The Royal College of Speech and Language Therapists Northern Ireland (RCSLT NI) response -

The RCSLT NI are calling for recognition within the ***Consultation on commencement of provisions under the Mental Capacity Act (NI) 2016 relating to Acts of Restraint*** of the important link between communication needs, disability and difference and behaviours that challenge that can often lead to the use of restrictive practices and restraint.

We support the overarching vision outlined in the draft policy and commend the Department for their commitment in developing this hugely important piece of work.

Almost 30,000 people living in NI report have a long-term Speech, Language or Communication Need (SLCN) (2011 Census). These can be acquired (brain injury, stroke) or lifelong (autism, learning disability), transient or persistent.

There are 42,000 people in NI with a learning disability (Mencap Northern Ireland) and 89% of people with learning disabilities need speech and language therapy intervention (Bradshaw, J, 2007). Research indicates that people with disabilities including SLCN are at greater risk of physical restraint (Webber et al., 2017).

People with SLCN may struggle to express their emotions and distress, which can lead to their behaviour being misinterpreted as challenging. This can result in restraint and escalation in hands-on intervention (Department for communities expert advisory panel for a new disability strategy March 2021.)

Recognition of SLCN provides opportunities to offer proactive support to minimise the use of more active strategies to manage behaviours that challenge (such as restraint). Proactive support may include communication strategies for the individual and/or changes in the communication environment to avoid incidents of behaviours that challenge, and effective de-escalation strategies tailored to the communication needs of the individual. Where situations have escalated, SLTs can provide support through reviewing the incident as part of a team to consider triggers and the active management used from a communication perspective. SLTs can also support staff through training and joint working to ensure communication supports such as easy read materials are available to help individuals understand their experiences of restraint.

The RCSLT NI office has consulted with specialist members working in a range of settings with people with learning disabilities, dementia and/ or mental ill health who regularly come into situations where restrictive interventions and/ or

restraint may be required. Their specialist knowledge and opinions are reflected in the feedback below.

Do you agree with the Department's proposal to commence sections 9(4)(a) and 12 of the Mental Capacity Act (Northern Ireland) 2016?

Yes

Has the fact that sections 9(4)(a) and 12 have yet to be commenced directly impacted you, either personally or in your place of work?

Yes

At times people are admitted into inpatient settings due to a breakdown in their community placement, often due to behaviours seen as challenging and they are detained under the Mental Health Order (MHO, 1986). Staff do not believe this is the correct legislation for such a scenario, yet without the new Mental Capacity Act (MCA, 2016) fully implemented, there is limited choice. For example, a person who is deemed ready for discharge however there is no suitable community placement available to enable this. It may not feel appropriate to continue to detain the person under the MHO and increasingly Deprivation of Liberty (DoL) safeguards are utilised as the more appropriate legislative process, yet at other times there is no suitable legal framework available to protect the patient. The MCA, specifically when these sections are implemented, could be used to properly safeguard and protect the patient ensuring due process and governance at all levels have been adequately achieved for the person who is awaiting discharge from a facility.

Additionally, having environmental elements that are, at their core, restrictive in nature needs careful thought when planning implementation of 9(4) and 12. For example, some of the inpatient settings have a seclusion room, CCTV, high levels of staff supervision and regular use of chemical restraint and safety intervention holds.

What positive impacts do you foresee in the commencement of sections 9(4)(a) and 12?

The RCSLT believe that people who are currently inappropriately placed (e.g., either no community placement available or delayed discharge) have an opportunity to be better heard. These new provisions take more account of the person's wishes, preferences and beliefs. They provide more scrutiny and oversight, involving families in processes that are not currently part of the MHO.

Furthermore, they will hold staff accountable for individual actions that may at times, go unchecked given the frequency they are sometimes used. For example, recently a patient asked to eat his meal in front of the television when a staff member responded, 'No, wait until after the meal.' Despite reasons for this response, it is a restrictive intervention which the staff member may neither have intended to use nor realised the nature of their response.

What negative impacts do you foresee in the commencement of sections 9(4)(a) and 12?

It is difficult to foresee all challenges or negative impacts ahead of commencement of these sections, but we are keen to learn more about how the MHO and MCA will interact and work together in practice.

When DoLS were first implemented, there was a significant demand on resources for staff which included training and time to complete the necessary training and documentation associated with the legislation. It is important to add that paperwork, and administration should be kept to a minimum of what is essential so as not to unnecessarily burden staff.

Do you foresee any significant operational challenges caused by the commencement of sections 9(4)(a) and 12?

We would hypothesise that there will be significant resource implications for staff due to training and upskilling requirements.

We would welcome additional information and clarification around the operational process and plans for implementation. Where it states, "these things need to be in place in order for them to be enacted", it doesn't make clear what 'these things' are.

Furthermore, explicit information is required on what constitutes an emergency restraint and what processes are in place to protect the person and the staff if an act of restraint is felt appropriate in the moment.

Using the example of an Emergency Department (ED), we attempt to demonstrate some questions and concerns raised by members.

- Which staff members can make the decision to restrain? Staff in ED may not have specific experience or training in working with a person with learning difficulties, autism or dementia, for example. Therefore, how can

we ensure staff are able to respond effectively to potential communication needs and to deescalate the situation and avoid restraint where possible?
- Are junior members of staff able to make this decision, or will it fall to more experienced members of staff?

The RCSLT NI would welcome clarity around the processes and levels of governance and scrutiny for both patients and staff members regarding emergency restraint.

Is the guidance within the Code of Practice clear at defining 'restraint'?

No

- Unfortunately, terminology within this Code of Practice is not consistent with the Department of Health's Regional Policy on Restrictive Practices (2023) despite the Code of Practice telling readers to refer to it. For practice to be safe, effective and consistent, terminology across all policy documents must be reliable. For example, the term 'medical restraint' is used in the Code of Practice versus 'chemical restraint' which is used in the DoH 2023 document, and additionally 'psychological restraint' a term used in the 2023 document isn't referred to here other than as part of 'restrictive choice' or 'withholding information'.
- Secondly, the Code of Practice lists 5 forms of restraint whereas the registered charity Restraint Reduction Network lists 8 forms. We know that many of our HSC services refer to the advice set out by this registered charity and our members feel that the 8 forms listed are significant and should be recognised within this Code of Practice.
- The Restraint Reduction Network also provide guidance on language around restrictions and restraint ensuring it is person-centred and reflects safe care. Section 2.5 in the Code of Practice says, "**threat** to use force" – this is not person-centred nor is it in line with the values of the HSC trusts and the Department of Health. There are more effective, positive, person-centred ways to explain how we can make someone aware of what may happen to them rather than the word 'threat'.
- Point 2.6 asks us to refer to other guidance from the Department of Health but does not signpost to or mention specific documents and / or networks to link with. Specific links would be useful.
- Section 9(4) mentions 'conditions for any acts of restraints' – explanation of these acts would be beneficial.

- There is a clear lack of any reference to communication in this section of the Code of Practice. We would advise that clear guidance is included to make it clear that people/ patients and families should be involved as much as possible in the decision-making process, care planning and post incident reflections. This will help all parties understand and prepare where necessary.
- The RCSLT NI would like to emphasise the importance of accessible and inclusive communication. Staff should be upskilled to recognise and support those with speech, language and communication needs to ensure they understand what is happening to them and around them. Training staff around communication, understanding the person's communication 'behaviours' so they are not misinterpreted as threatening. By understanding someone's communication, a quick response can often avoid escalation.
- The RCSLT would encourage all HSC staff to take part in the RCSLT's free, online communication access training (CAUK) to ensure all staff are trained in how to make their communication clear and easier for everyone to understand, regardless of their abilities.
- Additionally, adoption and recognition of the Five Good Communication Standards will help staff to better meet the speech, language and communication needs of individuals https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/good-comm-standards.pdf

Is the guidance within the Code of Practice clear at explaining the restraint conditions that must be met to be protected from liability?

No

- Our members feel more clarity is required about what meets the threshold of restraint. An example that our members raised is when staff engage in a restrictive practice to stop harm to another person, this may be to protect another patient or a staff member, for example the use of segregation. This is not necessarily in P's best interests, as the Code of Practice mentions. Although there is mention of referencing the DoL Code of Practice, the RCSLT NI would advise expansion of point 2.9 to ensure consistency across both Codes of Practice.
- Increased transparency is required around what happens when a restraint, for example using safety intervention holds to achieve essential

personal care, is used regularly. Will it be written into a person's care plan and therefore not require the incidents to be written up? If something is written as part of a care plan, how then can we ensure that it is regularly reviewed and that there is no risk of the intervention becoming overused as habitual practice? There is a risk that a restraint could be used as a blanket approach and that must be avoided.

- We would welcome explicit details around and reference to a daily intervention versus a crisis or emergency intervention. We know, for example that someone with a 1:1 likely has staff with them that are aware of their care needs and potential risks around behaviour and possible need for the use of intervention. This can be well planned, discussed with the person, family, multi-disciplinary team and documented. Yet it is important to recognise the stark difference between this and an emergency or crisis scenario where a staff member may have limited or no knowledge of the person and must act in the moment to protect the patient, another person or themselves. Staff would welcome more information around liability and protection for this.

Do you feel the draft Code of Practice is clear on 'Acts of Restraint'?

No

- The terminology throughout does not align with the terminology that is used within inpatient settings in Northern Ireland and amongst staff that are using these practices on a regular basis, nor is it consistent with the Department of Health's Regional Policy on Restrictive Practices (2023).
- Unfortunately, there is a clear lack of reference to prevention or de-escalation within this Code of Practice. The RCSLT would recommend the addition of information around how staff should proactively deescalate, including the importance of clear documentation of care plans. It is important to emphasise that there will be other steps to follow and try before restraint is deemed necessary. In this way, the least restrictive practice should be used at any time.
- We would welcome reference to post incident de-briefing for staff, the person and other patients that may have witnessed the incident. Restraints can be traumatic for everyone involved and this is an important step to ensure that all parties are aware of what happened, with time to reflect on how it could be prevented or de-escalated in future. It is important to note here that communication of incidents should be had in a clear and accessible way, suitable for the person's individual needs.

- More information around safeguards for the person and liability for staff when restraints are used as an active part of patient care without being planned. For example, giving a patient PRN medication in response to early warning signs of a person changing from their baseline and becoming physically aggressive.
- The RCSLT NI agree that the guidance is clear on the mandatory recording and reporting. We would however, welcome the addition of a mandatory de-brief for all parties involved including the person and their family. This will allow for any amendments/additions to be made for care/support plans and /or onward referrals to appropriate services as required, for example, speech and language therapy. We also feel that it is appropriate that in the final document that there is reference to listening to the person's voice. We would suggest that within any de-brief the person is included and appropriate communication tools are used to illicit their views. This would allow for recommendations/procedures to be put in place to hopefully prevent the reoccurrence of any future restraint. We would also note that it is possible that some families of those with speech, language and communication needs, may have speech, language and communication needs, disabilities or differences themselves, and this should be considered. We would strongly suggest that this is reflected in the final guidance so all involved can receive effective, accessible communication. Therefore, written and verbal advice must be user-friendly and easy-read versions are recommended.

Do you feel the draft Code of Practice is clear at differentiating between restraint, seclusion and deprivation of liberty?

No

- The cross over between DoL and restraint is not clearly articulated. Additionally, it doesn't align with the regional policy where the definitions vary. We would welcome more information and clarification around when a DoL becomes a restraint.

Do you have any other comments on the proposed Code of Practice?

- Section 9, (1) e – What is the implication for staff if a judgement call is made during an emergency restraint that a person lacks capacity, and it

later turns out this was not the case? It would be beneficial to include some information on this, with reference to the reality of fluctuating capacity.

- There is a lack of information around consent and capacity. It would be important to highlight the need to thoroughly and appropriately communicate options and decisions with the person regardless of their capacity. There is a need for accessible information, easy read documentation, however it is critical for staff to realise that in the moment, they can make small changes to their own communication to allow the person to better understand. The RCSLT would encourage all HSC staff to take part in the RCSLT's free, online communication access training (CAUK) to ensure all staff are trained in how to make their communication clear and easier for everyone to understand, regardless of their abilities.
  Additionally, adoption and recognition of the Five Good Communication Standards will help staff to better meet the speech, language and communication needs of individuals. https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/good-comm-standards.pdf
- The Use of Force Act recommends co-production and the RCSLT NI would welcome information on co-production and if this has been an integral part of the Code of Practice to date. What stakeholders were involved?

The Code of Practice is generally nonspecific in terms of detailed examples of restraint and our members have raised concerns and questions around **Eating, Drinking and Swallowing (EDS)** and **communication.**

- Around 15% of those with a learning disability and over 50% of people in care homes will require support with **EDS.** Speech and Language Therapists (SLTs) are the main professionals in supporting safe EDS and often make best interests' recommendations around safe practice. Advice may include using specialised equipment, for example a restrictive flow cup or a teaspoon – both aimed at reducing the amount of food and fluids taken at one point. Another regular example is the use of a gentle hand on the person's head to promote better head position for safer EDS. We would welcome clarification around these recommendations where the person lacks capacity to agree to use them, are they a form of mechanical restraint?

- Additionally, EDS recommendations may include avoiding certain food or fluid types that the person may be physically able to reach for. Staff often must remove these from the person to avoid a choking incident for example and to keep them safe. There have been times when a person has gone into the bathroom to drink water from a tap instead of the thickened fluids offered. If, to manage this risk, staff implement more levels of supervision, is this a form of restraint itself?
- **Communication** – many of the people at higher risk of needing restrictive intervention or restraint are more likely to require support with their speech, language or communication. Some of these people may have identified Augmentative and Alternative Communication Aids. Core Vocabulary boards are an example of these: Super-Core-30-low-tech-EN-Widgit-B-DIGITAL.pdf. If these have been recommended by a Speech and Language Therapist, they should be consistently available for the individual to use if they choose to. Proactive encouragement of the use of such aids could prevent escalation, support communication in the moment of restraint or support tension reduction interactions when staff have disengaged from restraining an individual.
- People may be using a schedule or transition card. For example, a person indicating they need the toilet by going there but staff taking them back to get the transition card that states it isn't time for that on their schedule. This is depriving the person of a basic human need and staff need support to rethink outdated practice with communication / schedule cards. It highlights our member's concern around regular practice that staff are not viewing as restrictive. Visual support strategies should be used to aid communication as part of a total communication approach. Visual strategies should be used to inform the person of what is going to happen or to suggest options of what is available, they should never be used to force compliance.
- The Code of Practice references those over 16years old and thereby includes young people. There are approximately 355,000 children and young people in the UK who have a learning disability of which approximately 40,000 will display behaviour
  that challenges and other neurodevelopmental, physical and mental health comorbidities. (Absould et al., 2019). These young people, who display behaviours that challenge, could be experiencing significant physical pain or alternatively, given that these children are at a substantially higher risk for all forms of abuse, neglect and social disadvantage (Absould et al., 2019) behaviours may be due to

safeguarding concerns. We would strongly suggest that this is referenced as a possibility for any new or unexpected behaviour as a cause.

Thank you for the opportunity to provide feedback on this important consultation. The RCSLT NI would welcome the addition of our *five good communication standards* to underpin this guidance. These standards reflect person-centred care, inclusion, accessibility and wellbeing and would increase the value of any service or document.

The five good communication standards:
Standard 1: There is a detailed description of how best to communicate with
individuals.
Standard 2: Services demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services.
Standard 3: Staff value and use competently the best approaches to communication with each individual they support.
Standard 4: Services create opportunities, relationships and environments that make individuals want to communicate.
Standard 5: Individuals are supported to understand and express their needs in
relation to their health and wellbeing.

Please do not hesitate to contact us if more information is required. We would be happy to help form any part of any further co-production/ consultations.

Thank you

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