer than some of the others discussed above.

Restrictive interventions in the form of physical (person to person) or mechanical restraint (straps) are often used for people with learning disabilities who require dental treatments (Newton, 2009) or other medical interventions. Also some people use weighted blankets as a sensory experience, a practice often prevalent in those with Autism. This practice should be used only as a sensory experience at the request of those with Autism and not as a form of restraint, although sadly this has occurred (College of Occupational Therapy, 2011). The use of restraint for dental or medical purposes or any accounts of weighted blankets is not the focus of this research, this research is focussing on RI's used as a reactive approach to challenging behaviours.

The term Restrictive Interventions (RI's) will be utilised throughout this thesis as a collective term that incorporates physical person to person restraint, chemical restraint and seclusion/ isolation except where it is necessary to distinguish between the specific approaches.

It is important at this point to recognise that literature cited in this literature review often uses terms as discussed above, such as 'restraint', without fully defining what the authors mean by this term. This highlights the problems with the terminology in this field, adding further confusion to the reader. This author acknowledges this problem and where possible will try to distinguish what exactly is being discussed. As no agreed definition of terms appears to exist with various authors and organisations each having their own, standardising these terms is essential to ensure better recording, improved practice and most importantly better care for the patients involved.

2:4:ii- Guidelines and Legislation on Restrictive Interventions:

Much has been written on the use of restrictive interventions in learning disabilities in terms of guidelines and good practice documents. However most of what is written is vague and some documents clearly take a contradictory stance to others. Additionally, as discussed above they are inconsistent with the terminology used so it is not always clear to the reader what exactly they are referring to. For example, in 2013 The Royal College of Nurses were lobbying the government for a body to regulate and accredit organisations that deliver training on physical restraint (Calkin, 2013) while the Department of Health launched new controls on patient restraint, a move to stop all RI’s (Anderson, 2014).

Although most of these guidelines and good practice documents are based on legal and ethical principles they are often vague, non-committal, open to interpretation and for many practitioners who are already stretched they are extremely lengthy and take a long time to read (Tosh et al, 2010). Although these ethical principles are extremely valid and important it is also apparent that any guidance needs to be more robust with clearer absolute “do’s and do nots” and needs legislation or something enforceable, not just optional good practice guidance behind them.

Below is a summary of those guidance documents that focus on learning disability services, while a briefer overview will be provided of the many more documents that are not exclusively aimed at learning disability services.

Of the guidance documents aimed at learning disability services, one of the first and most influential is the British Institute of Learning Disabilities (BILD) Code of Practice for Trainers in the Use of Physical Interventions (first published in 2001, updated in 2014). This document advocates that any physical intervention should be done with the minimum amount of force and for the minimum amount of time and should be used in a non-punitive manner and only when the safety of the patient or staff is seriously threatened. This also focuses on techniques that do not require pain compliance for their effectiveness and advocates safer restraint approaches.

The second guidance document is the Department of Health (2002) Guidance for Restrictive Physical Interventions. This is a supplementary document of Valuing People and is for all services for people (children and adults) with learning disabilities and services for people with Autistic Spectrum Disorder. This document recognises the need for the use of physical interventions but stresses that they should be "used as infrequently as possible, that they are in the best interests of the service users (patients) and that when they are used, everything is done to prevent injury and maintain a person's sense of dignity". It also states that they should be seen as "one part of a broader strategy" including risk assessments and preventative strategies and used when other non-restrictive strategies have been tried. In other words physical interventions are a last resort for services. Both of these documents talk about maintaining dignity and respect of the patient. Additionally, both documents outline the importance of training for any staff that implement physical restraint. This training should involve assessment for competence of the techniques. Both documents also discuss the legal implications for both staff and patients regarding the use of physical interventions.

The above two documents have led the way in this field within learning disabilities, however other guidance has also been written. This includes "Psychological Interventions for severely challenging behaviours shown by people with learning disabilities" (The British Psychological Society, 2004) and "Challenging Behaviour: A Unified Approach" (Royal College of Psychiatrists et al, 2007). The content of these documents with respect to restraint remains consistent with the previous two documents.

Although the consistent message given is good for all staff wishing to use them it is not entirely clear what those messages are. These four documents give very similar guidance but this is at the cost of clarity as they are all too vague to be able to support an individual's decision making process regarding whether to use RI's or not. The use of phrases such as 'minimum force', 'minimum time', 'in the patients' best interest', are all rather vague statements that are open to interpretation. It can be argued that these documents should have been clearer to remove any ambiguity. Additionally, the above guidelines focus on the delivery and content of training to improve staff knowledge and skills in restrictive practices and not on reducing the use of RI's. There is no evidence to suggest that training staff in physical skills reduces the number of incidents of challenging behaviour or reduces the use of restrictive interventions (McDonnell, 2009) which should be the aim. In fact some evidence suggests the opposite is true. Baker and Bissmire (2000) found that staff training had no impact on the number of incidents of challenging behaviour but did increase the use of RI's by staff.

Further guidance documents on the subject have been written but are not exclusively for learning disability services. These include (most notably but not exclusively) Violence: The short term management of disturbed/ violent behaviour in in-patient psychiatric settings and emergency departments (National Institute for Clinical Excellence (NICE), 2005); Violence and aggression: short-term management in mental health, health and community settings (NICE, 2015) and Mental Health Policy Implementation Guide (National Institute for Mental Health in England (NIMHE), 2004). Again, these documents use language that is somewhat vague.

The latest guidance, 'Reducing the need for restraint and restrictive intervention' (Department of Health, 2017) does at least appear to have a more robust and clear approach and, very importantly addresses using RI's in a wider framework of proactive and preventative approaches based on thorough assessments. Although other guidance has alluded to these, this is the first that actually recommends Positive Behavioural Support (PBS) and again, very importantly frames it within existing criminal and civil law. This is a welcome addition, giving staff and service providers a robust framework to work with. It is sadly though still only guidance without the authority to enforce it. As is often true with good practice guidance, good services will implement this approach and bad ones will not.

Despite the fact that most of the guidance advocates a reduction in the use of RI's the latest standards from the Nursing and Midwifery Council for the education of Nurses has, as a mandatory requirement, that all student nurses are taught how to restrain (NMC, 2018). It could be argued that this legitimises the use of RI's, encouraging them to be seen as the normal response to violence and aggression in health services unless avoiding RI's is given sufficient weight.

The above outlines the key guidance that impacts on the learning disability field however this is not the full extent of the guidance. Table 2 (below) shows the further range of guidance. Although not learning disability specific much of this guidance, whether it is implemented in LD services depends on the individual service provider and the staff it employs, for example some of this guidance is for all NHS services and some apply only to nurses.

Table 2:

Public or Professional body	Name of Document	Year
Report from the Committee of Public Accounts	Health and Safety in NHS Acute Hospital Trusts in England HC 350	Parliamentary Session 1997–98
Royal College of Psychiatrists	Management of Imminent Violence. Occasional Paper OP41	1998

Royal College of Nursing	Restraining, holding still and containing children and young people: Guidance for nursing staff	1999 (updated 2003)
Royal College of Nursing	Dealing With Violence Against Nursing Staff, An RCN Guide for Nurses and Managers	2001
Comptroller and Auditor General's Report	A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression HC 527	Parliamentary Session 2002–03
Report from the Committee of Public Accounts	A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression HC 641	Parliamentary Session 2002–03
NICE (National Institute for Clinical Excellence)	CG 25 Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments	February 1995a
NICE (National Institute for Clinical Excellence)	CG 25: Violence: managing disturbed/violent behaviour Understanding NICE guidance – information for service users, their advocates, families and carers, and the public	February 1995b
NHS Counter Fraud and Security Management Services	A Professional Approach to Managing Security in the NHS	2003

National Institute for Mental Health in England (Department of Health)	Mental Health Policy Implementation Guide: Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-Patient Settings.	2004
NHS Security Management Services	Promoting Safer and Therapeutic Services – Implementing the National Syllabus in Mental Health and Learning Disability Services	2005
Department of Health	Mental Health Act Code of Practice 1983 revised 2008	2008
Royal College of Nursing	Restrictive physical intervention and therapeutic holding for children and young people: Guidance for nursing staff	2010

(Used with thanks, taken from Inglis and Clifton (2013)

Despite this plethora of guidance there remains no legislation in place in the UK to monitor the use, frequency and impact of restrictive interventions in learning disability services and any involvement in studies in these areas is done voluntarily by the services, sadly many services who have something to hide would not participate. In other countries, such as Australia, Canada and Norway, legislation is in place and this provides much more robust guidelines on what RI’s can be used, when they can be used and the recording and monitoring of their use (Patient Restraint Minimization Act, 2001 and Søndenaa, Dragsten and Whittington, 2015).

Indeed even when legislation is introduced to reduce the use of RI's evidence suggests it has little effect. Søndenaa, Dragsten and Whittington (2015) is a Norwegian paper that explores the fact that following the introduction of legislation to restrict the use of RI's there has actually been a large increase in the number of restraints being reported. Søndenaa et al (2015) argue that the introduction of the legislation actually raised awareness around the use of RI's and helped inform and educate those involved. It is probable that the use of RI's did not increase with the introduction of the legislation but simply the recording of these interventions increased once the legislation is in place. This should be viewed positively as better recording processes ensures the safer utilisation of RI's for both staff and patients, however it does highlight that there was no reduction.

The Commons passing of the Bill "The Mental Health Units (Use of Force) Bill, (known as Seni's Law), which has recently received Royal Assent may be the first step in this direction in the UK (BILD, 2018b). Seni's law was introduced following another death, that of Seni Lewis, caused by restraint. The restraint was undertaken by Police but took place in an NHS Trust Mental Health Service. It was deemed that the police had used unnecessary amounts of force. The Bill is aimed at NHS Trusts and although by name focuses on Mental Health Services, as the focus of the Bill is on restraint, it should impact on learning disability services also. The Bill calls for more transparency about the restraint of patients from NHS services and increases in staff training that cover the traumatic impact being restrained has on patients and more training on de-escalation, so that restraint is a last resort. This is not new, we have heard this all before in the plethora of guidance that already exists but as this is now becoming law, it may carry more weight, although as yet the impact of this law has not been seen in practice.

In addition, the Mental Health Act (2015) and the Mental Capacity Act (2005) touch upon the use of RI’s. The MCA (2005) states that before staff members respond to people's challenging behaviour they should decide whether their desired outcomes can be achieved as effectively without the freedom of action of the people concerned being restricted. The Deprivation of Liberty Safeguards (DoLS) (Ministry of Justice, 2008) is an amendment to the MCA (2005). This amendment aims to protect people who cannot consent to their own treatment from care arrangements that deprive them of their liberty, such as the use of bed sides and locked doors, for example. If such interventions are utilised they must be deemed to be in the patient’s best interest. DoLS aims to:

- Ensure service users receive the care they need in the least restrictive ways.
- Prevent arbitrary decisions that deprive vulnerable people of their liberty.
- Provide safeguards for vulnerable people.
- Give people the right to challenge their unlawful detention.

DoLS do not address the emergency use of such interventions when a person’s behaviour is deemed to put others at risk.

Another aspect of the law that impacts on the use of restrictive interventions is the Human Rights Act (1998) and staff should be made aware that to use restrictive interventions on a person breaches articles of this act, most notably Article 3- “Prohibition of torture, no one shall be subjected to torture or to inhuman or degrading treatment or punishment” and Article 5- “Everyone has the right to liberty and security of person”. It can be argued that restrictive interventions can be considered inhumane and degrading and most restrictive interventions by definition are removing a person’s liberty.

The legal framework is in place however it does not seem to have impacted sufficiently on the use of RI's and they are still widely used, as discussed below.

2:4:iii- The extent to which Restrictive Interventions are used:

The latest figures show that RI's are on the increase for patients with learning disabilities. Figures obtained by the BBC File on 4 showed that patients with learning disabilities were restrained 22,000 times in 2017, an increase of almost 50% from 2016 (Adams, 2018). This includes an increase in the use of prone restraint from 2200 in 2016 to 3100 in 2017. This is despite the latest guidance from the government stating services most look to reduce it.

Sturmey (2009) collected data from 509 NHS services which accounted for 3902 patients- a significant sized study. He found that 80% of the services/ units reported using Pro Re Nata (PRN) (as the situation requires) medication and half used physical restraints. Seclusion, mechanical or other restraints were used much less, over 90% of units reporting not using these at all. Although Sturmey's results appear accurate his findings could be scrutinised due to the format of his research, which was the analysis of a survey completed by services around the UK. As the researcher has undertaken secondary analysis, a re-analysis of data collected for another purpose (Gerrish and Lacey, 2010), they are entirely reliant upon others that the results found are accurate and reliable and the researcher had no control over them. However despite these concerns this gives significant insight into the types of restrictive interventions utilised by services.

Sturmey's findings are supported by Webber, McVilly, Stevenson and Chan (2010) who found that chemical restraint was the prevalent type of intervention used. Of the routine interventions utilised (planned and regular interventions), 96% of those constituted routine behavioural medication. Of the emergency interventions, PRN medication constituted

57% of those. Mechanical restraint was a less utilised method of restraint only representing 9% of restrictive methods and seclusion only 7%.

Feldman, Atkinson, Foti-Gervais and Condillac (2004) showed that in a group of 625 individuals with a learning disability (ranging from mild to severe) there were 2625 interventions utilised for 1464 behaviours (553 of which were described as dangerous). They identified that 97.1% of the individuals were subject to some type of restrictive intervention. Their study involved people aged between 2.6 years old to 85.4 years old from a range of services in Ontario, Canada, including residential, vocational, schools and community supported living services. During the research period they found that the highest number of interventions consisted of behavioural control medication with 56.2% receiving this intervention, this was followed by physical restraint (12.3%) with confinement time out the next highest (11.4%). The next biggest was mechanical restraint (5.9%) and seclusion (4.5%). It is not fully explained what confinement time out is and how it differs to seclusion. This study also listed other behavioural interventions such as avoidance training and aversion relief and interestingly the study showed a reliance on aversive approaches over other interventions and approaches. This study also looks at what they describe as formal or informal interventions. Informal interventions means lacking documented input from a professional, written intervention plan and evaluation. Over 55% of all interventions in this study were classed as informal- this is a worrying statistic.

In another large study Deveau and McGill (2009) sent postal questionnaires to adult services in a region of England, these services included NHS, Social Services, Private and voluntary sector. They found that of the 137 services they contacted, RI's were used by 47% of the services on a regular basis including escorting (walking restraints), sitting or floor restraint.

In the study by Emerson, Robertson, Gregory, Hatton, Kessissoglou, Hallam, and Hillery (2000) 53% of the 500 patients displayed challenging behaviours and of that 53%, 44% had been physically restrained, 35% had received sedation, 20% had been put in seclusion and 3% had experienced mechanical restraint. This study involved randomly selected patients from a range of service providers including NHS residential campuses, residential village communities and ten different providers of community based dispersed housing schemes. Robertson, Emerson, Pinkney, Caesar, Felce, Meek, Carr, Lowe, Knapp and Hallam (2005) compared service settings (congregate and non-congregate services) and found patients in both types of services had high use of chemical restraint but physical restraint was higher in the congregate setting with over half the patients being in receipt of physical restraint. Scheirs, Blok, Tolhoek, Aouat and Glimmerveen (2012) in their Dutch study involving 475 residents found that over a period of 14 months 60% of the patients in the study had received a physical or mechanical restraint- although high it is an institution suggesting the patients have higher levels of challenging behaviours.

In a slightly different study in the US Friedman and Crabb (2018) looked at the use of waivers to allow RI's in their services. They found that of the waivers granted, 78.4% allowed restraint. This broad term includes physical, mechanical and chemical restraint, 75.7% allowed restrictive interventions (they define this as limited movement or access to other people, locations or activities) and only 24.3% of the waivers allowed seclusion, showing that restraint seems a more acceptable form of RI. In the US all service providers must adhere to the Social Security Act, which standardises service provision. Waivers allow services to waive key requirements and introduce something different, such as the use of restrictive interventions.

In contrast to the results found above Finn and Sturmey (2009) documented that the use of timeout (seclusion) was the predominant method of restrictive intervention used. The difference in findings could be explained by the fact that the participants within this study were defined as being dual diagnosed- having a learning disability ranging from mild to profound as well as at least one psychiatric disorder. Individuals with a psychiatric disorder may be treated differently in terms of restrictive interventions in comparison to individuals with no psychiatric diagnosis.

In Lovell's (2004) case study of fifteen patients, he found that patients with learning disabilities who self-harm are likely to receive anti- psychotic medication and mechanical restraint. This is a small case study and although the findings conflict slightly with those discussed above this may be due to the nature of the self- harming behaviours, whereas physical restraint appears more likely with aggression to others.

Bowring, Totsika, Toogood, and McMahon, (2017), Chapman, Gledhill, Jones, Burton and Soni (2006), Fleming, Caine, Ahmed and Smith (1996) McGillivray and McCabe (2006) and Niven, Goodey, Webb, and Shankar (2017) explored the prevalence of the use of anti-psychotic medication in those with learning disabilities. All of these papers are British with the exception of McGillivray et al, which is from Victoria, Australia.

Bowring et al's (2017) study looked at a total population in one geographical area with a population of 265 people with learning disabilities. They found that psychotropic medication was being used by 37.73% of the population with anti-psychotics the most common of these, at 21.89%. They also found that polypharmacy and high doses were common and the patients most likely to have these were people who displayed challenging behaviours and were older males.

Chapman et al (2006) surveyed 55 people who were prescribed psychotropic medication. Of these 55, 89% were prescribed anti-psychotic medication with 44% having more than one psychotropic medication. Most concerning however is that many of these people had been on the medication for long periods, without regular review and in 58.2% of the cases with no formal mental illness diagnosis given. A further 3.6% only had a diagnosis of Autism (not mental illness) and 1.8% only had a diagnosis of epilepsy.

Similarly, Fleming et al (1996) found in their research of 118 people with learning disability, 69% were receiving psychoactive medication for the control of challenging behaviours and only 8% had a psychiatric diagnosis. As with other studies polypharmacy was frequent and the medication was continued over long periods without review. Niven et al (2017) reviewed the records of 106 people with learning disabilities and of those they found 61 (58%) were currently prescribed psychotropic medications with no diagnosis of mental illness. Many of these had a diagnosis of autism.

The Australian study by McGillivray et al (2006) provided a comparison between cases reported in 1993 and again in 2000. This study found a slight drop in the number of reported cases, however of those still receiving psychotropic medication there was an increase in drug diversity and polypharmacy, high uses of antipsychotic medications and evidence of long-term use. Although this found a slight reduction in the number of those receiving psychotropic medication the same problems persist. As can been seen from the research above, although Fleming et al is an old paper it seems the findings are similar to that of more recent research.

Lundström, Antonsson, Karlson and Graneheim (2011) in a Swedish study looked at 556 patients with learning disabilities aged 16-90 from 118 group homes. Of these, 99 (17.8%) had been restrained in the previous week of undertaking the study and of these 99.2% had been exposed to more than one type of restraint, including 73.7% being restrained with a belt. It is important to note that some of the patients in this study had physical disabilities and some of the restraint practices were related to these physical disabilities.

The papers reviewed in this section appear to demonstrate that the most commonly used restrictive intervention is chemical restraint. Psychotropic medication continues to be used in people with a learning disability without the diagnosis of a mental illness and often for long periods and without review. The next most prevalent forms of intervention are physical restraint, then seclusion. Mechanical restraint appears to be the least used intervention but is more prevalent in patients who self harm. It is also clear that many patients with learning disabilities are exposed to multiple forms of RI's. Webber, McVilly and Chan (2011) identified that it is common for patients with learning disabilities to be unnecessarily restricted by more than one type of intervention. In this study they found that although 89% of individuals were subject to one type of intervention, 225 individuals approximately 25% were subjected to two types of restrictive intervention. The majority of the group were reported as having been subjected to both chemical and mechanical restraint or chemical restraint and seclusion. Additionally 15% were subjected to three types of restrictive intervention.

This section has gone some way to illustrating the extent to which RI's are used in learning disability services.

2:5- Theme 4- The nature of Patients, their learning Disability and other Diagnosis, the behaviours and staff reactions:

This section explores the nature of the patients, their learning disability and other diagnoses who display challenging behaviours. It will also explore the nature of the behaviours displayed and the interactions chosen by the staff. As there is no formal recording process required in the UK and the research in this area is limited it is difficult to obtain an accurate picture of the type of patients involved in episodes of restrictive interventions and staff responses to them.

2:5:i- Description of the Learning Disability, demographics and settings in which they live:

This section will look at which patients the literature identifies as being more likely to be involved in incidents of RI, and also the level of the learning disability and other diagnoses of the patients who display challenging behaviours and also the demographics and settings in which they occur.

Allen, Lowe, Brophy and Moore's (2009) quantitative study of 839 service settings and agencies for people with learning disabilities in South Wales explored the predictors of restrictive interventions. They screened the services to identify children and adults who displayed challenging behaviours and identified 901 participants from these services. Findings from this research recognised the relationships between types of restraint and patient characteristics such as age, mental health status and types of behaviour. The individuals most at risk of the use of restrictive interventions were those who were subject to formal detention under the Mental Health Act (restraint and sedation), had more severe challenging behaviour (seclusion), showed destructive behaviour (restraint and seclusion) were placed out of area (seclusion) and had behavioural plans in place for specific topographies (restraint and sedation). They also found that younger adult males who were classed as 'less able' were most likely to be subject to RI's. Individual differences such as challenging behaviour and service practices, such as detention under the Mental Health Act, predicted the use of RI's. People who are detained and people who are placed in out of area services are typically those deemed most challenging so this is of no surprise.

McGill, Murphy and Kelly-Pike (2009) identified that people subject to physical interventions were more likely to be young adults, male, not under legal restriction and with a high probability of having an autistic spectrum disorder, so in some agreement with Allen et al above. Research by Chaplin, Tsakanikos, Wright and Bouras (2009); Driescher, Marrozos and Regenboog (2013) and Webber, McVilly and Chan (2011) had similar findings to those discussed above. Chaplin, Tsakanikos, Wright and Bouras (2009) found that people most likely to be exposed to restrictive interventions are young adult males with the presence of autistic spectrum disorders. Likewise Tilli and Spreat (2009) found predictive variables of autism and being male leading to a higher likelihood of receiving RI's while Emerson, Robertson, Gregory, Hatton, Hessissoglou, Hallam and Hillery (2000) also found having a diagnosis of autism means you are more likely to receive RI's. In contrast, Sturmey, Lott, Laud and Matson (2005) found those most likely to be restrained also had significantly higher anxiety, pervasive development disability, schizophrenia, stereotypy, elimination disorder and impulsive control disorder.

Webber, McVilly and Chan (2011) in Australia found that those subjected to restrictive interventions were more likely to be young adult males, with multiple disabilities, including autistic spectrum disorders. Webber, Richardson and Lambrick (2014) again in Australia found that people who had a diagnosis of autism or a mental health diagnosis were more likely to be in receipt of RI's. Webber, McVilly, Stevenson and Chan (2010) also found that twice as many men had been restrained than females but importantly, this is not representative of the population of their study, which was more equally split between male and females. They also found a higher likelihood of having a diagnosis of autism or mental illness as a predictor of RI's.

Driescher, Marrozos and Regenboog's (2013) Dutch study of 421 inpatients with learning disabilities found that those patients that are male and have a history of criminal activity are more likely to be exposed to restrictive interventions. Additionally the study by Scheirs, Blok, Tolhoek, Aouat and Glimmerveen (2012) also from the Netherlands involving 475 patients in an institution aged between 12 and 95 years old identified that people with low adaptive functioning were more likely to be restrained, in agreement with Allen et al (2009) above.

Finn and Sturmey's (2009) study (based in a community day centre) discovered that the majority of individuals (64%) who were subject to multiple restrictive interventions have in addition to a learning disability a further diagnosis in the form of autism (40%), psychiatric illness (23%) and speech impairments (21%). They also found that transition periods and seatwork were the most common antecedents to challenging behaviours leading to restrictive interventions, implying boredom played a part or staff attention being elsewhere.

While the studies already reported looked purely at a sample with learning disabilities, the study by Turner and Mooney (2016) involved comparing people with learning disabilities to those who do not have a learning disability in eleven medium and low secure services. They found that people who did not have a learning disability spent longer in seclusion than those with a learning disability but interestingly and the reason for inclusion in this section, is that in both the LD and non-LD populations males spent twice as long in seclusion to females reflecting the findings of Webber, McVilly, Stevenson and Chan (2010).

It can be seen from the literature reviewed above that those most likely to be exposed to RI's are young adult males and have further complications including an autistic spectrum disorder, mental health problem or communication difficulty.

A further notable point identified from the literature is that most incidents of RI's are concerning a small number of patients. This is illustrated in Sturmey's (2009) large study of 3902 patients who noted this and in support, Webber et al (2010) who also found that a small number of patients are involved in the majority of the incidents of restraint and experience multiple types of restraint. Finn and Sturmey (2009) concur with those above in that within the first year of their study 17 of the participants (from a sample of 81) were accountable for 92% of restrictive interventions.

2:5:ii- What behaviours lead to restrictive interventions?

In Allen, Lowe, Brophy and Moore's (2009) large study of 901 people who displayed aggressive or destructive behaviours and had behavioural plans in place to monitor aggression, self-injurious and destructive behaviour, 22 per cent of participants experienced seclusion and these were patients who were described as more likely to show aggression, destruction and had more severe behaviours ('more severe' is not defined by the researchers). Webber, Richardson and Lambrick (2014) found that displaying aggression to others was the main factor leading to being secluded while self-harming behaviours led to physical restraint. Kaye and Allen (2002) employed a simple monitoring form to audit the frequency of usage of restrictive interventions during a 9-month time frame. Their study also identified similar reasons leading to the use of restrictive interventions including aggression, verbal abuse, self-injurious behaviour, arson, inappropriate sexual behaviour, absconding and environmental damage. Although 905 of these were release or breakaway techniques, 4% were removal (a type of walking restraint to move the patient) and physical restraint. The paper does not describe which behaviours led to which intervention.

Merineau-Cote and Morin (2013) provide support for all of the above research using questionnaires to gather data. A total of 192 questionnaires were distributed to support staff with a return rate of just 91, however in order to participate in the study respondents were recording about participants that had to meet set criteria including the diagnosis of a learning disability, to be age 18 or over and to have demonstrated at least one aggressive behaviour in the last six months. The set criteria allow the researchers to only obtain information from the desired participants, therefore excluding potential data from the wider sample who did not fit their criteria. Their results showed all participants presented at least one type of aggressive behaviour and 81.5% manifested two or more types of aggressive behaviour, 75.3% exhibited aggressive behaviour towards themselves, 75.3% towards others, 70.4% towards the environment, 51.9% verbal aggression and 40.7% inappropriate sexual behaviour. They found that all patients were on regular prescribed medication (but no detail of this is given) and 56% were prescribed PRN medication (again no detail is given but one assumes this is for behavioural purposes). During this study 63% received some form of RI for aggression to others, self or property, 44.4% were secluded, 42% physical restraint and the rest mechanical restraint. Of concern is that there were cases of seclusion (8), mechanical restraint (1) and physical restraint (1) for verbal abuse.

Sturmey, Lott, Laud and Matson (2005) identified similar results to those above regarding the types of behaviours displayed which led to restrictive interventions, recognising that physical aggression towards others accounted for 87% of these and where intense displays of emotion accounted for 79%. Least commonly reported challenging behaviours include antisocial behaviour (32%) and inappropriate sexual behaviour (30%). The findings by Sturmey et al show that the group that had been subject to restraint generally scored higher on measures of psychopathology and maladaptive behaviour.

Merineau-Cote and Morin (2013), Jones and Kroese (2007), Fish and Culshaw (2005) and Kaye and Allen (2002), all identify relationships between displays of behaviour and restraint use. Qualitative studies were undertaken by Jones and Kroese (2007), Dagnan and Weston (2006) and Fish and Culshaw (2005) and these studies involved the use of open unstructured interviews focusing on the views of individuals, both staff and patients. The findings of the studies are also comparable where Jones and Kroese (2007) found that factors rated as important to the contribution of restraint included feeling angry, being upset and causing trouble, leading to physical aggression. The sample included individuals with a mild learning disability who had been subject to restraint within the last six months. Dagnan and Weston (2006) interviewed NHS staff who stated that physical restraint was likely to be used for physical attacks on others more than for any other behaviour while Fish and Culshaw (2005) also recognise aggression to others as the main reasons for physical restraint. Similarly, Driescher, Marrozos and Regenboog's (2013) in their Dutch study found that physical assault is the main behaviour leading to the use of RI's as did Chaplin, Tsakanikos, Wright and Bouras (2009) who also found that physical assault was the behaviour most likely to result in restrictive interventions.

In contrast, Scheirs, Blok, Tolhoek, Aouat and Glimmerveen (2012) in another Dutch study of 475 patients in an institution, stated that behaviours other than aggressiveness were also a predictor of restraint which is of concern suggesting it may be being used unnecessarily. They did an archival study of patients documentation and the behaviours identified by the authors included destruction of goods, stealing food, eating inedible things, temper tantrums, smearing of faeces, withdrawal from group activity and stereotypical ways of acting. While some of these may appear to be a reasonable reason for the intervention (such as eating inedible things which may be highly dangerous to the person) others are not justifiable reasons for restraint (stealing food, temper tantrums, smearing of faeces, withdrawal from group activity and stereotypical ways of acting).

The paper below has a different focus to others in this section. Lundström, Antonsson, Karlson and Graneheim (2011) in a Swedish study investigated the prevalence and characteristics of individuals subjected to restraint. This study was somewhat different to the others discussed above in that many of the people they looked at had severe physical disabilities and many of the restraints used were for the purpose of supporting standing and other physical needs. However, some were for the purpose of behavioural management and the behaviours identified, which resulted in physical person to person restraint, were screaming and shouting (29.3% of the restraints) and refusing to get dressed (20.2% of the restraints). It is alarming that restraint would be used for such apparently minor behaviours. It is even more alarming that the paper identified that the services included in this research had no legal authority to restrain.

The literature reviewed in this section has identified that physical aggression and self-harm are the main types of challenging behaviours most likely to lead to restrictive interventions, on the whole with only some studies showing differences to this.

2.5.iii –Effectiveness of restrictive interventions:

There is little evidence to support the use of restrictive interventions having any long term effect on challenging behaviours. Evidence suggests that seclusion has no therapeutic value (Paley (2009) cited in Paley-Wakefield (2012), Allen, (2011)) and there is conclusive evidence that psychotropic medication is ineffective in reducing severely challenging behaviours (Deb, 2009 cited in Allen, 2011 and Tyrer et al 2008).

Two papers look at the effectiveness of medication, one mentioned earlier in this chapter is the research by Tyrer et al (2008) and the second used information from this same research (with many of the same authors), Romeo et al (2009). The original research by Tyrer et al (2008) looked at 86 patients from England, Wales and Australia who were randomised to groups to receive Risperidone, Haloperidol and a placebo. This research found aggression decreased in all groups but the biggest change was in the placebo group.

Romeo et al (2009) looked at the groups from England and Wales and reviewed the costs of these interventions. The groups from Australia were excluded due to differences in the funding. The costs included actual financial costs of the medication and the staff to support the patients but also looked at quality of life. This research found lower cost to the group given the placebo, aggression was highest from the group on Rispridone and quality of life was lowest from the group who had Haloperidol.

Further research on seclusion comes from Iwata, Rolider and Dozier (2009) where their study aimed to evaluate the use and effectiveness of timeout programmes. The study included 34 adults with a learning disability along with a form of challenging behaviour requiring formal treatment programmes and timeout was being used as part of the individual's programme as on-going treatment. Findings concluded that following the removal of timeout, 21 cases showed no increases in problem behaviour and no additional interventions were warranted. However, in 13 cases problem behaviour increased following timeout removal, but alternative less invasive techniques were implemented for all but 3 cases. This process resulted in the elimination of seclusion and timeout for 92% of cases. This study demonstrates that individuals are often subject to some type of restrictive intervention as part of a ‘routine’ or ‘behavioural plan’ however it has been demonstrated that this is not always necessary and alternatives could be identified.

2.5.iv- Risks associated with restrictive interventions:

The risks associated with restrictive interventions are high resulting in staff and patient injury and patient death as well as the potential for long-term psychological distress. Furthermore, inquiries into restraint related deaths suggest that people with learning disabilities are especially prone to suffering adverse consequences of being restrained due to a number of factors including being overweight (linked to their condition), the nature of the medication they may be on, cardiovascular disorders associated with some conditions in the population with learning disabilities and neurological issues to name but a few (Perry, White, Norman, Marston, Auchoybur, 2006).

Three papers were identified that looked specifically at restraint related injury or death of the person restrained. One of the main drives behind the ethical discussions on the continued use of RI’s is the risk of injury and death to both the patient and the members of staff. The studies by Tilli and Spreat (2009) and Williams (2009) were both quantitative studies from the US and looked at injuries sustained by the person restrained during RI’s. Tilli and Spreat (2009) did a simple frequency count over the period of a year. The participants were people with learning disabilities and, as described by Tilli and Spreat, significant behavioural problems. There were 123 males and 34 females with an age range of 6 to 45. In that time there were 1325 restraints applied, they explain the only restraint allowed is ‘emergency personal restraint’. Although it is not explicit the paper implies this means person to person physical restraint. Of the 1325 restraints, 15% of them failed to record if an injury occurred. Of the remaining 85% patient injury was reported 33% of the time. They determine that those injuries were minor (abrasions, bruising etc).

Williams’ (2009) study in a setting described as a large intermediate care facility looked at restraint use of 209 individuals with learning disabilities over a 12 month period. It looked at the use of both planned and unplanned restraints and the restraints included physical person to person restraint and mechanical restraint. They found that the injury rate was 0.46 injuries per hundred restraints, again a statistically insignificant number. Of the injuries reported, 60 were deemed non-serious and two serious. Their study also highlighted that planned restraints were safer than crisis-intervention or emergency restraints.

Paterson, Bradley, Stark, Saddler, Leadbetter and Allen (2003) reviewed restraint related deaths from a period covering 1979 to 2000. They searched through literature including health journals and the regular press and found twelve restraint related deaths of the patient in either learning disability or mental health services, in either health or social care environments in the UK. This figure may well be regarded as small based on the actual numbers of restraints that will have taken place over this time period, however this is not a statistical issue it is a moral issue and one death is too many. Their study illustrated certain techniques contributed to these deaths, including prone restraint, techniques that involve holding the neck and a technique referred to as ‘hobble tying’. This involves the hands being tied together behind a person’s back, the feet being tied together and then the hands and feet being tied to each other (Paterson et al, 2003). This highlights the importance of considering what type of restraint techniques are used and not just whether or not restraints are used.

As mentioned above although the number of injuries may be regarded as small and the number of deaths small, this issue should not be viewed as a statistical issue, it is an ethical issue and any injury or death is too many. Interestingly the above studies focus on patient related injuries and there appears to be a gap in the information about staff related injuries. Only one paper was found in this literature review that addressed staff injuries. In their qualitative paper Lovell, Smith and Johnson (2015) found some staff spoke about the need for RI's to be used earlier, not as a last resort, in order to avoid staff injuries. Importantly this research was undertaken in a secure learning disability service which may have a bearing on the nature of behaviours exhibited as they are more likely to be more challenging, physically able people more able to hurt staff.

Despite this evidence demonstrating the risks of RI's they continue to be a main response to challenging behaviours in many learning disability services.

2:5:v- The impact of Staff Training on Restrictive Interventions:

The literature search conducted produced many research papers on staff training but much of this research was determining staff knowledge of challenging behaviours (causes etc) and these papers were excluded as the focus of this literature review is on research that focuses on RI's.

Ten research papers were identified that did focus on training in RI's and the findings of these are highlighted below. Before the findings are addressed however a general note of caution must be used when looking at these findings as some of these papers had problems regarding bias in that the research presented in the papers was undertaken by the training organisations or people researching their own training and their own techniques. What also needs to be reiterated here is that training in RI's is a free market and anyone can create a business to deliver training in this area so consequently huge variation exists regarding the nature of this training. The British Institute of Learning Disabilities (BILD) run an accreditation scheme for training organisations and any that are accredited are required to deliver the training in RI's as part of an holistic approach including theory on why challenging behaviour occurs and proactive approaches. The techniques also have to be ones that do not require pain compliance to be effective. However, even among those organisations accredited there is a wide variation of this content and the physical techniques taught. In addition, this is an optional scheme and organisations do not have to be accredited to continue to operate.

Exactly what is taught to staff members is a decision made by individual service providers. Some services will chose to only have their staff taught release techniques and the reasons for this vary. It may be the service has patients that can be challenging but this degree of challenge is the easier types of behaviours to deal with such as grabbing of wrists and does not escalate further into physical attacks on others. Alternative reasons for only teaching staff release techniques could be simply the service in question has a no restraint policy or the other reason staff may only be taught release techniques could be if they are lone workers. Community based staff who go into the patient's home alone may require release skills but nothing further.

Of the research discussed in this section, all studies are from the UK. Baker and Bissmire (2000) report on pre and post training questionnaires for staff working in the independent sector. The training is a two day package that is delivered by an organisation that is accredited with BILD. In the study by McKenzie, Powell and McGregor (2004) the duration of the training and the nature of it is not discussed. The McDonnell (1997) paper focuses on a three day training package delivered by an organisation that is BILD accredited and again uses a pre and post training questionnaire. Durnin and Freeman (2005) focuses on a 12 day training package delivered to an NHS organisation and again is based on pre and post training questionnaires. More information is not given regarding the training.

Five of the eight papers identified highlighted positive impacts following training in RI’s. Unsurprisingly it is in some of these papers that the research was undertaken by the training providers. Baker and Bissmire (2000) McKenzie, Powell and McGregor, (2004) McDonnell (1997) all undertook quantitative surveys and identified that the participants felt more confident managing incidents of challenging behaviour following the training. While this may seem like a positive outcome, it is not if that confidence only comes through the use of RI’s.

McDonnell (1997) found, along with Durnin and Freeman (2005) increased knowledge following training. Edwards (1999) stated that staff self reported that they communicated better and had better teamwork when dealing with challenging behaviours following training. This paper consisted of qualitative interviews and the duration of the training is not explained but it is described as ‘Control and Restraint’ training. In contrast however, Lovell, Smith and Johnson (2015) stated that the staff found that the training did not prepare them for the realities of dealing with challenging incidents and undertaking RI’s with patients that are larger than them. They stated that the simulated staged incidents were done slower than the speed with which incidents occur in reality.

Additionally, Baker and Bissmire (2000) found that the training had no impact on the number of incidents experienced in the service but the use of RI’s did increase following the training. This is an interesting find, that the use of RI’s do not impact on the number of incidents, as they are merely reactive but after training staff may be relying on these techniques rather than attempting other approaches, such as proactive approaches or de-escalation.

Murphy, Kelly-pike, McGill, Jones and Byatt (2003) in their survey of 341 respondents from a range of service provision across the UK, found twelve different types of RI training were recorded and not all staff in services received training. As mentioned above, there are many businesses and organisations that deliver training in this area. The vast array of techniques can be problematic for staff and patients alike moving between services.

Kaye and Allen (2002) showed that even when staff are trained they do not use the full range of techniques taught to them. Their study was based on only one acute admissions service but they showed of the 42 techniques taught to the staff there, they were only utilising 15 of them. Forty two techniques does seem rather a lot and one could argue that fewer techniques being taught are better, due to there being less to remember potentially leading to staff actually getting them right.

Luiselli, Sperry and Draper (2015) found that staff viewed RI's as being more socially acceptable following the training, in contrast to other research in this area (including Cunningham, McDonnell, Easton and Sturmey, (2003) discussed further below in section 2:6:ii of this chapter).

The above papers show a wide variation in the nature of training offered. Although some research demonstrates an increase in the use of RI's following training, there should be a minimum requirement for some training for any staff involved in utilising them. There is also an argument for streamlining the training offered (less techniques) and the type of techniques taught.

2:5:vi- Restrictive Interventions are being utilised by staff with no policy or training:

A further find from the literature is that some services utilise RI's without appropriate training or policies in place.

Deveau and McGill (2009) contacted services in a region of England, including NHS, Social Services, Private and the voluntary sector. They found that of the 137 services they contacted, of those using physical interventions only (the term used in their paper so not restrictive interventions, but breakaway techniques only) just 65% had a policy. This figure does increase when those interventions are restrictive interventions to 82%, but this shows that 18% of services use RI's without a policy in place for their use. Similarly, Murphy, Kelly-pike, McGill, Jones and Byatt (2003) in their survey of 341 respondents from a range of service provision across the UK, found that two thirds had (or were developing) a policy, meaning that one third did not. While it is acknowledged that these figures are a little old it is shocking to think that RI's are used in services that do not have policies regarding their use and appropriate recording of the use.

Similarly Murphy et al (2003) found in services that were utilising RI's, not all staff in these services received training in them, while Deveau and McGill (2009) found that of the 137 services they contacted, RI's were used by 47% of the services on a regular basis and of these, 79% had staff that were trained to use them. This figure shows then that a shocking 21% of services had staff using RI's that had not received training on how to do so. It is abhorrent to think that staff are implementing RI's without training, raising the risk of injury to staff and patients and leading to accountability issues for the professionals involved.

Appropriate guidelines or policy and staff training should be a minimum requirement in services utilising RI's. Robust policies and guidelines can make it safer for all concerned and work towards reducing or eliminating restraint related injuries and deaths, both in the patient and staff groups. Appropriate policy, guidelines and legislation can ensure that all staff have a clear understanding of what techniques to use, when to use and the recording of any interventions. This is needed to ensure that any use of RI's is a transparent process. Appropriate training will ensure that staff members carry out safe interventions and holds that minimize the risk of injuries. The studies reviewed in this section present a sound justification for a statutory minimum requirement of policy and guidelines in place for staff, alongside robust training packages.

2:6- The perspectives of those involved:

This next section explores what do those involved in the use of restrictive interventions actually think about its use. Investigations into the impact the use of restrictive interventions has on those directly involved is scarce, their voices being somewhat on the periphery of the issue, not central to it, as should be the case.

2:6:i- The patient perspectives:

Previous work by Barksby (2008) involved a phenomenological study of the past experiences of people with learning disabilities who had been restrained, secluded, given medication to control their behaviour or other restrictive interventions (RI's). The sample in this study were people with learning disabilities who had a history of being exposed to RI's but had not experienced them for many years. In this research people reported many negative emotions associated with these memories, such as fear, anxiety and dislike of staff. However, some spoke of positive memories including 'playing up' for a laugh or when they were bored and 'playing up' when certain staff were on shift as they knew those staff struggled to restrain them. These findings raised the question of whether these recalled memories were accurate or if they were part of the person's coping strategy to deal with these past events.

This section of the literature review will explore further what the existing research shows. Six of the papers looked specifically at patients' perspectives of RI's and these were Murphy, Estien and Clare (1996), Sequeria and Halstead (2001), Hawkins, Allen, and Jenkins (2005), Fish and Culshaw (2005), Jones and Kroese (2007) and Merineau-Cote and Morin (2014).

Qualitative approaches were utilised in all the studies above and semi-structured interviews were the main source of data collection, as these are the best way to gain access to experiences, particularly in people who feel disempowered by their condition (Low cited in Saks and Allsop, 2013) as it can be argued many people with learning disabilities are. In all the studies the samples were consistent with that of qualitative studies, ranging between 5- 10 patients, except in the case of Murphy et al (1996) who interviewed a slightly larger sample of twenty six. All studies are from the United Kingdom apart from Merineau-Cote and Morin (2014) which is French. All studies interviewed patients with learning disabilities about their experiences and feelings of restrictive interventions and all six papers discuss findings of negative emotional experiences. These similarities in results strengthen all papers reliability and validity (Basit, 2010).

Murphy et al (1996) interviewed patients to explore many aspects of quality of life, one of which was restrictive interventions and they found that their sample had very strong negative feelings. They had experienced seclusion, restraint and chemical restraint and reported feeling sad and scared, although two patients in this study reported 'mixed feelings'. The report from Sequeira and Halstead (2001) found that individuals with learning disabilities held the perception that restraint was used for punishment and control; for staff to “prove they are in control”. The patients in this study reported pain, anxiety and mental distress, feeling sad, feeling bad and upset. The findings of Hawkins et al (2005) support these and participants’ accounts were primarily negative: they cited negative emotions including general dislike, sadness, fear, anxiety and disappointment.

A finding from Fish and Culshaw (2005)’s qualitative study of staff and patients was that the patients felt that physical interventions are sometimes used unnecessarily and therefore when implemented can be a distressing process for individuals experiencing them. They also found that patients feel physical restraint is used more often than needed, where other methods could be utilised, and patients felt that it was not always used as a last resort option (as the guidelines state it should be).

This is supported further by Jones and Kroese (2007) who discovered that negative feelings of sadness, anger, confusion and fright are experienced by individuals subject to physical restraint. It was found that these emotions were recognised both during and after restraint. Fish and Culshaw (2005) also found that the patients in their study reported feeling distress and negative emotional feelings but also that patients often felt physical pain as a result of restraint, often regarding this as a type of punishment. They found that patients felt more anger and frustration as a result of restraint as opposed to feeling calm or relaxed, they explained that it made them want to struggle and led to ‘kicking off’ more. Additionally, they described that in many cases the use of physical interventions was traumatising as a result of past experiences. They explained that the use of RI’s brought back memories of frightening experiences of sexual abuse especially if restraint was carried out by men. Merineau-Cote and Morin (2014) also found patients felt negatively about

RI's, and reported they felt sad and angry although some reported they understood why it was used.

The other two papers in this section had a different approach to those identified above. Cunningham, McDonnell, Easton and Sturmey, (2003) showed recordings of different types of restraint and ask the participants to rate them. Some of their participants were patients. This involved three types of restraint, two on the floor and one using a chair and although all types were viewed negatively by patients the chair restraint was viewed as least worse. Caution must be used with this paper as the research was undertaken by people from an organisation who teach the chair restraint technique.

One paper identified in the literature search looked specifically at patients' knowledge of their medication. Crossley and Withers (2009) conducted a grounded theory study and found that patients had very little knowledge about their medication, beyond their regime. They experienced side effects but some did not understand these, for example some who experienced drowsiness assumed the medication was given to them to make them sleep. Some expressed that the medication was to help them.

The final paper in this section is that of Crossley and Withers (2009) who as mentioned in the medication section above asked patients about their medication. The findings are, that on the whole patients feel negatively about the use of medication, there was little understanding of what it was for or knowledge of side effects.

Although the papers discussed cover a wide time period the consistency in the findings gives credibility regarding the validity and reliability of them. However, some caution must also be used as the studies are, on the whole, retrospective studies relying heavily on recall memory of the participants which is a significant limitation of these studies. It is important to know what patients understand about restrictive interventions as if they believe they are administered as punishment or if their administration reawakens past trauma, then their long term effectiveness will be negative.

Earlier in this literature review, when talking about aspects of our current laws that impact on the use of restrictive interventions the Human Rights Act was discussed. In the previous section it was highlighted that the use of restrictive interventions is breaching articles 3 and 5 of the Human Rights Act (1998) (freedom from torture and inhumane or degrading treatment and the right to liberty and security respectively). However, if the use of restrictive interventions is deemed as punishment by those in receipt of it then one could also argue that it is breaching article 7- no punishment without law. Therefore, the use of restrictive interventions is breaching potentially three articles of the Human Rights Act and is a human rights issue for all those involved.

Although it is important to gain the perspective of patients, it must also be acknowledged that any research involving people with learning disabilities will not be representative of the whole population as those involved need to be able to understand the nature of the questions and have the ability to answer them.

2:6:ii- Staff perspective:

The research in this area is particularly scarce, highlighting the need for more research being undertaken on the perspective of staff. Of the papers found for this literature review only seven of them addressed the perspectives of the people involved in the implementation of RI's. However, of those seven, three of them relate specifically to training and so are only briefly touched upon here. Of the remaining four papers, all are qualitative approaches and two of these involved patient and staff dyads and focused on specific events rather than all memories of RI's. These two are Hawkins, Allen and Jenkins (2005) and Merineau- Cote and Morin (2014). Hawkins, Allen and Jenkins (2005) study found that staff experienced negative emotional reactions prior to using restrictive interventions, expressing frustration as well as fear, anger, distress and dread. They also expressed feeling dread, fear, anger, sadness, worry, shock and frustration during the interventions, while they described feeling like they were 'walking on eggshells' and feeling drained afterwards. Merineau- Cote and Morin (2014) also reported that staff said carrying out the interventions was upsetting and traumatic for them, causing feelings of guilt, self-reproach, anxiety and disappointment. The staff involved in the Merineau- Cote and Morin (2014) study also stated that they felt RI's did not help calm the person down and that they felt that they were viewed by patients as punishment.

Similarly, Fish and Culshaw (2005) and Lovell, Smith and Johnson's (2015) stated that the staff they interviewed felt that using RI's was upsetting and traumatic leading to feelings of self- reproach and guilt, they described being devastated, being upset and blaming themselves. They also identified that staff felt they understood why patients felt they had to fight. Not surprisingly, staff reported having negative feelings about being assaulted.

Two of the papers looked at staff knowledge of medications used as a RI. Fretwell and Felce (2007) and Donley, Chan and Webber (2011). Fretwell and Felce (2017) is a British paper and Donley et al (2011) is Australian but alarmingly the findings were similar in that both identified staff have limited knowledge of the medications use and the potential side effects and both identified staff felt they required more training on this. Some of the staff in Fretwell and Felce (2007) were qualified nurses which is particularly alarming as it is the duty of any qualified nurse who is administering any kind of medication to know what that medication is for and the main side effects to look for.

Some of the research on staff perspectives has already been discussed above in the training section. Briefly to recap: Edwards (1999) reported staff felt better about utilising RI's following training, they expressed improvement in teamwork and communication between them and also expressed that the training legitimised the use of RI's and gave them clear rules in which to work in. However, training does not always dispel the negative feelings identified in the studies described above. In Lovell, Smith and Johnson (2015) staff stated that training did not prepare them for the realities of an actual incident and utilising RI's in practice. In the training they rehearsed the techniques in a role play situation but staff said they were done too slowly and the staff acting as patients were not as big or as aggressive as real life situations. Cunningham et al (2003) showed recordings of different types of restraint and ask the participants to rate them, the staff involved in this study also viewed all restraint techniques shown to them negatively but, like with the patients, viewed the chair restraint the least worse. The only paper found that did not indicate a negative view of RI's was Luiselli, Sperry and Draper (2015) that found that staff viewed RI's more socially acceptable following the training, this is in contrast to other papers in this section.

Although there is little research in this area, from that discussed it appears that the feelings from staff are predominantly negative. If this is indeed the case, it could lead to a reluctance to implement RI's when appropriate, misapplication of RI's and increasing staff turnover.

None of the papers in this section of the literature review specifically mention the term but it could be argued that the negative feelings mentioned in the literature above lead to moral distress in the staff involved. Indeed, this also links to the point raised in the introduction about those questions raised by the researcher based on her experience.

One well-established definition of moral distress is that “it occurs when one knows the right thing to do, but institutional or other constraints make it difficult to pursue the desired course of action” (Raines, 2000, p. 30 cited by Kälvemark, Höglund, Hansson, Westerholm and Arnetz, 2004). The researcher indeed questioned her actions when using restrictive interventions and considered how many other people come into this type of role with the intention of doing good, beneficence and not doing any harm, non- maleficence and yet find themselves implementing interventions that it could be argued are indeed doing harm.

Research on moral distress tends to focus on nursing in acute generic services such as emergency departments and findings show that moral distress can impact on job satisfaction, stress, retention and reduction in the quality of care (Spenceley, Witcher, Hagan, Hall, Kardolus-Wilson, 2017), no research was found on moral distress in learning disability settings and furthermore; importantly there is no research that considers the impact that staff exposed to moral distress have on the patients at the centre of this situation.

It can be argued that the use of restrictive interventions has become institutionally accepted practices in many service settings including learning disability services; a practice that may be morally and ethically jarring to some professionals leading to moral distress; however, this is an assumption that may not be true. As mentioned, no research was found in learning disability services around moral distress but research by Spenceley, Witcher, Hagan, Hall, Kardolus-Wilson, (2017) with staff involved in the care of people with dementia demonstrated a range of issues that lead to moral distress in those staff including conflicting expectations around care. One such conflict identified was the lack of medication prescribed to manage a patient's behaviour, resulting in those staff being exposed to violent behaviours. So rather than the issue for these staff being the use of a restrictive intervention (in this case medication) it was that they were not using it enough exposing them to violence. It will be interesting to explore if staff in this research experience moral distress around using restrictive interventions or the opposite, that the interventions are not effective enough, thus leading to moral distress. Indeed, as with caring for patients with dementia, staff working with those with learning disabilities are also exposed to violent behaviours from the patients.

The limited research in this area reinforces the need for further exploration. Only one of the papers covered in this section explored what staff think the patients feel and none explored what other patients who are observing the RI's may feel. In addition, no existing research explores positive outcomes from the use of RI's, all of which are covered in the research covered in this thesis.

As mentioned there is a noticeable absence of research that directly asks the key groups involved with RI's, the patient and staff what the impact of these interventions are on them.

2:7- Summary and conclusion:

This chapter has explored violence and aggression in health services, particularly in learning disability services and how they are managed. It has discussed the terminology used and what the different types of restrictive interventions are, as well as looking at the available guidelines and legislation.

It has looked at the literature regarding the extent that RI are used and it has also explored the nature of patients most likely to be subjected to RI's. Although the literature has found differences, it does indicate that young men with an additional diagnosis (of Autism or additional need) are more likely to be subject to RI's although some literature indicated that those with anxiety and who are less able are more likely to be subject to RI's. The literature highlighted differences in the types of interventions utilised but that most commonly utilised RI appears to be medication and physical restraint. These interventions are utilised primarily for physical assault and self-harming behaviours. These differences in findings illustrate the need for further research in this area and should be used to inform services particularly short- term assessment services.

It has reviewed literature that questioned the effectiveness of RIs and explored the risks they present, injury and death to those involved. The literature explored on the whole has demonstrated the ineffectiveness of RI's, raising the question as to why it continues to be the main response from services for patients with learning disabilities.

It has explored the training available to staff and what those most important groups, the staff and the patients perspectives are. In the training section it has been highlighted that training had no impact on the number of incidents experienced in the service but the use of RI's did increase following the training. It is alarming that some staff are utilising RI's without training or without policies in place regarding their use. There should be a minimum requirement of the level of staff training in any service where RI's are being utilised and a policy outlining the appropriate use and actions to be taken afterwards, such as recording practices. Regarding what both the patients and staff feel about their use, patients express that being restrained does not calm them down but does in fact make them more angry and want to display aggressive behaviours and staff expressed they feel guilt and are angry about using them. It is a concern how little research exists on these two groups- the two groups central to this issue and most impacted on when RI's are utilised. This literature review reinforces the need for further research into the area of patients' and staff perceptions as there is limited research in this area. Given then the increase in use, risk of injuries/ death, the huge variation in approaches to training and negative feelings from staff and patients the question could be asked why these interventions are still utilised as a standard approach to challenging behaviours. There is a need to establish if they are increasing and when and how are they being used, what behaviours lead to their use. There is a need to establish whether staff and patients can illuminate more about why they are being used and in what circumstances and what their opinions are on the use of RI's.

As mentioned in the introductory chapter, this research and indeed the researcher is not looking to create an argument to eliminate all reactive interventions. Clearly some patients present risks to themselves and others that require emergency management strategies and therefore it is not possible to eliminate the use of RI's in some populations, however well informed staff should lead to a reduction in its use. This literature review has looked at the existing research to highlight the current knowledge, demonstrate the gaps in that knowledge and acknowledge some of the challenges presented to staff, patients and service providers when utilising RI's.

Another thing to note is that challenging behaviour and the use of RI's is an international issue with literature from across Europe, the United States, Canada and Australia represented in this literature review with little difference demonstrated between the literature from these parts of the world.

While concerns have been raised about the use of RI’s in the above discussion it must also be acknowledged that some people with learning disabilities pose a risk to themselves, other patients, staff and members of the public and in some cases emergency use of RI’s are required. This research will however be exploring what the impact of these interventions is on those involved.

The effects of RI’s have been once again highlighted in the media and professional reports. Bearing in mind that much of the literature reviewed has had to rely on poor recording of incidents, the move towards the implementation of routine data collection in the larger organisations can provide a better picture of the impact RI’s have on the service. However, these data are just one facet of their impact. It is vital to ascertain the perspectives of these involved as well to look at the impact these interventions have.

The research aims are therefore:

1. To study the nature of incidents kept on record.
2. To explore the types of challenging behaviour exhibited and what the current interventions are and how incidents are managed.
3. Gather information from staff regarding the nature of incidents that occur.
4. To attempt to fill the gap in the currently available research on staff perceptions of these incidents.
5. To attempt to fill the gap in the currently available research on patients perceptions of these incidents.
6. To study the impact these incidents have on both staff and patients.
7. To make recommendations about how incidents can be managed in the future.

The evidence of the adverse effects of RI’s, the moral and ethical scrutiny and call for a change in practice discussed above is part of the reason why this research is timely; to establish the extent that RI’s are used and what staff and patients actually feel about the use of such approaches.

Chapter 3- Methods.

3:1- Introduction to this chapter:

This chapter gives a full overview of the research and methodological approaches undertaken. It will do this by giving a brief overview of the whole of this research project, it will describe the setting for all of the research and then a more detailed description of the methodological approaches in each element of the research.

3:2- Brief overview of this research:

The research consists of three parts, a quantitative study (which consists of a documentary analysis generating descriptive statistics) and two follow up qualitative studies, one involving qualitative interviews of staff and a second, involving qualitative interviews of patients. All three parts were undertaken in a specialist NHS learning disability service.

The first part of the study, the documentary analysis, took one year. The qualitative studies took a further two years, one year for the interviews of staff, transcribing and analysis, then one year for the patient interviews, transcribing and analysis. Below is a more in depth explanation of the process.

3:3- Setting for all three parts of the study:

To undertake the research required access to records and people at a learning disability service. The service chosen was a large NHS Trust in the Midlands that provides a range of services for people with learning disabilities. The range of services includes high secure services, locked rehabilitation services, assessment and treatment services (both for in-patients and as an out-patient service), day service provision, respite/ short breaks services and community learning disability teams. The researcher requested access to the division of the Trust that included all of the above apart from the high secure service.

3:4- Confidentiality:

Throughout this thesis reference will be made to this service, including the NHS Trust, specific services and departments within that Trust and patients and staff involved in the interviews. In order to maintain confidentiality all names (of services and people) and any other identifying factors are withheld, this is in line with the NMC (2018) and in accordance with the ethical approval received for this research.

3:5- Ethical approval:

Ethical approval is essential in health care research. The need to gain ethical approval to undertake research was introduced following many historical cases where people were involved in research without consent, without the right to refuse and in many cases, research that imposed harm on them.

Ethical approval was sought and gained to undertake this research and the proof of ethics committee approval can be found in appendix 2. The rights of all participants involved in research are vital however it is particularly necessary when involving a vulnerable group in research, such as people with learning disabilities. Despite being a vulnerable group and the challenges this presents when gaining ethical approval it is vital that people with learning disabilities are actively involved in research in line with the United Nation's Convention on the Rights of Persons with Disabilities (UNCRPD) and "nothing about us without us," which strive for the participation of people with intellectual disabilities in all aspects of life (Shakespeare & Watson, 2002; United Nations, 2006). More details regarding the process for gaining consent from the staff and patients involved can be found below in 3:8:iii and 3:9:iii.

3:6- Justification for the use of methods chosen in all three parts of the study:

Parahoo (2006) describes a research design as “a plan that describes how, when and where data are to be collected and analysed” while Burns and Grove (2003) state it is “a blueprint for conducting a study”. Lacey (2015 in Gerrish and Lathlean, 2015) explains that the research design is the most important part of the research process as it affects all other stages (such as sample selection, for example) and this section will present theoretical justification for the research design chosen.

There have been numerous hierarchies of evidence published in recent years with the growing emphasis on the need for robust evidence based practice in healthcare. Many of those hierarchies, such as that presented by Beck and Polit (2010) and others can help researchers identify the strength of evidence. The ranking is based on the validity of the research with much of that focus on “effectiveness”. This focus puts randomised control trials (RCT’s) at the top of many of these hierarchies and RCT’s are considered the most reliable evidence (Muir Grey, 1997, Sackett, Rosenberg, Gray, Haynes, and Richardson, 1996). Indeed, Parahoo (2006) identifies a RCT as the ‘gold standard’ of research design and places descriptive and explorative research lower down the hierarchy. Evans (2003) questions these existing hierarchies however and argues that the current focus on effectiveness is limited and other things should be considered including appropriateness. In many areas of study ‘effectiveness’ is not appropriate and indeed that is the case with this research as the purpose was to explore the impact of restrictive interventions, in part one looking at the frequency and nature of interventions utilised. Additionally, in the second and third element of this research the focus is on the experiences of those involved and again a RCT would not be an appropriate way to explore such concepts.

Many researchers follow, and argue the case for, just one paradigm, either the quantitative or qualitative approach and argue against integrating the two. Some argue that the two approaches are diametrically opposed and that integration of the two is impossible (Steckler et al, 1992). However, it could be argued that this is limiting and not only can the two approaches be complementary, each approach has strengths and limitations that can be countered by that of the other, as explained by Steckler et al, (1992). Likewise, The Medical Research Council (MRC) (2000) argue that multiple methodological approaches can be utilised as part of a framework within research design and that one can feed into the development of the other. Indeed, Steckler et al (1992) also argue that many areas in health care research are so complex that they require the application of multiple methodologies in order to properly understand them.

Evans (2003) argues that researchers should consider the impact their research has on participants and its acceptability. He also argues that sound research can be gleaned by a “breadth of evidence generated from a range of research methodologies” and acknowledges the contribution of interpretive and observational research supporting the approach utilised in this research.

Lacey from Gerrish and Lathlean, (2015) also explains that nurses should embrace both qualitative and quantitative approaches due to the breadth of questions that need addressing. The researcher acknowledges the strengths and limitations of both approaches and feels that the combination of the two gives a depth of information a single approach cannot achieve. In healthcare provision, the experiences of the human participants (staff and patients) are fundamental to effective care, indeed many complaints made about the NHS are about communication (14.9%) and attitude and behaviours of staff (9.9%) (Figures from NHS digital, 2016). Therefore, exploring those lived experiences, it could be argued, is as vital an area to research as any other. In this study the research will be a type of multi-method design where the designs are ‘complementary’ (Polit and Beck, 2004) this is where the findings of one study are clarified in another, in this case some findings from the quantitative study will be explored and clarified in the qualitative interviews (along with other issues to be explored).

The terms mixed methods and multi- methods are often used interchangeably, (Anguera et al, 2018) while others argue for distinct differences between these terms. One definition of mixed methods is “research designs using qualitative and quantitative data collection and analysis techniques in either parallel or sequential phases” (Teddie and Tashakkori (2010) cited by Anguera et al, 2018). Anguera et al, (2018) do also pose the point that there is a lack of clear definition of mixed methods in existing literature. Multi-methods as explained by Anguera et al, (2018) is “when different approaches or methods are used in parallel or sequence but are not integrated until inferences are being made”.

Further discussions by Anguera et al, (2018) suggest that a mixed methods approach applies to the combining of a qualitative and a quantitative approach while multi methods applies to research that may indeed use qualitative and quantitative but also may include more than one style of research in a study that are not confined to a qualitative or quantitative approach. Multi methods, as the name suggests may include multiple approaches and may include more than one type of qualitative study (or indeed more than one quantitative study). This is the case in this research that indeed it is a multi study project consisting of three elements, a quantitative study and two qualitative studies and Anguera et al, (2018) argue that different methodologies related to different questions can co-exist in the same study. Each study has different outcomes that cannot easily be triangulated but are seen as different aspects of the demands on a service.

3:6:i- Justification for part 1 of the study, the quantitative element:

The first stage of this multi-method study is a quantitative study. Quantitative studies view human phenomena as being amenable to objective study and measurement (Parahoo, 2006), which consists of measurable variables (Moule and Hek, 2011) and "seeks to generate numerical data that can be analysed" (Moule and Goodman (2014, p. 179). In this case the study aims to generate descriptive statistics to demonstrate the burden challenging behaviour has on the service. Descriptive statistics are used to describe, synthesize and summarise data (Polit and Beck, 2004) and illustrate the basic features of the data (Trochim and Donnelly, 2001).

This descriptive study utilises an existing database and not data that has been generated specifically for the purpose of this research. Moule and Hek (2011) acknowledge that often researchers will use data already collected by another agency instead of collecting their own and in this research this is the case. There are potential benefits to this approach. Steckler et al (1992) assert that researchers following a quantitative paradigm distance themselves from the phenomenon they are studying to maximise objectivity and utilising existing documentation has ensured objectivity. The data in this study were collected by others who, at the time of data collection, were unaware of the research and did not know the information was to be used for this research. This ensures that usual documentation techniques are maintained and ensures no bias in the way things are recorded in favour of a particular conclusion.

3:6-ii Justification for parts 2 and 3 of the study the qualitative elements:

Parts two and three of this study are qualitative in design and utilise a phenomenological approach. Phenomenological studies explore the meaning of the lived experiences of several individuals about a phenomenon (Moule and Goodman, 2014) and focuses on individuals' interpretations of experiences (Parahoo, 2006). The role of phenomenology is to explore and describe the experience from the participants' own perspectives rather than to define it (Moule and Hek, 2011) or quantify it. Therefore, phenomenological research takes into consideration the whole being and the values of the individual's experience (Reiners, 2012) and is about recognising and validating their unique experiences.

Phenomenological research is often split into two distinct schools: Husserl's Descriptive approach and Heidegger's Interpretive approach. Although this research is not strictly adhering to either school, it leans more towards that of Heidegger but intends to utilise the best of both approaches. Heidegger's phenomenology facilitates exploration and understanding of the human lived experience (Horrigan-Kelly, Millar and Dowling, 2016) through interpretation of experience not purely description and asks the question 'what does it mean to be….?' It is argued that most phenomenological researchers apply Heidegger's philosophy of phenomenology loosely (Horrigan-Kelly, Millar and Dowling, 2016). Husserl's descriptive approach advocates the bracketing of the researchers assumptions, so that the research be led by the participants and not be contaminated by the interpretation of the researcher. However, as discussed earlier in the section of researchers' preconceptions this is difficult to achieve in reality, researchers with prior knowledge and experience in an area cannot be truly objective and inevitably bring their own interpretations. In addition, Heidegger points out that participants are not always explicitly conscious so therefore interpretation of the collective experiences is required.

Interpretive Phenomenologists believe that knowledge is achieved through interactions between researchers and participants and that researchers cannot separate themselves from the research as they become enmeshed with it (Reiners, 2012). This is true with this research as the researcher was indeed already enmeshed in this area. The researcher used to work for the host Trust for many years and latterly in a senior position, she knew the services well and she was known to most of the staff who participated in the interviews. It was felt that this was an advantage for this study, when interviewing staff she felt it gave her credibility and empathy, in that she truly understood their roles and had worked in similar services. She had experienced many similar incidents involving dealing with challenging behaviours which hopefully made it easier for them to talk honestly. Likewise the interest in conducting this research was born from her own experiences, however it would be remis to assume that the staff interviewed here would have the same or similar experiences to those of the researcher.

In part two of this research, the qualitative interviews explored the perceptions of those staff involved in dealing with challenging behaviour and utilising RI's. It aimed to explore the impact facing challenging behaviours and utilising RI's has on them. The qualitative interviews of staff members aimed to shed light onto any patterns identified in the quantitative analysis, it addressed how staff members feel about the use of RI's and the emotions they experience during the interventions. They explored the extent to which staff feel comfortable, are prepared and appropriately trained to use them. The interviews explored if the staff utilising these interventions feel they are appropriately supported by colleagues and by the managers of the service.

Part three of this research consisted of qualitative interviews of patients with a learning disability who have displayed challenging behaviours and received RI’s. The interviews aimed to explore the impact RI’s have had on these patients. Although people with learning disabilities are a vulnerable group and the sensitivity of this research subject is acknowledged, conducting research with people with learning disabilities is paramount to ensuring empowerment and their involvement in the development of services, in line with the current philosophy. Over twenty years ago authors such as Oliver (1992) and Zarb (1992) (cited by Turnbull, 2013) asserted that research for people with learning disabilities characterised them as passive recipients of care. However current philosophy champions empowerment and to truly meet this, sensitive areas of research cannot be overlooked. Lees (2011) stresses that patient accounts are an important opportunity to learn for staff and Northway (2000) asserts that research about people with learning disabilities has usually involved views from families or carers so moving to research involving the person is an important step. However while undertaking research of a sensitive nature is important it must also be acknowledged that the process may cause distress or anxiety to the participant. Clarke (2006) highlights the potential for risks from the qualitative interview and the challenges of the researchers/ participant relationship. People with learning disabilities are a vulnerable group and the subject a sensitive and potentially difficult one and the researcher for this research must proceed with caution and sensitivity, for all interviews but especially those with people with learning disabilities.

Semi-structured interviews were utilised for both the staff and patient interviews, one set of questions for the staff and another for the patients. This ensured that the same information was asked of each participating person, but also allowed freedom for him or her to direct the topics discussed. Semi-structured interviews also allow the researcher to probe for further clarification if necessary or to further explore an issue raised by the participant. Interviews are considered the foremost method of data collection in phenomenological research (Farley and McLafferty, 2003) and the second most common source of data collection in nursing research (Moule and Hek, 2011). The questions asked were open-ended and asked for the participants' perceptions, understanding and experiences.

As the nature of these interviews broaches a subject that is sensitive it was important to give consideration to this. Elmir, Schmied, Jackson and Wilkes (2011) highlight the importance of building a rapport with participants when conducting research in sensitive subjects. As mentioned, as the researcher worked at the host Trust and had similar experiences it was felt that this aided the building of a rapport through shared acknowledgements of experiences. However as the researcher's last post at the host Trust had been a senior one it was also important that the staff did not feel that the research was part of a management initiative. This was addressed through the researcher stressing to participants that she no longer worked at the Trust and that the research is for the purpose of a PhD and that confidentiality will be maintained. Informal talk to 'catch up' took place to stress the informality of the process as Elmir et al (2001) stress that minimising power imbalances is a major concern when interviewing on sensitive subjects. Although the researcher had dressed smartly when in her last role at the Trust, when conducting the interviews she dressed casually as a way of reducing any sign of power imbalance.

Similarly with the patient interviews it was important to build a rapport and ensure the patients were at ease, which was aided through some informal questions, such as asking about their day or their interests, for example.

It was also important to give consideration to all participants (both staff and patients) at the end of the interview. For each participant the involvement consisted of only one interview with no follow up process and the researcher took care to not leave the participants in a state of distress at the end. Ending research involving people with learning disabilities can be problematic as highlighted by Northway (2000) and so care was taken to ensure people were not upset and the interviews ended with some general talk, similar to that at the beginning. This was particularly important for the patients and in some cases a staff member stayed with the patient to ensure they were not upset once the researcher had left.

3:7- Method for part one of the research, the quantitative study:

3:7:i- Research design:

Study one is a quantitative study that aimed to generate descriptive statistics to demonstrate the burden and impact challenging behaviour places on the service provider.

This was done through a retrospective study of documents to establish the number, nature and type of incidents that occur in the learning disability service and the type of interventions utilised by staff to deal with these incidents. This retrospective study of documents is an analysis of recordings of untoward incidents that occurred within a six-month period at the host Trust. For this, records from all parts of the learning disability service outlined above (in 3:3) were accessed and an objective review undertaken. The measurement in this case is the number of untoward incidents and the variables identified within them. Some of those variables included the nature of incidents, where incidents occurred, staff involved, frequency of the different interventions utilised and the factors associated with their use. It also establishes who is involved in these incidents and any trends regarding when incidents happen. It is also an opportunity for exploration of the nature of incidents prior to undertaking qualitative interviews to explore this phenomenon from the perspectives of those involved.

The primary element of this study therefore was to explore the nature of incidents of challenging behaviour and the chosen intervention utilised by staff when these incidents occur.

The study established therefore:

- The number of incidents in the chosen period
- Which parts of the service incidents of challenging behaviours occurred in
- When incidents occur (by month, day and time of day)
- Which staff are dealing with incidents (by gender/ age/ position or job role)
- Which patients are involved by age and gender (no further information regarding patients can be retrieved from the database)
- The type or nature of the incidents occurring (into predetermined categories)
- What types of incidents of challenging behaviours resulted in the identified interventions being utilised

3:7:ii- The database:

For the quantitative study data were extrapolated from the untoward incident forms (UIF's) already used within the host Trust. UIF's are electronic forms completed by staff following an incident and then the information from every form is stored on a central computerised system. This central computerised system was accessed by a Trust member of staff, a technician, at the request of the researcher. Specific information was requested and this information was then generated from the computer. Direct access to the system was not allowed for confidentiality purposes as the researcher was not an employee of the Trust. Specific questions were asked by the researcher and the technician sourced this information from the database.

These forms are a vital tool for the service, as part of patient information gathering and health and safety and their completion is a key aspect of each member of staff's duties. Due to the importance of these forms there is staff training and guidance regarding their completion, therefore it was decided that these forms could be used for this research and it felt unnecessary to add an additional level of recording purely for the purpose of this research. Adding a further layer of data collection could have diluted the data due to adding additional workload burden to the staff members, an unnecessary burden when a robust system already exists.

Moule and Hek (2011) explain that the reliability and validity of data collection in quantitative research is paramount as this affords credibility to the research findings. The recording system utilised for the database is an every day activity for many staff. This means they are familiar with the system and know what information is required where (on the electronic forms) and the appropriate level of feedback. If a new method of recording had been introduced for this study some staff may have not been sure of what information was required and this would have created another task to burden already busy staff. Any data obtained would have a high probability of being incomplete to the point of not allowing any valid conclusions to be drawn.

In addition, if staff were asked to complete additional documentation and are aware it is for the purpose of research this could have influenced their recording practises creating records with bias. By using the existing system normal recording practices are maintained and the potential for biased recordings towards the research aims avoided.

The Trust gather this wealth of information but it is usually not looked at a Division level, it is explored for each individual service or patient but rarely is the full impact of challenging behaviours viewed. Not all staff have access to this information (only those in senior positions) and it is only used as part of discharge reports or referral process, for example.

As mentioned all staff could complete an UIF and usually those who witness an incident will typically complete them, therefore many staff are involved in their completion and it can be any staff in the Trust. One form is completed for each incident of challenging behaviour, however what is deemed to be ‘one incident’ may vary between staff. For example a situation that may start as shouting, screaming and swearing could escalate to self-harm and there is little clarification as to if this is classed as one incident or several.

As with any recording system dependant on a number of different staff completing the forms there will be some variance due to personal perception, despite the rigorous guidelines and training on this matter provided by the Trust. This variance may be apparent in the different staff groups, for example Heaton and Whitaker’s (2012) study found qualified nurses had a more positive attitude towards challenging behaviours than nursing assistants. If this is true in the service where the study took place, this more positive attitude may impact on what and how incidents are recorded, therefore recording practises may be different.

Also the different staff groups from differing environments may have different perceptions, for example staff in the services with high numbers of challenging behaviours, such as Assessment and Treatment Services (ATS) may have higher tolerance to certain behaviours and may be desensitised to them leading to under-reporting. This was illustrated by Howard et al (2009) who found that staff in a medium secure unit had less fear of challenging behaviours than their peers working in the community and therefore viewed them differently. Additionally the environment or context the incident takes place in may influence whether behaviours are regarded as ‘challenging’ at all. For example shouting at an ATS may not be regarded as an untoward incident (UI) whereas for day services staff working in a community setting with members of the public around, the same behaviour may well warrant the completion of the UIF. This is highlighted by Emerson et al’s definition of challenging behaviour, the last line of that definition being, “behaviour that is likely to seriously limit or delay access to the use of ordinary community facilities” (Emerson et al, 1987). This potential for variance should be considered when reviewing the findings from this documentary analysis. While it is acknowledged that this is a potential weakness of the database, the database is nonetheless still regarded as being as robust as possible and as mentioned above it is unnecessary to add another recording tool for the purpose of this research.

At this point it is timely to acknowledge another limitation of the database. The database being utilised is a recording tool for the host Trust and can therefore only provide a snapshot in time of the number and nature of the untoward incidents that occur in the Trust. One factor for consideration is that there are varying occupancy numbers within many areas of the service and therefore the number of patients contributing to the UI’s across any period of time is not consistent.

The information was taken from the database and then illustrated in graph and numerical form, generated from excel to demonstrate the burden challenging behaviours place on the service. As explained by Field (2003) graphs are the easiest way to spot trends in the data as this enables the researcher (and the reader) to learn a lot about the dataset at a glance (Foster, Diamond and Jeffries, 2015). Additionally, where applicable, information will be presented as summary data such as mean, range and standard deviation.

When frequency of incidents were grouped according to month or days of week or times of day a one sample chi square test using SPSS was carried out to indicate whether the distribution of incidents was significantly different from chance.

3:7:iii- Sample/ participants:

In this study it was impossible to predict exactly what the sample size would be in advance as it would be all potential untoward incident forms generated by the division of the host Trust in the six month period. However, the researcher had been informed of the figures for the previous months preceding this study which gave an indication of how many they have, so it was possible to anticipate an adequate number of incidents would occur to give sufficient data. The decision was made that six months should generate a sufficient number of incidents. The period of six months was chosen also to minimise any anomalies due to seasonal variation. As all applicable untoward incident forms were to be utilised this is the total population available. To maximise the relevance of information gained through the research the sample should be as inclusive as possible (Parahoo, 2006) and so to have the total population for this six month period ensures that a full picture of the nature of incidents is gleaned.

The data from all incidents recorded on the Untoward Incident Forms (UIF) for the period 1st September 2013 to 28th February 2014 were requested and these recordings analysed. As mentioned, at the time of recording the incidents, staff members were unaware that the UIF's would be used for this research. This ensured that usual recording techniques were used and staff recordings were not influenced or biased by the knowledge that the UIF's were to be analysed for a research project.

The incidents required to be documented by the Trust are wide ranging and could include patients' incidents of challenging behaviour, drug errors, falls, accidents, theft of Trust property for example. This study however was only concerned with those involving patients' incidents of challenging behaviour (as defined in the literature review chapter). Therefore, the sample for this part of the research was all untoward incident forms involving patients' challenging behaviour. This term is not a term utilised in the database, the terms utilised in the database are:

- Disruptive behaviours
- Self-harm
- Violence to patients
- Violence to staff
- Violence to visitors/ others

These were collectively referred to as 'challenging behaviour' by the researcher.

Inclusion and exclusion criteria

Selection included all patient untoward incident forms that involved incidents of challenging behaviour from across the whole division. This included; socially unacceptable behaviours, destruction of property, self-injurious behaviours and violence and aggression to other patients, staff or visitors, therefore all patient untoward incident forms featuring challenging behaviour were analysed.

The exclusion criterion is untoward incident forms regarding anything other than incidents of challenging behaviour, such as accidents of patients (falls, etc) or accidents/ incidents involving just staff (falls etc) or other types of incidents such as drug errors etc. In addition, as discussed in the introductory chapter, restrictive physical interventions are often used for people with learning disabilities who require dental or medical treatments/ interventions (Newton, 2009) or other medical interventions. Any incidents of restraint for this purpose were not included in the sample also.

3:7:iv- Analysis:

The information was generated in simple rows of numbers identifying the information requested by the researcher but not any identifiable information such as names or patient identification numbers. The full questions asked are presented in the results section.

Data taken from the computer system were reviewed by the researcher. The researcher presented the data in a range of measurement scales and illustrative graphs for ease of reviewing.

Some scales were sometimes in the form of typical interval scales, for example for the recording of patient ages, staff ages, and other similar data. Nominal scales were also used with categorical data such as when recording the types of incidents and pie charts and percentages were also used.

In some cases the researcher grouped data together. One example of this is that the host Trust utilises a range of titles for staff members that are non- professional care staff. These are staff members that do not have a professional qualification such as Nurse, Occupational Therapists, Physiotherapist etc but many do have vocational qualifications. These are staff members that are on band two and three of the Agenda for Change pay scales. The range of titles included Health Care Assistants, Auxiliary Nurses, Day Care Officers to name just a few. For the purpose of the data analysis these were grouped together.

The full range of information gathered and conclusions drawn are presented in the results section.

3:8- Method for part two of the study, the qualitative interviews of staff:

3:8:i- Research design:

Part two of the research aimed to develop an understanding of the impact implementing RI's has on the staff who, as part of their job, have to deal with challenging behaviours and as a result have to utilise RI's and to explore what the impact of this is on them.

For this study semi structured interviews were utilised and this is explored further (below) in the data collection section. The questions utilised in the interviews primarily arose from the research aims supplemented by the findings of the quantitative research in part one of this study.

3:8:ii- Sample/ participants:

The sample for part two of this study was a subset of the nursing and care staff employed by the host Trust. Polit and Beck (2004) also explain that samples in phenomenology must meet one key principle: that they have all experienced the phenomenon being studied. Therefore, the participants for the interviews for part two of the research were staff members involved in the incidents of challenging behaviour and those involved in implementing RI's.

The staff members were sought from the locked rehabilitation service and the in-patient assessment and treatment service. Staff members were sought from these two service areas as the quantitative analysis identified these areas as having a high number of incidents and therefore the most staff that are involved in the use of RI's.

According to Ogier (1998) samples for descriptive studies should be small, often around ten (Polit and Beck, 2004) and recruitment should stop once data saturation is reached (Moule and Goodman, 2014). The aim in this research was to have a sample of twelve staff as it was felt this would achieve data saturation and be sufficient to glean a depth of information whilst also achieving a variety in the participants' demographic data (Moule and Hek, 2011). An important principle in qualitative research is to ensure the sample is sufficiently varied in characteristics to maximise the chances of capturing the range of views on the phenomena under study.

The sample was a purposive convenience sample. Purposive convenience sampling refers to a sample being identified by the researcher based on the researchers' knowledge of the population and being those readily available. It is acknowledged that this is often considered the weakest sampling technique (Moule and Hek, 2011) and some researchers frown upon its use due to the risk of sample bias and that the variety in characteristics required are not achieved. This risk was offset through the deliberate selection of staff members from both genders, qualified nurses and health care assistants and people of a wide variety of ages and number of years' experience so that the aim of capturing a wide variety of characteristics was considered when approaching staff from the two units. Therefore the sample consisted of six qualified nurses and six HCA's. Of each of these six, three were male and three female with a variety of number of years experience. This was chosen to give a breadth of perspectives and experiences. This type of sampling is appropriate in this research as they need to be people who deal with challenging behaviour and have undertaken the interventions.

Therefore, the inclusion and exclusion criteria for staff were:
Staff inclusion criteria-

- Staff involved in managing untoward incidents and implementing the interventions in one of the two units selected.

Staff exclusion criteria-

- Any staff not wishing to participate.

Initially staff members known to the researcher were approached and asked if they would like to participate, following this a snowballing approach was utilised as the researcher asked the initial participants to make recommendations for others who could be interviewed. Again this selection method has risk of limiting the range of views collected (Moule and Goodman, 2014) as people may recommend 'like-minded' people and so again this risk was considered and staff were advised that they should not just recommend their friends but could recommend anyone they felt would like to participate.

3:8:iii- Consent:

Initial contact was made by email, including a written explanation which was supported by participant information sheets (appendix 3). The staff members identified were given a period of time to think about their participation. Once they responded by email and agreed to participate, a convenient date, time and venue was set for the interview. Prior to the actual interview commencing, the participant information sheet was revisited to explain the purpose of the research and the researcher explained the wider context of the research and that it was hoped that any findings can help in the service development.

At the interview a consent form was signed and it was also explained to them that if following the interview they changed their mind they could inform the researcher and their interview would not be included in the analysis. A copy of the staff consent form can be found in Appendix 4.

No member of staff who was approached to be involved refused nor did anyone ask for their data and information to be withdrawn following completion of the interview.

3:8:iv- Data collection:

Data collection consisted of one single, audio-recorded semi- structured interview for each member of staff. The researcher allowed each member of staff the time to talk freely with no time restriction set on the interviews. The interview guide for the questions asked to the staff members can be found in Appendix 5.

Each interview was audio-recorded to ensure that a full and accurate record is kept of the responses given. It also allows the researcher to fully concentrate and listen to the responses, if the researcher was trying to manually record the responses as they were being given important information may have been missed. In addition it allowed the researcher to make a few additional notes about things that the audio recording did not pick up, such as non-verbal communication. One example of such notes included when a member of staff became upset and cried, this was recorded by hand as the crying consisted of just tears and no noise, therefore the crying would not have been picked up by the audio-recording.

The first interview conducted served multiple purposes. The findings were utilised in the main results but also the interviewee acted as a critical friend and gave feedback on the questions asked and therefore this first interview acted as a mini pilot study. Pilot studies can be utilised to test the data collection tools and for the researcher to practise research techniques (Moule and Hek, 2011) and in this case the researcher chose someone she knew well and trusted to give honest feedback but in a constructive manner. This interviewee also undertook member checking (discussed further later). A full pilot study was not undertaken despite the potential benefits due to time limitations however the feedback offered by the first interviewee was minimal and so did not alter the process or questions asked anyway.

3:8:v- Data analysis:

The researcher transcribed each interview as soon after the event as possible. There are software packages and indeed paid services that will undertake this for researchers however the researcher chose to undertake the process herself in order to be fully immersed in the data.

It is not uncommon in this type of research for the analysis to take place concurrently with the data collection process (Moule and Goodman, 2014) and in this case it was deemed most appropriate as the researcher is a novice. One benefit of this was often there was a period of a few weeks between each interview due to time restrictions accessing staff and so the transcribing process could be taking place in between interviews.

Once the first interview had been transcribed, the interviewee was asked to member check the information. This process can aid objectivity and is where the interviewee verifies the information collected by the researcher. This was done by simply emailing the transcription to the participant and as mentioned above no changes were requested by the participant as a result of this.

Following further interviews, each one was transcribed as soon after the event as possible in the same way by the researcher and no further member checking took place. As the interviews were being transcribed, analysis took place by the researcher. Following this, another researcher (the supervisor) also reviewed the transcripts and both independently highlighted relevant text and allocated initial codes. The researchers then met to discuss any discrepancies and why these had occurred. This discussion led to the initial set of codes and themes. This is a strength in the analysis of this research as two researchers independently identified themes. The themes were extrapolated from the transcribed interviews and these themes are the findings of this study.

Themes have been mentioned above and at this point it is important to establish what is meant by this. In this research a theme is a patterned response (Braun and Clarke, 2006) or the capturing of important responses from the participants. As this is a qualitative approach themes were not simply identified through frequency but through significance of an issue and as explained by Braun and Clarke (2006) the identification of themes and patterns of meaning "in relation to the research question". In keeping with this, the analysis took a theoretical approach in that it was driven by the researchers theoretical and analytic interest (Braun and Clarke 2006). The data were analysed and initial codes identified, through the labelling of sections of the data. Following this, these were searched to identify similar ideas and concepts raised in the data and the themes and sub-themes emerged. These were reviewed and in some cases merged until the final themes were decided upon, each theme was then defined. This process followed that outlined by Braun and Clarke (2006) as shown below:

1. Phase 1- Familiarising with the data
2. Phase 2- Generating initial codes
3. Phase 3- Searching for themes
4. Phase 4- Reviewing themes
5. Phase 5- Defining and naming the themes
6. Phase 6- Producing the report.

3:9- Method for part three of the study, qualitative interviews of patients:

3:9:i- Research design:

The aim of part three of this research is to develop an understanding of the impact of RI's on those patients who are exposed to them. It explores the impact RI's have when utilised as an intervention on them and their thoughts and feelings about these interventions.

3:9:ii- Sample/ participants:

The sample/ participants were a subset of the patient population exposed to RI's. These patients were selected from the locked rehab service and the ATU's, as with staff this was due to the fact that this is where most UI's occurred therefore increasing the likelihood of getting patients who had experienced these interventions. However another reason was due to the fact that the patients in these services were more able, with less severe learning disabilities than those accessing some other services (such as the Day Services) therefore these patients are more likely to have the necessary skills to take part in the interview process.

Patients' selection:

Following the staff interviews, some staff members were then asked to make recommendations for patients that could be interviewed. Limited availability of appropriate patients resulted in other staff members being approached to make recommendations of appropriate patients. Having identified these individuals, their participation in the study was discussed with the appropriate key individuals/ significant others involved in their care, such as their named nurse, service managers, and of course the patient themselves. The patient's level of understanding and communication skills were taken into account regarding their suitability to be involved in the study. Once it was deemed appropriate by the necessary people the patient was approached to take part in the study.

Patients' inclusion criteria-

- people who have been exposed to the interventions
- people that have the appropriate communication skills to partake in the interviews
- people that have the appropriate level of understanding regarding the nature of the questions.
- people who have the capacity to consent to involvement in the interviews.

Patients exclusion criteria-

- Patients unable to give informed consent.
- Patients for whom it is deemed the interview will be detrimental to their well being (for example they may get anxious, angry or upset as a consequence of the interview questions) based on the feedback from their staff.
- Patients not exposed to the interventions.

At the outset of this research it was hoped that, as with the staff members a wide cross section of patients would be found, however all the patients interviewed were male and of similar ages. One of the services utilised for the participants in this research is a male-only patient group and so limits the chance of finding females but the other caters for both males and females so it was hoped that some females would have been available in order to reflect the quantitative findings but sadly there were not. It is acknowledged that this is a potential for scrutiny of this part of the study.

3:9:iii- Consent:

Once patients had been identified by staff they were approached by the researcher supported by a member of staff known to the patient. At this point it was important to establish the individual patients' communication abilities and this was established by liaison with the staff team/ named nurse and some general discussion with the patient.

All aspects of the study and what is required of them were outlined and as with staff, the patients were given participant information sheets (Appendix 6).

As with staff, patients were given time to digest the information and give it their full consideration. For all patients this took a day or two after which the researcher returned to conduct the interview, at a convenient date, time and place. The venue was also agreed to be one appropriate for the patient, in discussion with the appropriate others, but in all cases it took place within the service setting, however away from the main ward environment.

Due care was afforded to assess the patients' capacity to consent to being involved with the research in line with the Mental Capacity Act (MCA, 2005), as to date there are no established measures around consent to participate in research (Dye, Hare and Hendy 2007). It was stressed to the patients that participation is entirely optional and their decision will have no impact on the care they receive at all. The participant information sheets also explained the purpose of the research, the wider context of the research and that it was hoped that any findings could help in the service development.

Consent forms were signed by the patients involved and a copy of these can be found in Appendix 7. There was also an alternative version available that utilised symbols for anyone who required it, which can be found in Appendix 8. Patients were asked questions to ensure they fully understood the nature of the research.

Once the patient agreed to be interviewed, they were offered a choice of member of staff to sit with them during the interview to ensure they had someone they felt comfortable discussing any issues in front of. All patients interviewed chose a member of staff they liked to be present. No patients approached to be interviewed said no, in fact all appeared to be happy and willing to share their experiences.

3:9:iv- Data collection:

Data collection consisted of the single interview which aimed to give a much needed insight into the perceptions of those accessing services and these findings will feed into packages of care and inform decision making for interventions used in the future. The interviews explored how patients feel during RI's, if they understand why staff use them and also how patients feel if they witness other patients being restrained. The interview guide for the questions asked of the patients can be found in Appendix 9.

3:9:v- Data analysis:

As with the staff interviews transcripts were made of the patient interviews as soon after the event as possible. These transcripts were then analysed and themes extrapolated from them in the same way as explained above.

3:10- Conclusion of chapter:

This chapter has outlined the methodological approaches used in this research and given justification for those choices. The following chapter presents the results of part one of this research, the quantitative analysis.

Chapter 4: Results from the analysis of the database of Untoward Incidents.

4:1- Introduction to the chapter:

This chapter will present some of the information gleaned from the analysis and review of the untoward incident forms completed by the Learning Disability Division in the chosen NHS Trust.

4:2- Data presentation:

The following results are the descriptive statistics that demonstrate the impact challenging behaviour has on the service. When referring to the various services in the Learning Disability Division of the Trust they can be divided into the following categories or service groups:

- Assessment and Treatment Services (ATS)
- Community learning disability teams (CLDT's)
- Day service provision
- Locked rehabilitation (rehab) service
- Short break services

These will be utilised throughout this chapter, when the data looked at refers to service areas.

4:3- Number of incidents:

The total number of untoward incident forms completed by the Learning Disability Division during the period 1st September 2013 and 28th February 2014 was 426. One UIF equates to one incident. Of the 426 UIF's 312 were of incidents of challenging behaviours (as defined in chapter 2). This means the remaining 114 events recorded were situations not involving patients displaying challenging behaviours, this could include non-patient incidents such as a member of staff injuring themselves while undertaking a manual handling manoeuvre, for example. The following analysis focuses on the 312 incidents that did involve behaviours that were categorised as 'challenging behaviours' demonstrated by the patients in the services that the directorate consists of.

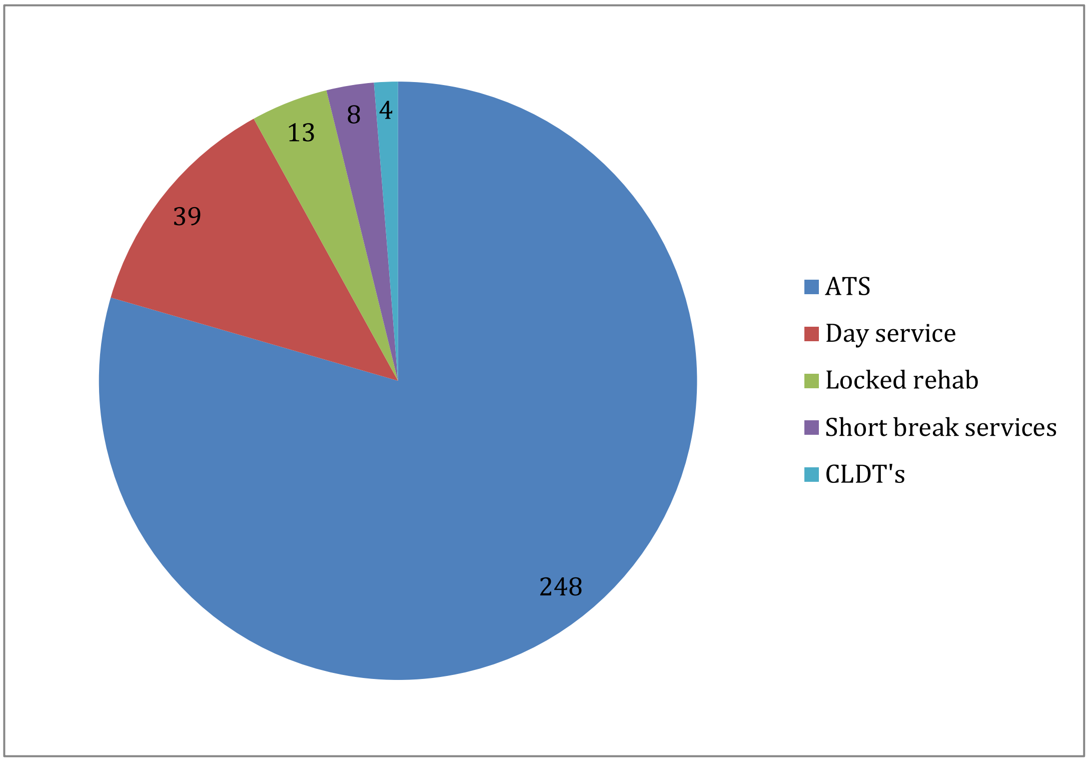
4:4- Where incidents occur:

The first step of this documentary analysis is to look at where the incidents take place.

4:4:i- Where incidents occur by service groups:

The pie chart below (figure 1) illustrates the breakdown of where the incidents take place by service groups.

Figure 1: Where incidents occur.



This pie chart shows that:

- 79% of UI's were recorded occur at the ATS
- 12.5% occur at the day services

- 4.2% at the locked rehabilitation services
- 2.6% at the short breaks service
- 1.2% occur at the CLDT’s

As can be seen in the pie chart and figures above, the biggest number of incidents took place in the assessment and treatment services (79%) and this is as may be expected due to the nature of the services and the needs of patients that access those services. Likewise, the smallest number of incidents took place in the CLDT’s (1.2%) and again this is a reflection of the nature of the services and the patients they cater for.

To be more meaningful, when looking at these figures it is necessary to consider the number of patients accessing these services also. For the six months of this study, the ATS’s initially consisted of two separate services, one a 7 bed unit and an 11 bed unit. During this period they merged to become one larger 18 bedded unit. The locked rehabilitation service is an 8 bedded unit which was not full for the duration of the period being reviewed and had 6 patients at this time.

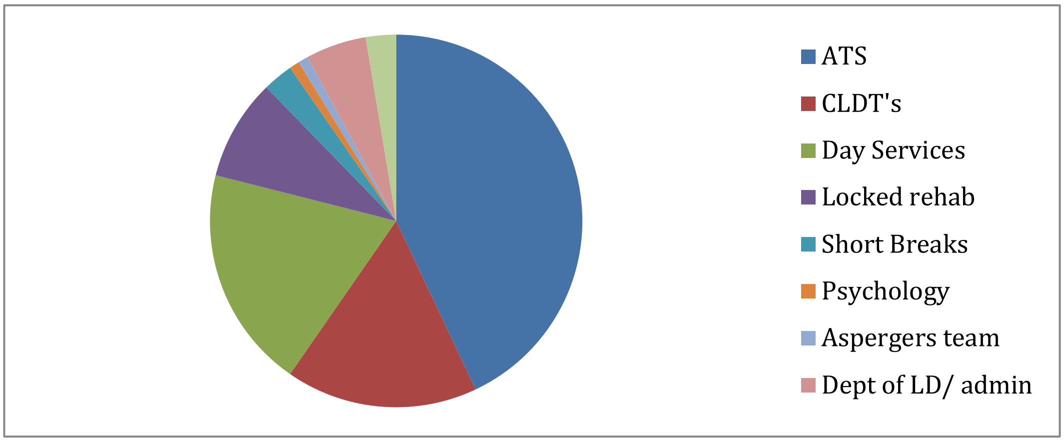
The Day Services provision consists of three services geographically spread across the county. They are specialist day services catering for people with learning disabilities, challenging behaviours and additional needs. They cater for a varying number of patients each day: one of the day services caters for between 16 and 20 patients depending on day, (Monday- 16, Tuesday- 18, Wednesday- 20, Thursday- 18 and Friday- 18). The second day service caters for between 10 and 15 patients per day, again with the highest number attending on Wednesday. The third day service offers 20 places a day, however 12 of these are for regular attenders and 8 are for Assessment and Treatment patients. Therefore, this service’s figures can vary from day to day depending on the number of Assessment and Treatment patients.

When considering the number of incidents from each service group it is important to remember that the figures from the ATS are from a maximum of 18 patients while day services figures, the second highest figure of 13% is from a maximum of 55 patients (depending on the day of the week). Therefore, it is clear that a high number of incidents are arising from a small number of patients within the ATS. Additionally, some activities undertaken by day services may be community based and the location of the behaviour may influence what is deemed a challenging behaviour and consequently the recording practices. For example, shouting and swearing in an ATU may not seem to warrant the completion of an untoward incident form but in the community it would.

4:4:ii- Where other UI's occur by service groups:

This section will briefly look at where the other UI's (not incidents of challenging behaviour) occurred simply for comparison. Of the other UI's recorded, 114 in total were incidents other than challenging behaviour, so clearly the largest group of UI's are incidents of challenging behaviour. Figure 1a and table 3 show where these were recorded. It can be seen in the pie chart below that there are a number of other services not identified above, this is due to the fact that they did not have any incidents of challenging behaviour and so do not occur elsewhere in these results.

Figure 1a: Untoward Incident Forms- other than challenging behaviour.



The pie chart shows:

Table 3:

Service/ department	Actual Numbers	Percentage
ATS	49	43
CLDT's	19	17
Day Services	22	19
Locked Rehab	10	9
Short Breaks	3	3
Psychology	1	>1
Aspergers Team	1	1
Department of LD/ Administration	6	5
Health Facilitation	3	3

The focus of this research is on UI's that involve challenging behaviour so little attention is to be given to these figures however there are a couple of things worthy of noting: Firstly the biggest number of these incidents took place in the patient areas, ATS, Day services etc. and not in non-patient areas such as the administration area. Any possible correlation between these two facts may be worthy of exploring in another study. It could simply be related to the fact that there are more people in these areas as clinical staff out number administrative staff substantially, alternatively it could be that in these areas the completion of this documentation is an ordinary, every day procedure therefore staff are more likely to complete them.

Secondly, of the services that have patients, most of them have higher UI's that are involving challenging behaviour than UI's that are not. One interesting anomaly is the high rate of non-challenging behaviour incidents from CLDT's; 19 incidents that were not challenging behaviour incidents compared with the number of incidents from CLDT's that did involve challenging behaviour (only 4). Of the main patient focussed service groups discussed in figure 1 the CLDT's are the only one where non-challenging behaviour UI's are higher than those involving challenging behaviour- again this is worthy of exploring in another study. One would need to look further into the nature of these incidents which have occurred in the CLDT's but one possible explanation may be due to community staff often working independently, driving in to areas that may not feel safe etc and the nature of incidents may be a reflection of this type of situation.

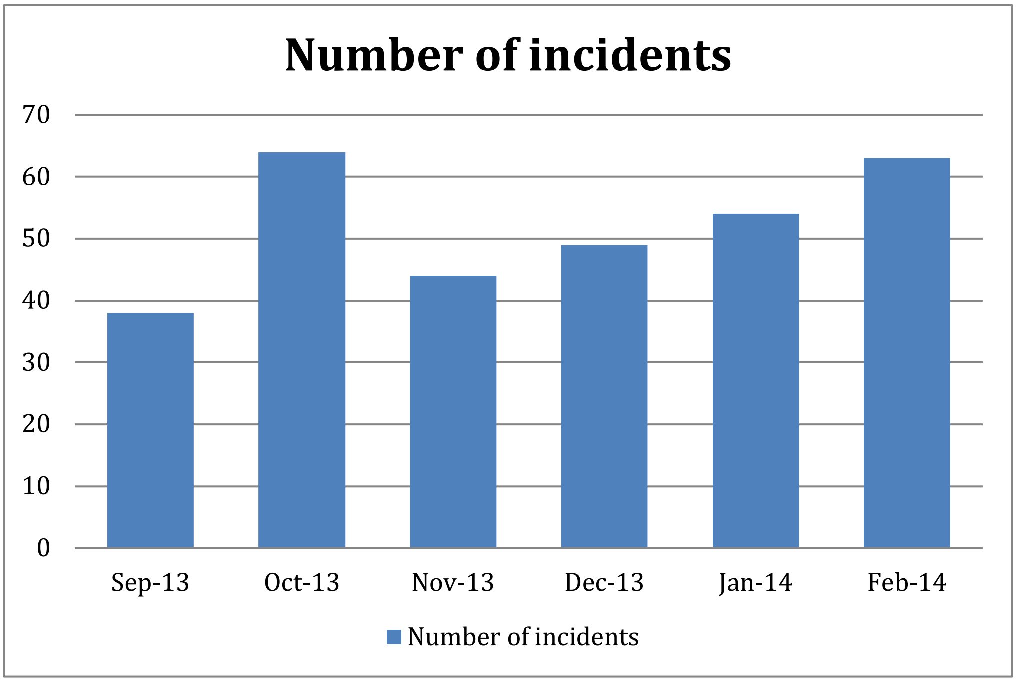
4:5- When incidents occur:

The next step of the documentary analysis was to study the incidents with regard to when they take place.

4:5:i- Did frequency of incidents vary across the months:

The figures below are for all of the incidents of challenging behaviour (312) across all of the service groups.

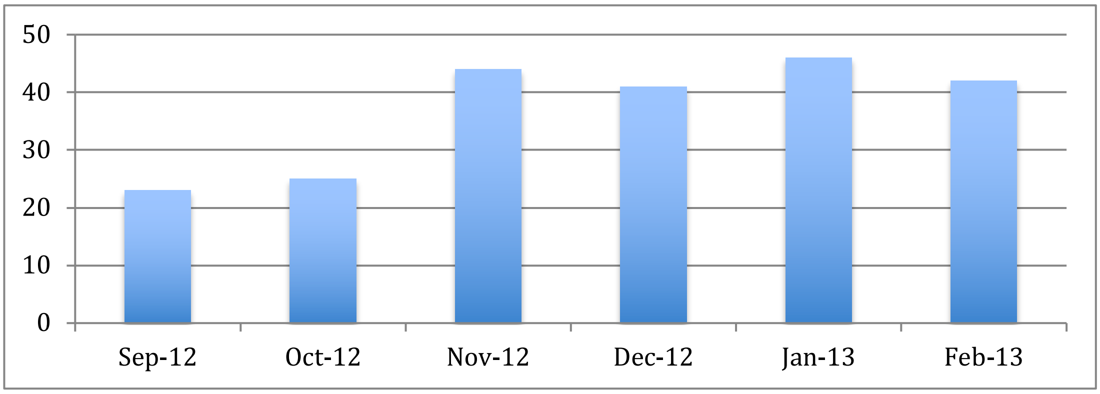
<u>Figure 2: When incidents occur by month.</u>



There was an average of 52.2 (SD 10.1) incidents per month during this period. As can be seen from figure 2 the highest number of incidents over the six-month period took place in October 2013 (64) and February 2014 (63) and the lowest in September 2013 (38). A one sample chi square test indicated that the frequency of incidents does not differ significantly between months. Although small increases, there are increases nonetheless and one possible explanation for the peak months could be the admittance of specific patients to services however this would need further exploration to confirm this. At the time of this analysis the access the researcher had to the database did not allow figures to be broken down by individual.

Figure 2a shows the same period for the previous year, September 2012 to February 2013. There is a difference between the figures for the two years (t =2.8, df = 5, p< 0.04 with the earlier year having a mean number of incidents of 36.9 (SD = 10.1) per month. Although there is a discontinuity between February and September 2013, figures from the two sets of data suggest a gradual increase in UI's in this service but a longer monitoring period would be required to fully explore this. One possible explanation may be the changing nature of the LD service and the changing nature of the patients referred to the service. This is an aspect that was explored in the qualitative interviews.

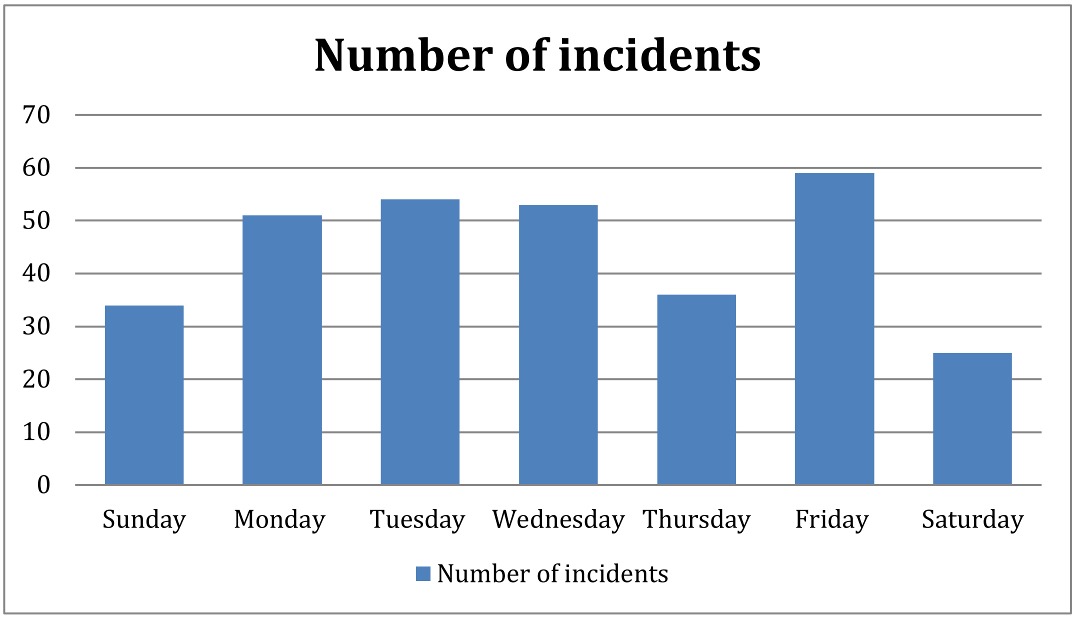
Figure 2a: Number of incidents by month for previous year.



4:5:ii- Did frequency of incidents vary across the days of the week:

Figure 3 shows the number of incidents of challenging behaviours by day of the week.

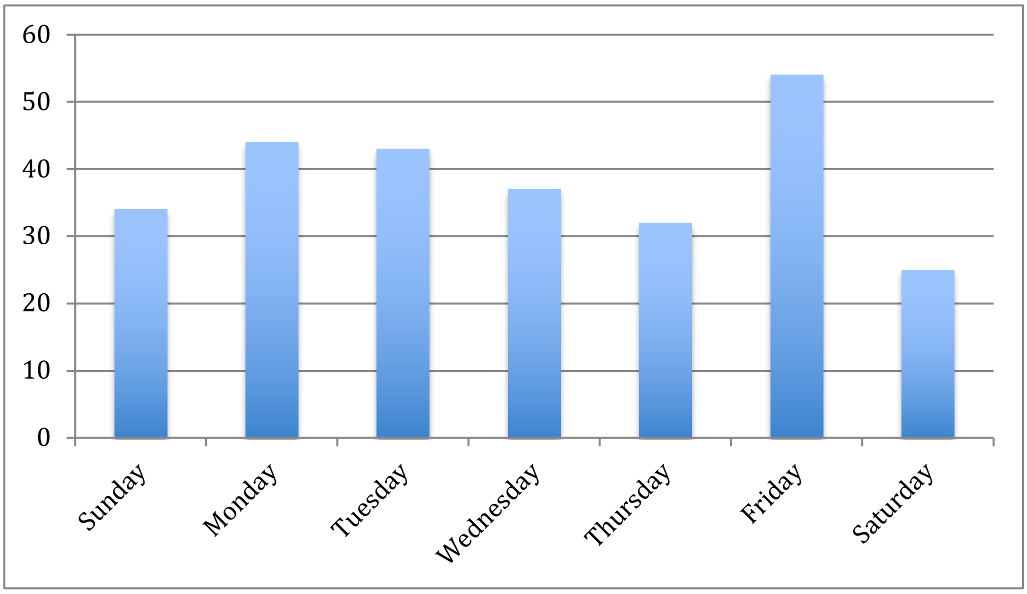
Figure 3: When incidents occur by day.



The average number of incidents for each day of the week was 44.6 (SD = 12.8) and ranged from 25 for Saturday to 59 for Friday. A one sample chi square test indicated that the distribution of incidents across days of the week is significantly different from chance (chi square = 21.9, df = 6, p <0.01). Some of the services that completed UIF's during this period are Monday to Friday services; this includes the Community Learning Disability Team's (CLDT's) and day service provision. This accounts for the dip in the number of incidents on Sundays and Saturdays.

The slight dip on Thursdays and peak on Fridays however are not accounted for through such a simple factor as patient access to the service. Figure 3a shows the data for the days of the week the incidents occur for the services that are 7 days a week services only (locked rehab, ATS and short breaks services).

Figure 3a: When incidents occur by day (24/7 services only).

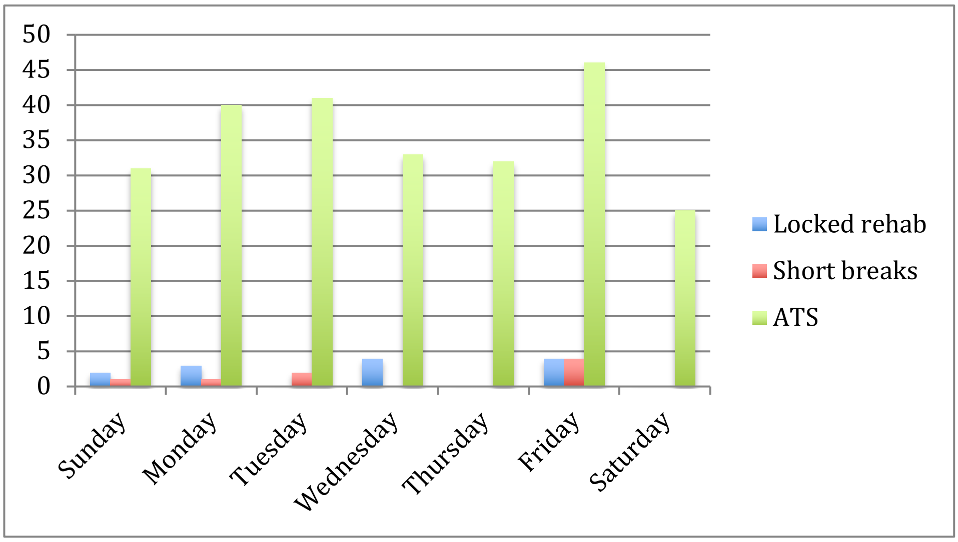


These services had a mean of 38.4 (SD 9.5) incidents per month with a range from 25 to 54. A one sample chi square indicated that even when data for five day a week services are removed, the distribution of incidents across days of the week remains significantly different from chance (chi square = 14, df = 6, $p < 0.05$).

The trend demonstrated by the above two graphs is very clearly the same. To investigate whether this pattern is attributable to any particular service, figure 3b shows the above information broken down by service groups.

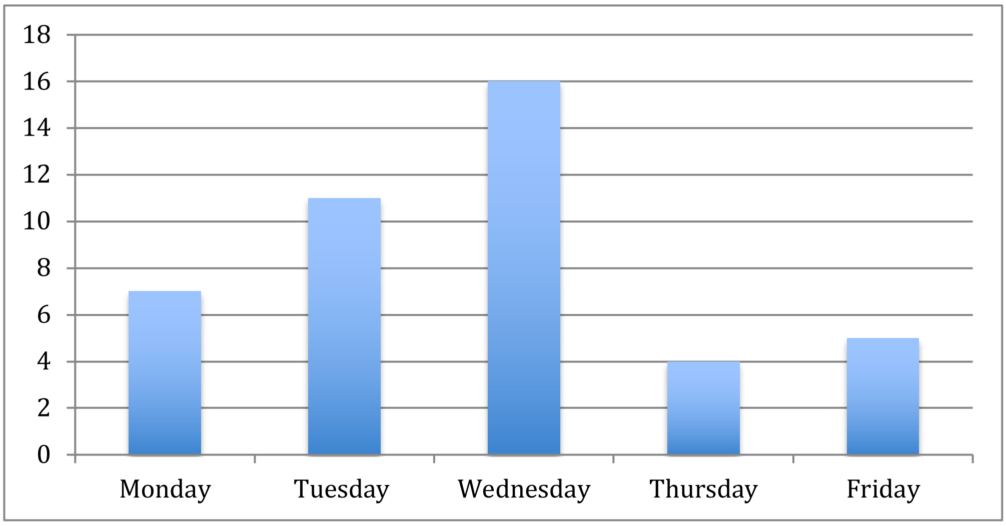
Figures for the locked rehab services and the short breaks services are too small to analyse. Figures for ATS show a mean of 35.4, SD 7.2 and range from 25 to 46, with the highest rate on Friday. However, a one sample chi square indicated that the pattern over the week was not significantly different from chance (chi square = 8.75, df = 6, $p > 0.05$). Although figures are small when broken down by individual service, there is evidence that this peak on Friday is attributable to all of the services that operate seven days a week, although the ATS contributes more data points than the others it does still justify some consideration.

Figure 3b: When incidents occur by day (24/7 services only) by service group.



Interestingly the high rates for Fridays are not reflected in the figures from the service groups that only operate Monday through to Friday (day services and CLDT's). The mean number of incidents for each day was 8.6, SD = 4.9. A one sample chi square indicated that the distribution of incidents across days of the week in Monday to Friday services differs significantly from chance (chi square =11.3, df = 4, $p < 0.025$) with lowest figures on Thursday (n = 4) and highest on Wednesday (n = 16) (see figure 3c below).

Figure 3c: When incidents occur by day (Monday to Friday services only).



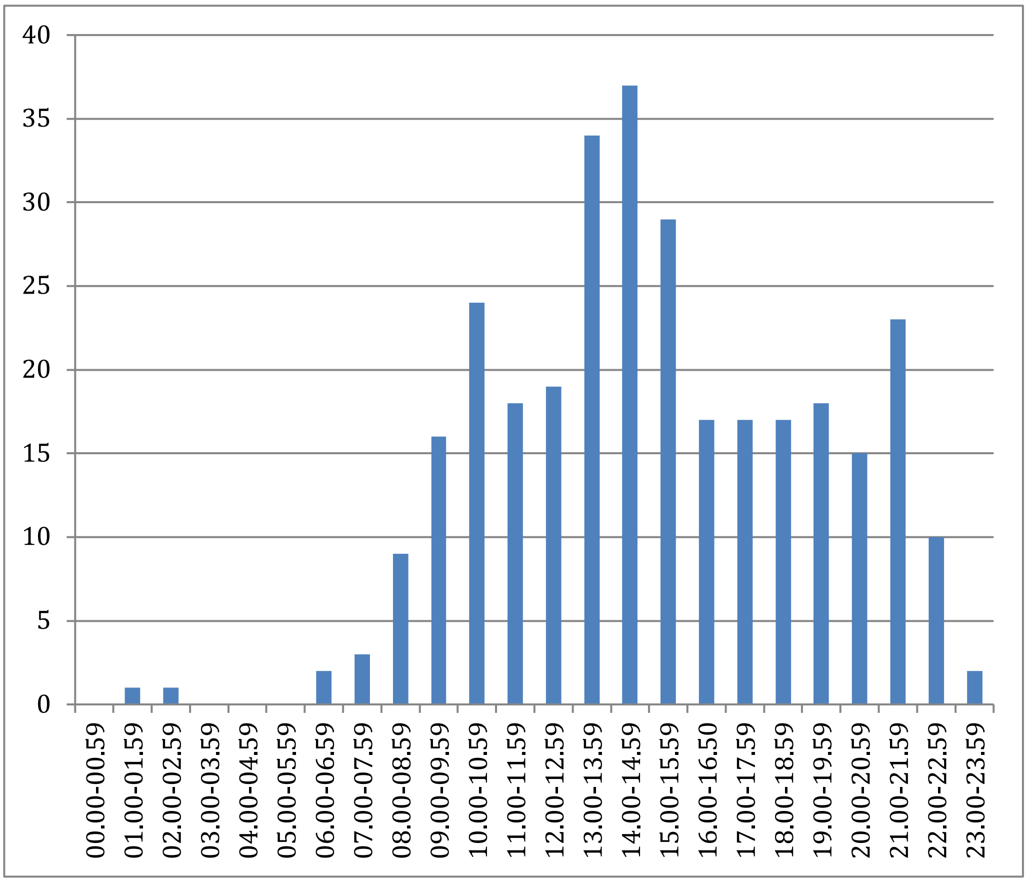
The number of incidents ranged from 4 for Thursday to 16 for Wednesday. The greatest number of these incidents took place in the day service provisions, therefore it would be useful to look at what occurs on Wednesday in these services for further exploration of these statistics and this will be explored in the staff interviews. Indeed in two of the three day services the number of patients attending on Wednesday is the highest of any other day, which may be a contributing factor but this needs to be explored, is it simply the number of 'actors' involved or is there something else happening in these services on Wednesdays?

4:5:iii- What time of day do incidents occur?

Further analysis was undertaken of the times of day incidents occur. There was an hourly mean of 13.5, SD + 11.3. ranging from zero to 37. A one sample chi square indicated that the distribution of incidents across 24 hours was significantly different from chance (chi square = 195.5, df = 23, $p < 0.001$). As one would expect incidents are hugely reduced over night. This is easily accounted for by the fact some services are not in operation over night (as mentioned above, CLDT's, day service provision etc) and of those services that are in operation over night, on the whole, the patients will be asleep.

During waking hours the times with least incidents are early in the mornings 06.00- 07.59 (some people may not be awake for some of this time and day services and CLDT's are not in operation at these times) with a gradual increase until 10.00- 10.59 which shows a peak of 24 incidents. Over lunch 12.00- 12.59 this number dips a little with then a sharp rise between 13.00- 13.59 to 34 incidents and 14.00-14.59 with 37 incidents and 29 incidents between 15.00 and 15.59. This may be a relevant factor to consider for the Trust as this is around the time the day services are closing. The process of preparing to go home may well be contributing here. There is then a slight rise again 21.00-21.59. This is illustrated in the graph below, figure 4.

Figure 4: When incidents occur by times.



The post-lunch time peaks could be accounted for by staff being busy with other tasks such as preparing for change over of shift, tidying up after lunch or drug administration rounds for example, or a post-lunch lull in activity. The peak at 21.00-21.59 could be around preparing for bed and night time routine, and again change over of shift. This information could be fed into the services for further exploration and also can be utilised with regards to staff planning of rotas and when planning other events such as multi- disciplinary meetings, etc. This was also explored in the qualitative interviews with staff.

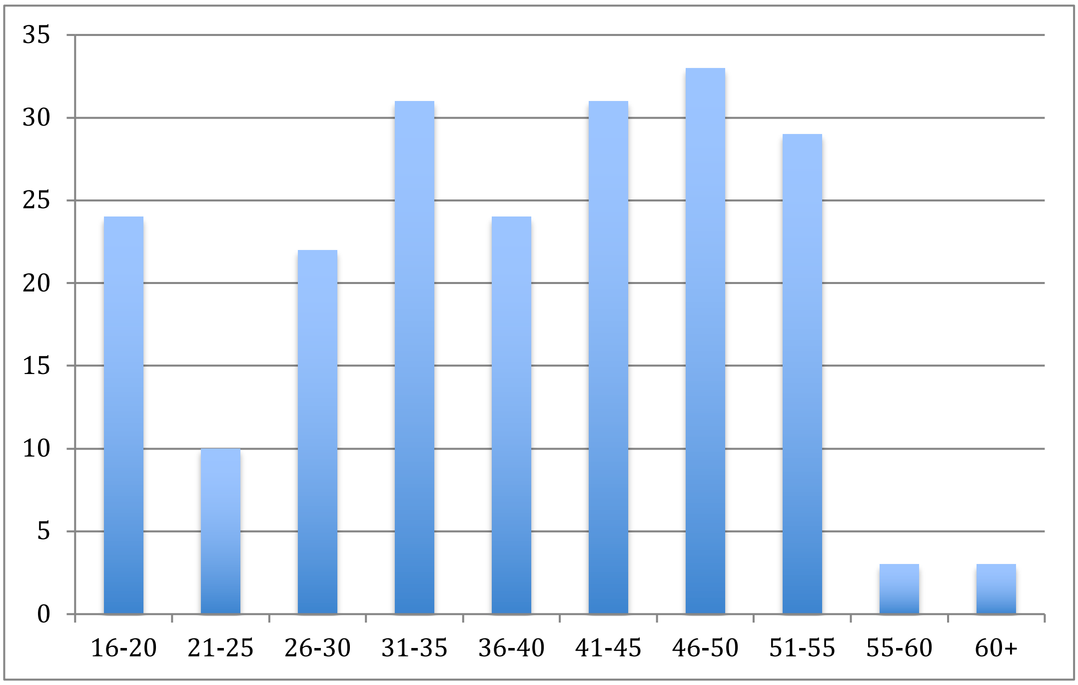
4:6- Demographic data of staff dealing with incidents:

The next area to address was the staff involved with incidents. From the 312 UI's being analysed 219 are recorded as having a member of staff involved and it is not clear why a member of staff was not included for the other incidents. This may be due to staff not having an active role in the incident or could be due to a failure to record accurately.

4:6:i- What are the ages of staff dealing with incidents:

Firstly, the age of the staff dealing with incidents was explored and this is shown in figure 5a below.

Figure 5a: Staff ages in age bands- involved in UI's.

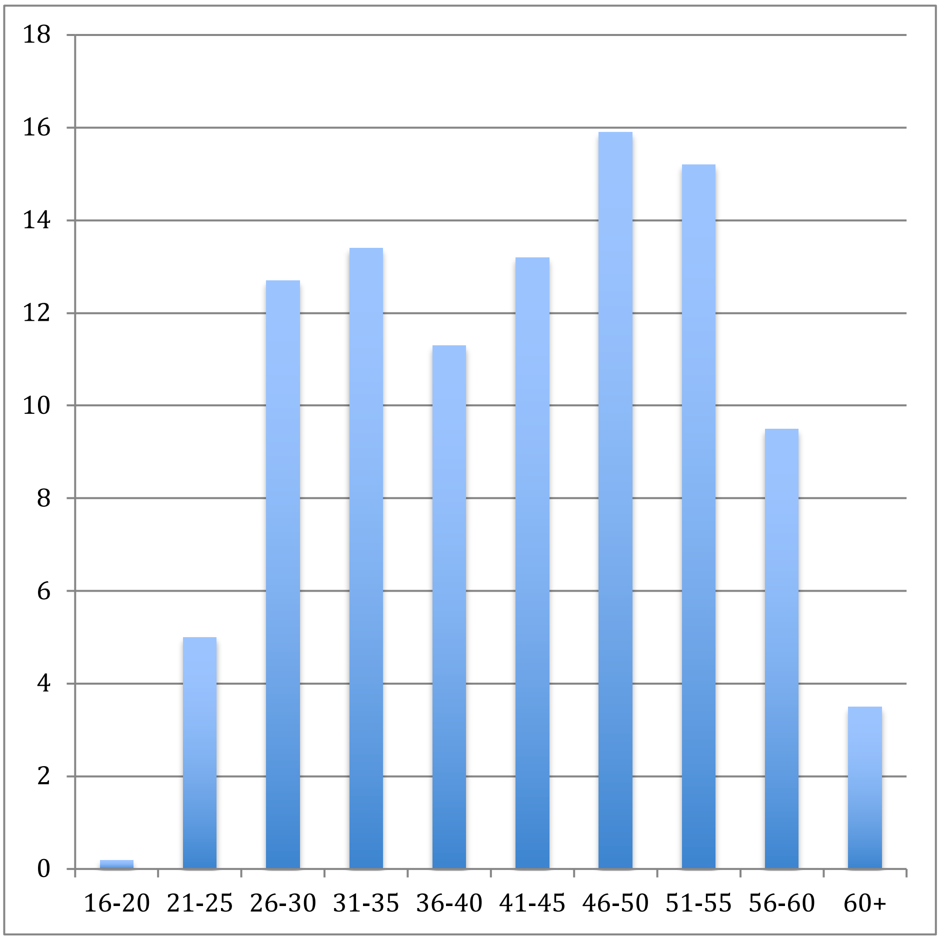


The age ranges utilised above were chosen as they are those used by Health Education England however it is important to note that the Trust used for this research do not employ staff younger than 18. As can be seen in the bar chart above the age ranges are fairly evenly spread apart from a slight dip with the 21-25 year old age bracket and then again above 55 years old.

In interpreting these figures, at is important to note that some members of staff were involved in more than one incident. Indeed, the high numbers of incidents in the 16-20 band can be explained by the fact that one 20 year old was involved in 18 incidents.

Health Education England (2013) figures (figures 5b- below) show the following figures for the age bands in the NHS and is clear that the LD Division's figures of staff involved in UI's follow a very similar pattern to that of the National figures of staff employed. Little can be drawn from this as at the time of data collection the age profile of the staff was not available however it is simply for comparison.

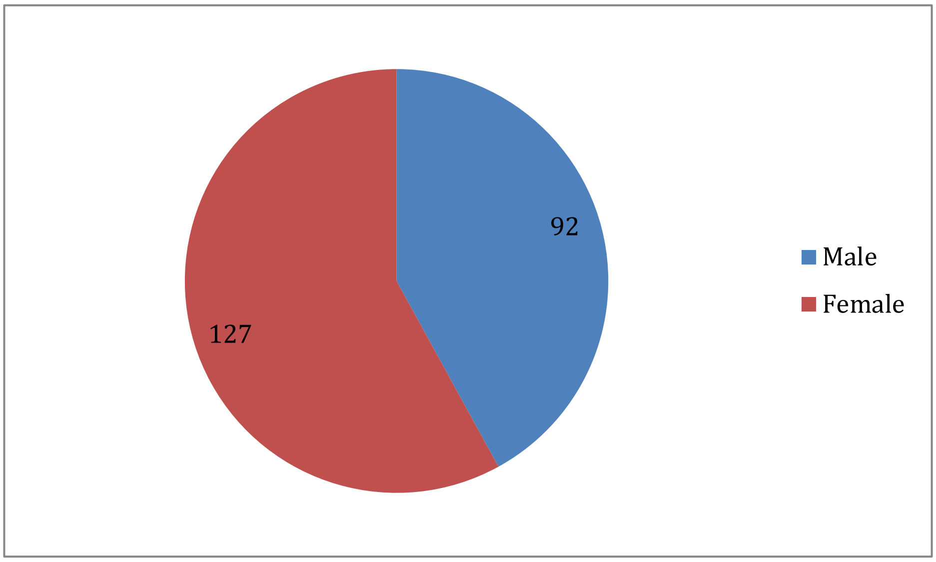
Figure 5b: National figures in age bands of staff working in the NHS.



4:6:ii- What is the gender mix of staff:

Next the gender of the staff dealing with the incidents was looked at and this is illustrated in figure 6 below.

Figure 6: Gender of staff.

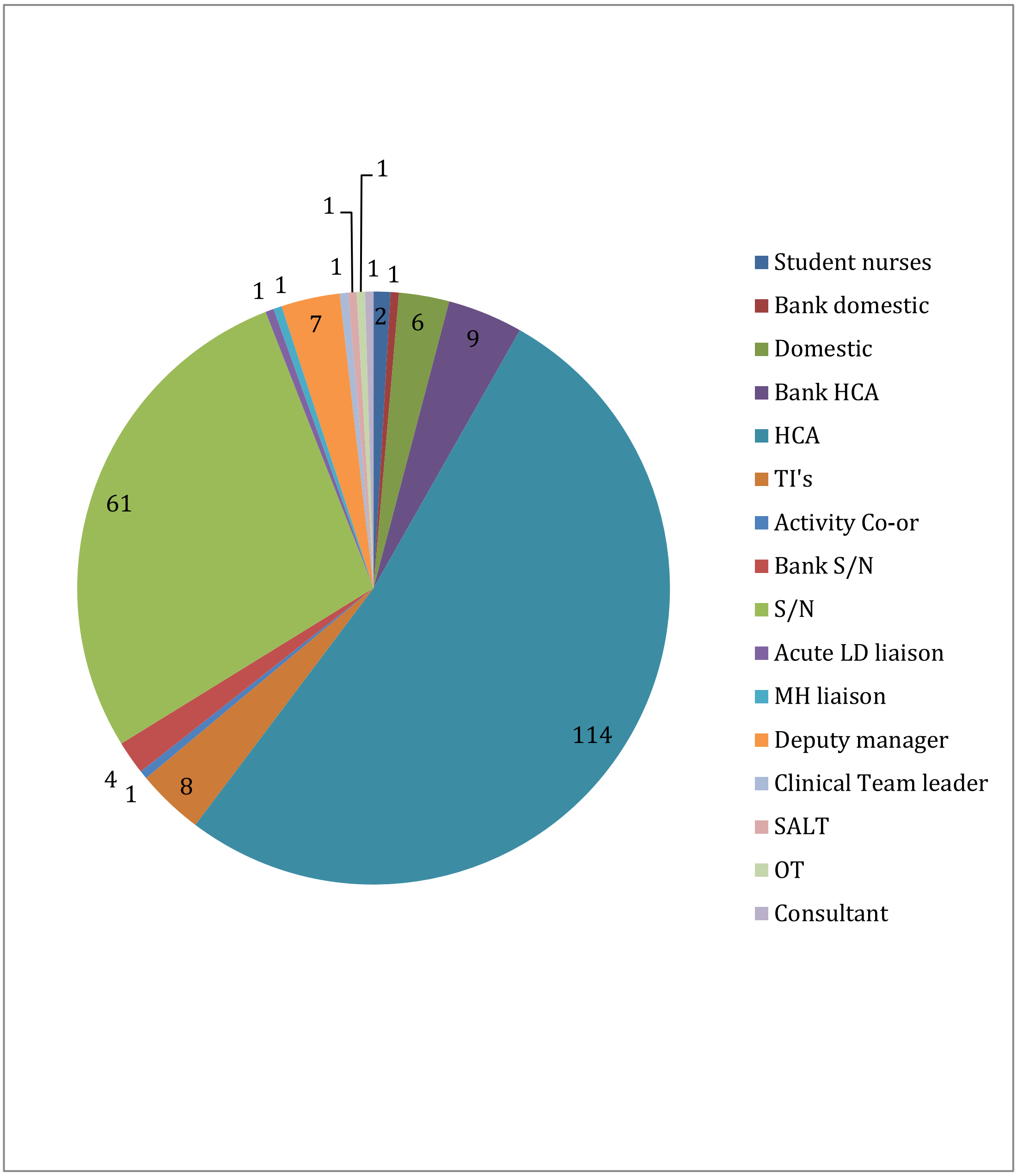


As demonstrated by the pie chart 127 (58%) incidents involved female staff and 92 (42%) involved male staff. As with the information above on the age of staff, it would be useful to know the full demographic of all employees in the Learning Disability Division of the Trust to allow interpretation of this figure. It would also be useful to know how many staff appear more than once and again highlighting a limitation of this data. The figures for employees in the NHS nationally are 65.8% females and 34.2% males (Health Education England, 2013), if the service used for this study is representative of the national figures this shows that males are more likely to be involved in an UI. The possible reasons or explanations for this are explored in the qualitative interviews.

4:6:iii- Positions/ job roles of staff:

The next area looked at is the positions/ job roles of the staff dealing with the incidents. This is illustrated in Figure 7 below.

Figure 7: Staff position/ job roles.



In the UIF's completed a broader range of job titles were given than illustrated above and so some categories have been combined. This has only occurred where the positions involve the same duties and the difference in title is due to subtle contractual differences and when the person was employed and does not affect the role undertaken. The example of this is: Health care assistant (HCA), health care support worker, nursing assistant and nursing auxiliary. All of these are fundamentally the same job and the title relates to when the person was employed (titles have changed over the years) or in some cases which department they are in. These have been collectively referred to as Health Care Assistant's (HCA's).

The most notable thing from the above graph is that over half of the UI's recorded, 114 (52%) involved a Health Care Assistant. It has to be acknowledged that there are more health care assistants working across the service and that they are the 'front line staff' in most care settings and those included in this review are no exception to that. It is therefore inevitable that they are the people reported to be dealing with the incidents. Although maybe predictable this information is invaluable to the service providers regarding the level of training required and support that should be offered to this staff group. Many professionals within the service will have received extensive education on dealing with violence and aggression or challenging behaviours prior to qualifying but the HCA's will only have the 'on the job' training offered by the Trust. The Trust therefore must ensure this training is fit for purpose and meets the needs of these staff.

Technical Instructors and Activity Co-ordinators are similar to HCAs in that these are people without a professional qualification such as nursing, OT, physiotherapy etc. Many staff in these roles have qualifications but they are vocational qualifications not professional qualifications. Although it is acknowledged that these roles are different to a HCA, they could be combined as these are all roles that can be classed as 'non- professional qualification'. If, therefore, the figures for Technical Instructor's, activity co-ordinator and HCA were to be added together this would give a total of 123 incidents and 56% of all incidents. Clearly showing that those staff without a professional qualification are more likely to be dealing with incidents.

As mentioned above some titles given in the UIF’s were combined however those described as ‘bank’ HCA or ‘bank’ nurses were not combined with non bank staff of the same position. This is due to the fact that the term ‘bank’ refers to staff that are working in environments that are not their usual place of work therefore not knowing the usual routines and protocols but more significantly not knowing the patients. This may be a factor that contributes to the occurrence of an untoward incident, hence they were not combined with the other figures for HCA’s and nurses.

While it is acknowledged that ‘bank’ staff are people working away from their normal place of work however, if one was to add ‘bank’ HCA to the figures above in order to make one large group of all patient facing staff without a professional qualification, this would give 132 incidents, or 60% of all incidents. This figure of 60% is significant to the directorate with regards to those staff most likely to be dealing with patient incidents and their training requirements to deal with these incidents.

Again as mentioned above, it is important to acknowledge that more people are employed in this ‘non-professional qualification’ group, however it is still an important factor that those most likely to be dealing with incidents are those at the lowest end of the hierarchy and with the least professional qualifications.

The next highest group dealing with incidents is the ‘staff nurse’ group. This group are the next highest group with regards to the number of staff in these roles and also the next highest to have face to face contact with patients (after the HCA’s), so these figures are again, not a surprise and are indicative of the nature of the roles.

The 7 incidents involving the ‘deputy manager’ category are somewhat of an anomaly in these figures. Further exploration identified that this is the same person, one deputy manager in one service and they are a nurse.

The category of ‘consultant’ was listed simply as that and does not state if it is a psychologist or psychiatrist.

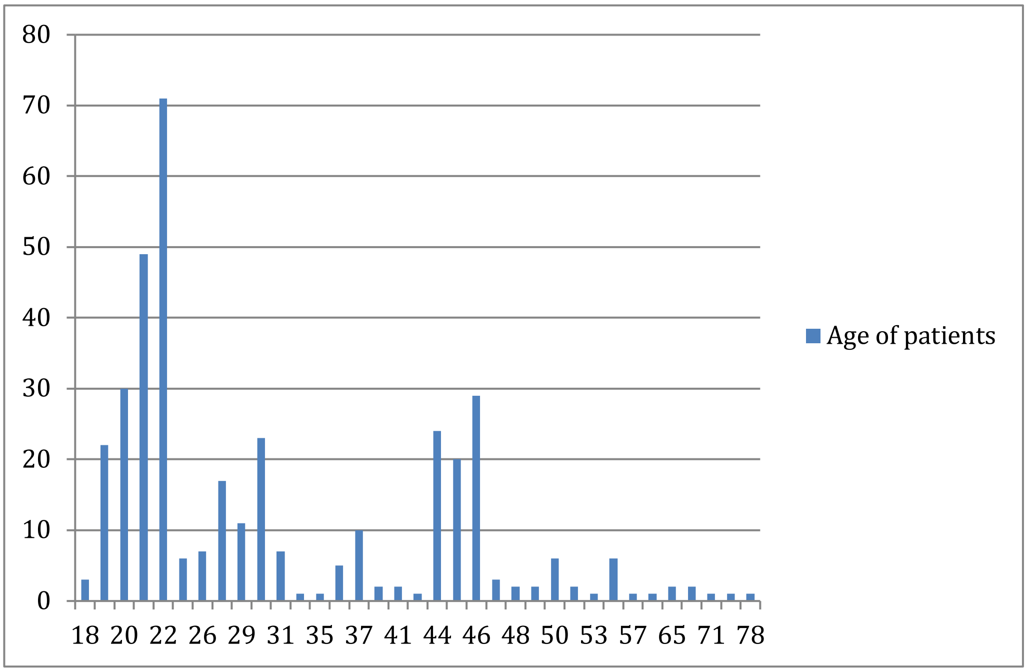
4:7- Demographic data of patients

4:7:i- Age of patients:

A total of 373 patients were involved in the 312 incidents, this is due to the fact that in some cases there was more than one patient involved in the incident (patient to patient violence) and in some cases more than two patients. It must be noted here that of these 373 reported patients some of them will no doubt be the same patient occurring more than once. This factor should be taken into account when considering the information below. It is also important to note that with regard to some of the data below some information is not available due to omissions in the recordings.

The age range of the patients involved in UI’s was from 18 to 78, an indication of the diverse range the service caters for. As can be seen in the graph below (figure 8) the majority (239, 64%) of the incidents involved patients aged 30 years old or under although there is a slight rise in mid 40’s age range. As with all these figures one must be mindful of which patients were admitted as in-patients during this period and one or two patients may skew the results.

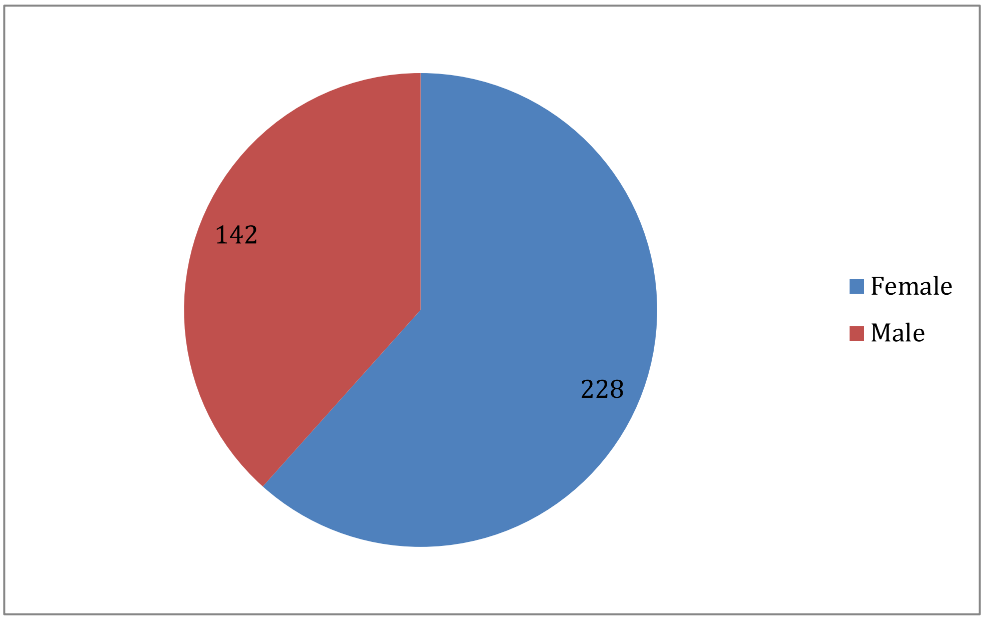
Figure 8: Age of patients.



4:7:ii- Gender of patients:

The gender split is illustrated below in figure 9. This shows that the biggest per cent of the incidents involved female patients.

Figure 9: Gender of patients.



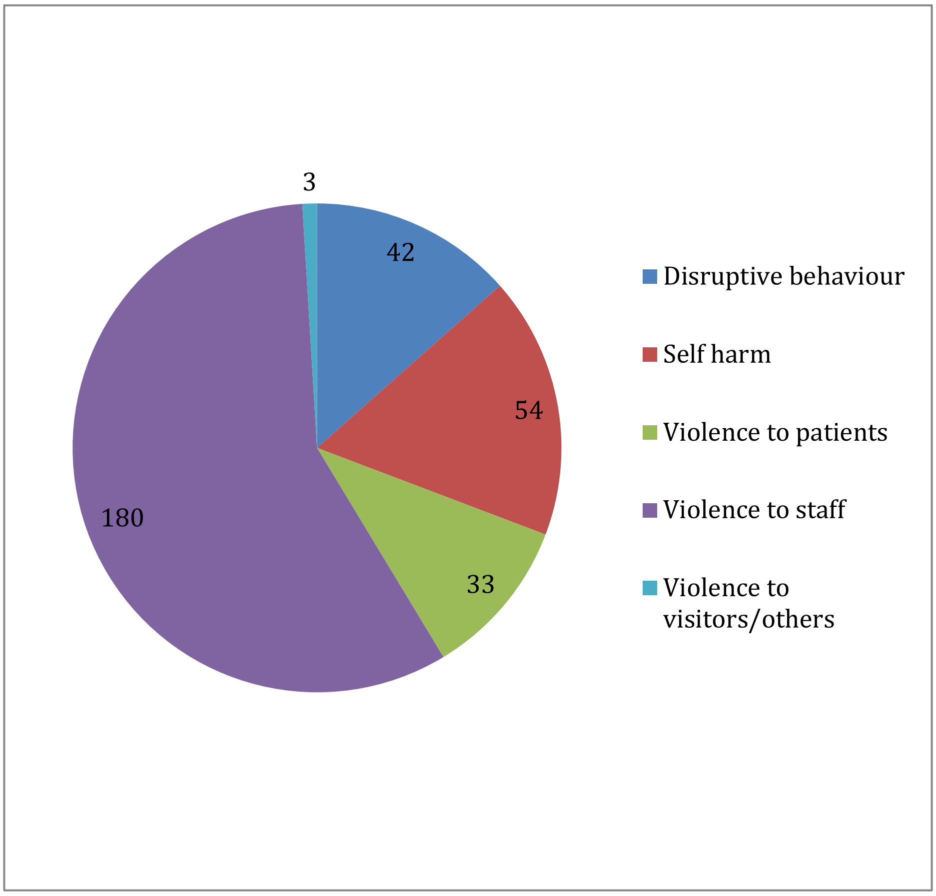
Further examination of the data revealed that the number of UI's involving female patients is affected due to the admittance of two individual females aged 21 and 22 who during the time of this study were particularly challenging.

As can be seen above these figures add up to 370 as some information was missing from the data.

4:8- Type of incidents:

The next aspect to address was the type of incidents that took place in the division and this is illustrated in the chart below (figure 10) which gives a breakdown of the type of incidents being recorded across the services.

Figure 10: Type of incidents.



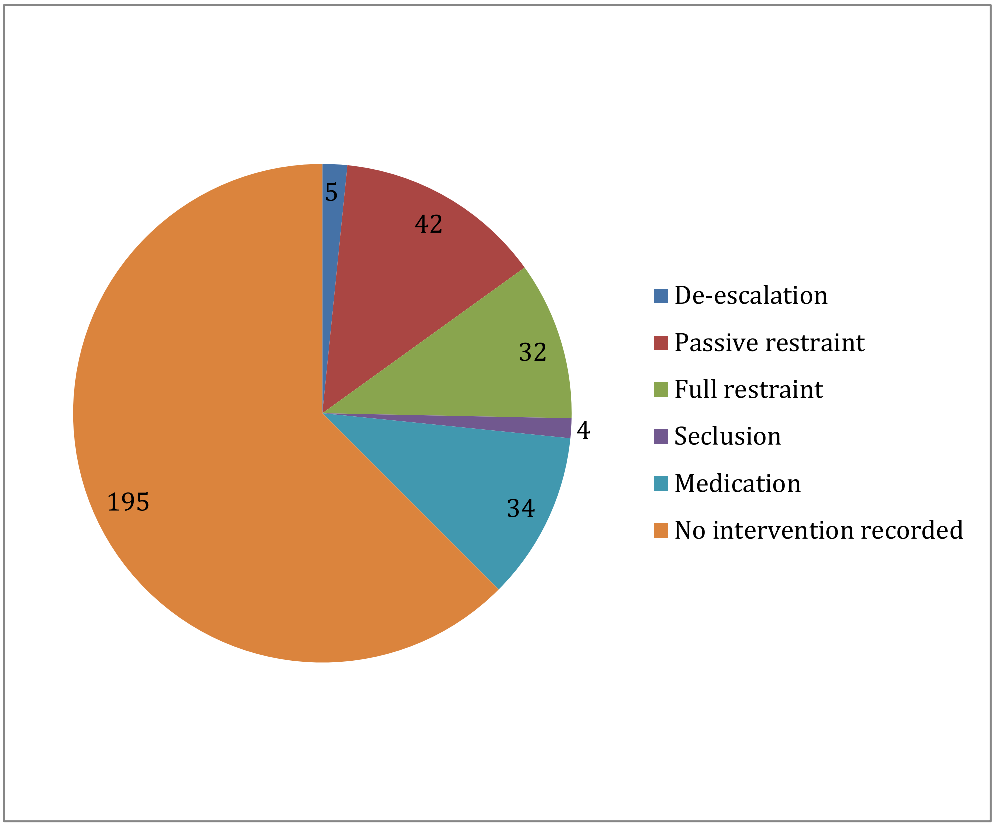
As can be clearly seen from the pie chart of the total number of incidents, 58% the biggest classification of type of incident is violence to staff.

Of the remaining types of incidents 17% were classified as self-harm, 13.5% were classified as disruptive behaviour and 10.5% was classified as violence to patients. Examples of disruptive behaviour include such things as damage to Trust property, shouting/ swearing, stripping. Only 1% were classified as violence to visitors/ others, a very small number. Some services have very few visitors anyway however this figure also potentially includes incidents to others while out in the community, so it is encouraging that it is so low. Additionally, the violence to other patients is relatively low and violence to staff is high, one possible explanation for this could be that staff 'protect' the other patients and visitors at a cost to themselves. If this is the case it would be more useful for the recording form for UI's to reflect this- it is acknowledged that the current recording form for UI's does not allow for two types of incidents to be recorded or two forms completed. Again, the high number of incidents classified as violence to staff can help the service with regard to staff planning and future training requirements. This is another aspect that was explored with staff in the staff interviews.

4:9- Intervention/ Outcome of incident:

Following the type of incidents (above) the next area to review is the outcome of those incidents and the intervention utilised by staff. This information is shown in Figure 11 below.

Figure 11: Outcome/ intervention.



The above graph shows 63% of the total 312 incidents reviewed had no intervention recorded, only 171 interventions were recorded. (These figures added together total 366 not 312. This is due to the fact that in some cases more than one intervention was utilised). This lack of recording interventions is an area for improvement in the recording system for the service, as without this information significant details regarding the effectiveness of interventions is lost. Additionally, nationally there is pressure for LD services to demonstrate a reduction in restraint and seclusion 'Reducing the need for restraint and restrictive intervention' (Department of Health, 2017) and so again without this information being recorded the services are unable to demonstrate accurate data for this.

Of the total number of incidents of challenging behaviour, the largest number recorded intervention was 13%, described as passive restraint. Passive restraint includes staff sitting with the patient, talking and encouraging them to stay where they are but without force. It may include placing staffs' hands on the patients.

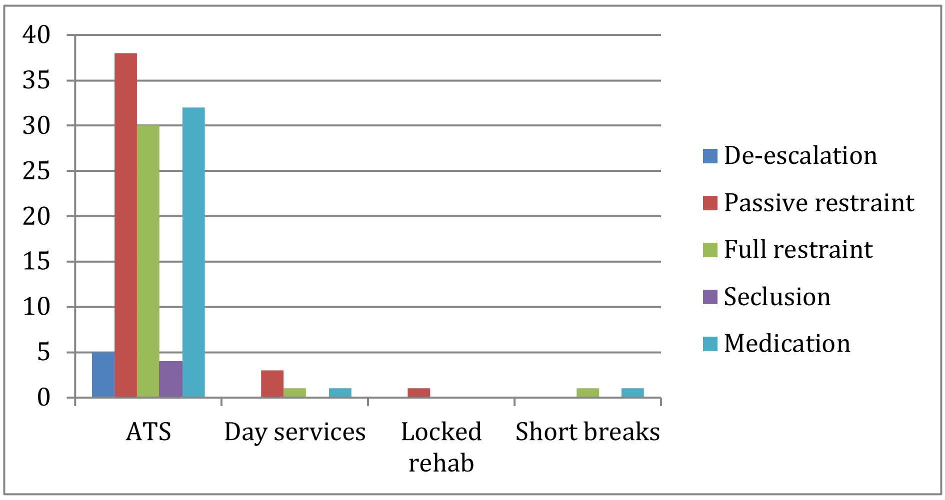
Of the remaining incidents, 11% resulted in medication being given and the type of medication utilised is explored later. A further 10% resulted in full restraint being used. Full restraint is where staff hold a patient against their will with force. In this service it consists of prone floor restraint and a sofa restraint.

Only 1% resulted in seclusion being utilised. Seclusion involves placing the patient alone in an environment specifically for that purpose. Staff have access to them to talk and offer drinks etc through a hatch but the patient is alone.

In the incidents recorded, only 2% were described as using de-escalation techniques. This is an area of improvement for the directorate as de-escalation should be a first option intervention (as considered best practice).

Figure 12 below shows in which service groups these interventions were used.

Figure 12: Frequency of use of intervention by service groups:



As illustrated above, the majority of interventions recorded took place is the ATS and unsurprisingly the pattern of interventions in the ATS reflect those of the whole service. Notably all incidents of seclusion taking place in the ATS as the ATS is the only area of the directorate that has the facilities for seclusion.

Of the remaining recordings, the next highest number of recordings took place in day service provision, although these figures are still very low. In day service provision one incident resulted in full restraint, one incident of giving medication and three resulted in passive restraint. Of the rest, one incident resulted in full restraint and one occasion of giving medication took place in short breaks services; one incident resulted in passive restraint in the locked rehabilitation service. It is difficult to draw any conclusions from this with so many missing entries and the numbers are so small.

4:10- What types of incidents lead to these interventions:

The table below (table 4) gives a breakdown of which behaviours lead to which interventions. This is followed by a discussion of each.

Table 4- What types of behaviours lead to these interventions:

Type of behaviour	Type of intervention N (% of column)				
	De-escalation	Passive restraint	Full restraint	Medication	Seclusion
Violence to staff	2 (40)	26 (58)	22 (67)	7 (20.5) 12 (35) described as physical assault no	2 (50)

				‘victim identified	
Self-harm	2 (40)	7 (15.5)	5 (15)	6 (17.5)	1 (25)
Violence to patients		1 (2)	1 (3)	3 (9)	
Disruptive behaviour	1 (20)	9 (20)	4 (12)	4 (12)	1 (25)
Clinical care		2 (4.5)	1 (3)	2 (6)	
Total	5	45	33	34	4

4:10:i- De-escalation:

Of the five incidents that resulted in de-escalation techniques being utilised, two were due to violence to staff described as ‘assault and injury’, two were due to self–harming behaviours described a ‘self-mutilation’ and one was categorised as disruptive behaviours then described further as ‘inappropriate behaviour’.

4:10:ii- Passive restraint:

Of the 45 incidents that resulted in passive restraint, the largest number of incidents that resulted in passive restraint being utilised was due to incidents of violence to staff and this is 26 incidents. Of this 26, one was due to ‘verbal abuse’, one was due to ‘threats’, seven was due to ‘attempted assaults on staff’ and 17 were due to ‘physical assaults on staff’.

Nine of the incidents that resulted in passive restraint were due to disruptive behaviours and of these nine, one was described further as ‘inappropriate behaviour’ three were described as ‘damaging Trust property’ one was classified as security and described as ‘possessing a prohibited item’, and four were due to ‘aggressive/ hostile’ behaviours.

A further seven incidents that led to passive restraint being utilised were due to self-harming behaviours and of these seven two were described further as ‘cutting’- the other five had no further description.

Of the remaining, a further two incidents were categorised as clinical care and described as ‘enforced medication’- a category not previously referred to and one was categorised as violence to other patients and described as attempted assault. It is worth noting that passive restraint was the most frequently used intervention for violence to staff, self-harm and disruptive behaviour, positive for the service.

4:10:iii- Full restraint:

Of the 33 incidents that resulted in full restraint being utilised, 22 incidents were categorised as violence to staff, eight of which were described as ‘attempted assault’ and 14 were described as ‘physical assault’. One incident was described clinical care and as ‘enforced medication’ as mentioned above.

Five of the incidents that lead to full restraint were due to self-harming behaviours, one which was described further as ‘head-banging’ and one was described further as ‘ligature used’, the other three had no further description.

Of the remaining incidents that lead to full restraint being used, four were categorised as disruptive behaviours, one described further as ‘aggressive/

hostile' and three described as damaging Trust property. One incident that led to full restraint was categorised as violence to patient but described as 'harassment'.

It is acknowledged that minimal amounts of information are provided in the forms however, the use of full restraint for behaviours such as 'aggressive/ hostile' and 'harassment' needs to be considered carefully by the Trust due to the requirements to reduce these types of interventions.

4:10:iv- Medication:

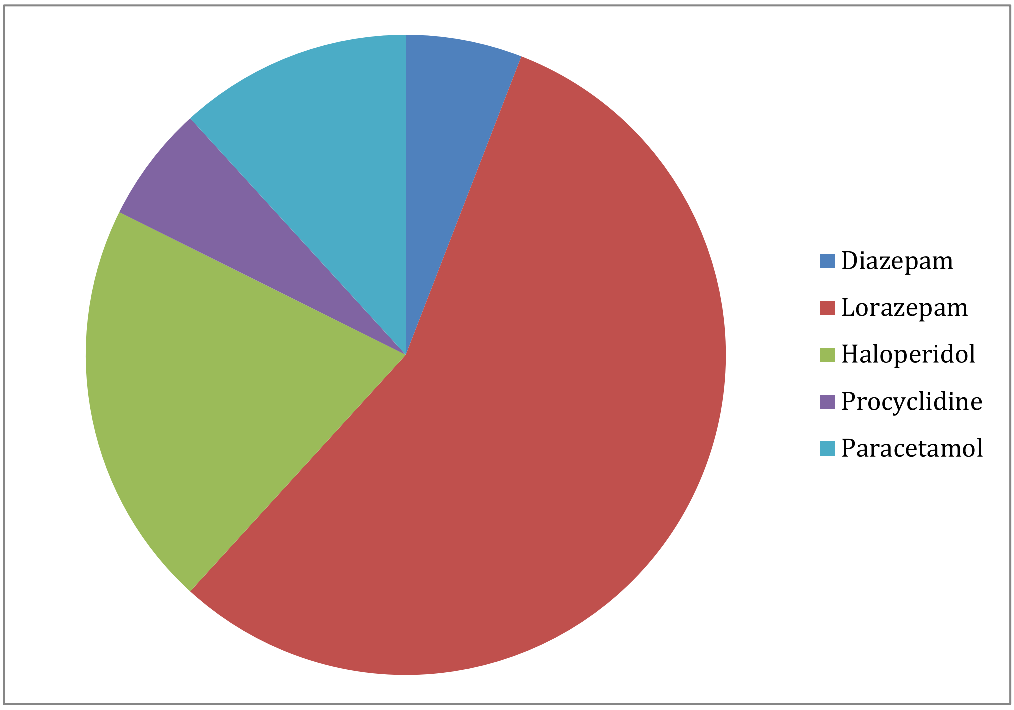
The other intervention mentioned above is medication. In this period, there were 34 cases of medication being utilised as an intervention for an UI, of these 34, 32 were given to patients at the ATS, one was given at Day Service provision and one at the short breaks service.

Of these 34 doses administered the reasons given were:

- 12 were given for what was described as 'Physical assault' and it did not specify if this was to staff or patients.
- 7 were given for violence to staff
- 6 were given for self-harm
- 4 were given for disruptive behaviour (in 3 cases described as damaging Trust property)
- 3 were given for violence to patients
- 2 (of pain relief) were given for injuries sustained during restraint (put into the clinical care category in table 2).

Of these 34 cases of medication being given as an intervention as discussed above, figure 16 (below) illustrates what type of medication was given. Diazepam and Lorazapam are medications from the drug group benzodiazepines which act on the brain and central nervous system to produce a calming effect. Haloperidol is a drug from the group anti-psychotics that works on neurotransmitters and again has calming effects. Of the 34 cases of medication being given, 19 (56%) resulted in lorazepam being administered, 2 (6%) Diazepam and 7 (21%) Haloperidol. Added together this is 28 (83%) of the occasions were medication was given, they are drugs utilised for calming/ sedating purposes. The service should consider this in light of recent calls to reduce the use of this type of medication. Procyclidine is medication from the drug group anticholinergics which treat symptoms of Parkinson's disease or involuntary movements due to the side effects of other drugs (such as benzodiazepines and anti-psychotics). As can also be seen, on four occasions Paracetamol was given. Paracetamol is a common analgesic given for pain relief.

Figure 13: Types of medication given.



4:10:v- Seclusion:

As mentioned above there were 4 four incidents in the period that resulted in seclusion being utilised, of these four, the reasons given are:

- 2 Violence to staff, described as ‘Assault- Physical’

- 1 self-harm described as ‘cutting’
- 1 disruptive behaviour described as ‘no victim’ and ‘dirty protests’

It is assumed that the self-harm behaviour could not be stopped without the patient being placed in seclusion and from the information given it is not clear as to why the disruptive behaviour incident warranted seclusion.

4:11- Overall comments of the types of interventions:

One of the most concerning things about the figures illustrated in table 2 is the lack of use of de-escalation. Another concern is the use of restrictive interventions for behaviours that could be argued do not warrant that level of interventions, such as disruptive behaviours.

A further observation is that there is no relationship between the type of incident and the intervention used. It appears that the whole range of interventions are used for the whole range of behaviours, generally speaking. This is true of violence to staff, the biggest category and most other categories. Only violence to patients did not result in the use of de-escalation or seclusion. This is again worthy of further exploration as this is an area that it could be argued seclusion is most suitable for, in order to separate the two patients involved. As mentioned above it is note worthy that passive restraint was used for several categories of behaviour including those that could be classed as more serious such as assault to staff. This should be applauded and encouraged in the future.

4:12- Closure of this section:

This section has illustrated the findings from the quantitative study of this research. This exploratory study has given insight into the burden and impact challenging behaviour places on the Division and in many areas raised more questions. These findings will be discussed further in the next section of this chapter.

4:13- Summary of the findings from the quantitative study:

The purpose of the quantitative analysis of the dataset was exploratory, simply to understand the nature of the incidents that occur in the Division that provides acute services for people with learning disabilities. By doing this the impact of these incidents can be seen. The aim was also to drive the questions to be explored in the qualitative interviews and to feed back to the Division and aid in future planning.

This analysis has shown, not surprisingly the main area UI's occur is the ATS. No doubt this will be of no surprise to the Division but the figures in this study show the significance of these services with 79% of the UI's taking place here. As mentioned previously it is clear that a high number of incidents are arising from a small number of patients and indeed in a small area of the service: the ATS and one would expect the more 'challenging' patients to be in ATS and not living in the community. The findings also suggest that context determines what form an UI takes, for example the Community teams had a higher number of UI that are not involving patients. The lack of patient related incidents in the community is not due to a lack of recording, as they do record other incidents but suggests that these areas are not having patient related incidents.

This study has shown that the number of untoward incidents varied over the six month period however, from the same period the previous year the figures have increased and this would warrant further exploration as to why this is the case. Although only two six month periods were compared and no data were available for the intervening months, both histograms suggest an increasing rate, from the earliest to the latest month for which data were available. This warrants regular re-examination of the incident rate and search for explanations. Are there environmental triggers such as a change in staffing or a change in admissions policies that result in a different population of people being admitted to these services? This issue was also explored with the staff interviews and so is discussed again later.

The distribution of incidents across days of the week was significantly different from rates that would be expected by chance. Highest rates occurred on Fridays in the services that operate 24 hours a day seven days a week and this requires further exploration to look at why this happens: is it in response to staff behaviours, environmental factors or something that happens on Fridays? There is also a slight dip on Thursdays and this dip and the peak on Fridays cannot be accounted for through such a simple factor as patient access to the service in the same way as it can in day services as the number of patients does not vary in the services that operate 24 hours a day seven days a week. This information could be fed into the services for further exploration and also can be utilised with regards to staff planning of rotas and when planning other events such as multi- disciplinary meetings, etc. These aspects were also explored in the staff interviews.

In services that operate Monday to Fridays only, the highest rate was on a Wednesday and it may also be useful to look at what occurs on Wednesday in the Monday to Friday services for further exploration of this finding. Contacting the managers of the day services to explore how many patients access the services each day revealed that in two of the three day services the number of patients attending on Wednesday is the highest of any other day, which may be a contributing factor. When looking at these factors the number of staff members on duty on these days should also be considered, which was not available for this study. While it may well simply be due to the numbers of patients accessing the service, this may be over-simplifying the issue; it could be due to something that happens or does not happen on a Wednesday or indeed staff behaviour. For example, due to increased numbers some activities may not be possible or patients receive less staff attention. Additionally, staff may anticipate Wednesdays will be challenging due to the increase in numbers therefore their behaviours may trigger incidents, as staff may be anxious or on edge, resulting in a challenging day.

The study also showed some peaks and troughs regarding the number of untoward incidents throughout the times of the day. The reason for the peaks in the times of day UI's occur could be explored to see if changes could be made to ameliorate this situation. These changes could be environmental, organisational (changes to routines etc) and interpersonal (changes to staff mix or actions). Other factors contributing to this could be that patients are anticipating certain activities (such as medication rounds, meal times, for example) or due to a lack of activity and when little is happening. Indeed, Finn and Sturney's (2009) study identified transition periods as a peak time for UI's to occur, which may be the case here, suggesting boredom and lack of engagement is a factor regarding when incidents occur. Explanation for these peaks were explored in the qualitative interviews.

Regarding the staff, the data gathered in this study clearly demonstrate that the front line staff in the "unqualified, non- professional" categories (such as HCA's etc) are the main staff dealing with UI's. As front-line staff they are clearly the ones dealing with patients and as a result are often the 'victims' of challenging behaviours. Again, this was an area discussed in the staff interviews and emphasises the importance of ensuring some staff interviewed were HCA's. The second highest group involved in incidents were nurses, again reinforcing the benefit of interviewing them. HCA's are by far the largest staff group in number, followed by nurses. Typically, HCA's and nurses are allocated to one environment as their work base and spend the majority of their working day there, whereas other professionals, such as consultants and therapists often move between services, therefore this finding is not a surprise. However, this is still invaluable information for the Trust as it emphasises the need for extensive support and training to be offered to these staff regarding dealing with incidents of challenging behaviour.

These data indicated that a high percentage (62%) of incidents that occurred in this period involved female patients, which is in contrast to much of the existing literature as identified in the literature review chapter of this thesis, (Allen, Lowe, Brophy and Moore's (2009), McGill, Murphy and Kelly-Pike (2009), Chaplin, Tsakanikos, Wright and Bouras (2009), Driescher, Marrozos and Regenboog (2013), Webber, McVilly and Chan (2011) Chaplin, Tsakanikos, Wright and Bouras (2009) and Tilli and Spreat (2009) all identified males were most likely to receive RI). Further exploration did identify there were two females admitted to the ATS during this time who were involved in many untoward incidents that impacted these figures. This is a still a curious finding that contradicts other research. One explanation for this could be that female patients are viewed more harshly than male patients due to societal norms and expectations that females are the softer gender. There is little research in this area but one paper that goes someway to support this proposition is Sygel et al (2017). In this paper 26 professionals were given six case vignettes to assess in a mental health service. Some of these vignettes featured people who had a learning disability and others did not. In this research it was found that female patients with a learning disability were rated more likely to be at risk of criminal recidivism, suggesting they were viewed more harshly.

This highlights one of the limitations of this dataset as individual patients could not be identified. Had that been the case exploring patients' diagnoses and history would have added a wealth of useful information.

Regarding the nature of the incidents, the study shows that the highest number of UI's (58%) are violence to staff. This is vital information and again warrants further study. This could be an ethnographic study to fully explore the role staff play in the incidents, if any. Again, this information needs to be fed into existing training systems and in the planning of future training. This factor also justifies the qualitative elements of this research, to explore the impact on staff of being a 'victim' of patient violence. One explanation for this could be that staff are 'sacrificing' themselves, in that if an incident appears to be developing as a patient to patient incident staff may put themselves between the two patients, likewise if a patient is self-harming staff may intervene and in turn that results in the patient turning their behaviour towards the staff. This is supported somewhat by the findings from the staff interviews (chapter 5) regarding staff members' thoughts about self-harming behaviour.

The nature of interventions utilised by staff was also explored. It is apparent that the whole range of restrictive interventions available to staff are utilised. The study did not identify any patterns regarding which intervention is likely to be used over another for certain types of behaviours. An exploration of this is also worthy of discussion. Is the choice a pre- determined decision based on a robust care plan for the individual patient or is it led by other factors such as staff choices, staffing levels etc. Also, it would be useful to determine how many recorded occasions of using restrictive interventions are classified as planned interventions and how many are classified as emergency responses.

Only 5 incidents (2%) of the total number of incidents recorded during the research period documented used de-escalation as an intervention. This may be due to under-reporting with staff not considering this strategy as an intervention or because the nature of the form does not prompt for more than one entry. If they are being utilised this needs to be evidenced in the reporting systems as this is currently not the case. If this represents the true figure, there needs to be an increase in the use of de-escalation techniques being utilised, in line with current best practice and the Trust need to be able to evidence this. The untoward incident form needs to have the option to record more than one intervention to be useful.

The service may also want to consider whether the use of the more aversive interventions (seclusion and full restraint) is appropriate for behaviours that do not pose a risk to anyone, such as disruptive behaviours, in line with current recommendations 'Reducing the need for restraint and restrictive intervention' (Department of Health, 2017). The Trust needs to be able to demonstrate a reduction in the use of restraint and seclusion and an increase in de-escalation. Are aversive approaches such as seclusion and full restraint being used when less aversive approaches would be effective? Is this because of staff interpretation of the level of risk posed or because they are less confident or familiar with the less aversive interventions? While it is acknowledged that the nature of this service is that it caters for people who display challenging behaviours and to be admitted there, one must display these behaviours the requirement is that services utilise other approaches to manage them.

One further conclusion drawn from this study is regarding the way incidents are recorded. There needs to be a significant improvement in the recording of what interventions are utilised following an UI as too many (63%) had no intervention recorded at all. Even if it states 'calmed when staff spoke…' for example, this would be useful data. The information is extremely useful when considering what interventions work for patients, which are effective and which are not. If the forms were to be amended to state an intervention must be recorded, or document how the incident ended it would improve this area of documentation. At the moment it seems the Trust are missing an opportunity by not using this information for planning of services and the training the staff receive. The lack of entries is also a worry from a Health and Safety perspective. If anyone, staff or patients have adverse circumstances following an UI the lack of detail in the documentation leaves the Trust vulnerable to litigation or other negative consequences.

This also raises further questions about recording. Currently there is no way to determine how many incidents are recorded. How do staff decide what warrants the completion of an untoward incident form? Lovell and Skellern's (2013) qualitative study identified that many staff viewed violence as part of the job so did not always record incidents. Indeed, their study also identified what defines an incident in the first place was a complicated one, open to interpretation and varied between professionals. This could well be a factor in this Trust and so robust definitions of what warrants reporting would be useful to staff.

4:14- Methodological Issues involved in this study:

The data utilised for this study are routinely collected by the Trust, this is a positive and ensures that the information was not biased towards any hypothesis. Had staff been aware that the recordings were going to be scrutinised and analysed for this particular purpose they may have recorded differently. The weakness of this is that the system was not developed for the purpose of research and therefore had limitations. It resulted in an inability to cross correlate some of the variables, relate incidents to patient occupancy or staff levels or identify how many incidents originated from the same patients or involved the same staff. This would have created a wealth of more useful results. There were two cases where this had been possible, the 20 year old HCA and the deputy manager. These could be determined as they were the only people in these categories at the time. This leads one to suspect that other staff may also be involved in several recorded incidents.

Access to the database was limited to information gleaned in simple numerical form based on specific information requested. Had full access been granted other areas may have been explored that were not considered at the time but would have been evident when looking at the raw data.

The quantitative study has only been able to provide a snap shot in time of the nature of incidents occurring in the service and represents those patients in the service at that time. As mentioned earlier, with all these figures one must be mindful of which patients were admitted as in-patients during this period and one or two patients may influence the results. A repeat of this study would help explore if these results are truly typical of this service. In addition, expanding the study to a period of twelve months would have been beneficial. This would have given a better picture of the impact of challenging behaviour and the use of restrictive interventions on the Trust. It would have demonstrated a more complete picture of any seasonal variations that may have occurred in this study period and been less susceptible to any additional unrecorded factors that may have influenced admission patterns for example closure of a service, change in management at a service etc. As is mentioned in the results, two ATS did merge during this period. This period of disruption may have led to an increase in untoward incidents, if patients sensed any feelings of being unsettled by the staff.

In addition, if patient details had been available it would have been possible to explore more about the nature of the patients, as it was, the only information gleaned was age and gender of the patients. The patient's diagnosis, time spent in services and other such information would have given a richer source of information. It was impossible to tell from the data how many different patients were responsible for the incidents. Limited information was available but from this it could not be determined how many ‘repeat offenders’ there were.

Another limitation was the fact that so many incidents did not have any staff recorded at all with no way of determining why this is the case. It could be a failure to record by the staff. Similarly, a further limitation was the extent of missing information regarding the type of intervention utilised, a further failure to record

4:15- Conclusion of this chapter

This chapter has presented the results from the quantitative element of this research and given a summary of these. It has also presented some of the methodological issues arising from the dataset.

There are limitations to the data utilised, most notably the inability to explore details of the individuals involved. This would have given a much richer study. The Trust would benefit from further study in this area. A further limitation is regarding where information was omitted, this has limited its use for this study and also for the benefit of the Trust concerned.

Despite these limitations there have been many useful findings derived from this study and it would be beneficial to the Trust to repeat this work to conclude if these results are typical for the service.

As mentioned above several aspects gleaned from this part of the research will be explored in the interviews with staff, including the days of the week and times of the day incidents are most likely to happen, which staff are involved with incidents and the nature of the incidents.

While some of these findings will be of no surprise to leaders within learning disability services this research highlights the need for appropriate and additional specific training support for front line staff.

Chapter 5: Results from Staff Interviews.

5:1- Introduction to this chapter:

This chapter looks at the findings from the qualitative interviews undertaken with the staff. The findings from these interviews are presented in themes below.

5:2- Staff interviewed/ Participants:

Qualitative interviews were undertaken with twelve staff members. These twelve staff members consisted of six females and six males and three of each were qualified nurses and three were health care assistants (HCA's). The age range of all staff members was 27 to 54 and the range of number of years' experience was 7- 20. One male qualified nurse had previously worked as a HCA but had only been a qualified nurse for one year.

The interviews took place in their places of work and were arranged at a time convenient to each individual staff member. On the whole this took place at handover periods to ensure the staff member could be released from their duties for the interview. The researcher did not wish to inconvenience the staff by expecting them to give the interview in their own time while at the same time understanding that staff cannot easily be released from shift so undertaking the interviews at the handover period enabled the staff to be released and did not impact on their own time.

Prior to the interviews staff members were reminded about the participant information sheet and consent sheet and asked to sign them. Staff were also reminded that they could request the interview be stopped at any time and that they could ask for their contribution to be excluded if they changed their mind. The researcher also stressed that their contributions would remain anonymous and that no identifying information would accompany their quotes, however if they disclosed a safeguarding issue or other issue of concern that would be acted upon. No staff withdrew during or following the interview and no safeguarding issues were disclosed. The interviews ranged from 24 minutes and 7 seconds to 37 minutes 2 seconds.

The interviews were transcribed by the researcher as soon after each interview as possible. This was to ensure as much recall from memory in case any of the recording was unclear and also so that additional information could be included, such as any significant gestures made by the staff member. This was necessary as several staff made gestures indicating the aggression involved in an incident they were relaying but also some staff cried or had tears in their eyes.

The quotes used below are coded according to who said them. These codes are:

- C= Health Care Assistant
- Q= Qualified Nurse
- M= Male
- F= Female

Then each person also has a corresponding number.

5:3- Themes:

Six themes were identified from the transcribed interviews and are as follows:

1. What staff believe about the nature of the patients and the incidents
2. Role Conflict
3. Negative impact on staff
4. Negative impact on Patients
5. Significance of the team
6. Preference for aversive techniques

These themes are now to be discussed below.

5:3:i- Theme one- What staff believe about the nature of the patients and the incidents:

Interviewees were shown information from the quantitative study. The first was regarding the fact that the six-month period that was utilised for this study showed a slight increase in total number of incidents from the same period the year before. The staff members were not surprised to see that the number of incidents had risen. They explained that there was a changing nature in the type of patients they were getting in their services, patients were more able, with mild learning disabilities and mental health issues. Some staff felt that the change in the service's name came at the time of the change in patients: the service changed its name from Learning Disability Service to Intellectual Disability and some staff felt this coincided with the change in the nature of the patients, however they could not articulate why this was:

> *We are having a lot of like younger patients coming through the door, even younger than me and I'm only in my 20's erm who are quite violent and really strong. And like when the terminology changed to Intellectual Disability it suits it, it suits this unit. Because they are very, very mild………really challenging CF1*

Other staff agreed that the nature of their patients has changed, to younger and more able people:

> *I mean we do seem to have a change in client so we do have younger…. we've got a lot younger and they seem to be….. not all of them are younger but a lot are and more able QF1*
>
> *We've got much more able patients now, younger and more able QM3*

Additionally, staff members were asked if they felt their service had a 'bad day', a day where they felt that incidents were more likely to happen.

Some staff did think this was the case and were confident in their response:

> *in my experience it could be around the MDT day when they know that's happening QF1*

However, on the whole staff did not recognise that their service had a bad day until presented with the results from the quantitative data, when staff responded with understanding, this is the day that the multi- disciplinary meetings and ward rounds take place. Several staff agreed with this:

> *Ah ward round days CF1*

Staff acknowledged that as they are busy and a lot is happening this can be a trigger for incidents:

> *Because everywhere is busy a lot of the patients know that the doctors will come and they're going to get seen there's a lot of anxiety about what's going to happen*
>
> *Researcher: Yes because decisions can be made that….*
>
> *Yes regarding their care and they have a lot of visitors, social workers carers, and it's just a busy time so I think…..Yeah and with it being busy we obviously have to answer the phones and stuff, bringing people onto the unit it's taking our time away from them when they actually need it more on those days. Yes but I've always even at …….*other service *ward round days have always been the same CF1*

Staff felt that the patients understand the significance of ward rounds and MDT meetings and the impact these can have on them:

> *I notice more the patients get upset and agitated more when it's ward round because it reflects what's gonna happen. And whether they're gonna go on home leave or whether they're gonna get to go, be discharged or they're gonna have to be here for another*

> *couple of weeks or their section's being renewed or…….Er, can they have section 17, they don't want to, some of them don't want to be here anyway so when can I leave. So that, that winds, that causes, sort of tension and anxiety for them QF2*

As well as days of the week, some staff also commented on the times of day incidents are more likely to occur. Several implied it is simply due to meal times being busy times and staff being busy elsewhere:

> *we've just got the usual breakfast meal time handover QF2*

> *Yes I would say food because we have lunch about half past 12 or 1 and some go to the canteen after for a drink so it's just like hectic CF2*

The quote below suggests that it is a busy time but also that it is more complex than that and also depends on the patients that are in at the time and clearly some of the patients' behaviours impact on the others:

> *It varies depending on what patients we have cos there's been weeks where I absolutely dread meal times and there's been weeks where we've had to split meal time just because of the pure mixture of the patients that we've got in CF1*

One member of staff suggested it is a more complicated than simply staff members are busy at meal times and that it relates to power dynamics between the staff and patients:

> *Lunchtime is a flash point because, how can I put it, some staff…. If you are serving food, you've got power, power to say no, if they ask for seconds or whatever, they can say no QM1*

Staff were also asked about the number of incidents involving male members of staff in dealing with incidents. This question created some interesting responses:

> *you know, it's more of a male thing QF1*

> *Yes I do….. probably like sometimes some of the guys, say the aggression is towards a female they'll kind of…. they do step in and kind of, not that they like the restraint but they'll get in that protective role and they'll still at some point they probably don't need to do that but they feel that as a male a woman is being targeted so they will intervene and perhaps taking it too…. it is a bit of a mans world if you know what I mean QF1*

Some female staff spoke about it could be a macho thing or chivalrous act:

> *Males and I think sometimes the males can, I don't know if it's a dominating thing or a protecting thing of the women CF1*

> *I just think that male staff sometimes have that knight in shining armour, I mean obviously in some situations when patients are screaming and shouting and spitting and wanting to punch you and kick you, you… I think the males first reaction is, we need to protect the female staff QF3*

One member of staff felt strongly about the fact that numbers were higher with male staff and returned to it several times throughout her interview. The quotes below are from the same member of staff and there were others from this person, littered throughout their interview. She appeared to imply that she felt sometimes a man can aggravate a situation:

> *I mean I've had to tell a male to go and leave it and I'll sort it and have some time out CF2*

She also felt that the males do not want female staff to get hurt:

> *Yes I think there is, cos obviously you may think I'm being sexist but it's like the males again whether they do it cos they don't want us to get injured cos we're women CF2*

One male member of staff commented on this prior to being asked, he volunteered the information when speaking about incidents. When asked further about his statement he could not elaborate:

> *I'd sooner be in the way be the one that gets hit, that's not a sexist thing or anything…….just I would CM2*

One male member of staff acknowledged it was due to physical appearance:

> *I don't want to get hurt, but more importantly I don't want the females to get hurt, a woman in their 20's or 30's…. I mean, it doesn't matter on my ugly face but……CM3*

Staff members were shown the figures indicating that most incidents were dealt with by HCA's and this may be expected as there are indeed more of them and they are the front line staff. This was supported by comments from some HCA's:

> *I just suppose there are more of us and we are basically interacting with the patients all the time CF1*

One HCA suggested it was due to HCA's having more direct contact with the patients, being 'on the shop floor' was how she described this:

> *At the end of the day we are on the shop floor. No disrespect to the nurses what so ever because they do go on the shop floor but not as much as us CF2.*

Additionally, it was suggested by one HCA that it was more complicated than mere numbers of HCA's and them having more direct contact with patients and that in many cases patients understand the difference in roles, between nurses and HCA's:

> *It's hierarchical, so quite often if a HCA was to go in and try you know calm somebody down or whatever they wouldn't take no notice of you because you're not authority CF3*

Some qualified nurses felt it may also be due to other factors. The person below implied that nurses are able to avoid and prevent incidents better:

> *It comes down to training, nurses have more knowledge, to see the function of the behaviour QM1*

This point was supported further regarding qualified nurses having more insight:

> *they* (HCA's) *don't see the bigger picture that actually there is something going off with this person it could be this person's in pain, it might not be anything you know, you might just need to sit and talk to them QF3*

During the interviews staff were also shown the number of incidents in each category, showing that 'violence to staff' is the biggest category. They were asked for their thoughts about this. One person was surprised by this and thought they had more self-harming behaviours. This person also expressed that self-harming behaviours were their worst behaviour to deal with so this may be reflected in their perception that there are more of them:

> *I think it's changed, I think in the past it was more patient to staff. Erm followed by patient to patient but it was majority patient to staff yes erm I think these last couple of years though its more…. its more increase in self harm…I've noticed that's increased QF1*

Others also concurred with the above point, believing that self-harm is the predominant behaviour, but also acknowledges large amounts of other behaviours:

> *We do get a bit of self-harm or self-injurious behaviour erm we have got a lady in segregation who self-harms everyday……..She's a head banger*
>
> *So we every time she head bangs we have to put an IR1* (untoward incident form) *in. She has actually got a pouch on the top of her head from where she bangs it so much CF1*

Regarding why challenging behaviours occur, one member of staff (QM1) also stated that patients are bored and this is a contributing factor to why behaviours occur while another agreed:

> *There's not enough activities for them QF2*

This point is supported by the patients (see chapter 6).

The responses from staff above are invaluable for service planning, regarding the number of staff to rota on shifts particularly when MDT meetings will be taking place but also to consider the staff mix and dynamics, as well as planning for future staff training.

5:3:ii- Theme two- Role conflict:

The next theme identified is that of role conflict, the opposing roles of nurse or carer and authoritative disciplinarian. The impact of this professional conflict was illustrated by quotes from most staff. Several people spoke about these opposing roles and the conflict this gives to them, clearly most staff see their role as being therapeutic and rehabilitative, however restraining a patient conflicts with this:

> *we had a patient who was psychotic and erm was really unwell, and he believed that we was poisoning him, food drink everything and*

> *he needed his depot and I had quite a close relationship with him so erm it was quite hurtful for me to see that but we had to restrain him to give him his depot but I knew that, you know, it was the right thing to do for him and it was so………Erm I think it's harder when you've got a good relationship because you don't want to ruin that therapeutic bond that you've got with that person CF1*

Despite restraint being a common approach in learning disability services clearly staff are not happy about carrying it out:

> *It's not a nice experience, I feel like I've failed. I'm thinking is this legal, is this punishment? How do you convince someone when you are there pinning them down that you are there to help them? They must think, these are people who aren't on my side QM1*

The quote below illustrates this conflict, not so much with what they said but rather with how they said it, this person is an intelligent and articulate person but struggled to finish sentences, each section had long pauses between them:

> *Long pause…..can I be really……. I, I don't know whether restraining is a positive experience to be honest because I think that initial……… the initial moment when you know you have to go and restrain……. It's been something that you've thought 'well that ended up in a right mess' QF3*

When commenting on how he feels it impacts on the patients, one staff nurse commented:

> *It was meant to be a safe place, I'm not sure it always felt like that QM1*

One person also suggested this is not the reason he does this job:

> *I feel relieved when it's* (restraint*) finished, it's not what the job is supposed to be about QM3*

When discussing a restraint that the person did not feel was necessary one person expressed how she views restraint:

> *And they said no you're gonna have to basically take hold and we ended up in a heap on the floor and it's just so undignified, it's just horrible for the clients horrible for us QF1*

Staff are clearly aware this conflict impacts on the therapeutic relationship they have with the patients:

> *I've known it effect a relationship I had with a patient, he looked at me like I'd let him down, so I felt like I had CM1*

Staff also expressed how restraint contradicts why they do this type of job:

> *I'd rather talk to them and use humour and knowing the person rather than restraining them because 9 times out of 10 you haven't got to restrain them if you talk to them and get to know 'em…….but obviously create an environment that's more therapeutic to them*

Several times staff members used the word 'battle' to describe situations, which again highlights the way they feel about these situations:

> *Because you know you're having to hold this person down this person that being held down is probably in such a crisis point that they don't know what they're doing erm and I suppose it's about the staff team being able to recognize when is the right time to talk to that patient and, you know, and the other thing is getting into a constant battle with your patient I've been in them situations before as well, where they're aroused they're shouting they're swearing you know, and you can find yourself being dragged into that kind of shouting QF3*

The staff appear to be demonstrating that there is a huge ethical conflict central to the role they play and this conflict is apparent as a regular occurrence throughout their ordinary working practices.

5:3:iii- Theme three- Negative impact on staff:

As well as the professional conflict illustrated above staff also spoke about the impact the use of restrictive interventions has on them, impacting on their personal time and well-being. Staff explained that they think about issues that have occurred during a shift when at home:

> *Yeah but sometimes I can go home and it does play on my mind, I've had a few sleepless nights I won't lie CF1*

Talking specifically about restraint staff explained they felt anxious:

> *if it's not gone so good then you can still be left quite anxious about it, it's quite upsetting yes, it's not my favourite thing in the world QF1*

While others stress they find self-harm upsetting:

> *Self-harm I find it quite damaging to witness as well QF1*

Several staff spoke about how during an incident their adrenaline kicks in. This was consistently reiterated by staff:

> *Your adrenaline is pumping no matter what. It is stressful QF2*

> *my adrenalin is pumping and I always try and think, is there another way because obviously restraint is just literally the last resort and no one wants to be fighting with anybody CF1*

> *It's just that, and then your adrenaline starts going don't it CF2*

Similarly, staff spoke about not liking the experience of restraint:

> *You get het up, adrenaline going, I've never enjoyed restraint QM1*

> *it's a constant battle and actually you're not achieving anything you're just stressing each other out so then the restraint becomes even more stressful QF3*

Some staff expressed concern regarding what may happen, the anticipation:

> *I don't want a broken nose CF2*

> *I feel intimidated about what they might do, it does depend how well you know them QM3*

Staff expressed preferences regarding certain behaviours and typically there was a dislike for self-harming behaviours:

> *Self-harm…. I'd rather not, I mean punches or anything like that we can put up with that and sort it out sort of thing but the severity of self-harm….CF2*

> *What do I like the least probably self-harm. I'd rather they go for me. Yes I find it quite…. Self-harm I find it quite damaging to witness as well. Erm……..I'd rather them just hit me you know where you stand if they come for you QF1*

The quote below sums up the collection of thoughts and emotions staff experience, the physical impact on them, the psychological impact on them and the professional questioning about their actions:

> *Your hearts pumping and the adrenalin is pumping and you might be uncomfortable because you might be on your knees or whatever and I suppose all the way through you are thinking oh god when is it gonna end. You're tired, ready to be going home I suppose still a*

> *little bit anxious I suppose you do question, did we do the right thing CF3*

As can be seen by the comments above many staff personally experience negative emotions and thoughts as a result of utilising RI.

5:3:iv- Theme four- Negative impact on patients:

Building on the themes two and three above: staff also expressed concern for the impact restrictive interventions has on the patients and acknowledged they are often counter-productive. Several staff agreed that it must be a frightening experience for the patients:

> *I think it's frightening for them, they're not quite sure what's happening, obviously you're having to try and remember to tell them what's going off as well and I think from the incident I described earlier I think, we spoke to him first and actually told him what we were gonna do before we even did it so he also prepared himself but I…. suppose it's like with anything, it's them not knowing what's happening and how its gonna turn out for them, even if they're in denial QF2*

Staff acknowledge that RI do not calm a patient down:

> *as well as trying to calm them down in a way you're probably having the opposite effect to a certain extent CF3*

> *It's obviously more heightened when they're being restrained (their emotional state) QF2*

Several staff expressed concern about the impact of RI, particularly the impact restraint can have on the patient due to the patient's history:

> *I imagine they feel frightened, disempowered, I wonder if we re-traumatise people. I think it makes it worse. Others feel confusion, this is a team not to be messed with QM1*

One member of staff stressed how scary it must be the first time a patient is restrained:

> *I mean when they're new, the first time…. they don't know what's going to happen!!!!! They're not gonna understand!!!! They're not going to be happy CM3*

And that the interventions can lead to the patients being hurt:

> *You get the odd one that will say, get off me you're hurting me CF2*

Staff also spoke about the impact on other patients, not the patients receiving the RI's but others that are around observing. On the whole staff felt that it must be a distressing experiencing for those observing. One person stated:

> *Yeah, I mean it's not nice for them cos they don't understand what's going on. And they kind of think well will that happen to me 'n' that and obviously again it's about talking to them, supporting them, reassuring them QF2*

> *I think they're frightened and I think it is quite frightening cos we have one in particular here, he just takes himself off and gets all in a tizzy. You know, he won't come out is room*
> *Researcher: While there's a situation?*
> *Yeah and afterwards it's getting him out again and just saying, look you're safe and you know, obviously they see us restraining someone and they think, my god! CF2*

Staff also acknowledge that the patients observing do not always understand what is happening to their fellow patients:

> *they are nervous, afraid like deers in headlights, I've heard them say why is that person being beat up? QM2*

While this was a common response from the staff others also felt that the impact on those observing was not always negative:

> *I think they must feel shocked and I think they could be frightened erm and scared maybe and I mean…. I've known in the past some have used it… you know, hierarchy, you know, they use it against the other person, you know, they think it's funny but I think most probably on looking would think ah this isn't a good situation QF3*

Staff also experienced patients laughing at those being restrained and wanting to watch the incident:

> *I've known some want to stand around and have a laugh, you have to tell them to go but they don't and they're laughing and saying ah you're in trouble, it may just be relief that it's not them though! CM1*

Despite some feelings expressed by the staff that the use of RI's may be a positive one and make some patients laugh when they are used on others, on the whole staff perceive that the impact of RI's is a negative one on the patients. The staff members expressed that the patients must feel fear, anger and frustration. They also expressed that it does not calm them down, in fact is probably counter-productive and has the opposite effect as well as damaging the therapeutic relationship.

5:3:v- Theme five- Significance of the team:

Several staff spoke about the crucial role played by the team in utilising restrictive interventions. On the whole this works positively but some incidents could undermine team cohesion.

When asked to recall occasions where restrictive interventions had been utilised and the situation had been positive several staff members stated the reason it was positive was due to teamwork. They spoke about the importance of working as one and trusting each other. Good communication and each person having and knowing their role are important factors regarding whether the restraint is a success or not:

> *probably because we've got a good team I think we all communicate really well I think we sort of make a group decision of is this what we need to do erm and we've made that decision as a team I suppose and we've done it because we needed to CF3*

The intervention being pre-planned also was a positive factor:

> *It was good as it was planned as anything, we all knew what we were gonna do we all knew where we were gonna hold, who was gonna give the injection, who was gonna do the talking QF2*

Staff identified that leadership was also a factor in a positive outcome:

> *Until you get one person that's confident enough to be the third person to give people instructions (during restraint) QF3*

The need to feel confident in your colleagues is particularly important if the restraint is being utilised to carry out an injection- a high risk activity for the nurse involved:

> *So it was easier for me to feel confident in the people that were actually restraining, for me to give the injection and it was done within seconds*

> *Researcher: And do you think that's important being able to trust your colleagues*
> *Yes, very much so, without the trust you don't know what's gonna happen*
> *QF2*

The need to feel you can trust your colleagues is reinforced by concerns when a member of the staff team does not know the patients or service:

> *And just hope that as a team we can handle it because you just need one, that doesn't and I don't mean this derogatory but like if you have bank staff I mean because you know your team and how you work because you've been working with somebody for such a long time CF2*

In support of the above points, the opposite is also true, when you feel you cannot rely on your colleagues this has a negative impact:

> *Yeah and also you have some that do a wide berth I've known some staff that when you really have got to restrain and there is no other…staff have done a diversion somewhere else erm I suppose, if your alarms don't go off, I've had experience where your alarms don't go off and you're kinda shouting for staff to come so that's difficult and I think it can be quite…it's upsetting QF3*

Additionally, staff spoke about differences in opinion regarding decisions regarding a patient and what interventions to use. The quote below suggests that there are times when a restraint has had to go ahead in spite of the team not agreeing this is the right course of action but staff members have to go along with it once it has been initiated:

> *having a conflict in the team, there's been times where, I've known, you know, I've known deep down, I've thought to myself we don't need to be doing this but somebody else has gone in before you so*

> *you feel like you're dragged into a restraint when necessarily, in your mind you think it could've been dealt with differently but I suppose you just have to get on and deal with QF3*

The same person went on to described a situation where the staff felt divided over the care and treatment for one patient and the damaging effect it had on the team:

> *a couple of years ago we had a patient who totally split the team in two, there was total burn out, you'd got one that, you know, so many staff sat on one side, staff sat on the other side and those of us in the middle trying to pull the team together for consistency QF3*

Several staff discussed the positives of debriefing and how this has influenced their practice:

> *Debrief changed how we worked with that patient QM2*

One explained it helped staff see the value in what they had done:

> *When we calmed a patient down without giving PRN, we did a debrief and I asked the team are you proud that we did this without PRN? I don't think they thought of it that way QM1*

Another person commented on the value of reflection leading to debrief:

> *If I've had an incident myself erm, sometimes I want to talk about it there and then but other people want to talk about it when they've gone home reflected on it and then think oh maybe I need to talk to somebody about it all just to get my head around it because obviously your family don't really need to know what's going off as such so it's better to bring it back to work to talk to somebody QF2*

While a successful team with good communication can lead to the use of RI being a more positive experience for the staff, many staff spoke about situations where they felt their colleagues caused or exacerbated the situation:

> *Some staff are short and sharp and like brick walls….it causes incidents QM2*
>
> *I worked with one guy who basked in the glory of dealing with a patient, enjoyed it and I'm there thinking you're the one that triggered it QM1*

Others explained they felt some staff were too ready to utilise RI:

> *I've known people instigate things and you think that didn't need to happen, they jump in there and there's other things that you could have done first. And there's other things I would have done before restraint (they're)….too eager. Like they, I don't know if they get an adrenalin rush from it or what but QF1*

One female member of staff felt this was more likely in male staff:

> *Yes probably and I think I'm not being sexist or anything like that but I think a womans' approach is sometimes better than the male approach. How we come across you know CF2*
>
> *Yeah obviously I'd say yeah, that happens and like I've just said to you and no disrespect and I'm not being sexist but I think it depends who's there and the approach and how they say things and I sometimes think males make it worse, I don't know why, I don't know… well I do, its their whole approach and how they come in like….(actions aggressive) sometimes they take it personally and they act all macho CF2*

Staff spoke about when they feel they have been involved with restraint unnecessarily:

> *I've known, you know, I've known deep down, I've thought to myself we don't need to be doing this QF3*

It appears that in services that utilise restrictive interventions, their use can be an everyday occurrence and yet the impact of their use is bigger than many other ordinary interventions staff engage in on a regular basis, highlighting the ethical challenges presented by these interventions. This theme highlights the crucial role of working as a team: good teamwork can lead to the successful employment of an intervention and interestingly has an almost bonding effect. Likewise, if not everyone is in agreement about the use of the intervention, staff members feel they have to go along with it once it has been initiated and so the use of restrictive interventions can cause divisions and consequently have a negative impact on the team.

5:3:vi- Theme six- Preference for aversive techniques:

In complete contrast and contradiction to many of the opinions expressed above there were expressions of a preference for more aversive techniques to be used when restraining. In recent years the Trust have utilised a number of private providers for their Physical Intervention training. Two of these providers used interventions that it could be argued are the 'nicer' approaches, the least aversive type: techniques that do not rely on pain compliance for their effectiveness but those that rely on balance, leverage and momentum. These techniques do not use prone restraint either. More recently the Trust moved to an alternative approach, one that does use some degree of pain compliance and does use prone restraint. The names of the training providers have been removed from the quotes below for confidentiality reasons.

Despite the overwhelming responses of not liking using restrictive interventions and the perception that the patients must feel frightened, as illustrated above, several of the staff interviewed expressed a preference for the new, more aversive approaches:

> *Yes comparing to what we did years ago, it's more aversive, because we did, I did* Private Provider 1*, and then* Private Provider 2 *and then moving it up to* Current Approach*, I actually quite like* Current Approach*, QF2*
>
> *It's better (Current Approach), oh yes definitely erm* Private provider 1…. *Horrendous! CF2*

Staff are aware that the current provider uses techniques that rely on pain compliance but still prefer them:

> *You see I had my doubts because when I was doing* Private Provider 2 *I thought* Current Approach *is really bad but it's not it's not ….. on* Current Approach *some of the breakaways like if you're being attacked and stuff they do use pressure points CF1*

It was felt that these approaches are justified due to the change in patients as discussed earlier:

> *We are having a lot of like younger patients who are quite violent and really strong and I think* Private Provider 2 *was more for physically disabled and less able not the type we get here CF1*

Staff expressed understanding of the risk of asphyxiation for people with learning disabilities associated with prone restraint and yet still prefer these techniques and incorrectly, feel that they are safe, despite many high profile cases to the contrary:

> *I definitely prefer ………*Current approach*. Yes, it's safer, I feel like it's…….I know with* Private Provider 2 *when they were doing floor restraint it was on their back obviously because of asphyxiation erm*

> *but current approach is done in such a way it's just so much safer for the patient in my opinion and for the staff CF1*

As discussed in the literature review, Paterson et al, (2003) found 12 accounts of restraint related deaths, most of which involved face down approaches, either simple prone restraint or 'hobble tying'. There are other, more recent accounts of prone restraint related deaths, not least of all the high profile case of David 'Rocky' Bennett (BBC, 2017). It is interesting that despite the plethora of accounts of deaths in prone restraint the staff perceive it to be safer.

Staff similarly expressed opinions on the inadequate nature of the training, which is supported by some of the findings in the literature review: that the training is not like real life. In the literature review, it was highlighted by Lovell, Smith and Johnson (2015) who stated that the staff found that the training did not prepare them for the realities of dealing with challenging incidents and undertaking RI's with patients that are larger than them. They stated that the simulated staged incidents were done slower than the speed with which incidents occur in reality:

> *I know when I've done it on training when you do the five day, when you, when you do it artificially kind of thing, it's supposed to be……role play is role play no matter what, it's never gonna be as real as the real thing QF2*

Also, regarding the limitations of training:

> *You know you don't want to twist their arm the wrong way or anything like that… so it's really...it's getting it right, but it never ends up how they show it QF1*

A positive about the role-play element experienced during training was also raised though:

> *I think that's quite a good thing because you then know how that patient feels when you actually do it to them QF2*

Again this theme highlights the conflict experienced regarding the use of RI's, on the one had staff do not like using them, and acknowledge the negative impacts of their use, and yet prefer the more aversive approaches. Again they acknowledge the inadequacy of the training but also acknowledge the benefits of the role-play element.

5:4- Summary of the findings of the results from the staff interviews:

The section above has presented the findings from the staff results and this next section will briefly present a summary of these findings.

Six themes were identified and these were: what staff believe about the nature of the patients and the incidents, role conflict, negative impact on staff, negative impact on patients, the significance of the team and preference for aversive techniques.

The first theme represents much of how staff reacted to the questions that arose from the quantitative study. In some cases staff were surprised at what the quantitative study had highlighted, one example of this is regarding a 'worse day', most staff did not think they have a bad day until they saw the data but could then explain it. Other things highlighted to them came as no surprise at all; one such aspect was that meal times can be problematic. Some staff felt this was simply due to staff being busy at these times while others felt it was more complex than that. One male staff nurse felt this was a time staff could abuse their position and demonstrate their power over the patients, the power to say no.

Staff felt that the nature of the patients accessing the service had changed, to being younger and more able and some felt this change coincided with the change in the service name from 'Learning Disability' to 'Intellectual Disability'.

The quantitative findings illustrated a high proportion of incidents involving females while most of the literature reviewed identified young males as those most likely to be in receipt of restrictive interventions. While the existing literature concurs with this to a certain extent, in that younger patients are more likely to be in receipt of restrictive interventions most of the literature in the literature review identified males were the most likely to be involved. McGill, Murphy and Kelly-Pike (2009), Webber, McVilly and Chan (2011), Webber, Richardson and Lambrick (2014), Webber, McVilly, Stevenson and Chan (2010), Driescher, Marrozos and Regenboog's (2013), Scheirs, Blok, Tolhoek, Aouat and Glimmerveen (2012) and Finn and Sturmey's (2009), all identified in their studies that younger male patients were most likely to be in receipt of restrictive interventions. One explanation for this could be that female patients are viewed more harshly than male patients due to societal norms and expectations that females are the softer gender as mentioned in the quantitative study discussion section.

The next theme, and arguably, the most important theme to arise from the staff interviews is that of role conflict. Many staff spoke about the dichotomy the role presents. On the one hand, nurse or carer who wish to be supporting, kind and build positive relationships with the patients, and on the other that of authoritative disciplinarian, who restrains the patient when they demonstrate behaviours deemed inappropriate or dangerous. This conflict appears to be prevalent throughout many of the decisions staff members make regarding their patients. The statements from staff not only corroborate the view that ethical conflicts pervade their nursing practice within such settings, but also suggest they are intrinsic to their role. This is a conflict that exists in other areas of nursing, such as forensic mental health environments. Research by Jacob (2012) in forensic mental health settings found that controlling, disciplinary and correctional practices by staff in response to the patient's behaviour generate a power imbalance and an interpersonal distance that is problematic for therapeutic nurse-patient relationships and the custodial aspect of forensic services is in conflict with the role of the nurse.

This theme also influences and underpins some of the other themes identified, for example in three of the themes (negative impact on well-being, impact on the team and negative impact on patients) staff expressed the destructive nature of using restrictive interventions on themselves, the team and the patients and yet also expressed a preference for the more aversive approaches.

A further theme identified in the staff interviews is the negative impact staff experience as a result of implementing restrictive interventions. Staff spoke about their adrenalin pumping before and during the use of restrictive interventions and spoke about sleepless nights and incidents playing on their mind after their shift had finished, they also stated it was upsetting and left them feeling anxious. This is reflected in the existing literature as identified by Hawkins, Allen and Jenkins (2004) in their grounded theory study where staff spoke about negative emotional reactions, before, during and after the use of restrictive interventions. Similarly, in the qualitative studies of Merineau- Cote and Morin (2014) and Fish and Culshaw (2005) they identified that using restrictive interventions left staff feeling anxious and upset and had feelings guilt and self-reproach. Furthermore, staff expressed that self-harming behaviours were more difficult for them to deal with and observe. While it is well documented staff will experience negative emotions when dealing with challenging behaviours, few identify different levels of emotional reaction for differing behaviours. One study that does acknowledge this is

Lambrechts, Kuppens, and Maes (2009), in their research using questionnaires to explore associations between attributions and emotional reactions they found that staff felt most negatively about aggressive and destructive behaviours and severe self- injury while Fish's (2000) qualitative study somewhat agrees with this as she identified that staff felt feelings of inadequacy, guilt and anger when dealing with self-harming behaviours.

Closely related to this, staff also discussed the significance of the team when using restrictive interventions. Interestingly their use can have a positive or negative impact on the team. Staff gave examples of when they felt things went well it united them but also times where they disagree about the intervention it can result in a divisive impact on the team.

Staff also showed empathy with regards to what the experience must be like for the patients and on the whole staffs' perceptions were that it is a negative experience although some did acknowledge there are a minority who sometimes enjoy it. Most notably however, staff acknowledged the damaging impact restrictive interventions can have on the individual and can re-traumatise them and make them more angry and therefore be counter-productive. In addition, they acknowledge the damage the use of restrictive interventions can have on the therapeutic relationship and the patients' perceptions of them.

In contrast to much of what has been highlighted so far, the staff also demonstrated a preference for the more aversive techniques used to restrain patients. While this contradicts many of the opinions above, this also reinforces the idea of the conflict staff members feel. They do not wish to use the interventions and acknowledge the negative impact on themselves, the patients and the teams and yet chose the most aversive. This suggests the staff interviewed are experiencing moral distress as discussed in the literature review (chapter 2:6:ii). The staff expressed a dislike to using restrictive interventions despite the fact that they are the approved approach to managing challenging behaviours and yet, given the choice chose the most aversive approaches. These findings are a reflection of those highlighted by Spenceley, Witcher, Hagan, Hall, Kardolus-Wilson, (2017), as highlighted in the introduction, who found that staff experienced conflict and moral distress as they wanted more aversive medication to control the behaviours displayed by the patients in their study. This conflict led to moral distress and similar responses are demonstrated here. It highlights further the conflict staff feel between not wanting to use the restrictive interventions but also maintaining their own safety. This turmoil could have implications to the service as it may impact on how staff respond to patients challenging behaviours and so have an influence of the relationships between staff and patients. It may also impact the decisions staff make about which interventions to use; maybe choosing a more aversive approach over a less aversive approach which will also impact on wider aspects of the service, not only those relationships between staff and patients but also other consequences such as risk of injury (to staff and patients) and the trust not showing a reduction in the use of restrictive interventions.

When discussing staff responses it is important to acknowledge that two distinct staff groups were interviewed. While Nurses and HCA’s work closely and in some areas part of their roles overlap, they are not the same. One is a professional group that must undertake a minimum three-year degree course and subsequent minimum requirements of further continuing professional development for revalidation, the other requires (upon initial commencement of the role) no formal qualification or training. It is interesting then, to compare the findings from these two groups. On the whole the identified themes were supported by quotes from both groups: nurses and HCA’s. Although they did not disagree, the only aspect that created tension between the two groups responses was when discussing that HCA's were the main group to deal with incidents of challenging behaviour. Some HCA's became defensive in their response while some qualified nurses suggested that HCA's had less insight and understanding of the function of behaviours due to their lack of training/ less training. Heaton and Whitaker (2012) undertook a postal questionnaire survey and this found that qualified staff had a more positive attitude than non-qualified staff towards challenging behaviours. This may be due to, as identified by some staff members in this research, their greater understanding of the function of the behaviour, more strategies available to them to handle the behaviour and more confidence in doing so.

Another area of interest is the response from the male and female staff in both staff groups. Again, as above, the themes were supported by quotes from both male and female members of staff apart from the issue regarding men dealing with incidents of challenging behaviour. Some female staff expressed how they felt that men could make situations worse by reacting too early, something which resonates with other studies. Klienberg and Scior (2014) and Knotter et al (2016) identified that male staff were more likely to use restrictive interventions than females. Some females acknowledged that this could be a chivalrous act while some felt it was a sexist or chauvinist act. Some men acknowledge that they react to protect females, stating they felt it was more appropriate they were injured than younger females.

5:5- Methodological issues for the study:

It is acknowledged that these results may not reflect the experiences of all staff and patients in LD services dealing with challenging behaviours. Regarding the staff interviews a group of qualified nurses and health care assistants were interviewed and no other health professionals employed by the service. These staff groups were chosen as they are the largest staff groups in the Trust and the largest ones dealing with the highest number of UI's (as identified in the quantitative study), however the Trust employs many other health professionals who are not represented in these interviews and this is acknowledged. The sample was chosen to include enough variation in the relevant variables to capture all of the possible views. It is acknowledged that the views represent only staff members from two groups, in two services from within one particular service at one point in time. Within the nursing and health care assistant groups, the participants were chosen to try to achieve a wide range of staff, both male and female staff, varying ages and varying number of years working for the service, so it is hoped that within these two staff groups, the participants were able to provide a wide range of views.

The staff members were from the assessment and treatment service and the locked rehabilitation service, so not representative of all nurses and health care assistants in the Trust. These areas were chosen as these are two of the areas where the use of restrictive interventions was highest (excluding day services) so staff most likely to be able to comment on the use of restrictive interventions. Staff from the day services were not asked to be interviewed as the intention was to interview staff and patients from the same services. The patients in the ATS and locked rehabilitation service were able to be involved with interviews whereas the patients in the day service were not, due to severity of their learning disability. Staff in community teams were not asked as they had no involvement in the use of restrictive interventions during the time of the quantitative study. It may be beneficial for future research to explore the experiences (if any) and thoughts of these staff. Staff who use restrictive interventions regularly could become 'immune' to them and accept them as an ordinary part of their shift, which would not be the experience of those who use them less often. This is supported by Howard, Rose and Levenson (2009), when they compared staff working in a high secure environment for people with learning disabilities with high levels of challenging behaviours with a group of staff working in a community setting with low levels of challenging behaviours. The staff from the secure environment reported significantly lower fear of violence and higher self-efficacy compared with community staff. This may also be due to staff becoming more confident and skilled in dealing with challenging behaviours.

As mentioned in the methods chapter, the researcher used to work for the Trust and was already known to some of the staff interviewed. It was deemed an advantage for the research as it gave the researcher credibility, understanding and empathy. Those staff knew that the researcher had been in the position of having to deal with challenging behaviours and had indeed undertaken a wide range of restrictive interventions when employed by the Trust. It is hoped that the staff felt this gave the researcher credibility and that they would be at ease as the researcher understood their role and that she would be empathetic to their circumstances. However it could have also been a limitation as some staff may have used caution when expressing their opinions due to the role the researcher used to hold at the Trust, which was a senior position, it could have been the case that some staff saw the researcher as part of the management team still, despite having been left the Trust for several years. It is hoped that this potential limitation was countered by interviewing some staff who did not have any prior knowledge of the researcher and by emphasising to those staff who did know the researcher from when she worked at the Trust that she no longer works there and is not part of the management team. The researcher dressed casually and spoke about her current role prior to the commencement of the interviews to emphasize that this researcher is not part of a management strategy. It is hoped that these factors helped to overcome any risk of staff holding back.

5:6- Conclusion of this chapter:

This chapter has presented the results of the staff interviews, a summary of the findings and some of the methodological issues associated with this part of the research. The next chapter will present the results from the patient interviews.

Chapter 6: Results from Patient Interviews.

6:1- Introduction to this chapter:

This chapter looks at the findings from the qualitative interviews undertaken with the patients. The findings from these interviews are presented in themes below.

6:2- Patients interviewed/ Participants:

Qualitative interviews took place with three patients. As described in the methods chapter the original intention was to interview more patients than this, ideally anything up to twelve. Finding patients that are able enough to understand the questions, articulate enough to respond to them and not become distressed by their nature proved challenging, so only three appropriate patients were identified during this research process.

All three patients were male and aged 36 (patient 1), 46 (patient 2) and 53 (patient 3). Patient one had a diagnosis of mild learning disabilities and schizophrenia, while patient two and three had a diagnosis of mild to moderate learning disability and nothing further. All had a good level of verbal comprehension and good verbal communication and there was no requirement to simplify the questions. All of the patients could read to varying degrees. Two of the patients read the Participant Information Sheet (appendix 6) and only asked for clarification on one or two words, while the third asked for it to be read to them. All three stated they understood the information. Additionally, all three could sign their names. They all had a history of being in-patients in a variety of services. Patient one had spent most of his life in a range of different services (including prison). Patient 2 and 3 had spent many of their adult years in services. The range of services they have resided in included high secure NHS and private services, NHS assessment and treatment services, NHS locked rehabilitation services and, as mentioned in patient 1's case, a brief period in prison. They had all spent a period of time in secure NHS services as well as assessment and treatment services. At the time of the interviews two of the patients were currently in-patients in services at the host Trust, the third had recently been discharged from the ATS at the host Trust and was now living independently and on the case load of a community nurse (also in the host Trust).

The interviews took place in a location deemed most appropriate for the patients, which for two of the patients was in the service that they were currently an in-patient and for the third patient it was in his own home as he had recently been discharged. In all three cases the patients were given the option to have someone else present during the interviews and in all three cases they chose to have a member of staff present. For the two in-patients the person they chose was their named nurse and for the out-patient they also chose their named community nurse. The interviews lasted 19 minutes and 31 seconds, 22 minutes and 42 seconds and 14 minutes and 34 seconds, (an average of 18 minutes and 34 seconds).

Upon arrival for the interviews the researcher reminded the patients about the nature and purpose of the interview and the patients were asked again to ensure they still wished to be involved. The patients had been given participant information sheets prior to the date of the interview and were asked to sign consent forms on the day. A copy of the consent form can be found in appendix 7 along with an alternative one with simplified language and symbols/ pictures (appendix 8). They were also told if they changed their mind at any point they could stop and ask that their interview not be included. All patients signed the consent form (two signed the regular one and one signed the alternative, simplified version) and no- one asked to stop or for their information not to be included.

Again, upon arrival and prior to starting the interview, the researcher engaged in small talk about other issues to try to ensure the patients were at ease.

As with the staff interviews, these interviews were transcribed as soon after the event as possible to aid memory recall and any other important information.

The quotes below are coded to which patient said them as Patient 1 (P1), Patient 2 (P2) and Patient 3 (P3).

6:3- Themes:

Three themes were identified from analysis of the transcribed interviews. These were:

1. Them and us
2. Overwhelming negative reactions reported regarding restrictive interventions
3. Understanding and insight

6:3:i- Theme one- Them and us "One or two of us used to give 'em what for" (P2):

The first theme to be discussed has been identified as 'them and us'. While the staff had highlighted the importance of a good relationship with the patients, accounts from the patients about their experience of restraint indicated that the use of restrictive interventions had actually made a good relationship less likely. There were many comments from the patients that indicated a sense of 'them and us'; the patients versus the staff, where the patients perceived that staff were the enemy and not there to support them. This is illustrated by the quotes below.

This sense of them and us could have led to further incidents, as the quote below illustrates, when he perceived the staff were laughing at them it made them retaliate:

> *One or two of us used to give 'em what for, used to give it back to them, back to the staff who was laughing and think it was funny (P2)*

This view of 'them and us' is shared further, again highlighting the risk that further incidents occur by way of retaliation:

> *Yeah a way out (of this situation) and sometimes used to get the other… the other patients….erm sometimes if the staff put you on the floor or dragged you into a room where they'd put you in there against the wall and lock you up, some of the patients used…you used to kick off (P2)*

This interviewee recounts how he felt compelled to get involved suggesting a sense of solidarity with the other patients when staff were perceived as picking on them:

> *There was a big member of staff he was big he was out here (actions with arms of a large person) and he got quite aggressive with one of the patients that was with me sitting up, erm and then a load of staff come running and I know I should have stopped but I got involved and I had to be restrained and it's not nice (P1)*

This feeling of them and us sensed by the patients towards the staff did give solidarity and a sense of camaraderie towards other patients, uniting them against a common 'enemy'.

> *Sometimes used to say to the patients that we've got to do something about this (P2).*

Many responses to questions indicated that the patients' interpretation was that the interventions were not for their benefit but almost for the staff team's entertainment and that staff did not have the patients' well-being as a priority:

> *Yeah some had a bad attitude, but I might just see it that way, they might not had a bad attitude but I didn't like most the staff anyway. I didn't bond with any anyway that's for starters (P3)*

There were several mentions of the staff laughing, this perception by the patients has clearly a damaging impact on the therapeutic relationship between staff and patients.

> *I used to see some of 'em laugh (P2)* (while restraining)
>
> *Some of 'em* (the staff) *used to laugh and think it was funny, yeah think it was funny (P2)*

Twice the patients expressed that this was making the situation worse, from their point of view:

> *And then they put more staff on the ward and then sometimes they used to laugh and think it was funny and that just made things worse (P2)*
>
> *They* (the staff) *used to laugh and think it was funny and that used to make things worse (P3)*

Patients also indicated they felt unsupported, reinforcing the idea of 'them and us':

> *I don't know and some of the patients used to, used to erm, they used to, threaten suicide and some of them used to harm themselves, because they said they couldn't cope with it and*

> *sometimes they used to feel very vulnerable and with all the things what was happening erm….used to feel vulnerable and that (P2)*

The above quote mentions feeling vulnerable, suggesting to the patient that the service is not a safe place. Similarly, when discussing their experiences of being restrained patients often spoke about being intimidated by the staff, again threatening the therapeutic relationship. They stated:

> *And it's like, I mean like I said I've been restrained by quite big people I mean if they were small…..and it is intimidating you think bloody hell look at the size of him and he's being…you know…*(gestures the staff being aggressive). *And it's like, I think because they're big, they used to be big, this is what I thought at the time, they are here to intimidate people (P1)*

> *You used to have the staff follow you wherever you went, you used to have 'em watching you in the toilets and the bathroom and that (P2)*

Staff had expressed the importance of having a good relationship to patients' recovery and well-being, however, patients reported that relationships were not always positive:

> *They used to just say to us, that we're not here to be your friend we are just here to do our job, to do our job and that used to rile some of us up quite a bit they used to say they're not here to be your friend or anything just here to do our job and used to make the person and people feel even worse (P2)*

> *I don't like most of the staff (P3)*

> *I felt angry and I hated them for it* (P2)

Specifically, when asked about his experience of seclusion:

> Researcher- *And what about if they put you in a side room by yourself how did you feel about that?*
>
> Patient- *I hated them for that, I hated them for doing that, no, I didn't like them and I hated them (P2)*

P2 above had reported that he did not bond with any of the staff.

These views expressed by the patients are detrimental to maintaining positive relationships between the patients and staff and ultimately detrimental to the well-being of the patient.

In agreement with the staff, patients did understand the benefits that a positive relationship could bring and spoke about the importance of positive relationships with staff:

> *I think what it is as well, is if you build a relationship with a member of staff then it's easier because they will support you but if you go to a place where you don't know staff you don't know patients, it's like you feel singled out, you think to yourself well I don't know them they don't know me…….I didn't know like I said you've got to get to know people (P1)*

This comment below highlights the challenge for services with high staff turnover making relationships less likely:

> *Because some staff didn't stick around then some of 'em moved on (P2)*

Not all accounts from the patients were negative and further discussion in this theme identifies some positive accounts and funny stories recalled from the patients' time in various in-patient services.

The statements below were made by patients who were smiling or laughing while recounting these events. This shows that in these cases the use of restrictive interventions could be counterproductive.

> *It was funny there, some staff had a bad back so couldn't restrain us so we would kick off then (P1)*
>
> *We used to give it back to the staff who was laughing and think it was funny* (laughing) *(P2)*

One patient recalled a time he absconded from a secure service, he stated:

> *I actually absconded from a secure ward ermmmmmm (laughing) and erm…. It wasn't that secure then* (laughing) *and erm anyway there was a patient on the ward that used to work for Safestyle UK and he taught me how to take double glazed windows out (P1)*

These accounts could have been due to the patients trying to demonstrate bravado.

To sum up this theme, the perception of the patients is that the staff are not 'on their side'. The staff may not have been laughing at the patients or even about the incident, it could have been something else completely but how staff members' actions are viewed by the patients is important. The patients could have viewed the staff members as conspiring against them due to the behaviour of the staff. Staff need to be aware of how their actions, all of the time, but particularly during and post-incident are viewed by the patients and the negative impact this can have. If patients see the staff members as not on their side and conspiring against them this is going to have a detrimental effect on the staff patient relationship and consequently a detrimental effect on their rehabilitation and recovery.

6:3:ii- Theme two- Overwhelming negative reactions reported regarding restrictive interventions "I just used to wish there was a way out of this" (P2):

Given the views expressed in the previous theme, it is not surprising that negative experiences were identified from the patient interviews and dominated much of the interview content. Patients were asked to recall incidents of restrictive interventions and if they could remember what they were thinking and feeling at these times. On the whole the patients hated the experiences but it appears that they believe they could not stop them. All the patients could recall many incidents of restrictive interventions and shared several situations. These accounts consisted predominantly of negative memories.

> *Well I just used to think I wish there was a way out of this P2*

When asked specifically about seclusion, patients stated:

> Researcher- *So what did you do all day?*
>
> Patient- *Nothing! You couldn't do owt*
>
> Researcher- *How did that make you feel?*
>
> Patient- *Pissed off actually, yeah but on the first occasion I ripped…..I wrecked the seclusion place*
>
> Researcher-*Is that 'cause you are feeling angry about….*
>
> Patient- *Angry yeah. Angry about being in there (P3)*

This quote reinforces the negativity the patient felt towards the staff and that the interventions led to further incidents of challenging behaviours.

The quotes below also relate to how the patients feel about seclusion:

> *Hmmm, it's not a nice place really, it depends how long you got to stay in there for basically. The longest I've been in is two to three days (P1)*

> *It won't nice, it wasn't nice really (P2)*

Again, the quote below demonstrates how the intervention of seclusion only exacerbated how the patient felt and led to more incidents:

> *On the first occasion I wrecked the seclusion place…… I wrecked all the shower petitions* (partitions) *down* (in the seclusion room) *(P3)*

This quote shows the negative thoughts the patient was experiencing:

> Patient- *I was in seclusion twice actually when I first got to* ……………. Place 1 *I kicked off and ended up in seclusion then and erm, and I was in there for a long time*
> Researcher- *Hmmm, can you remember what you were thinking when you were in there?*
> Patient- *Er ……I just thought to myself, what am I doing in here?*
> Researcher- *Anything else?*
> Patient- *Erm…. I want to be out, out of here, I don't want to be in here (P3)*

The patients were also asked what they felt about when being restrained and clearly the patients can recall it hurting during the restraint and sustaining minor injuries. The patients stated:

> *Used to get carpet burns and few bruising and used to get some carpet burns and some of them got quite a lot of bruising on 'em (P2)*

Asked how being restrained made them feel:

> *I was angry (P3)*

> *They used to do so it hurt me. I didn't like it (P1)*

Two of the patients interviewed expressed emotions around the use of medication:

> *I used to be frightened of being injected, it's not a nice thing (P1)*

> *I didn't like it, I didn't, you know, I didn't like it (P2)*

The above quotes illustrate that the use of restrictive interventions make the patients feel angry and afraid.

Even when staff intervened to save a person's life this was viewed negatively:

> Patient-*Oh yes I was yes, I was restrained in my room*
>
> Researcher- *Yes*
>
> Patient- *Yeah because I tried to put a belt around me neck and strangle meself*
>
> Researcher- *Ok…..and how did you feel about the staff there when they tried to restrain you to stop you doing that*
>
> Patient- *Erm…… annoyed annoyed*

The way the patients spoke about the use of restrictive interventions was as if there was an inevitability about them being used. The quote below illustrates this as the patient associates being in these services with receiving the interventions; the two being intrinsically linked. When asked about his experience in one service he followed this statement up with the quote below, implying an association in his mind between the services and the use of restrictive interventions:

> *But then I got meself into trouble again didn't I? With the hospital and I ended up going to* (place 2) *unit (P3)*

When asked at the end if they had anything to add, the patient's comment reinforced this association:

> *Erm I just hope that I never end up in a place like that again cos I didn't like it and it wasn't fair for my parents (P3)*

One patient expressed how the techniques have changed:

> *I mean it's changed a lot, I mean when I was first locked up it was a bit you know, they used to do so it hurt me (p1)*

At the end of one interview when asked if the patient had anything else to add his final comment illustrated that this patient understood that some services are not open about the use of restrictive interventions.

> Researcher- *There don't have to be, I just thought you might have something else but if you've not got anything else to tell me that's fine*
> Patient- *Erm…..no just that, just that its not good for some people is it?*
> *Researcher- I would have thought not*
> Patient- *It makes you wonder, some of it is hidden init*
> Researcher- *Yep*
> Patient- *It wouldn't surprise me, if some bad stuff is happening some places (P2)*

As well as all the negative emotions experienced as illustrated above, patients also expressed that the experience of being in these services was negative as it was boring: another factor that could lead to incidents of challenging behaviour. When asked if they wanted to say anything else one patient stated:

> Patient: *Oh yes there is a few things. When I was in……..* place 2 *unit there was not much things to do*
> Researcher*: Was it boring then?*
> Patient: *Well…it was boring yes*
> Researcher*: I will make sure I pass that on*
> *Patient: Sometimes it was boring and sometimes it wasn't*
> Researcher*: Yeah…..is there anything else you want to tell me?*
> Patient: *Well in ……….*Place 1 *it was just the same, boring. Nothing to do.*

> Researcher: *And so hopefully you never will but if you had to go to somewhere like that again do you think it would be better if there were stuff to do*
> Patient: *I don't relish the thought of being, going to a place like that again (P3)*

In summary, negative emotions about the actual experience of receiving restrictive interventions and towards those staff that utilise them was a common thread through all three patient interviews. It seems from their experiences that the use of restrictive interventions does not reduce or limit the chances of challenging behaviour but could in fact increase it.

6:3:iii- Theme three- Understanding and insight "basically they are trying to help me" (P1):

Despite the previous two themes highlighting patients seeing staff members as the 'enemy' and the negative feelings they associate with restrictive interventions, in contrast, patients also spoke about the interventions in a way that demonstrated their understanding about why they were used by staff although sometimes this came with hindsight:

> *Back in the day when they used to do it I used to think they do it for fun but now I look back on things my minds more clearer (P1)*

When asked to think about what they thought the staff were experiencing when undertaking restrictive interventions and what they thought the staff thought about the interventions there was an understanding that staff members are undertaking these interventions as part of their job and that entailed actions that were for their own good:

> Patient- *Basically they're just doing a job, in it, trying to protect others, themselves and me basically*
> Researcher- *Yeah yeah. Okay so you do understand why staff…*
> Patient- *Have to restrain me, yeah (P1)*

The same patient reiterated the same point later:

> *so basically they are trying to help me*
> *it's only for me own good really (P1)*
>
> *And at the end of the day they're just doing their job aren't they (P1)*

Asked if he knew why staff restrained him, another patient responded:

> *Er yes because I was, I got out of control. And also well they just wanted, they wanted to keep me safe (P3)*

And why they restrained others:

> *Out of control, people was out of control (P3)*

Patients also demonstrated an understanding of their role regarding what leads to restrictive interventions being utilised:

> *I've done really well, what is it now, 7 or 8 years, but that's what I'm saying back then I had no understanding as well cos I was really poorly but now, when I sit back and look at things it's a lot easier (P1)*
>
> *And I dint like it cos I was poorly and that and I wanted to get better and get back to me old self again (P3)*

As well as the insight highlighted above, patients showed insight and understanding regarding the different interventions, what works for them and knowledge of them.

One patient showed he had a good knowledge about the use of medication and knows that he has to be motivated and involved:

> *I can't see medications the answer cos it's not just down to that, it's down to me as well (P1)*

He also expressed an opinion regarding the use of PRN medication:

> *I don't like being forced medication (P1)*

Another felt the medication helped but clearly it was not used in isolation. He stated:

> *The medication helped me get better and the staff talked to me, that helped me get better (P2)*

He also expressed a familiarity with the side effects of medication:

> *Yeah used to give people bad side effects and that hmmmm- some people had….it used to make their eyes roll. One patient had a fit over it, well a couple of them did and the other it used to give them lock jaw and just make the eyes roll and just made them not feel good (P2).*

After speaking about a service in the past, one patient then referred to where he was now. The patient clearly has a lot of understanding about the nature of the services and understands the differences between when he has been detained under the Mental Health Act and when not, as he stated:

> *Cos here, I've been informal (P1)*

Patients appear to have a lot of insight into their circumstances, into the interventions utilised by staff and clearly disliked some of them. This insight would definitely be useful in discussing interventions with patients, as advocated by the approach, positive behavioural support.

6:4- Summary of the findings of the results from the patient interviews:

The section above has outlined the findings from the patient interviews and this will now be followed by a summary of these.

The three themes identified were: Them and us, overwhelming negative reactions reported regarding restrictive interventions; and understanding and insight.

A major theme identified was ‘them and us’ and the fact that the patients perceive this is hugely important to the patient/ staff relationship going forward. Patients acknowledged that successful placements needed relationships with the staff and to bond and so the fact that, on the whole they see staff as ‘against’ them is a huge barrier to these crucial relationships. Most of the comments identified in this theme were negative. Many of the accounts that the patients spoke about were from several years ago but they were fluent in providing significant details, of these events. This highlights the long term effects of their experiences and what they see happening to others. As mentioned above, it is not yet seen as good practice to offer patients debriefing or counselling following incidents of restrictive interventions but some would benefit from these.

The patients saw the services they had been in as intimidating and not safe places. They often interpreted staff behaviours as negative and ‘against’ them; things that threaten the therapeutic relationship between staff and patients. These findings are re-enforced by the existing literature in the literature review, including Murphy, Estien and Clare (1996), Sequeria and Halstead (2001), Hawkins, Allen, and Jenkins (2004), Fish and Culshaw (2005), Jones and Kroese (2008) and Merineau-Cote and Morin (2014) who all found the patients had negative emotional memories of the use of restrictive interventions. Patients viewed staff as laughing about incidents, not an appropriate behaviour at all. While staff laughter may not in any way have been connected to the incident or the patient, this does re-enforce the need for staff to be aware of how their actions, all of the time, but particularly during and post-incident are viewed by the patients and the negative impact this can have.

Although the patients recounted funny tales about their time in services and when restrictive interventions were used, these tales still reinforce this feeling of ‘them and us’. In the results the idea of a sense of camaraderie between the patients was mentioned, this camaraderie and the funny stories shared could be all part of coping strategies utilised by the patients both during the incidents and when reflecting back on them, such as during these interviews. It must be noted that the funny accounts were made with hindsight, recalling situations from several years ago. This is supported by Alpass, Neville and Flett’s study from 2001, who found that humour was an effective coping strategy for stress in their male sample. Although the Alpass et al study is not involved with those with learning disabilities, they are male, older patients with long term illness or disability, as the sample in this research are an able sample, with mild to moderate learning disabilities they may well have adopted the same approach.

It was identified in the literature review (chapter 2:6:i) that the use of restrictive interventions is breaching the human rights of those in receipt of them and that these breaches of human rights may leave the person feeling disempowered and devalued.

It is well reported that people with learning disabilities often have little choice and control over their lives (Jingree, Finlay and Antaki, 2005) while Fyson and Kitson (2007) argued that two policy agendas in learning disability services, the promotion of choice and independence and the policies around adult protection failed to connect, they are in fact often in direct conflict. The same can be argued about choice, independence and human rights being in direct conflict with the use of restrictive interventions. This is a bigger issue than can be discussed here, but it is evident in those people with learning disabilities that are inpatients in assessment and treatment services. Two observations from the patients’ interviews can be seen as ways that the patients reclaim some power, control and agency over those that disempower them. The first is the use of humour, something that is particularly apparent in those comments above made about staff. The use of humour and camaraderie between the patients may be one way those involved feel they can reclaim some power, control and agency over those that disempower them. The second is evident in the patients' reports of damaging their environments in response to restrictive interventions. This latter observation also underlines the risk that restrictive interventions could inadvertently increase the frequency of challenging behaviour and therefore the use of restrictive interventions is counter productive.

It may be of no surprise that two of the themes identified concerned negative views. Although it may have been predicted that the findings would be negative this does not however render this research as unnecessary, on the contrary, this type of research is needed to fully understand the experiences of people with learning disabilities in services where restrictive interventions are used and what the impact of their use has on those who are at the centre. The patients expressed that they misinterpret staff motivation for using restrictive interventions and this leads to a chasm between them, reducing the possibilities of a good therapeutic relationship, something that should make further challenging behaviours less likely.

In contrast, although patients believed that staff motivation for using restrictive interventions was inappropriate- for their entertainment and they enjoyed it, the patients did also show some understanding of why staff use them appropriately, what led to them and understand that it is part of their job. This suggests that they would benefit from as much explanation as is possible both before and after incidents. Of course, given the mental state of some of them early in treatment this would be challenging, but it should nonetheless become good and typical practice.

While these are contradictory views this highlights the complexity of emotions involved when restrictive interventions are used.

Patients also demonstrated understanding regarding their part in their recovery and incredible insight regarding specific interventions such as the side effects of medication. One of the most important findings in this theme is the fact that the patients interviewed have demonstrated knowledge regarding the interventions and in some cases expressed dislike of some more than others. Although restrictive interventions may be required to be used with patients this finding reinforces the fact that people with learning disabilities should be at the centre of the decisions made about their life. Although these principles have been embedded in learning disability service philosophies for several decades now it has not filtered through to some of the more challenging aspects of the services, such as the management of challenging behaviours. Evidence from research such as this will reinforce the need for patients to be at the centre of decisions about how best to manage their challenging behaviours, as is advocated in positive behavioural support approaches (discussed further in chapter 7).

6:5- Methodological issues for the study:

While the limitations of this research are acknowledged, it is also acknowledged that there is a dearth of research involving people with learning disabilities and so research that involves them is to be welcomed. This dearth is due to a number of reasons, notably some of the ethical challenges associated with including them (Northway, Howarth and Evans, 2014) and the assumption that people with learning disabilities will agree with or yield to suggestions from the researcher. This research challenges this presumption and the findings justify including people with learning disabilities in research. As mentioned in theme 1 above, the patients may have been trying to demonstrate bravado to impress the researcher and their named nurse but their candid responses identified in the other themes demonstrate that they were comfortable enough to be honest and did not appear to give responses that they thought the researcher wished to hear.

It must also be acknowledged that these are individual accounts and like all qualitative research are subject to their own preconceptions about the incidents and the passage of time. Other people present at the incidents recalled may have different versions and not verified the accounts of the patients involved in this research. This does not detract from this research however, if these accounts are what people believe about the incidents it is important to know that and to try to understand their perspective. This is explained by Northway (2016) who recognizes that if services are to be person centred and humanistic then recognising, valuing and respecting the knowledge of those who use the services has to be integral to our practice, even in services for those who present with challenging behaviours.

It is acknowledge that the sample size in this study was small. While it is not necessary to have large sizes in qualitative research, it was still smaller than was initially hoped for. Although interesting themes were drawn from the patients interviewed, a larger and more diverse sample may have identified a greater range of views. Additionally, it is acknowledged that those interviewed in this study are not representative of all people with learning disability who have been exposed to restrictive interventions. The patients in this study were able enough to understand the nature of the questions and able to articulate their answers. Many people with learning disabilities would not have the skills to do this and so their views are not represented in this study. The patients also needed to be well enough to not get upset or angry by the nature of the questions. These factors meant that the patient group is small and not representative of the whole learning disabled population. A person with a more severe learning disability and less understanding may have differing opinions on the use of restrictive interventions than those people interviewed here. Having a more severe learning disability may mean that those patients do not understand what is happening and the insight demonstrated by these patients regarding staff 'just doing their job' may not be shown in those less able. In addition, each patient was approached by and recommended by staff nurses which may have led to some sampling biases. For example, they could have referred people that they thought would make certain responses.

The researcher has experience in this area and so it was felt this was an advantage that helped put the patients at ease. The patients discussed services both in the host Trust and elsewhere and the researcher was familiar with those services and so could engage knowingly, for example one patient spoke about the journey his parents had to take to get to a service he was in, as the service was known to the researcher she could follow up on this point.

Likewise, the researcher was familiar with the staff members who supported the patients. The prior experience of dealing with patients who display challenging behaviour and the familiarity of the staff involved meant that the researcher was at ease when interviewing the patients. The patients all had a recent history of challenging behaviour and had the interviewer been anxious about interviewing them, they would have no doubt have picked up on this. This could have resulted in their answers being less honest or refusing to answer at all.

The researcher made clear the purpose of the study but also informed the participants of the researcher's job and that the findings will be passed on to student nurses. Some of the participants appeared pleased that their opinions would help others.

Despite the negativity and seeing staff as the 'enemy' the patients all spoke calmly and they were able to move between topics easily. Patient one when asked at the end of the interview if he had anything else to add he stated:

> *Er no not really…. Just…. this has quite actually helped me doing this, get things off my chest you see, I feel better about meself, I've enjoyed every minute* (P1)

This is an important point to take from these interviews. Debriefing for staff involved in untoward incidents has been seen as good practice for many years but this is not a practice that extends to patients. This point has highlighted that it may be beneficial for patients if it were to be offered.

Another observation made by the researcher is that all patients interviewed had very clear memories of incidents of being restrained. No patient had to think about their responses for a period of time. In some cases patients spoke about recent restraint experiences but also of past ones in other services and even with incidents from several years ago their memories were still very clear. They gave fluent accounts and provided a good level of detail suggesting they had a clear memory of the incidents they were discussing. One acknowledges that these memories may have changed over time and indeed may be different to how other people present recollect the incidents, however the fact that these incidents stay in their minds is still worthy of note.

Building on the point above, another observation was the ease in which the patients spoke about their experiences. Although they were recalling feeling angry and afraid they gave their accounts without becoming distressed or agitated. Obviously this is good, in that the experience of the interview and recounting their experiences did not cause them any anxiety or problems but also it could be a sad indication that this is just an ordinary and inevitable part of their life. This point is illustrated by the quote below where one patient spoke about his experience of seeing another patient kill himself:

> *well me and a patient, we'd been to get a drink and we heard someone choking so I looked and there was a patient stringing up, so we started shouting staff and that and by the time the staff come he was dead (P1)*

Regarding this incident he stated:

> *And erm I couldn't sleep it gave me bad memories (P1)*

Only shortly after recounting this incident, this patient had moved on and was recounting another incident with ease.

It is important to acknowledge that the patients had clear memories of their experiences, were happy to talk about them and actually appreciated the opportunity to do so.

6:6- Conclusion of this chapter:

This chapter has presented the results of the patient interviews where four themes were identified.

The main conclusions that can be drawn are that patients have negative feelings regarding the use of restrictive interventions and felt staff motivation for using them was for their entertainment and power, damaging the potential for therapeutic relationships to develop. Despite these views that staff used them for their entertainment, the patients did express an insight into why staff used restrictive interventions appropriately and patients would benefit from as much explanation as is possible both before and after incidents.

Their memories were not always negative but these observations were made with hindsight. It also appears that the patients in this research benefitted from talking about their experiences emphasising the need to introduce debriefing for patients.

Further discussion and synthesis of the results will take place in the discussion chapter (chapter 7) and present the clinical messages that can be taken from this research.

Chapter 7: Discussion Chapter.

7:1- Introduction to this chapter:

This chapter will present a synthesis of the results of the three studies. It will also present a further section on the methodological issues of this research.

7:2- Discussion of the findings from the study:

It was identified in the quantitative study that 300 untoward incidents from 312 used in this analysis took place in the Assessment and Treatment Service (ATS), the day services and the locked rehabilitation service combined, and of these 248 (79%) were in the ATS. These services employ qualified nurses and HCA's. It is also important to note that of the total number of incidents 58% consisted of violence to staff and of the total number of incidents 56% were dealt with by HCA's or other staff in the 'unqualified professional' category. All of these factors combined highlight the importance that should be placed on the appropriate training and support to these staff groups.

This is reinforced further by the findings in the staff interviews where staff expressed negative emotions around dealing with these incidents and the impact these have on them, such as sleepless nights, fear and anxiety. Managers need to take this on board and take action to support staff, not simply in an altruistic way but because of the impact this has on the services they offer. Research by Rose, Home, Rose, and Hastings (2004) identified positive correlations between negative emotional reactions and staff burnout and this research suggests that these staff are at risk of burnout. Burnout can lead to long term sickness levels and high turnover of staff, both of which lead to inconsistencies in service delivery and consequently increases in challenging behaviours: an ever increasing cycle. This leads to additional costs to the organisation, such as covering sick pay and the costs of recruiting new staff as well as the unseen costs incurred through dealing with incidents of challenging behaviour, such as staff time. The support offered to address the above needs to be multifaceted and there is not a quick fix available.

There is no evidence from this research or other available literature that restrictive interventions reduce episodes of challenging behaviour in number or severity and in some cases can make the situation worse, as indicated by the staff and patient interviews, therefore exploring other approaches is imperative.

One area that needs to be addressed is to increase the knowledge and awareness of staff around challenging behaviour, especially the HCA's. It was alluded to by some qualified staff in the staff interviews that HCA's do not have sufficient understanding of the causes of behaviour and cannot recognise precursors while some staff felt that other staff members exacerbated a situation by over reacting and being too quick to restrain. Education and training could help ameliorate this situation.

Firstly, staff members need to understand that the reasons challenging behaviours occur are complex and multifaceted, as was discussed in the literature review so is not revisited here, but the reasons challenging behaviours occur are rarely personal to the staff involved. If staff training can reinforce this so challenging behaviours are seen as a symptom of the person's learning disability and/ or a reaction to their environment it can help staff and ultimately impact on how staff respond to these behaviours. This point was illustrated by Stanley and Standen (2000) who found in their research involving experienced care staff, relationships between attributional dimensions: if the carers regarded the behaviour as something the person is in control of this resulted in negative emotions from the staff while behaviours deemed uncontrollable resulted in more positive responses. This benefits both the staff (to avoid negative emotions and burnout) and the patients (less aversive responses).

Secondly staff members need more training on recognising the functions of behaviour and some fundamental training in functional analysis and recognition of triggers and antecedents. Research by Luiselli (2009) and Larue et al (2016) amongst others, support the premise that assessing antecedents and functional analysis reduce levels of challenging behaviours and consequently the use of restrictive interventions, while Sclafani et al's (2008) study with people with dual diagnosis of learning disabilities and mental illness found that staff training in understanding behaviours reduces the use of restrictive interventions, reinforcing the need for effective staff training in this area.

This approach will have multiple outcomes, firstly it will reduce the reliance on restrictive interventions by staff when patients present with challenging behaviours (in line with the requirements of DoH, 2017) benefitting staff and patients, but also the service can be a specialist service offering better assessments and treatment recommendations, as the name of the service suggest, rather than being 'gate keepers' of patients with learning disabilities until an alternative service can be found.

As was reported in chapter 4 (figure 11) no intervention was recorded by staff members at all in many incidents. Of the total number of incidents 195 (63%) of the 312 incidents had no outcome recorded. This is a lost opportunity to learn about the effectiveness of various approaches etc but also leaves the service open to criticism. Some kind of intervention must have been utilised, even if it was distraction/ diversion, this must be recorded. If restrictive interventions are being utilised and not documented this leaves the service open to potential for litigation from patients and their families and staff if they sustain an injury.

A further issue that needs to be addressed is that services should have clear guidelines to standardise what constitutes an incident, for example if more than one staff member is injured during an incident should this require more than one form? This would then have implications as it will increase the number of incidents being recorded, however if this information is included, the service would then get a truer picture of the nature of the challenging behaviours that occur in the service.

Additionally, as mentioned in the discussion section of the quantitative results, staff that work in areas with high levels of challenging behaviours often see them as part of their job and have high levels of tolerance for violence, therefore may not always record them (Lovell and Skellern, 2013). Clear guidance should be provided to staff members of what incidents require the completion of an untoward incident form and any behaviours, if any, that do not require an UIF, and this should be consistent across all areas of the service.

Some of the themes identified from the staff interviews and those from the patient interviews are clearly intrinsically linked. The theme 'role conflict' identified in the staff interviews and 'Them and us' from the patient interviews are closely aligned. Both staff and patients identified the importance of good therapeutic relationships and that the use of restrictive interventions negatively impacts on this. Staff felt the use of restrictive interventions conflicted with the role of being a nurse/ carer, while patients explained they see staff as intimidating, that they felt angry and hated staff and this impacted on their relationships.

Staff identified a negative impact on themselves, in some cases on the team and the perceived negative impact on patients, while patients also reported negative impact on themselves. This is supported by research from Mental Health services: Frueh et al, (2005) found mental health patients who had been restrained were distressed a week after the intervention.

These points support the issue of moral distress as discussed in the literature review. The use of restrictive interventions conflicting with the role of the nurse or carer and the impact using them has on the staff involved demonstrates moral distress.

All of the above illustrates that many of those directly involved, staff and patients, are uncomfortable with the use of restrictive interventions and it has long term implications for them, so the obvious answer is to take all means possible to avoid their use. This will be beneficial for all parties but also meets the requirements of NICE (2015) and DoH (2017) so services can evidence offering alternatives and moving away from a reliance on restrictive interventions, as well as avoiding breaching patients human rights.

The reality of the assessment and treatment service in the host Trust is that it will always be where the most challenging patients in the region go. Therefore, it is unrealistic to expect challenging behaviours to disappear and unrealistic for staff not to use interventions to deal with these behaviours. It has been suggested that if staff find themselves using restrictive interventions then this should be regarded as a failure (Hopton, 1995) but this is unreasonable and unrealistic in services such as those in this study (especially ATS) and the use of restrictive interventions cannot be fully removed. Indeed, the opposite is true and a lack of intervention in an incident would be ethically and legally difficult to justify.

However, in the quantitative study it was identified that in some cases restrictive interventions were used for behaviours that it could be argued do not warrant such approaches. For example it was reported that on four occasions where full restraint was implemented the incident was categorised as disruptive behaviours, (one described further as ‘aggressive/ hostile’ and three described as damaging Trust property) while a further case that led to full restraint was categorised as violence to patient but described as ‘harassment’. The use of full restraint for behaviours such as ‘aggressive/ hostile’ and ‘harassment’ needs to be considered carefully due to the requirements to reduce these types of interventions (NICE, 2015 and DoH, 2017), therefore services must look to utilise alternative approaches for such behaviours.

DoH (2017) recommends Positive Behavioural Support (PBS) and this is an area that services should be looking to implement. However, to implement PBS properly takes time to undertake full Functional Assessments to understand the person’s behaviour and to work in partnership with the patient about how staff can react to their behaviour. Lovell, Smith and Johnson (2015) explain that as staff and patients get to know each other, the need for restrictive interventions diminishes. The reality of Assessment and Treatment Services is they do not have the luxury on initial admittance to get to know the patients and to implement PBS. It would be useful for services to be able to have a distinction between planned and unplanned use of restrictive interventions for such purposes. In services such as ATS there will be emergency admissions where restrictive interventions or another intervention has to be used to prevent harm to a patient or others. This is distinctly different to situations with an existing known patient. While services should be planning to implement PBS long term, they also need to have approaches available to them as short-term interventions, while still evidencing a move away from restrictive interventions.

The obvious approach should be more use of de-escalation techniques. The latest research on de-escalation found that the use of de-escalation has no impact on the frequency of challenging behaviours. Leach et al,

(2019) undertook a rapid evidence assessment (similar to a systematic review but with concessions) and found that de-escalation does not reduce the number of violent incidents, however training in and the use in practice of de-escalation does increase staff knowledge, confidence and skills in dealing with challenging behaviours. The aim of de-escalation is not to reduce number of incidents of challenging behaviour, it is to diffuse them and minimize them as quickly as possible when they do occur.

As mentioned above, challenging behaviours are inevitable in the ATS, the nature of the service is for the most challenging patients in the region, if they do not display challenging behaviours they would not be there, so it is unrealistic to expect levels to drop. Increased knowledge, confidence and skills in dealing with challenging behaviours lead to a reduced number of lost work-days, improved staff retention, reduced complaints and consequently reduced expenditure (Leach et al, 2019).

In this research both staff and patients spoke about the importance of positive therapeutic relationships and de-escalation is less damaging to these positive long-term relationships than restrictive interventions, therefore addressing the conflict facing staff between maintaining the safety of everyone around while caring for those patients with challenging behaviours.

When the need to use restrictive interventions does occur, as it undoubtedly will due to the nature of the patients in these services appropriate support systems should be put in place for both staff and patients. The Trust where the study was carried out do currently advocate debriefing however this is an optional process for staff involved. It is not a formal requirement and is not available to patients. There is little research in this area within learning disabilities however there is research from mental health services to support the implementation of this for those patients able enough to participate. One such study is Goulet et al (2018) who implemented a post seclusion or restraint programme of de- briefing and found it helped staff and patients overcome the discomfort of seclusion and restraint but also reduced the frequency and duration of time spent in seclusion over a six month period. A second paper from mental health services is Ling et al's (2015) qualitative study which found that debriefing helped to re-establish the therapeutic relationship between staff and patients. This is something services for people with learning disabilities could consider.

7:3- Methodological issues of this study:

Limitations are inherent in almost all research and the limitations of this study are acknowledged. The methodological issues for the individual components of this research were addressed previously, following each set of results, therefore this section simply addresses those issues that apply to all of this research.

7:3:i- The Trust/ the Learning Disability Service:

The sample for all aspects of this research came from one NHS Trust and so are not a full representation of all LD services or indeed all people with a learning disability. The Trust that participated in this study has an array of services from CLDT's through to locked services. Although the high secure service was not used in this research, the locked rehabilitation service and the assessment and treatment services (ATS) were, through to day services and community teams. In recent years some NHS Trusts have closed their ATS's which means this Trust is providing a different range of services to many others, therefore the researcher does not suggest that it is representative of other services. However, this breadth of services means that the representation is more than would have been available in many Trusts. Indeed, in neighbouring counties, the NHS Trusts have removed all in-patient services. Similar research in these areas would give a very different picture. However, removing these services does not make the problems go away. In these neighbouring counties they still have challenging patients and in many cases when these people require in-patient care they are often referred to the services used in this research or other private providers, therefore their picture would be very different, but not a true picture of the extent of the problem that challenging behaviour presents. The depth of service provision in this Trust means that the depth of the issues has been captured.

Chapter 8: Future Directions.

8:1- Introduction to this chapter:

This chapter will present the future directions recommended from this research.

8:2- Future Directions:

The following recommendations are made based on the research undertaken and other aspects identified in this thesis, such as issues identified from the literature review. These recommendations were drawn up when thinking about the service used in this research however the recommendations have wider reaching influence and should be adopted in all learning disability services. A brief list of the recommendations is presented below with a more detailed explanation about them to follow:

1. Improve recording and standardisation of what is an incident
2. Improve alternatives to RI's mainly de-escalation then PBS and clearer 'do and do not's" regarding restraint
3. Introduce debriefing for staff and patients
4. Training to underpin all of the above especially to HCA's
5. Standardisation of language used for restrictive interventions
6. More research around the use of restrictive interventions

These recommendations are explored further below.

7:4:i- Recommendation one- Improve recording:

The quantitative study highlighted flaws in the current recording processes utilised by the service in this study and this is an area that needs to be improved. This can be achieved through several actions. The first is that the form needs to be changed. The electronic forms completed to record untoward incidents were not designed as a tool for monitoring patient interventions, the form was designed as a Health and Safety tool, however this system provides a wealth of data that is often wasted and unused. Minor tweaks of this form could make it a useful tool for patient monitoring. The current form allows little flexibility, it does not have the option to record more than one staff member involved, or more than one intervention. As mentioned above the current form is a wasted opportunity to achieve a much more useful set of data that could be used for an individual patient, each service setting or the Learning Disability division as a whole.

Robust guidelines regarding what counts as one incident needs to be implemented also so that staff know exactly what requires one form, or more than one form but also, and more importantly what behaviours require recording as an untoward incident. As discussed above staff members frequently exposed to challenging behaviour regard them as part of their role and so may not always record them. In order for a service to have a full understanding of the nature of their patients and the impact this has on their staff members, the data collected must be complete and this can be achieved by these guidelines.

If this can be improved it can be a useful tool regarding service planning, such as staff rota's for example but also to wider organisations such as commissioning bodies and inspectors.

7:4:ii- Recommendation two- Improve the use of alternatives to restrictive interventions:

Services must utilise and evidence the use of de-escalation more during incidents and evidence the development of PBS.

As mentioned in the literature review (chapter 2) in the section on guidelines and legislation (2:4:ii) the recent DoH guideline 'Reducing the need for restraint and restrictive intervention' (DoH, 2017) advocates using RI's in a wider framework of proactive and preventative approaches and recommends the use of PBS. In order to undertake PBS properly and successfully any strategies implemented need to be based on thorough, in depth and detailed functional analysis and assessments. In order to do this level of assessment correctly takes time. By nature of assessment and treatment services the patient will invariably arrive in a state of distress and will be displaying challenging behaviours immediately that require intervention, therefore the staff do not have the luxury of time to conduct the necessary assessments prior to the need to deal with challenging behaviours. They therefore need to be skilled in the use of de-escalation approaches that are likely to be effective for all those who may access the service. This will often be based on very little information about likes and preferences. While those patients are accessing the services, these in depth assessments will be undertaken and a full PBS approach utilised long term.

Improving staff confidence and use in using de-escalation skills has implications across the service, staff will be less stressed, distressed and at risk of burnout, the patients will be less afraid, the therapeutic relationship will be less damaged and the DoH (2017) requirements will be met.

7:4:iii- Recommendation three- Introduce de-briefing to staff and patients:

Both staff and patients spoke about the negative impact of restrictive interventions. Staff gave examples of incidents playing on their minds and having sleepless nights while patients recalled incidents from several years ago with clarity. One patient thanked the researcher for the interview and said it had been good for him, to get things off his chest. Debriefing as an approach to support staff has been utilised in this learning disability service for many years but it is not widely used for patients.

The feedback from this research and all be it limited published research from mental health services indicate this would be beneficial.

7:4:iv- Recommendation four- Training:

All staff should receive a mandatory and robust package of training to implement all of the above recommendations. Staff cannot be expected to change the way they work over night, instead this requires somewhat of a culture shift so will need to be launched as a new initiative. Ideally the training should be delivered in staff teams from each service (not a mixture of staff from across the Learning Disability Division), this means that the training can be more meaningful and focus on real patients not scenarios. Additionally, the training can work as a team building exercise.

The training needs to focus on causes of challenging behaviours, functional analysis and recognising precursor behaviours. It also should introduce the new requirements regarding recording processes (recommendation 1), include thorough de-escalation training, using role play and staff recognising the role they play in incidents (recommendation 2) and how to properly implement de-briefing and who is responsible for implementing it (recommendation 3).

All of this training needs to be underpinned by strong leadership and management. As mentioned this training should involve a shift in culture by the service to a supportive approach for staff but also an emphasis on the assessment and treatment nature of the service and not a gate keeping service. Olivier- Pijpers, Cramm and Nieboer (2018) found that elements of organisational culture such as values and resources, had a direct link to levels of challenging behaviour through the actions of the staff while Larue et al’s (2018) finding also support that strong leadership, team cohesion and training reduce levels of challenging behaviours. This combined approach will limit the risk of staff burnout, improve the service delivery and reduce the reliance on restrictive interventions.

7:4:v- Recommendation five- Standardisation of the language used to define interventions and outline what are acceptable interventions:

As was identified in the literature review, in research and guidance on the subject of restrictive interventions, there are currently many terms used when talking about these interventions. This is true if one compares one set of guidance to another, but also within single research papers. One example of this is research by Feldman, Atkinson and Foti-Gervais and Condillac (2004) who talk about confinement time out and seclusion. It is not explained what confinement time out is and how it differs from seclusion. This type of complicated language is confusing to service providers and staff delivering the services.

The terminology used within these services is important to avoid confusion and ambiguity. Guidance needs to be explicit and robust and would benefit from absolute do's and do not's regarding the type of techniques that can be used. This could be made clearer locally but ideally at national level and enforced by legislation and not as optional opt in approaches as is the case currently.

7:4:vi- Recommendation six- More research around the impact of the restrictive interventions:

It would be beneficial to undertake more research around the impact the use of restrictive interventions has on those directly involved.

One area specifically would be to explore this subject with people with more severe learning disabilities. As was acknowledged in the methodological issues section of the patients interviews, the patients involved in this research were able, had mild to moderate learning disabilities and able to understand the questions and articulate answers. It must be considered that the impact of using restrictive interventions on those less able could be different. Theme three in the patient results identified that the patients in this research had some understanding and insight into why the interventions are being used. In those with more severe learning disabilities this may well not be the case, due to having more severe learning disabilities, others may demonstrate less understanding of what is happening to them and why and consequently they may experience more fear. In addition, the negative impact of these interventions may be greater on those with more severe learning disabilities as they may have fewer skills and emotional resilience to deal with it.

It would also be of benefit to include females with learning disabilities in future research. Often restraint techniques involving laying on the floor and females may experience greater negative impact of this, especially anyone who has experienced sexual abuse in the past.

To fully understand the impact of restrictive interventions on people with learning disabilities, the research should represent the wider population, as people with learning disabilities are not a homogeneous group, so conducting research in a wider population than that in this research is vital.

The literature review identified the extent of injuries to patients while involved with restrictive physical interventions. High profile cases have helped raise awareness of this issue. It has been suggested that the voice of those central to this issue is lacking (Edwards, 1999) and the fact that staff members become injured during the implementation of restrictive interventions is an area lacking in research and awareness. There is little research in this area but one study (Johnson, 2012, cited in Lovell et al, 2015) identified that staff injuries outweigh those sustained by patients by as much as four times, indicating that research in this area is over-due and warranted. Staff members in these interviews spoke about injuries they have sustained in the course of dealing with challenging behaviours and implementing restrictive interventions. Research in this area would be useful to explore the emotional and physical impact this has on the staff members involved and the degree of injuries sustained but also to support service providers. Injuries sustained at work can lead to increase sickness, staff turnover as well as the potential for litigation so this would be a useful area to know more about. Available information was limited in the present study but for a clearer picture of their impact, it would be useful to explore fully the cost that the continued use of restrictive interventions has by looking at staff absences and staff turnover.

A further area to explore would be to identify what behaviours lead to the use of restrictive interventions and staff members' decision-making process. It would also be useful to explore any long-term impact of restrictive interventions on frequency of incidents of challenging behaviour. This would need to be in a service where the patients stay for longer periods of time, such as secure services, to explore if the use of restrictive interventions is a deterrent for repeated incidents.

7:4:vii- Delivery of the recommendations:

The recommendations outlined above are things that have minimal cost to services but could have a cost saving impact and are realistic and achievable, not an ambitious wish list.

Chapter 9: Concluding Chapter.

9:1- Introduction to this chapter:

This chapter will conclude the thesis.

9:2- Conclusions of this study:

This research set out to look at the impact of restrictive interventions. This has been done through exploring the impact in multiple ways, on the service provider, on the staff who undertake the interventions and on the patients who receive them. The results show that the impact is considerable.

From the literature review, it was identified that there is extensive conflicting and confusing terminology used in documents regarding restrictive interventions. Additionally, there is little research that focuses on the impact that restrictive interventions have on those central to the issue: the staff members and the patients.

The quantitative study found that most incidents are arising from a small number of patients, a reflection on the nature of those services. The quantitative study also identified gaps in the recording process, an area for improvement. Due to perceptions of what constitutes an incident and lack of clear guidance on this there is no way of establishing the proportion of incidents that result in the completion of the untoward incident forms and when they are completed, there are gaps in the details regarding the nature of the incident and interventions used.

The data suggests there is an upward trend in the number of incidents and this could be a reflection on the changing nature of the patients. Key information that is useful for the service was found such as key times and days. Staff interviews indicated that these peak times coincided with periods when staff were busy with mealtimes or MDT meetings. A further interesting finding, that conflicts with much of the literature in this area is that a high proportion of the incidents involved female patients. This aspect of the study highlighted that the impact of restrictive interventions in key parts of the service is significant, with a high number of incidents of challenging behaviour which lead to costs for the service- costs in terms of staff time predominantly.

The staff interviews identified a conflict between their role as a therapeutic and rehabilitative agent and enacting a restrictive intervention and the damaging impact the interventions could have on the therapeutic relationship with the patients. Staff experience negative emotional reactions that stay with them away from the work place but a good team with good leadership can lead to a less negative impact on staff. Staff also felt that patients must be afraid, disempowered and confused by the use of restrictive interventions. It appears that there is currently nothing in place to support patients through this and the patient interviews identified that it was useful to talk about their experiences, suggesting that offering de-briefing to patients and not just to staff would be beneficial.

Some of the findings from the staff were echoed by the patients. Patients expressed a sense of 'them and us' with the staff and again many negative emotions, while also acknowledging the benefits of positive relationships.

There is no evidence in the literature to suggest that the use of restrictive interventions reduces incidents of challenging behaviour, indeed the opposite may be true as patients expressed that restrictive interventions makes them more angry and staff do not like using them. The continued use of restrictive interventions has the potential for cost implications for the Trust, due to increase risk of burnout, high staff sickness levels and staff turnover, concluding that the impact of restrictive interventions is significant to all concerned.

Good staff support, through leadership and de-briefing and thorough training should see a reduction in the use of restrictive interventions and more use of alternatives such as de-escalation and Positive Behaviour Support**.**

It is acknowledged that some of the findings from this research are reflected in that of other research in this area, and most definitely some of these findings will be of no surprise, such as both staff and patients not liking using restrictive interventions. However, some of the findings add new knowledge to this area. No previous research in learning disability services has identified the role conflict and subsequent moral distress experienced by staff regarding the use of restrictive interventions: a significant issue for staff training and support. Furthermore, no other research has identified the parallel findings of 'role conflict' and 'them and us' (from the patient interviews).

This research also identified that while patients do not like being on the receiving end of restrictive interventions some actually understand why staff use them. This level of insight and understanding adds to the knowledge in this area. Further new knowledge gleaned from this research is that staff and patients corroborated and echoed each other's view point in many areas most noticeably in the main themes identified in each: those of role conflict and them and us. This finding is significant and should be used to inform future decisions regarding the use of restrictive interventions in learning disability service.

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Turner, K. V. and Mooney, P. (2016) A comparison of seclusion rates between intellectual disability and non-intellectual disability services: the effect of gender and diagnosis. **The Journal of forensic Psychiatry and Psychology.** Vol. 27. No. 2. Pp. 265- 280.

Tyrer, P., Oliver-Africano, P.C., Ahmed, Z., Bouras, N. Cooray, S., Deb, A., Murphy, D., Hare, M., Meade, M. et al (2008) Risperidone, haloperidol and placebo in the treatment of aggressive behaviour in patients with intellectual disability: a randomized controlled trial. **The Lancet.** Vol. 371. Pp. 57-63.

United Nations (2006). **Convention on the rights of persons with disabilities.** https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2. html [Accessed 18 September, 2017]

Webber, L. S., McVilly, K. R. and Chan, J. (2011) Restrictive Interventions for People with a Disability Exhibiting Challenging Behaviours: Analysis of a Population Database. **Journal of Applied Research in Intellectual Disabilities.** Vol. 24. Pp. 495- 507.

Webber, L.S., McVilly, K.R., Stevenson, E. and Chan, J. (2010) The use of restrictive interventions in Victoria, Australia: Population data for 2007-2008. **Journal of Intellectual and Developmental Disability.** Vol. 35. No. 3. Pp. 199-206.

Webber, L.S., Richardson, B. and Lambrick, F. (2014) Individual and organizational factors associated with the use of seclusion in disability services. **Journal of Intellectual and Developmental Disability.** Vol. 39. No. 4. Pp. 315-322.

World Health Organisation (2010) **International Classification of Diseases (10th ed.)** WHO. Geneva: World Health Organization.

World Health Organisation (2018) **International Classification of Diseases (11th ed.)** WHO. Geneva: World Health Organisation.

Williams, D. E. (2009) Restraint Safety: An analysis of Injuries Related to Restraint of People with Intellectual Disabilities. **Journal of Applied Research in Intellectual Disabilities.** No. 22. Pp. 135-139.

Appendices.

Appendix 1- Matrix of the literature contained in the literature review:

Paper	Type of paper/ Methodology and Method:	Results:	Themes
Adams, L. (2018) 'Shameful' use of restraint on disabled patients. **File on 4.** BBC.	Report	On the increase	The extent to which physical interventions are used
Allen, D., Lowe, K., Brophy, S. and Moore, K. (2009) Predictors of restrictive Reactive Strategy Use in People with Challenging Behaviour. **Journal of Applied Research in Intellectual Disabilities.** Vol. 22. Pp159- 168.	901 participants from different services. Statistics	Those detained more likely to have restraint and sedation. More severe CB led to seclusion Destructive behaviour restraint and seclusion	What behaviours and who
Allen, D. (2011) **Reducing the use of restrictive practices with people who have intellectual disabilities.** British Institute of Learning Disabilities: Kidderminster.	Quantitative research	Seclusion has no therapeutic value	Effectiveness of PI

Baker, P.A. and Bissmire, D. (2000) A pilot study of the use of Physical intervention in the crisis management of people with Intellectual disabilities who present challenging behaviours. **Journal of Applied Research in Intellectual Disabilities.** Vol. 13. No. 1. Pp38- 45.	Quantitative research All staff trained in a service	Found staff confidence increased, no change in number of incidents but increase in use of RPI's	Training Guidelines and Legislation
Barksby, J. (2008) **Perspectives of people with learning disabilities about restrictive interventions.** Unpublished Masters Research.	Qualitative research with patients	Negative experiences of Restraint	Patient perspective
Bowring, D.L., Totsika, V., Toogood, S. and McMahon, M. (2017) Prevalence of Psychotropic medication use and association with challenging behaviour in adults with an intellectual disability: A Total Population Study. **Journal of Intellectual disability Research.** Vol. 61. No. 6. Pp. 604-617.	Total population sample.	70.57% of PWLD were prescribed at least one med Pschotropic meds used in 37.73% Polypharmacy and high doses were common. Factors included, older adults, type of residency, displaying CB and males more likely.	Medication theme
Buckley, P. (2013) **Violence at Work.** Health and Safety Executive: London.	Comment paper		Background on violence and aggression

Chaplin, E., Tsakanikos, E., Wright, S. and Bouras, N. (2009) Clinical Psychopathology, Untoward Incidents and the Use of Restrictive Procedures in Adults with Intellectual Disability. **Journal of Applied Research in Intellectual Disabilities.** Vol. 22. Pp169-178.	All UIF's (397) for a group of service users (65) over 6 years	Physical assault= most common incident for restraint males with autism	What behaviours and who
Chapman, M., Gledhill, P., Jones, P., Burton, M. and Soni, S. (2006) The Use of Psychotropic medication with adults with learning disabilities: survey findings and implications for services. **British Journal of Learning Disabilities.** No.34. Pp.28-35.	Survey. 55 people	89% prescribed anti-psychotics. 47% anti-depressants. 44% more than one category. 22% more than one anti-psychotic. no diagnosis in many cases	Medication
Cox. H. C. (1987) Verbal Abuse in Nursing: A Report of a Study. **Nursing Management.** Vol. 18. No.11. Pp. 47-50.	Survey USA	Front line staff most at risk	Background to Violence and aggression
Crossley, R. and Withers, P. (2009) Antipsychotic Medication and People with Intellectual Disabilities: Their Knowledge and Experiences. **Journal of Applied Research in Intellectual Disabilities.** Vol.22.Pp77-86.	Grounded Theory	Little knowledge about their medication, beyond their regime. They experienced side effects but were accepting of them.	Medication Patient perspectives

Cunningham, J., McDonnell, A., Easton, S. and Sturmey, P. (2003) Social validation data on three methods of physical restraint: Views of consumers, staff and students. **Research in Developmental Disabilities.** No. 24. Pp307- 316.	Questionnaire based on rating types of restraint on students, staff and PWLD.	All rated all types of restraint as bad but the chair restraint was least worse. PWLD rated them the worse. Biased as written by training provider who teaches chair restraint.	Patient perspectives Staff perspectives
Dagan, D. and Weston, C. (2006) Physical intervention with people with intellectual disabilities: The influence of cognitive and emotional variables. **Journal of Applied Research in Intellectual Disabilities.** Vol. 19. Pp219-222.	Staff interviewed qual and quant data gleaned.	RPI followed 14 (37.8%) of physical attacks and 2 incidents of verbal attacks. Other approaches were used in the other cases. Staff reported emotions of anger, sympathy and satisfaction with the intervention.	What behaviours and who
Deveau, R. and McGill, P. (2009) Physical interventions for adults with intellectual Disbailities: Survey of use, policy, Training and monitoring. **Journal of Applied Research in Intellectual Disabilities.** Vol. 22. Pp145-151.	Postal questionnaire Survey	RPI used by 47% of the services. Of these 65% had a policy 79% did staff training	Training Legislation and Policy What interventions
Donley, M. ,Chan, J. and Webber, L.S. (2011) Disability support workers' knowledge and education needs about psychotropic medication. **British journal of learning disabilities.** No. 40. Pp.	Australia Mixed methods Survey and interviews	Untrained staff giving out meds they know little about acknowledged themselves.	Medication

286- 291.			
Drach-Zahavy. A., Goldblatt. H., Granot. M., Hirschmann. S. and Kostintski. H. (2012). Control: Patients' Aggression in Psychiatric Settings. **Qualitative Health Research.** Vol. 22. No.1. Pp. 43-53.	Qualitative research Mental Health setting		Background to Violence and aggression
Driescher, K. H., Marrozos, I. and Regenboog, M. (2013) Prevalence and Risk Factors of Inpatient Aggression by Adults with Intellectual Disabilities and Severe Challenging Behaviour: A Long-Term Prospective Study in two Dutch Treatment Facilities. **Research in Developmental Disabilities.** Vol. 34. Pp. 2407- 2418.	Five year study. 421 pwld Dutch study	Best predictors are aggression early in treatment, coping skills deficit and impulsiveness.	What behaviours and who
Durnin, S. and Freeman, S. (2005) Training to meet the challenge. Learning Disability Practice. Vol. 8. No. 1. Pp. 18-22.	Comparing staff on a 12 day programme with those that did not receive the training.	Those that did the training had increased knowledge especially on preventing CB's.	Training theme

Edwards, R. (1999) The laying on of hands: Nursing staff talk about physical restraint. **Journal of Learning Disabilities.** Vol. 3. No.3. Pp136- 143.	Qualitative semi structured interviews	Main findings: better communication after the training and know what the communication is about. Better teamwork	Training. Staff perspectives
Emerson, E., Robertson, J., Gregory, N., Hatton, C., Hessissoglou, S., Hallam, A. and Hillery, J. (2000) Treatment and Management of Challenging Behaviours in Residential Settings. **Journal of Applied Research in Intellectual Disabilities.** Vol. 13. Pp. 197-215.	Cross sectional study. 500 SU's. report	53% of the 540 showed CB Of that 53% 44% had physical restraint, 35% sedation, 20% seclusion, and 3% mechanical restraint	What behaviours and who What interventions
Farrell, G.A. and Salmon, P (2014) Do zero Tolerance policies deskill nurses? **Nursing Times.** Vol. 110. No. 6. Pp. 14-16.	Report	Policies	Background to violence and aggression
Feldman, M. A., Atkinson, L., Foti-Gervais, L. And Condillac, R. (2004) Formal Versus Informal Interventions for Challenging Behaviour in Persons with Intellectual Disabilities. **Journal of Intellectual Disability Research.** Vol. 48. Pp. 60-68.	Survey		What interventions

Finn, L.L. and Sturmey, P. (2009) An analysis of the distribution and social antecedents in a community day service for adults with intellectual disabilities. **Journal of Applied Research in Intellectual Disabilities.** Vol. 22. Pp179-186.	Quant analysis of records	A small proportion of SU accounted for all use of RPI	What behaviours and who What interventions
Fish, R.M. (2000) Working with people who harm themselves in a forensic learning disability service: experiences of direct care staff. **Journal of Learning Disabilities.** Vol. 4. No.3. Pp193- 207.	Nine in-depth, unstructured interviews.	Powerful emotions ranging from anger to inadequacy and guilt. Positive relationships on the whole but sometimes felt manipulated. Stated need more training.	Staff perspective
Fish, R.M. and Culshaw, E. (2005) The last resort? Staff and clients perspectives on physical intervention. **Journal of Intellectual Disabilities.** Vol. 9. No.2. Pp. 93-107.	Qual interviews of staff and patients	Patients blame other patients and the ward atmosphere for incidents. PI made them more frustrated and brought back memories of frightening experiences Staff said it was upsetting and traumatic to them, causing feelings of guilt and self reproach	Patient perspectives What behaviours and who Staff perspectives

Fleming, I., Caine, A., Ahmed, S. and Smith, S. (1996) Aspects of the Use of Psychoactive Medication Among People with Intellectual Disabilities Who Have been resettled from Long-stay Hospitals into dispersed housing. **Journal of Applied Research in Intellectual Disabilities.** Vol. 9. No. 3. Pp194-205.	Interviews to gain quantitative data. 118 adults	69% were receiving psychoactive meds for the control of CB. Only 8% had a psychiatric diagnosis. Polypharmacy was frequent. Meds continued over long periods of time without review. Over reliance over long periods	Medication
Ford, S. (2017) How to deal with rising assaults on NHS staff? Simple stop counting. **Nursing Times: On the pulse.** www.nursingtimes.net	Opinion piece	Figures on violence and aggression	Background to Violence and aggression
Ford, S. (2018) New strategy pledges 'stronger protection' from violence for NHS staff. **Nursing Times on line.** www.nursingtimes.net	Opinion piece	Figures on violence and aggression	Background to Violence and aggression
Fretwell, C. and Felce, D. (2007) Staff knowledge of the side effects of Anti-psychotic Medication. **Journal of Applied Research in Intellectual Disabilities.** No. 20. Pp. 580-585.	Staff questionnaire about their knowledge of meds and side effects	Limited knowledge of side effects, only two. Most staff felt under informed.	Medication

Friedman, C. and Crabb, C. (2018) Restraint, restrictive intervention and seclusion of people with intellectual and developmental disabilities. **Intellectual and developmental disabilities.** Vol. 56. No. 3. Pp. 171-187.	US study Looking at waivers to allow RPI's	Waivers allowed Restraint 78.4% Restrictive interventions 75.7% Seclusion 24.3%	What interventions
Hampton, R. (2013) Assaults on NHS Staff. **National Health Executive.** Jan/ Feb 2013. P. 72.	Report	Statistics on assaults on staff	Background to Violence and aggression
Hawkins, S., Allen, D. and Jenkins, R. (2005) The use of physical Interventions with people with intellectual disabilities and challenging behaviour- the experiences of service users and staff members. **Journal of Applied Research in Intellectual Disabilities.** No. 18. Pp19-34.	Qual 8 service user/ staff pairs asked about their experiences	Experiences intrinsically linked SU understand the process and their role. SU cited negative emotions inc general dislike, sadness, fear, anxiety and disappointment. Staff neg emotions, fear, anger, distress, dread,	Patient perspectives Staff perspectives
Health and Safety Executive (1999) **Zero Tolerance Policy**. Health and Safety Executive: London.	Report on policy	Zero tolerance policy	Background to violence and aggression

Heaton, S. and Whitaker, S. (2012) The attitudes of trained and untrained staff in coping with challenging behaviour in secure and community settings. **International journal of developmental disabilities.** Vol. 58. No.1. Pp. 40-47.	Quant Postal questionnaire comparing trained and untrained staff in secure and community settings re attitude	Qualified more positive Little difference in attitude from secure to community Care staff most likely to be injured.	Staff perspectives
House of Commons: Committee of Public Accounts (2002-3) at WWW.parliament.uk	Report	Cost of violence and aggression	Background to violence and aggression
Howard, R., Rose, J. and Levenson, V. (2009) The Psychological impact of violence on staff working with adults with intellectual disabilities. **Journal of Applied Research in Intellectual Disabilities**. Vol. 22. No. 6. Pp. 538-548.	Survey. Community V Med secure	Secure staff less fear than community therefore viewed V&A differently	Staff perspectives
Iwata, B. A., Rolider, N. U. And Dozier, C. L. (2009) Evaluation of Timeout Programs through Phased Withdrawal. **Journal of Applied Research In Intellectual Disabilities.** Vol. 22. Pp. 203-209.			What intervention s

Jones, P. and Kroese, B. S. (2007) Service users' views of physical restraint for people with learning disabilities. **British Journal of Learning Disabilities.** No. 35. Pp. 50-54.	Qual 10 semi structured interviews	Can be potentially abusive, staff should try other things. Not calm them down.	Patient perspective What behaviours and who
Kaye, N. and Allen, D. (2002) Over the Top? Reducing Staff Training in Physical Intervention. **British Journal of Learning Disabilities.** Vol. 30. Pp. 129- 132.	Quant Frequency and use	42 RPI's taught only 15 used not using what taught	Training What behaviours and who
Knotter, M.H., Stams, G-J.J.M., Moonen, X.M.H. and Wissink, I.B. (2016) Correlates of direct care staff's attitudes towards aggression of persons with intellectual disabilities. **Research in Developmental Disabilities.** No. 59. Pp. 294-305.	Netherlands Multilevel analysis 475 staff	Positive team= positive response to CB Senior staff and females showed less responsive attitude Patient details	Staff perspectives
Lovell, A. (2004) People with Learning Disabilities who Engage in Self-injury. **British Journal of Nursing.** Vol. 13. No. 14. Pp. 839- 844.			What interventions

Lovell, A. and Skellern, J. (2013) 'Tolerating Violence': A qualitative study into the lived experience of professionals working within one UK learning disability service. **Journal of Clinical Nursing.** Vol. 22. Pp. 2264-2272.	Qual. Phen Semi structured interviews	Interpretation of what is violence, themes, the realisty of violence, change over time and tolerance.	Staff perspectives
Lovell, A., Smith, D. and Johnson, P. (2015) A qualitative investigation into nurses' perceptions of factors influencing staff injuries sustained during physical interventions employed in response to service user violence within one secure learning disability service. **Journal of clinical nursing.** No. 24. Pp. 1926-1935.	Qual Staff	Negative devastating, upsetting. De-escaltion not PRI's the answer	Training Injury & Death Staff perspectives
Luiselli, J.K., Sperry, J.M. and Draper, C. (2015) Social Validity Assessment of Physical Restraint Intervention by Care Providers of Adults with Intellectual Disabilities. Behaviour Analysis Practice. Vol. 8. Pp. 170-175.	Quant. Looking at appropriateness of interventions. Social validity questionnaire, asking staff about their thoughts on restraint	Done by training provider. On the whole positive responses.	Training Staff perspectives
Lundström, M.O., Antonsson, H., Karlson, S. and Graneheim, U.H. (2011) Use of Physical Restraints with People with Intellectual Disabilities Living in Sweden's Group Homes.	Sweden Investigate prevalence and characteristics of individuals subjected to restraint. 556 PWLD aged	99 (17.8%) been restrained in previous week. Of these 99.2% more than one type 73.7% with a belt. Some for physical	Who restrained and why What intervention s

Journal of Policy and Practice in Intellectual disabilities. Vol. 8. No. 1. Pp. 36-41.	16-90 from 118 group homes.	reasons some for Behaviour- screaming and shouting. No legal authority.	
McDonnell, A. (1997) Training care staff to manage challenging behaviour: An evaluation of a three day training course. **British Journal of Developmental Disabilities.** Vol. 43. Part 2. No. 85. Pp. 156- 162.	21 care staff 7 males 15 females, including qualified nurses, HCA's, student nurses and psychology assistants. Survey testing knowledge and confidence, done before and after the course.	Significant increase in confidence and knowledge. Research done and article authored by the owner of the training organization.	Training
McGillivray, J.A. and McCabe, M.P. (2006) Emerging Trends in the Use of Drugs to manage Challenging behaviour of People with Intellectual Disability. **Journal of Applied Research in Intellectual Disabilities.** No. 19. Pp163-172.	Australia. Comparison between 1993 and 2000 reported cases of drugs use. Large sample.	A small decrease in the proportion of individuals receiving meds from 5 to 4.5 % population however increase use in drug diversity and polypharmacy.	Medication
McGill, P., Murphy, G. and Kelly-Pike, A. (2009) Frequency of Use and characteristics of people with Intellectual disabilities subject to Physical Interventions. **Journal of Applied Research in Intellectual Disabilities.** Vol. 22. Pp152- 158.	Postal questionnaires	Frequent PI reported Restraint most common Mainly young males, Autism	What behaviours and who

McKenzie, K., Powell, H. and McGregor, L. (2004) The impact of control and restraint training on nursing students. Learning disability practice. Vol. 7. No.9. Pp. 34- 37.	Quant. Survey. Students nurses receiving training in RPI's.	Increased confidence to deal with CB.	Training theme.
Merineau-Cote, J. and Morin, D. (2013) Correlates of restraint and seclusion for adults with intellectual disabilities in community services. **Journal of Intellectual disability Research**. Vol. 57. Part 2. Pp. 182- 190.	Quant. 81 adults mail survey.	Prevalence 63% restrictive measures 44.4% seclusion, 42% physical restraint and 27.2 mechanical restraint.	What behaviours and who
Merineau-Cote, J. and Morin, D. (2014) Restraint and seclusion: The Perspectives of Service Users and Staff Members. **Journal of Applied Research in Intellectual Disabilities.** Vol. 27. Pp447- 457.	Interviews with SU and their carers. Looking at their understanding of RPI's, its impact on their relationship, their emotions and alternative interventions.	RPI's were experienced negatively by SU and carers. SU reported feeling sad and angry. Staff feel anxious. SU understood the reason for RPI and also discussed alternatives.	Patient perspectives Staff perspectives
Murphy, G. H., Estien, D. and Clare, I. C. H. (1996) Services for People with Mild Intellectual Disabilities and Challenging Behaviour. **Journal of Applied Research in Intellectual Disabilities.** Vol. 9. N0. 3. Pp. 256- 283.	Qualitative		Patient perspectives

Murphy, G., Kelly-pike, A., McGill, P., Jones, S. and Byatt, J. (2003) Physical interventions with People with intellectual disabilities: Staff Training and Policy frameworks. **Journal of Applied Research in Intellectual Disabilities.** Vol. 16. Pp. 115-125.- 457.	Questionnaires on policy and training	Two thirds had a policy or were writing one. 12 types of training recorded vary in degree and type of training.	Training Legislation & policy
Niven, A., Goodey, R., Webb, A. and Shankar, R. (2017) The use of psychotropic medication for people with intellectual disabilities and behaviours that challenge in the context of a community multidisciplinary team approach. **British Journal of Learning Disabilities.** No. 46. Pp. 4-9.	Review of records 106 people	50% plus on antipsychotics with no diagnosis of MI	Medication
Paley- Wakefield, S. (2012) Is legislation needed to limit the restraint of clients? **Learning Disability Practice.** Vol. 15. No. 3. Pp. 24- 27.	Opinion piece	Looking at legislation	Effectiveness of PI

Paterson, B., Bradley, P., Stark, C., Saddler, D., Leadbetter, D. and Allen, D. (2003) Deaths associated with restraint use in health and social care in the UK. The results of a preliminary survey. **Journal of Psychiatric and Mental Health Nursing.** No.10. Pp. 3-15.	Documentary review. MH and LD.	12 cases of deaths in restraint	Injury & Death
Perry, D. W., White, G., Norman, G., Marston, G. and Auchoybur, R. (2006) Risk Assessment and the Use of Restrictive Physical Intervention in Adults with a Learning Disability. **Learning Disability Practice.** Vol. 9. No. 6. Pp. 30-36.	Quantitative research	Risks associated with medication/ condition etc	Risks associated with PI
Robertson, J., Emerson, E., Pinkney, L., Caesar, E., Felce, D., Meek, A., Carr, D., Lowe, K., Knapp, M. and Hallam, A. (2005) Treatment and management of challenging behaviours in congregate and noncongregate community-based supported accommodation. **Journal of Intellectual Disability Research.** Vol. 49. Part 1. Pp. 63-72.	Quant	High use of Anti-psychotic meds Use of RPI in congregate settings	What interventions

Romeo, R., Knapp, M., Tyrer, P., Crawford, M. and Oliver-Africano, P.C. (2009) The treatment of challenging behaviour in intellectual disabilities: cost effectiveness analysis. **Journal of Intellectual Disability Research.** Vol. 53. No.7. Pp. 633- 643.	RCT From the Tyrer research	Lower cost to placebo group Aggression highest from rispridone and lowest to haloperidol QoL Lowest for haloperidol and highest for risperidone	Medication
Rose, D., Home, S., Rose, J.L. and Hastings, R.P. (2004) Negative Emtional Reactions to Challenging Behaviour and Staff Burnout: Two replication studies. **Journal of Applied Research in Intellectual Disabilities.** No. 17. Pp 219- 223.	Data analysed of staff rated their emotional reactions to CB	Positive correlation between negative emotional reactions to CB and emotional exhaustion.	Staff perspectives
Royal College of Nursing (RCN). (2001) **Dealing With Violence Against Nursing Staff, An RCN Guide for Nurses and Managers.** RCN: London.	Report/ guidance		Background to violence and aggression
Sequerira, H. and Halstead, S. (2001) 'Is it Meant to Hurt, is it?' Management of Violence in Women with Developmental Disabilities. **Violence Against Women.** Vol. 7. No. 4. Pp. 462- 476.	Qualitative research	Negative experiences	Patient perspectives

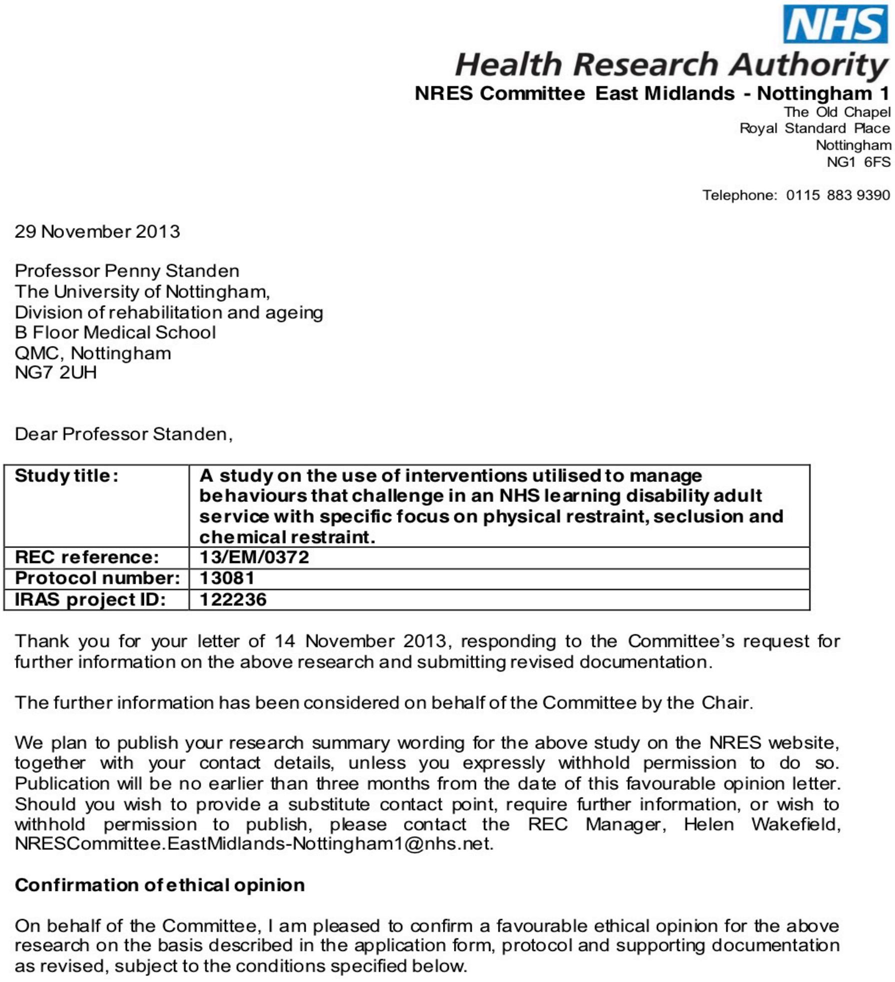
Scheirs, J.G.M., Blok, J.B., Tolhoek, M.A., El Aouat, F. and Glimmerveen, J.C. (2012) Client factors as predictors of restraint and seclusion in people with intellectual disability. **Journal of Intellectual and Developmental Disability.** Vol. 37. No.2. Pp. 112-120.	Dutch 475 residents aged 12-95 Rating severity of restraint	Low adaptive functioning, CB, high intellectual level predictors of restraint. Specific behs	What behaviours and who What interventions
Sofield, L. and Salmond, S. W. (2003). Workplace Violence: A Focus on Verbal Abuse and Intent to Leave the Organisation. **Orthopaedic Nursing.** Vol. 22. Issue 4. Pp. 274-283.	Survey	Who most at risk-front line staff	Background to violence and aggression
Søndenaa, E., Dragsten, F., Whittington, R. (2015) Practitioner Explanations for the Increasing Use of Restraint Measures in the care of People with Intellectual Disabilities in Norway 2000-11. **Journal of Policy and Practice in Intellectual Disabilities.** Vol. 12. No. 1. Pp. 58-63.	Norway. 195 staff. Semi structured questionnaire on why use of restraint increased following legislation to reduce it. Postal.	Care staff said greater awareness of regulations and ethical issues. More planned less unplanned previous under reporting was also an explanation	Legislation and policy
Stansfield, J. and Cheseldine, S. (1994) Challenging To Communicate. **Human Communication.** May/ June 1994. Pp. 11- 14.	Report	Challenging behaviour and communication	Background to violence and aggression
Sturmey, P. (2009) Restraint, Seclusion and	National Audit survey	80% used PRN half used	What intervention

PRN Medication in English Services for People with Learning Disabilities Administered by the National Health Service: An analysis of the 2007 National Audit Survey. **Journal of Applied Research in Intellectual Disabilities.** No. 22. Pp. 140-144.		mechanical and personal restraint.	s
Sturney, P., Lott, J.D., Laud, R. and Matson, J.L. (2005) Correlates of restraint use in an institutional population: a replication. **Journal of Intellectual Disability Research.** Vol. 49. Part 7. Pp. 501- 506.	US Compare 52 clients who had been restrained with 52 who had not	Differences in behaviour were the reason	What behaviours and who
Tilli, D. M. and Spreat, S. (2009) Restraint safety in a residential setting for persons with intellectual disabilities. **Behavioral Interventions.** No. 24. Pp.127-136.	USA Quant study on person to person restraint in a service for severe CB. Restraint only used if person was in immediate danger to self or others. In one year 1325 restraints to 157 SU.	15% no recording. 33% a SU was injured- 99% of which were minor. No staff mentioned Found predictive variables autism gender- male	Injury & Death What behaviours and who
Turner, K. V. and Mooney, P. (2016) A comparison of seclusion rates between intellectual disability and non-intellectual disability services: the effect of gender and diagnosis.	Study from 11 medium and low secure services.	Seclusion longer for nonLD Male twice as long as female (in LD and non)	What behaviours and who

The Journal of forensic Psychiatry and Psychology. Vol. 27. No. 2. Pp. 265- 280.			
Tyrer, P., Oliver-Africano, P.C., Ahmed, Z., Bouras, N. Cooray, S., Deb, A., Murphy, D., Hare, M., Meade, M. et al (2008) Risperidone, haloperidol and placebo in the treatment of aggressive behaviour in patients with intellectual disability: a randomized controlled trial. **The Lancet.** Vol. 371. Pp. 57-63.	RCT 86 patients weeks 4, 12 and 26.	Aggression decreased in all groups but biggest in placebo group.	Medication
Webber, L.S. McVilly, K.R. and Chan, J. (2011) Restrictive Interventions for people with a Disability Exhibiting Challenging Behaviours: Analysis of a population database. **Journal of Applied Research in Intellectual Disabilities.** No. 24. Pp. 495-507.	Australia 12 month period study of reports	Subjected to chemical, mechanical restraint and seclusion. Routine not last resort. Young males with multiple disabilities inc autism	What behaviours and who What interventions
Webber, L.S. McVilly, K.R., Stevenson, E. and Chan, J. (2010) The use of restrictive interventions in Victoria, Australia: Population data for 2007-2008. **Journal of intellectual and developmental Disability.** Vol. 35. No. 3. Pp. 199-206.	Data Aus	9% of total LD population had RPI's 2 x more males than females but this is not representative of the population. 25-44 age group but biggest age group 15-25. Autism 31% 18% MI	What behaviours and who What interventions

Webber, L.S., Richardson, B. and Lambrick, F. (2014) Individual and organizational factors associated with the use of seclusion in disability services. **Journal of intellectual and developmental Disability.** Vol. 39. No. 4. Pp. 315-322.	Australian Quant	Age, autism and MH diagnosis factors leading to being secluded	What behaviours and who
Williams, D. E. (2009) Restraint Safety: An analysis of Injuries Related to Restraint of People with Intellectual Disabilities. **Journal of Applied Research in Intellectual Disabilities.** No. 22. Pp135-139.	USA. 209 restraints over 12 month period analysed.	0.46 injuries per 100 restraints. Planned restraint as part of a behaviour management programme safer than crisis intervention.	Injury & Death

Appendix 2- Ethical Approval:



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29 November 2013

Professor Penny Standen
The University of Nottingham,
Division of rehabilitation and ageing
B Floor Medical School
QMC, Nottingham
NG7 2UH

Dear Professor Standen,

Study title:	**A study on the use of interventions utilised to manage behaviours that challenge in an NHS learning disability adult service with specific focus on physical restraint, seclusion and chemical restraint.**
REC reference:	**13/EM/0372**
Protocol number:	**13081**
IRAS project ID:	**122236**

Thank you for your letter of 14 November 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager, Helen Wakefield, NRESCommittee.EastMidlands-Nottingham1@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Evidence of insurance or indemnity		31 July 2013
Interview Schedules/Topic Guides	Patient, V1	16 September 2013
Investigator CV		17 January 2007
Investigator CV	Student	
Investigator CV	supervisor	
Letter from Sponsor		17 September 2013
Other: Interview Schedules for participants - staff	1	16 September 2013
Other: Letter of support from CI and academic supervisor		14 September 2013
Participant Consent Form: Patient	1	17 September 2013
Participant Consent Form: Staff	1	17 September 2013
Participant Consent Form: Adapted	2	14 November 2013
Participant Information Sheet: Patient	1	16 September 2013
Participant Information Sheet: Staff	1	16 September 2013
Participant Information Sheet: Adapted	1	14 November 2013
Protocol	1	16 September 2013
REC application	122236/502483/1/411	16 September 2013
Response to Request for Further Information		14 November 2013

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/EM/0372 Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely,

pp

Mr Robert Johnson
Chair

Email:NRESCommittee.EastMidlands-Nottingham1@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Mr Paul Cartledge*
Shirley Mitchell, Nottinghamshire Healthcare NHS Trust

Appendix 3- Participant Information Sheet for Staff:

Participant Information Sheet- Staff
(Final Version: 1)

Title of Study: A study on the use of interventions utilised to manage behaviours that challenge in an NHS Learning Disability service with specific focus on physical restraint, seclusion and chemical restraint.

Name of Researcher(s): Justine Barksby, Prof. Penny Standen

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

The purpose of the study is to explore the perceptions of staff involved in physical restraint, seclusion and chemical restraint. It is hoped to explore your perceptions of implementing these interventions, do you feel prepared and appropriately trained to do so, are you appropriately supported when they have been utilised and ask for examples of when you have had to use them.

The primary purpose of the study is for a PhD for the researcher Justine Barksby. While this is the initial reason for the study it is also hoped that the findings are useful to the service/Trust and the findings will be fed back to the management of the directorate and if appropriate influence future training needs.

Why have I been invited?

You are being invited to take part because as part of your role, you have been involved in the implementation of the interventions mentioned above. The Untoward incident forms were reviewed and we saw from them that you had been involved in an incident. We are inviting 10 members of staff like you to take part in the interviews.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

We are asking you to be interviewed about your experiences of implementing the interventions. We will ask questions but you will be free to talk about your experiences, as little or as much as you wish. It is envisaged that the interview will last approximately one hour, however may be less or more than this at your request. The interview will be the full involvement required of you. The interview will take place in a private room at your place of work in order to minimise intrusion and inconvenience for you. It will take place between yourself and the researcher (unless you require someone else to be present) and the interview will be recorded.

Expenses and payments

Participants will not be paid to participate in the study and no costs are expected to be incurred.

What are the possible disadvantages and risks of taking part?

The main disadvantage or risk associated to you is the inconvenience for the time it takes to conduct the interview. By undertaking the interview at your place of work we are hoping to minimise this as much as possible. A further risk could be if you became upset by the issues we discuss in your interview, for example if you recall an incident that resulted in you getting hurt.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help service developments in the future. We will feed back any findings from the study to the management of the directorate and it is hoped, these may (if appropriate) influence future training delivered. It may also influence other factors such as policy and procedures on supporting staff after an incident or documentation required, for example.

What happens when the research study stops?

Your involvement will stop after your interview however the overall findings will be fed back to the participants in the form of a report. If for some reason the study has to stop before completion it is hoped that the findings so far will still be utilised.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints. Details can be obtained from your hospital. You can also contact Notts Healthcare NHS Trust PALS on 01159 6911300 or through the website www.nottinghamshirehealthcare.nhs.uk/contact-us/patient-advice-and-liason-service.

Will my taking part in the study be kept confidential?

All documentation for the study will be treated as confidential and held securely. Each participant will be assigned a study identity code number so they are not identifiable and to maintain anonymity and only the research team will have access to this information both during and after the study. The papers (such as consent forms) and recordings will be kept locked away in a secure cupboard in a locked room and in line with the Data Protection Act 1998.

The information you provide will only be used for the purpose of this study and subsequent reports. The researchers and sponsors (who monitor the quality of research) are the only people that will have access to the identifiable information. After the appropriate time period all the information will be disposed of in line with the Data Protection Act 1998.

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the service will have your name removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (name) will be kept for 3 years after the end of the study. All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don’t want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you chose to withdraw from the study during the interview the interview will cease immediately. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research study

As mentioned previously the results of the study are to be utilised for a PhD theses. The results will also be presented (either in person or in the form of a report) to the management board of the Directorate. A copy of this report will also be available to the participants.

Additionally the findings of the research may be written up for the purpose of publication in a professional journal and/ or presented at a conference.

In all of the above examples there will be no means of identifying any participant involved in the study.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is not being funded.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Nottinghamshire NHS Trust Research Ethics Committee.

Further information and contact details

Chief investigator:	**Miss J Barksby** School of Nursing, Midwifery & Physiotherapy University of Nottingham B Floor reception QMC Nottingham NG7 2UH
Co-investigators:	**Professor PJ Standen** Professor of Health Psychology & Learning Disabilities Division of Rehabilitation and ageing B Floor, Medical School QMC Nottingham NG7 2UH

Appendix 4- Consent Form for Staff:

The University of Nottingham

CONSENT FORM- staff
(Final Version 1: date 16/09/13)

Title of Study: A study on the use of interventions utilised to manage behaviours that challenge in an NHS Learning Disability service with specific focus on physical restraint, seclusion and chemical restraint.

Name of Researcher: Justine Barksby, Prof. Penny Standen

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number …………dated..................................... for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

2 copies: 1 for participant and 1 for the project notes

Use of Interventions: Consent form. Final Version: 1 date: 16/09/13 REC reference13/EM/0372

Appendix 5- Interview schedule for the staff interviews:

The University of Nottingham

Questions for staff- Qualitative interviews.

The researcher (PhD student) will introduce herself and make sure the participant is comfortable.

They will be reminded of the purpose of the interview and that everything they say will remain confidential unless they disclose something that may put others at risk in some way.

As the interviews are semi-structured, the questions are there to prompt discussion and therefore may not be followed rigidly but below is the template of the questions to be asked and issues to explore.

Questions:

Can you recall an incident or several incidents when you have been involved in implementing an intervention to manage challenging behaviours, this may include physical restraint, seclusion or administering chemical restraint?

Can you recall an incident where you have implemented an intervention that went ‘well’, it had a positive outcome? What made it a ‘good’ experience? Did you feel prepared, emotionally and physically? Is there anything else that could improve it further?

Can you recall an incident where you have implemented an intervention that went badly? Why was a ‘bad’ experience? What would you differently now?

Can you recall how you felt prior to implementing an intervention, particularly physical restraint or seclusion?

Can you recall how you felt during the intervention?

Can you recall how you felt after the intervention?

How do you think the patients feel that are having the intervention done to them?

Do you think it helps defuse the situation or help them calm down? If not why not, if yes why?

How do you think the other patients feel that observe the intervention?

What happens in your service after such an intervention has been utilised? Could this be improved in any way?

In your service do you think there is someone (or some people) who always ‘put themselves forward’ to deal with incidents? If yes, who is this and why do you think they do?

Looking at figures from the whole service, I found that a much larger number of incidents involved HCAs than any other category of staff. Do you have any ideas as to why that might be?

The figures from the whole service also showed that there were peaks in incidents on certain days and at certain times of day. In your service is there a typical ‘bad day” or time? Which day/ time is this and why do you think it is like that? What contributes to this?

Use of interventions: Questions for staff. Final version 1. Date 16/09/13. REC reference13/EM/0372

What type of incidents (self-harm, violence to staff, violence to patients etc) do you experience the most in your service? How do you feel about these types of incidents? (Show service wide data if required).

The interview will be concluded by the PhD student thanking them for their time and offering them an opportunity to ask any questions they may have about the research.

Appendix 6- Participant Information Sheet for Patients:

The University of
Nottingham

Participant Information Sheet- Patient
(Final Version: 1)

Title of Study: A study on the use of interventions utilised to manage behaviours that challenge in an NHS Learning Disability service with specific focus on physical restraint, seclusion and chemical restraint.

Name of Researcher(s): Justine Barksby, Prof. Penny Standen.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

The purpose of the study is to explore the perceptions of patients involved in physical restraint, seclusion and chemical restraint. It is hoped to explore your perceptions of these interventions and discuss your experiences.

The primary purpose of the study is for a PhD for the researcher Justine Barksby. While this is the initial reason for the study it is also hoped that the findings are useful to the service/Trust and the findings will be fed back to the management of the directorate and if appropriate influence future training needs of the staff.

Why have I been invited?

You are being invited to take part because you are a patient in this service and have been exposed to these interventions during your time here. We are inviting 10 patients like you to take part in the interviews.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

What will happen to me if I take part?

We are asking you to be interviewed about your experiences of the interventions. We will ask questions but you will be free to talk about your experiences, as little or as much as you wish. It is envisaged that the interview will last approximately one hour, however may be less or more than this at your request. The interview will be the full involvement required of you. The interview will take place in a private room within the service in order to minimise intrusion and inconvenience for you. It will take place between yourself and the researcher (unless you require someone else to be present) and the interview will be recorded.

Expenses and payments

Participants will not be paid to participate in the study and no costs are expected to be incurred.

What are the possible disadvantages and risks of taking part?

The main disadvantage or risk associated to you is the inconvenience for the time it takes to conduct the interview. By undertaking the interview in the service where you are a patient we are hoping to minimise this as much as possible. A further risk could be if you became upset by the issues we discuss in your interview, for example if you recall an incident that resulted in you getting hurt.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help service developments in the future. We will feed back any findings from the study to the management of the directorate and it is hoped, these may (if appropriate) influence future staff training delivered. It may also influence other factors such as policy and procedures on supporting patients after an incident or documentation required, for example.

What happens when the research study stops?

Your involvement will stop after your interview however the overall findings will be fed back to all the participants in the form of a report. If for some reason the study has to stop before completion it is hoped that the findings so far will still be utilised.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints. Details can be obtained from your hospital. You can also contact Notts Healthcare NHS Trust PALS on 011596911300 or through the website www.nottinghamshirehealthcare.nhs.uk/contact-us/patient-advice-and-liason-service.

Will my taking part in the study be kept confidential?

The manager of the service and your named nurse will be aware you are taking part however what you say will be confidential. All documentation for the study will be treated as confidential and held securely. Each participant will be assigned a study identity code number so they are not identifiable and to maintain anonymity and only the research team will have access to this information both during and after the study. The papers (such as consent forms) and recordings will be kept looked away in a secure cupboard in a locked room and in line with the Data Protection Act 1998.

The information you provide will only be used for the purpose of this study and subsequent reports. The researchers and sponsors (who monitor the quality of research) are the only people that will have access to the identifiable information. After the appropriate time period all the information will be disposed of in line with the Data Protection Act 1998.

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the service will have your name removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (name) will be kept for 3 years after the end of the study. All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you chose to withdraw from the study during the interview the interview will cease immediately. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research study?

As mentioned previously the results of the study are to be utilised for a PhD theses. The results will also be presented (either in person or in the form of a report) to the management board of the Directorate. A copy of this report will also be available to the participants. This will be produced in other formats if required.

Additionally the findings of the research may be written up for the purpose of publication in a professional journal and/ or presented at a conference.

In all of the above examples there will be no means of identifying any participant involved in the study.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is not being funded.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Nottinghamshire NHS Trust Research Ethics Committee.

Further information and contact details

Chief investigator: **Miss J Barksby**

School of Nursing, Midwifery & Physiotherapy
University of Nottingham
B Floor reception
QMC Nottingham
NG7 2UH

Co-investigators: **Professor PJ Standen**

Professor of Health Psychology & Learning Disabilities
Division of Rehabilitation and ageing
B Floor, Medical School
QMC Nottingham
NG7 2UH

Appendix 7- Consent Form for Patients:

CONSENT FORM- patient

Title of Study: A study on the use of interventions utilised to manage behaviours that challenge in an NHS Learning Disability service with specific focus on physical restraint, seclusion and chemical restraint.

REC ref:

Name of Researcher: Justine Barksby, Prof. Penny Standen

Name of Participant: **Please initial box**

1. I confirm that I have read and understand the information sheet version number 1 dated..................................... for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐

3. I understand that data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

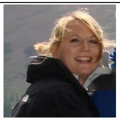
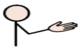
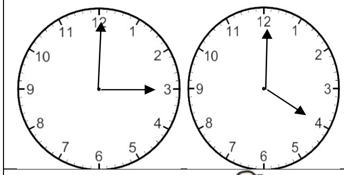
3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes

Use of Interventions: Consent form. Final Version 1 date: 16/09/13. REC reference13/EM/0372

Appendix 8- Alternative Consent Form for Patients:

Consent form   for study:

Use of interventions utilised to manage behaviours that challenge

 	I agree to talk to Justine and answer questions.	
	I have had a chance to ask questions about the research.	
	I understand it is my choice to be involved in this research and that I can change my mind at any time.	
	I can have a member of staff with me if I want.	
	It will take place at my unit.	
	It will last about 1 hour.	
	I understand it is for a study.	

Use of Interventions: Adapted consent form. Final version 2. date: 14/11/13 REC reference13/EM/0372

The University of
Nottingham

	I understand that a record of what I say will be made.	
	I understand a report will be written. My name will not appear in the report.	
	I understand that my personal information will be kept safe, like the law says it must be.	
Name of participant	Date	
Counter signature	Date	

Appendix 9- Interview schedule for the patient interviews:

The University of
Nottingham

Questions for patients- Qualitative interviews.

Please note the exact language used may be altered depending on the patients' ability to understand and if necessary alternative means of communicating (such as Makaton) may be utilised if required.

The researcher (PhD student) will introduce herself and make sure the participant is comfortable.

They will be reminded of the purpose of the interview and that everything they say will remain confidential unless they disclose something that may put others at risk in some way.

As the interviews are semi-structured, the questions are there to prompt discussion and therefore may not be followed rigidly but below is an example of the types of questions and issues to explore.

Questions:

Can you recall an incident or several incidents when you have been physically restrained, secluded or received chemical restraint? Can you tell me about those incidents?

Do you understand what these interventions are?

Do you understand why they are used?

Can you recall an incident where you have been restrained or secluded that went 'well', it had a positive outcome? What made it a 'good' experience?

Can you recall an incident where you have been restrained or secluded that went badly? Why was a 'bad' experience? What would you change?

Can you recall how you feel prior to being physically restrained or secluded?

Can you recall how you feel during the intervention?

Can you recall how you feel after the intervention?

How do you think the staff feel that are implementing the intervention?

Does it help you calm down? Why?

How do you think the other patients feel that observe the intervention?

The interview will be concluded by the PhD student thanking them for their time and offering them an opportunity to ask any questions they may have about the research.

Use of interventions: Questions for patients. Final version 1. Date 16/09/13. REC reference13/EM/0372