



Reducing restrictive practice: Developing and implementing behavioural support plans

Louise L Clark, Darren L Shurmer, Dominika Kowara, Ian Nnatu

The importance of reducing restrictive practices in mental health settings is an issue of national importance. *Positive and Proactive Care* (Department of Health, 2014) states that mental health services have the duty to reduce restrictive interventions and must have a senior lead reporting to the trust board who is accountable for taking this forward.

Behavioural support plans are recommended in *Positive and Proactive Care* (Department of Health 2014) and also by the Care Quality Commission. This article details the work of a large London mental health NHS trust and the development of bespoke behavioural support plans and subsequent implementation process. The aim of these plans is to proactively reduce restrictive practice through examination of contributing factors that can affect the behaviour of patients. Development of the behavioural support plans follows the work of Clarke and Clarke (2014) considering the biopsychopharmacosocial (BPPS) approach to psychiatric nursing.

Effective risk management in mental health is complex and amalgamates a variety of expertise from many sources. A multidisciplinary approach, based on interprofessional working is essential to dynamic psychiatry, improving practice between differing disciplines and thus enhancing understanding of the needs of people who access mental health services (Moxham et al, 2016). Effective communication between the multidisciplinary team (MDT) can provide a more comprehensive and patient-focused model of care (Barker and Walker, 2000). The evidence gathered to complete behavioural support plans enables clinicians to make informed decisions regarding bespoke person-centred interventions that will help to manage behaviours that may appear to challenge services. Awareness of the many different factors that contribute to such behaviours can aid all healthcare professionals in delivering care in the least restrictive way.

Available literature surrounding the management of challenging behaviour predominantly focuses

ABSTRACT

The importance of reducing restrictive practices in mental health settings is an issue of national importance. This article details the development and implementation of bespoke behavioural support plans at a large London mental health trust. The tool was developed and piloted by staff on a male psychiatric intensive care unit (PICU), caring for patients with complex mental and physical health needs. These patients present with challenging and acutely disturbed behaviour which cannot be managed in an open setting. The behavioural support plans are based on a biopsychopharmacosocial approach in conjunction with an appraisal of the patient's current environment and past incidents, to examine contributing factors to the patient's behaviour. This information is used to form a management plan, including primary, secondary and tertiary interventions, thus proactively reducing tertiary restrictive practices such as restraint, rapid tranquilisation and seclusion. The plans are now used trust-wide with patients who have complex needs. As a result of the success of this intervention, a second pilot is now underway, where behavioural support plans have replaced traditional care planning.

Louise L Clark

Nurse consultant in acute and restrictive practice: West London Mental Health Trust; and visiting lecturer, King's College London

Darren L Shurmer

Healthcare assistant, West London Mental Health Trust, Askew Ward; seconded postgraduate mental health nursing student, Florence Nightingale Faculty of Nursing and Midwifery, King's College London

Dominika Kowara

Registered mental health nurse, West London Mental Health Trust, Askew Ward

Ian Nnatu

Consultant psychiatrist, West London Mental Health Trust, Askew Ward; and honorary senior clinical Lecturer, Imperial College, London
Email: Darren.shurmer@wlmht.nhs.uk



on working with people with learning disabilities (Deveau and McDonnell, 2009; Ridley and Jones, 2012), children (Greene et al, 2006) and people with dementia (Cunningham, 2006).

Currently, there is little literature on how problematic behaviours can be successfully managed on psychiatric intensive care units (PICUs). The 'Safewards' model proposed by Bowers et al (2015) describes a link between conflict and containment on acute wards. This model has been shown to be effective in reducing rates of containment (including seclusion), however, it does not address all the causes of potential challenging behaviour that might lead to confinement or seclusion. Behavioural support plans incorporate the safe use of reactive diversion tactics (use of *pro re nata* medication and soft furnishing/de-escalation areas) alongside a range of individualised, proactive preventative strategies (day-to-day activities tailored to the patient).

Behavioural support plans help the clinician to systematically gather information about each patient and aid a more comprehensive psychiatric formulation. This contributes to the development of interventions that will effectively address complex needs, improve patient care and reduce restrictive practice on PICUs and acute wards. It is expected that their implementation will reduce the numbers of restraint and seclusion and have a positive impact on patient recovery. Seclusion events tend to be concentrated among a fairly small number of patients (Oster et al, 2016) and should only ever occur as an absolute last resort when all other management strategies have been exhausted. This supports the legitimacy of tailoring interventions and devising innovative, evidence-based behavioural support plans for patients with high-risk and complex needs.

Development of the tool

The behavioural support plans were developed and piloted at an inner London PICU. It is a 12-bed unit for male patients who have complex mental health—and in some cases physical health—care needs who present with challenging or acutely disturbed behaviours, which are difficult to manage in a less secure setting. The unit is intended to provide short-term interventions, with a suggested average stay of around three weeks and a maximum stay of six weeks.

Patients are generally referred to PICU by other local services assessment or treatment wards and return to those wards once they have achieved a degree of stability and their risks can be managed in an open setting. The unit also provides an 'outreach service' to all assessment and treatment wards in the trust's local services for female patients (or male patients with complex needs who may be identified as needing extra

behavioural support), or possible admission to female PICU services outside the trust.

A PICU admission, by definition, is a restrictive intervention, and should therefore be avoided if at all possible. The intensive care outreach nurses (ICONS) work with the multidisciplinary team to write and implement the behavioural support plan, in the hope that a PICU admission can be avoided and the patients' needs can be met through less restrictive means.

The assessment begins with a MDT discussion focused on the patient, based on the model described by Clarke and Clarke (2014). The model is designed to enable the team to view the patient from a more holistic perspective, taking into account specific BPPS domains, in addition to the influence of the current environment. As the tool is designed with the patient at its heart, the patient and their family/carers should be actively encouraged to participate in the assessment and discussion process. Their views should be recorded and considered when management plans are developed. It is also advised that the majority of members of the MDT contribute, to generate a detailed, open-minded and robust view from a variety of perspectives.

As mirrored in the psychiatric formulation, it is good practice to begin by taking a history from a BPPS perspective. A full physical examination is performed and biological factors are recorded on to the model to prevent diagnostic overshadowing. This should take into account any known or suspected medical conditions, family medical history, and issues related to general physical health. Once these have been established, the discussion can move on to psychological and mental health issues including symptomology, current mental state and any known diagnosis.

Aetiology is considered from predisposing, precipitating and perpetuating factors which will inform possible prognosis. Coping strategies, previous trauma and self-esteem are also included in this section. Pharmacological factors are recorded incorporating current medication and side effects, substance use, smoking status and use of over-the-counter medication. Social factors including family constellation, support networks, life stresses and relationships are noted.

Finally, the patient is considered within the context of their current environment (Clarke and Clarke, 2014). This element of the equation may be quite similar for many patients as they share the PICU environment. However, there will be factors which are specific to individuals such as relationships with other patients and staff, staff attitudes and a lack of access to ground leave or the no-smoking trust policy. It should be noted that the examples for each category are provided solely for illustrative purposes, and are

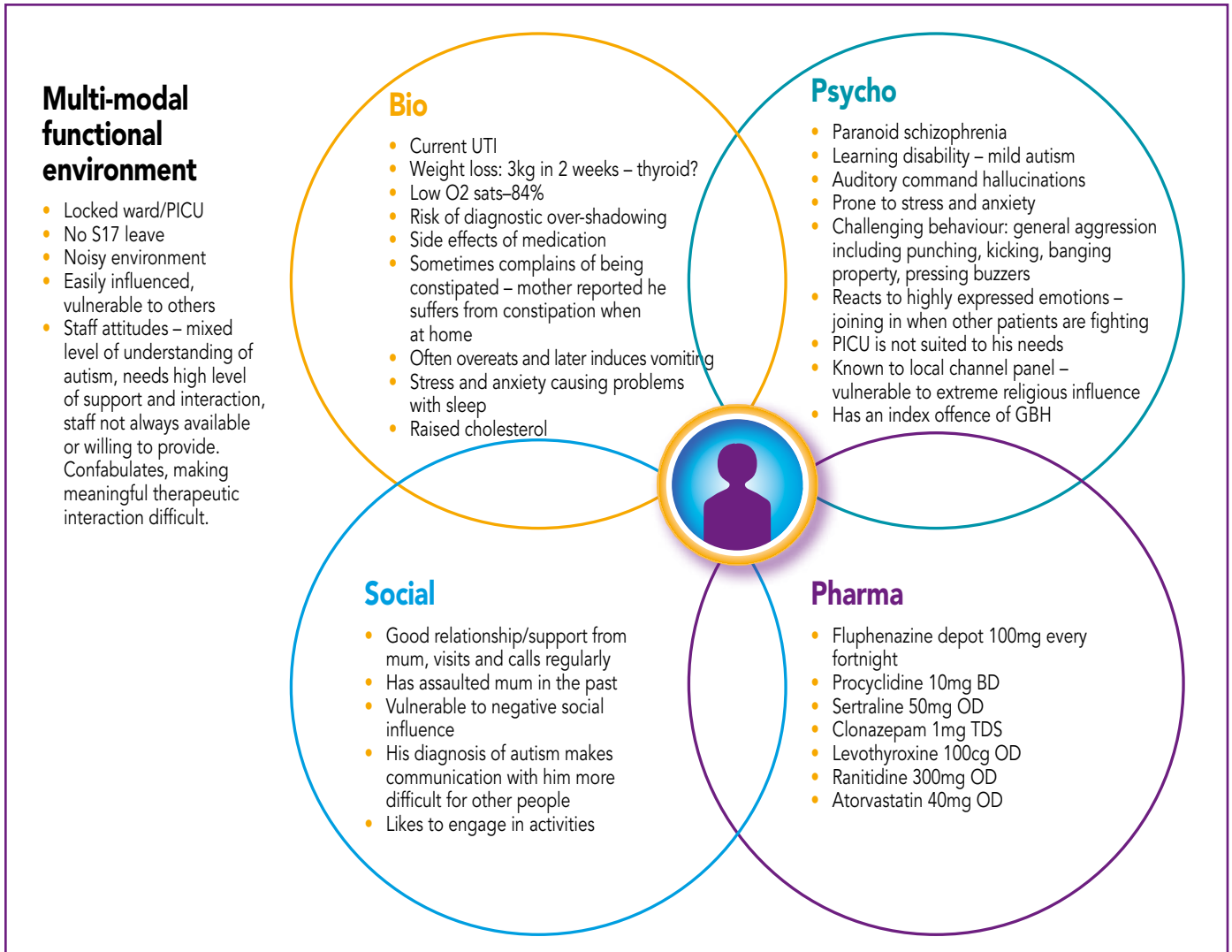


Figure 1. Biopsychopharmacosocial assessment incorporating multi-modal functional environment

by no means exhaustive. It is also to be expected that, as these categories interact with each other to produce a complete picture, factors are likely to cross category lines. For example, it is clear that substance misuse, while broadly considered a pharmacological issue, has obvious biological, psychological and social precipitants and effects.

The information gathered from this discussion is then summarised in a brief paragraph (as shown in *Appendix 1*) which serves as the basis for BPPS psychiatric formulation. Areas for further investigation are identified, which may include medical or neurological investigations, psychological assessments, assessment of possible learning disability, diet, sexual health/disease or substance misuse. A decision is then made regarding what information the team will be gathering, as a bare minimum, patients on the pilot site have their bowel status, sleep pattern and vital signs monitored on a daily basis. Other monitoring may include intake/output charts, seizure charts or

Table 1.		
PICU: Restrictive interventions	April–March 2015/16	April–March 2016/17
Rapid tranquillisation	5	2
Restraint	63	36
Seclusion	42	15

menses charts (female patients), as well as any other data collection methods deemed necessary.

A highly detailed Antecedent-Behaviour-Consequence chart (ABC) is then completed for all untoward incidents to inform risk assessment and subsequent management. Antecedents must establish the patient's presentation at that time from a BPPS perspective, and take into account the influence of the environment (including where the incident occurred, who was present and what else was happening at the time). Behaviours must not simply be recorded



Behavioural support plans have proven popular with patients, resulting in a more collaborative style of risk management, contributing to a reduction in restrictive interventions

as the apex of the incident in question, for example, 'patient smashed a window', but must provide a detailed picture of what occurred (including what the patient said, their body language and what other people present did and said). The aim is to establish any particular trigger factors that immediately led to the window being smashed. Consequences must look at who dealt with the situation, what they did, how quickly the situation was resolved and what the patients' mental and physical state was in the immediate aftermath and then a short time later and how effective the intervention appeared to be. From this an action plan is generated with the patient, establishing how best to support them should this situation arise again—it is also added to the risk management plan. The team then work with the patient to identify risks factors (both risks to them and risks they pose) and triggers to challenging behaviour based on the information gathered. Factors which predispose, precipitate, perpetuate and protect against these triggers and challenging behaviours are then examined, again from a BPPS perspective.

Finally, a risk management plan is implemented predominantly based on the public health model approach to violence prevention (Department of Health, 2012). The MDT, in conjunction with the patient will agree primary, secondary and tertiary risk management strategies.

Primary interventions are designed to be preventative, and are strategies that can be put into place on a day-to-day basis to help support the patient and prevent situations where incidents may occur. Secondary interventions are used when the team (or the patient) notices that the patient may be moving away from their baseline behaviour, and an incident may be about to occur. Such strategies are designed to offer the patient psychological

containment, by recognising and validating their distress, and suggesting strategies that may help to reduce that distress. These do not necessarily have to be complicated (e.g. a number of patients report that a cup of tea and a chat, or going to a quiet place to listen to some music are their most effective strategies for reducing anxiety or anger levels).

Tertiary strategies tend to be restrictive interventions (i.e. restraint and seclusion), and should only ever be used as a last resort, once all other avenues for a safe resolution are exhausted. This plan is agreed and signed by the team and the patient and serves as a contract. This model provides the team with a number of de-escalation strategies that can be used, and clear evidence should there be a need to move through the stages of the model from primary interventions to secondary strategies. However, it also provides the patient with a way to challenge the team if they feel that their needs have not been met as discussed in the plan. For example, if a tertiary intervention is used without any attempt at secondary intervention strategies, the patient is well within their rights to state that staff have not fulfilled their side of the contract and that the restrictive practices used may not have been justifiable.

Discussion

The pilot using this model of behavioural support plans was successful, both on the male PICU and with outreach patients of both sexes. On the male PICU, not only have incidents of restraint and seclusion been reduced (including time spent in seclusion), but incidents of serious challenging behaviour have also declined.

Behavioural support plans have proven popular with patients resulting in a more collaborative style of risk management, contributing to a reduction in restrictive interventions. As a simple introduction to the model a large copy of the public health model approach to preventing violence and aggression was put on the wall in a side room on the ward. Staff and patients study this model together, many patients commented that they were pleased that they were being asked for their input about how best to support them, and that interventions apart from PRN medication, restraint and seclusion were being considered.

Some of the comments raised had a powerful effect on staff members, and illustrated that although the staff strived to do their best on a daily basis, there were areas for improvement, and some of these were very simple to implement. Sample comments included;

'The staff are so miserable first thing in the morning, cheer up!'



'When I am yelling, I am not trying to be aggressive.'

'I have something inside which gets dangerous if I don't let it out. If I am not being a danger to anyone, please let me shout.'

'Please remember that whatever I might do to you, I am here because I need your help.'

As a result of the information gained from this exercise, the MDT produced a statement about how the ward plans to further reduce restrictive practices thus creating an ethos that will lead to better collaboration and better support for patients.

Conclusion

After a discussion with the MDT, it was decided that the behavioural support plans would form the basis of ward rounds to inform assessment and interventions. A pilot is now underway whereby the behavioural support plans have replaced traditional care plans on the PICU.

The behavioural support plans were presented at the trust-wide Nursing Leadership Forum and have been implemented on open wards for patients with complex needs. They have also been crucial

KEY POINTS

- This article discusses the development and implementation of behavioural support plans, piloted on a psychiatric intensive care unit (PICU)
- Behavioural support plans have been shown to reduce restrictive practices
- The article explores possible reasons for patients exhibiting challenging behaviour from an individual perspective utilising a bio-psycho-pharmaco-social approach
- Intensive care out-reach nurses (ICON's) have used behavioural support plans on acute wards to prevent admissions to PICU

in managing patients who were initially referred to a PICU from an open ward in preventing PICU admissions. In addition, all patients leave the PICU with a behavioural plan so that MDTs on open wards have a better understanding of their needs and a plan in place to manage difficult situations.

The behavioural support plans also proved to be a useful tool for teaching speciality doctors due to their foundation being based upon traditional psychiatric formulation process. This has also been beneficial in joint teaching sessions across the MDT and had enhanced a more collaborative approach to assessment, treatment and care. **BJMHN**

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Appendix 1. BPPS Summary

Mr DS is a 45 year old Algerian gentleman with a diagnosis of paranoid schizophrenia and autism, currently resident on a local services PICU. He was transferred from an open ward two weeks ago, when his challenging behaviour became unmanageable. These behaviours include damage to property and assaultive behaviours, and are exacerbated by auditory command hallucinations, feelings of unmanageable anxiety and a tendency to react to high expressed emotion. D has an index offence of GBH, committed against a member of the public who he got into an altercation with, punching him and breaking his nose. D also has physical health complaints. He is currently suffering from a UTI and has lost 3 kilos in the past two weeks. His oxygen saturation levels are also low. D has a good support network, his mum visits regularly and calls when she cannot visit. However, he has also assaulted his mum in the past. Due to his learning disability, D is vulnerable to negative social influence, and is known to the local Channel Panel as someone who is at risk of being radicalised. D's learning disabilities also make it difficult for him to communicate, and for others to communicate with him, but he finds it easier to engage through activities. D is currently maintained on fluphenazine fortnightly LAI, clonazepam, procyclidine, sertraline, levthyroxine, ranitidine and atorvastatin.

Further investigations: Thyroid function; specialist autism assessment

Risk factors (BPPS perspective): Exploitation by others; physical health issues; physical harm from others; physical harm to others; damage to property; currently in an environment not suited to his needs; diagnostic overshadowing

Known challenging behaviours: Verbal hostility; property damage; physical assault

Information gathering (please tick):

- ABC charts
- Bowel status
- Intake/output charts
- Menses charts
- Seizure charts
- Sleep charts
- Stool charts
- Stool charts
- Vital signs: Daily

Observation level/frequency/comments

Currently on 15mins enhanced observations

Trigger factors: Staff lack of understanding of effective de-escalation methods for people with autistic spectrum disorders; calls to or visits from family; influence by others; viewing aggressive behaviour by others; being alone which leads to anxiety and subsequently aggression.

Appendix 2. Management plan

Good therapeutic engagement with the staff member giving constant reassurance to D. Give D a good daily routine so that he understands what is happening next and there are no sudden changes.

Primary prevention strategies:

- o Follow management plan as above
- o D will appreciate 'warm up' conversations from staff therefore not bombarding him with instructions
- o Give instructions to D in the order that events will happen
- o Ask D to repeat what you have said a few moments later to see if D has understood you
- o D likes painting in bright colours, please allow time for this every day, after lunch
- o Encourage attendance at OT groups with his 1-1 present
- o Speak slowly and do not give too much information at one time
- o Use D's name frequently, it will help to keep him focused
- o Keep vocabulary simple
- o Avoid strings of commands or question
- o Use pictures, drawings and photographs by way of explanation
- o Touch and hugs are important to D in order to reassure him
- o Staff to gain and maintain a working knowledge of techniques used to engage with and de-escalate individuals with learning disabilities, particularly autism
- o Aim to use staff with whom D has a good relationship to calm him before an incident occurs
- o Try to talk without using any emotion, if you think he is anxious for example, attempt to communicate this with words
- o If you think D is lying, think about what the intention is behind the lie. For example, if he is saying that he is allowed leave, then he is still communicating his intention/desire, which is that he wants to leave
- o Concentrate on closings/endings with mum's visitations. At the end of the visit one staff member should take mum to the MDT room to debrief, while the other takes D to the OT room to do an activity. With the mum you can reflect on how things went during the visit and see how she is feeling. With D, attempt to avoid conversation about the visit, this time should be used to help him calm down and take his mind off of his mum.

Secondary prevention strategies

- o Offer D reassurance in a quiet place, preferably the garden
- o Supply paper and coloured pens
- o Change of observing staff may help, especially if the initial observing staff is not well known to him
- o Offer PRN
- o Allow D space to 'vent', providing his behaviour is not going to cause injury to himself or others
- o When agitated, staff to ask D to move where other patients are not present and cannot witness D's behaviour - Invite D to make use of quiet space, for example his bedroom or the soft furnishing area.
- o When D is calm, engage with him to understand his perspective on the incident and explain to him the consequences of his actions

Tertiary prevention strategies

- o Do everything possible to avoid restraint and seclusion. D does not like confined spaces and a closed seclusion room only makes him feel more anxious.