Restrictive practice legal, ethical issues and de-escalation techniques

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De-Escalation

- **RT is a “last resort” intervention**

- ‘de-escalation’:
  - an explicitly collaborative process involving a range of verbal and non-verbal interventions that aim to reduce agitation and distress, with the purpose of averting aggression or violence.
- The goal of RT is
  - to achieve a state of calmness without sedation, sleep or unconsciousness

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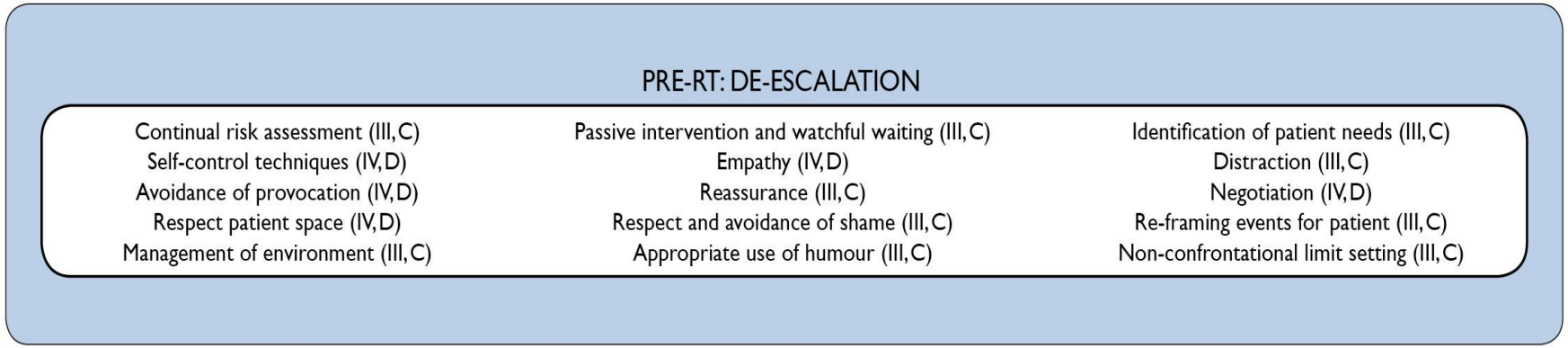
De-Escalation



- The following de-escalation components *are* effective:
  - continual risk assessment
  - management of environment,
  - passive intervention
  - watchful waiting
  - reassurance,
  - respect and avoidance of shame
  - appropriate use of humour,

De-Escalation

- The following de-escalation components *may be* effective:
  - self-control techniques
  - avoidance of provocation
  - respect patient space,
  - empathy, negotiation (IV; D).

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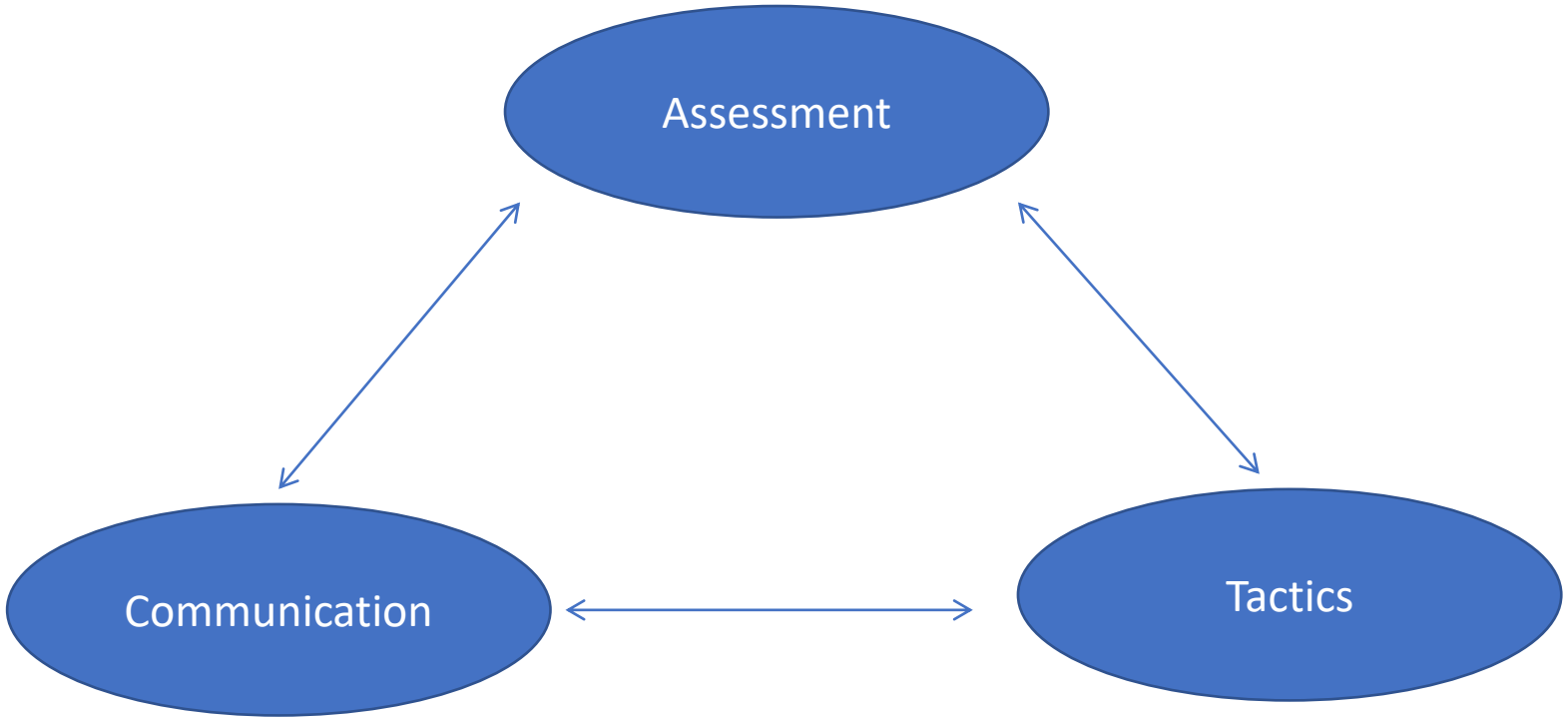
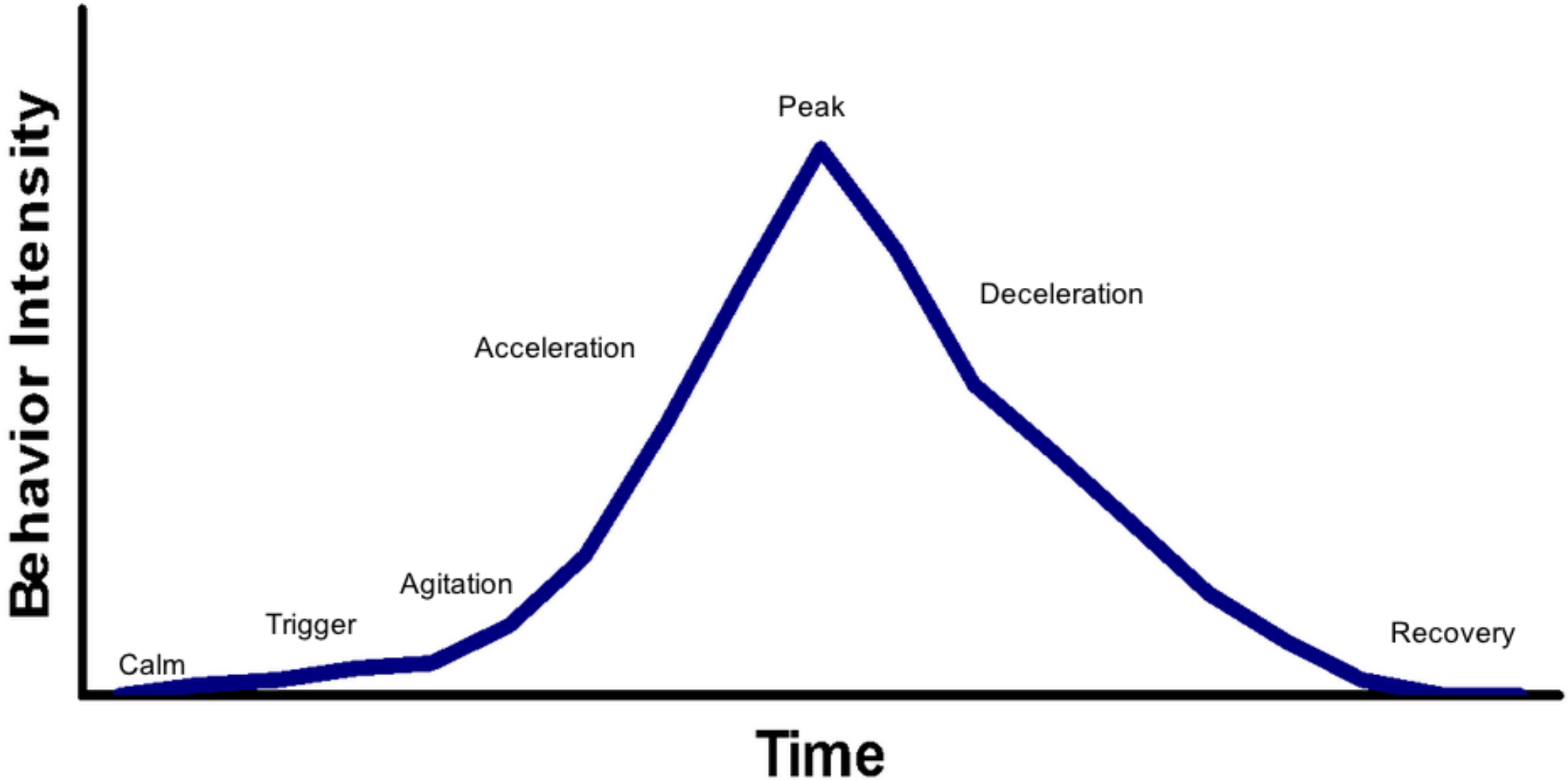
One example model:

The ACT Model (Dix & Page 2008)




Behavior Intensity
Peak
Deceleration
Acceleration
Agitation
Trigger
Calm
Recovery
Time

De-Escalation

„These skills are so important because:

> “However stressful the situation becomes, clinicians should be easily identifiable, well trained, presenting positively and confidently in their actions as lack of confidence will exacerbate the anxiety of the patient”
>
> (Patient’s Perspective)

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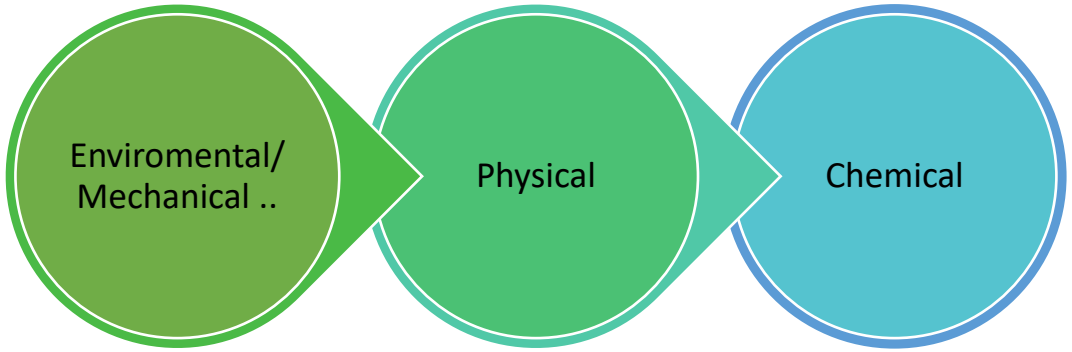
Rapid Tranquillisation- a Restrictive Practice

Culturally different attitudes to restraint/ seclusion/ mechanical restraints

“Chemical restraint”



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According to the Mental Health Act Code of Practice (2015):

"restrictive interventions are deliberate acts on the part of other person/s that restrict a patient's movement, liberty and /or freedom to act independently in order to take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no significant action is undertaken and to end or reduce significantly the danger to the patient or others".

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Rapid Tranquillisation as a restrictive practice

- Rapid tranquillisation (RT) is often considered a form of chemical restraint, which may be used in an emergency situation when prescribed
- If RT is given it should be done so as the least restrictive option, with intramuscular and intravenous administration as a last resort
- All providers are required to report all incidents of RT and data is collected alongside other restrictive interventions
- The CQC monitor RT reporting alongside the quality of staff training, local polices and post-incident reviews.

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Legal framework

- MHA 1983
- MCA 2005
- Common Law

MHA 1983

- The powers to treat patients detained under the Mental Health Act (MHA) 1983 are set out in Part 4 and 4A of the MHA 1983
- Treatment for mental disorder may be given with or without the detained patient's consent; therefore, compulsory treatment may be a severe infringement of a patient's rights without strict adherence to the legislation.
- Although the Mental Health Act permits some medical treatment for mental disorder to be given without consent, the patient's consent should still be sought before treatment is given, wherever practicable.
- Neither the existence of mental disorder nor the fact of detention under the Mental Health Act should give rise to an assumption of incapacity. The person's capacity must be assessed in relation to the particular decision they are being asked to make.

- Sections 63 of the Act provides the authority to give appropriate treatment to detained patients with or without their consent in the first 3 calendar months starting with the first time they are given such treatment.

MHA 1983

- After medication has been given for the first three months under Section 63, Section 58 then comes into force. The purpose of this section is to provide further safeguards and protection for patients who require further treatment.
- If the patient lacks capacity or does not give consent after the initial 3-month period, a SOAD must be requested from the CQC.
- Section 62 authorises the administration of urgent treatment in emergency circumstances where other parts of the Act cannot be used.

Urgent treatment is:

Treatment, which is necessary to save a person's life and,
Treatment which (not being irreversible) is immediately necessary to prevent a serious deterioration of a patient's condition or,
Treatment which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering to the patient or,
Treatment which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to themselves or others

RT……

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Mental Capacity Act 2005

- **The Mental Capacity Act 2005(MCA 2005) outlines five principles**

The five principles are:

- *assume a person has the capacity to make a decision themselves, unless it's proved otherwise*
- *wherever possible, help people to make their own decisions*
- *do not treat a person as lacking the capacity to make a decision just because they make an unwise decision*
- *if you make a decision for someone who does not have capacity, it must be in their best interests*

treatment

- *and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms.*

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Mental Capacity Act 2005

- Capacity is decision specific. This is particularly relevant when working within mental health services and supporting patients make decisions in relation to their physical health.
- An important distinction needs to be made between capacity and consent
- In mental health, we make decisions based on *both* capacity and consent.

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Further legal frameworks

- Prior to the Mental Capacity Act (MCA) the duty of “necessity” provided a general power to take such steps that were reasonably necessary and proportionate to protect others from the immediate risk of significant harm.

- The common law doctrine of necessity, enabling treatment without capable consent and restraint, has now been codified by ss 5 and 6 of the MCA thereby drastically limiting the limiting the scope of the common law in this regard.

- There are statutory (Criminal Law Act 1967) and common law powers outside of the MCA or the MHA that can be used to restraint or detain people

- These include the power to detain in a situation of necessity a person of unsound mind who is a danger to himself or others

- Lord Griffiths stated in Black v. Forsey3 that the power is "*confined to imposing temporary restraint on a lunatic who has run amok and is a manifest danger either to himself or to others a state of affairs as obvious to a layman as to a doctor."*

In Summary …….

- RT is a last resort intervention.
- All opportunities to de-escalate situations prior to RT should be attempted
- RT is a restrictive intervention
- It should be reported, monitored and viewed with other restrictive practices such as seclusion and restraint.
- The MHA provides the appropriate safeguards for the use of RT.

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