



HM Government

Reducing the Need for Restraint and Restrictive Intervention

Children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings

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Contents

Foreword.....	5
1. Introduction	7
Definitions.....	9
Status of this Guidance	10
The Legal Framework.....	12
Relationship to Other Advice and Guidance.....	12
Inspections	12
Role of Commissioners	13
2. A Positive and Proactive Approach to Behaviour	14
3. Values and Principles.....	17
Core Values.....	17
Key Principles.....	18
4. Key Actions for Settings and Services.....	20
A Clear Strategy	21
Governance and Accountability	22
Involving Children and Young People, Parents and Carers.....	23
Evidence-Based Approaches	24
Behaviour Strategies	24
Positive Behavioural Support	25
Training and Development of Staff	28
Assessing and Managing Risks.....	30
Planned and Unplanned Interventions.....	33
Settings and Services where Children and Young People May Not Be Known.....	34
Escalation	35
Safeguarding the Welfare of Staff.....	36
Recording and Reporting.....	36
Post-incident Support	37
Reviewing Actions to Improve Support.....	37
De-briefing and Post-incident Review.....	38
Monitoring.....	39
Transitions.....	39
5. Different Forms of Restraint	40

Physical Restraint.....	41
Mechanical Restraint.....	41
Medication (Chemical Restraint).....	42
Withdrawal (Imposed and Autonomous) and seclusion.....	43
Long-term Segregation under the Mental Health Act 1983 in Hospital Settings	45
Summary	46
6. Annex A. Legal Duties and Relevant Guidance	48
Human Rights Act 1998.....	48
Equality Act 2010.....	49
Deprivation of Liberty.....	50
Health Services	50
Mental Health Units (Use of Force) Act 2018	51
Health and Social Care.....	52
Schools.....	52
Use of Medicines.....	53
Children’s Homes	54
Residential Holiday Schemes for Disabled Children.....	55
Relevant Guidance	55
7. Annex B. Positive and Proactive Approaches to Supporting Children and Young People Whose Behaviour Challenges	57
Case Study 1. A whole school approach to reducing restraint and risk - from the Principal of a Special School.....	57
Case Study 2. Open-Door: patient involvement to reduce admissions due to crisis.....	58
Case Study 3. In-depth needs analysis and staff training support a child in school and hospital	59
Case Study 4. A local authority meeting needs through positive behavioural support....	61
Case Study 5. Multi-disciplinary team around the child to plan routine medical visits	62
Case Study 6. Positive behavioural support helps a child to communicate their needs .	62
Case Study 7. Preparing an accessible environment and practice for a medical examination	63
Case Study 8. A multi-disciplinary therapeutic team prepare a child for complex medical tests.....	64
Case Study 9. Adapting the classroom and lessons to help a child with acquired brain injury remain in school.....	65
Case Study 10. Short breaks provider working with parents for greater stability of support	66
Case Study 11. Art-Psychotherapy and multi-disciplinary team involvement help a child in care with Attachment disorder	67

Case Study 12. Community facing therapeutic school: improving transition from school to work.....68

Foreword

Every child and young person has a right to be treated with respect and dignity, and deserves to have their needs recognised and be given the right support. Some children and young people with learning disabilities, autistic spectrum conditions or mental health difficulties may react to distressing or confusing situations by displaying behaviours which may be harmful to themselves and others and are at heightened risk of restrictive intervention to minimise the impact of their behaviour, on them and on other people.

Children and young people, their families and carers have said that restraint and restrictive intervention are traumatising. These children and young people also recognise that there may be times when these approaches may need to be used for their protection and to keep them, and others, safe. We know that use of restraint and restrictive intervention can have long-term consequences on the health and wellbeing of children and young people, and that it can have a negative impact on staff who carry out such intervention. Using positive behaviour support and other alternatives which can de-escalate challenging behaviour, and tackle the reasons for it at source, should be the preferred approach.

There will, however, be times when the only realistic response to a situation will be restraint or restrictive intervention. In a school, if a young child is about to run into a busy road, for example, or a pupil is attacking a member of staff or another pupil and refuses to stop when asked, then reasonable force to stop this may be necessary. And the same would be true in, say, a hospital if a child were attacking staff. But wherever possible, it should be avoided; and proactive, preventative, non-restrictive approaches adopted in respect of the behaviour that challenges.

Restrictive intervention should only be used when absolutely necessary, in accordance with the law and clear ethical values and principles which respect the rights and dignity of children and young people, and in proportion to the risks involved. It can never be a long-term solution, and we are particularly concerned about long-term or institutionalised uses of restrictive interventions.

This advice is designed to support relevant education, health and care settings and services in putting in place measures which will help them:

- understand the needs of children and young people, including the underlying causes of and triggers for their behaviour;
- develop strategies and plans to meet those needs and regularly review them as children change
- adapt the environments in which children and young people are taught and cared for so as better to meet their needs; and

Reducing the Need for Restraint and Restrictive Intervention

- provide appropriate support for children and young people whose behaviour challenges, without the use of restraint or restrictive intervention.

It sets out relevant law and guidance and provides a framework of core values and key principles to support:

- a proactive approach to supporting children and young people whose behaviour challenges; and
- a reduction in the need to use restraint and restrictive intervention.

At any particular time, the key question for everyone involved with children and young people whose behaviour challenges should be:

“What is in the best interests of the child and/or those around them in view of the risks presented?”

This guidance sits alongside a range of other work to help ensure that children and young people with the relevant conditions receive the support they need. Supporting the appropriate use of restraint and restrictive intervention is one element of a much wider range of measures to safeguard the human rights of, and to provide effective support for, these vulnerable individuals in relation to their education, health and care.

We hope this advice helps settings and services to reflect on and develop their practice, have confidence to provide better support for children and young people whose behaviour challenges, and provide safe environments in which they can thrive.



Caroline Dinenage
Minister of State for Health and Social Care



Nadhim Zahawi, Parliamentary Under-Secretary of State for Children and Families

1. Introduction

About this Guidance

- 1.1 This guidance is non-statutory.
- 1.2 Where the text uses the word 'must' in this guidance, it refers to a legal requirement under primary legislation, regulations or case law. Where the text uses the word 'should' it refers to a recommendation, advice or good practice.

Aims of this Guidance

- 1.3 This guidance aims to help settings and services take action to understand:
- the underlying causes of children and young people's behaviour that challenges;
 - the times and situations when behaviour that challenges is more likely to occur; and
 - the steps settings and services can take to support children and young people, including through the development of behaviour support plans

so as to reduce the incidence and risk associated with that behaviour, promote and safeguard the welfare of children and young people in their care and improve their quality of life. Eliminating unnecessary and inappropriate use of restraint is vital in achieving this. It is particularly important in relation to children, who are still developing both physically and emotionally, and for whom any potentially traumatic experience at this formative stage in their development could be very damaging and have long-term consequences.

- 1.4 Use of restraint carries risks and can be damaging to children and young people. It may, however, be the only realistic response in some situations (for example, to prevent a child running into a busy road or to prevent a violent act against another person). But wherever possible, it should be avoided; and proactive, preventative, non-restrictive approaches adopted in respect of behaviour that challenges. The personal costs to children and young people's development and welfare and to staff from the use of restraint are well documented.¹ These include damage to children's physical, psychological, social and emotional wellbeing and to their neuro-cognitive, behavioural and emotional development. Restraint can be traumatising for children and repeated use of restraint can have damaging, re-traumatising effects. Research² has shown that restraint and seclusion increase

the daily cost of care and contribute to significant workforce turnover. Conversely, it also shows how hospitals and residential programmes have achieved significant savings by redirecting existing resources to support additional staff training, implementing prevention-oriented alternatives, and enhancing the environment of care.

- 1.5 Children and young people with learning disabilities,³ autistic spectrum conditions⁴ and mental health difficulties⁵ may often respond with behaviour that challenges (verbal or non-verbal) when they are in pain, or experiencing sensory overload, or when confronted with situations they do not understand or environments in which they cannot easily cope, which cause anxiety or fear, and for which they are unprepared. Such behaviour may be perceived as 'naughty' or 'bad' if the child or young person is unable to follow instructions or fit in with existing rules and structures and it can be a form of communication for children and young people who are unable to communicate verbally. The likelihood of such behaviour can often be anticipated by those who know the child or young person well. Measures to understand the range of communication used by children and young people to express emotions, including distressed behaviour, should be put in place. Measures to identify triggers of distressed behaviour and to prevent or address it should also be developed with the involvement of the child or young person and their family, and careful assessment, with multi-agency planning and support to create the right environment for education, care and support.
- 1.6 Like the physical use of force, the threat of using force can also impact on the emotional development and well-being of a child or young person. It should only be made where it will be understood by the child or young person; and where there is a real possibility of injury or harm to the child, young person or others (or in other scenarios where restraint can be used that are prescribed in legislation applying to particular settings).
- 1.7 This guidance is not intended to address actions which are intended as a disciplinary penalty. Such practice is outside the scope of this guidance.⁶ This guidance is designed to help settings and services adopt a preventative approach to supporting children and young people whose behaviour challenges. It highlights action to improve assessment and understanding of the range of communication used by children and young people including the reasons for and nature of distressed behaviour, including behaviour that challenges, planning of support, and assessment and management of risks. It promotes the use of evidence-based practice to create an environment in which the likelihood of the need for restraint is reduced. Where restraint and restrictive interventions are used they should be used appropriately, only where necessary and for the minimum time required, by trained staff and in line with the Human Rights Act 1998, relevant international obligations such as the UN Convention on the Rights of the Child and the UN

Convention on the Rights of People with Disabilities, core values and key ethical principles.

Definitions

- 1.8 The terms restrictive intervention and restraint are used interchangeably in this guidance to refer to:
- planned or reactive acts that restrict an individual's movement, liberty and/or freedom to act independently; and
 - the sub-categories of restrictive intervention using force or restricting liberty of movement (or threatening to do so).
- 1.9 Law and guidance set out the permitted purposes for which restraint and restrictive intervention can be applied in different settings and services, such as preventing injury, protecting property and reducing danger (see Annex A for details). Health, education, and care professionals will often have a common law duty of care towards children and young people who are under their care or supervision. If someone has such a duty, it means they must take reasonable care to prevent foreseeable harm coming to the child or young person.
- 1.10 In this guidance restrictive interventions and restraint can include, depending on the circumstances:
- Physical restraint: a restrictive intervention involving direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.
 - Restricting a child or young person's independent actions, including removing auxiliary aids such as a walking stick or coercion, including threats involving use of restraint to curtail a child or young person's independent actions.
 - Chemical restraint: the use of medication which is prescribed and administered (whether orally or by injection) by health professionals for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.
 - Mechanical restraint: the enforced use of mechanical aids such as belts, cuffs and restraints forcibly to control a child or young person's individual's movement.
 - Withdrawal: removing a child or young person involuntarily from a situation which causes anxiety or distress to themselves and/or others and taking them to a safer

place where they have a better chance of composing themselves. We also refer to this concept below as Imposed Withdrawal.

- Seclusion: supervised confinement and isolation of a child or young person, away from others, in an area from which they are prevented from leaving, where it is of immediate necessity for the purpose of the containment of severely disturbed behaviour which poses a risk of harm to others. (Schools can use seclusion or isolation rooms appropriately as a disciplinary penalty without this constituting a form of restraint or restrictive intervention. Separate guidance is provided on this issue for schools).⁷
- Segregation: where a child or young person in a health setting is not allowed to mix freely with others on a long-term basis.

1.11 Further information and advice on these types of restraint and restrictive intervention is provided in Chapter 5.

1.12 The term 'parent' used throughout this guidance refers to all those with parental responsibility, including parents and those who care for the child. Where there is a Care Order in force, the local authority has the power to restrict the exercise by the child's parents of their parental responsibility, if the welfare of the child so requires.⁸

Status of this Guidance

1.13 This guidance is non-statutory and advisory. The guidance applies to the following settings and services:

- local authorities;
- Clinical Commissioning Groups;
- maintained and non-maintained special schools, special academies and special free schools;
- independent educational institutions which have applied to the Secretary of State for Education for approval under section 41 of the Children and Families Act 2014;
- special post-16 institutions;
- children's homes (including secure children's homes);
- residential holiday schemes for disabled children;

Reducing the Need for Restraint and Restrictive Intervention

- local authority and independent fostering service providers; and
- NHS-commissioned health services.

1.14 This advice is intended for those responsible for providing education, health and social care to children and young people under 18 years of age with learning disabilities, autistic spectrum conditions and mental health difficulties in these settings. Children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties are at greater risk of displaying behaviours that challenge and are therefore at heightened risk of experiencing restraint and restrictive intervention.

1.15 It is intended for the following, where they have responsibilities for the care of children and young people under 18 with learning disabilities, autistic spectrum conditions or mental health difficulties who may present behaviour that challenges:

- those involved in local authorities; clinical commissioning groups; maintained and non-maintained special schools, special academies and special free schools; special post-16 institutions; independent educational institutions which have applied to the Secretary of State for Education for approval under section 41 of the Children and Families Act 2014;⁹ children's homes; residential holiday schemes for disabled children; local authority and independent fostering service providers; and all settings providing health care commissioned by the National Health Service.

1.16 It will also be of interest to but is not intended for:

- mainstream schools (including Academies and Free Schools), particularly those with Special Education Units and Special Educational Needs resourced provision;
- general further education colleges;
- independent mainstream schools and colleges;
- providers of alternative provision (AP) including Pupil Referral Units (PRUs), AP Academies and AP Free Schools;
- Early Years providers (maintained or independent that are not part of special schools); and
- the police and staff working within Young Offenders Institutions and Secure Training Centres, for whom other guidance applies.

The Legal Framework

1.17 The use of all forms of physical intervention and physical contact, or even imminent threat of force, are governed by criminal and civil law. The unnecessary or inappropriate use of force may constitute an assault and may also infringe the rights of a child or young person under the Human Rights Act 1998. The use of restraint can be justified for purposes set out in relevant legislation. Different settings and services will need to abide by any legislation which applies to them. Annex A sets out the legal framework for different settings and services in more detail and lists relevant guidance. It is important for settings and services to be familiar with the legislation and any associated guidance on the use of restraint that applies to them, not least as in some cases the requirements and expectations will go beyond what is in this guidance.

Relationship to Other Advice and Guidance

1.18 The guidance reflects, as appropriate:

- The principles set out in the guidance Positive and Proactive Care: reducing the need for restrictive interventions (Department of Health, 2015) produced for services supporting adults; and
- The advice in the Association of Directors of Children's Services: Protocol for Local Children's Services Authorities on Restrictive Physical Interventions in Schools, Residential and Other Care Settings for Children and Young People (ADCS, 2009).

1.19 It does not replace other current and relevant guidance that applies to the relevant service or setting and should be read alongside the documents referred to in Annex A.

Inspections

1.20 The Care Quality Commission (CQC) and Ofsted will have regard to this guidance when assessing whether relevant institutions and service providers are providing safe and appropriate education and care. Where restraint practice fails to meet the expectations or requirements of relevant regulations, statutory guidance or standards CQC or Ofsted will take action as appropriate. This may, where appropriate, include enforcement action.¹⁰

1.21 In November 2018 the CQC was commissioned by the Secretary of State for Health to review the use of restraint, prolonged seclusion and segregation for

people with mental health problems, a learning disability and/or autistic spectrum conditions. The review will consider whether and how seclusion and segregation are used in registered social care services for these people. This will include residential services for young people with very complex needs – such as a severe learning disability and physical health needs - and secure children’s homes. This aspect of the review will be undertaken in partnership with Ofsted, which has published the review's [terms of reference](#).

- 1.22 The [interim report of the review](#) was published in May 2019, and the Government committed to implement its recommendations in full. The NHS Long Term plan commits NHS England to work with the CQC to implement its recommendations.¹¹

Role of Commissioners

- 1.23 NHS and local authority commissioners will need to assure themselves that the providers of the services they commission have the necessary knowledge, skills and competencies to support effectively those whose behaviour challenges and have arrangements in place to promote positive behaviour, reduce risk, and eliminate unnecessary or inappropriate use of restraint. This includes assuring themselves that providers of care and/or education services meet the needs of the children and young people concerned; providers are regularly and rigorously reviewed; and that failure to comply with contractual obligations leads to prompt action to safeguard and promote the welfare of children. Settings and those who commission services should ensure that the services they commission are consistent with the advice in this guidance.

2. A Positive and Proactive Approach to Behaviour

- 2.1 Behaviour is a means of communication and has a cause and a purpose. Behaviour that challenges may signal a need for support and it is essential to understand its underlying causes. It may, for example, be the result of a medical condition or sensory impairment, previous trauma or neglect, or be exacerbated by an unmet need or undiagnosed medical condition. It may reflect the challenges of communication, or the frustrations faced by children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties, who may also have little choice and control over their lives. These factors may result in behaviours that are challenging. Behaviours that challenge may reflect the impact on a child or young person of being exposed to challenging environments which they do not understand or where positive social interactions are lacking or personal choices are limited. These children and young people need support to have their needs met in different ways and to develop alternative ways of expressing themselves that achieve the same purpose but are more appropriate. Behaviour support plans, drawn up with the involvement of the children, parents and young people, help to understand better a child or young person's experiences and behaviour and the steps that should be taken to meet their needs.
- 2.2 Eliminating unnecessary and inappropriate use of restraint and minimising the need for its use calls for settings and services to have a good understanding of the children and young people in their care, a strong commitment to meeting their needs and a systematic, positive and proactive approach to behaviour with:
- policies, strategies and practices which promote a positive culture and improve the quality of children and young people's lives;
 - arrangements which identify, assess and manage risk well;
 - high quality training for staff;
 - involvement of children and young people, parents and carers, and advocates as appropriate;
 - arrangements for carefully assessing the needs of children and young people and the underlying causes of their behaviour, including through developing behaviour support plans;

Reducing the Need for Restraint and Restrictive Intervention

- tailored support for individual children and young people that takes account of their particular wishes, vulnerabilities, learning disability, medical condition or impairments, and their interaction with the environment in which they are taught and cared for and responds to their growth and development over time; and
- clear arrangements for governance and accountability in respect of behaviour and responses to behaviour that challenges.

2.3 Settings and services should have a 'hierarchy of responses' to support those whose behaviour challenges. This is likely to include:

- creating a supportive environment in which children and young people are taught, treated and cared for, which seeks to address factors that are likely to increase or decrease the likelihood of restraint (illustrated particularly by case studies 1, 2, 9 and 12 in Annex B);
- deployment of approaches and techniques to maintain positive environments and de-escalate or calm situations that are appropriate to the child or young person and take account of their rights and views (illustrated particularly in case studies 3, 5, 7, 8, 11 and 12); and
- development of staff skills and expertise and the use of appropriate external expertise when needed (illustrated in case studies 3, 4, 6 and 11).

2.4 In considering their 'hierarchy of responses', settings and services will need to ensure they fulfil their duties under the Equality Act 2010, including the duty to think ahead and make reasonable adjustments to avoid discriminating against disabled people. Adjustments include the ways they organise themselves, deploy resources and in their day-to-day practice; alterations to physical features; and the provision of auxiliary aids and services. Speaking first to children, parents and young people will enable settings and services to gain an understanding of where reasonable adjustments may be necessary and help them to consider the nature of any adjustments to be made. Further information on the Equality Act can be found in Annex A.

2.5 Special schools, children's homes, NHS commissioned health services and local authority approved providers of foster care have specific responsibilities to protect the welfare and safety of children and young people in their care.

2.6 Staff should have reasonable grounds for believing that restraint is necessary to justify its use. They should only use restraint where they consider it is necessary to prevent serious harm, including risk of injury to the child or young person or others. Staff should use their professional judgement to decide if restraint is necessary, reasonable and proportionate. This will involve assessing the risks

involved, taking account of the needs of the child or young person (including as set out in any relevant behaviour support plans drawn up for them) and the circumstances of each case, including the availability of alternative approaches to restraint. To be confident in their judgement, staff should also ensure they know the scope of the legal powers authorising restraint and keep abreast of changes and developments in the understanding of what constitutes good practice in this area. When a decision is being made whether and how to restrain a child, their best interests are a primary consideration. This does not mean that the child's best interests automatically take precedence over other considerations such as other people's rights, but they must be given due weight in the decision.¹² Furthermore, since children are developing physically and psychologically and this makes them particularly vulnerable to harm, the potentially serious impact of restraint on them will require weighty justification.

3. Values and Principles

- 3.1 A positive and proactive approach is vital to anticipate potential triggers for behaviour that challenges, and minimise the likelihood of, or avoid the need to use, restraint (examples of practice in education and health settings and services are given case studies 1-12 in Annex B). Where use of restraint is necessary to safeguard children, young people and others from harm, it should be consistent with clear values and sound ethical principles, comply with the relevant legal requirements and case law and be consistent with obligations under the European Convention on Human Rights, the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities.¹³
- 3.2 The following core values and principles set the ethos within which settings and services¹⁴ should operate when carrying out the key actions set out in Chapter 4. These values and principles cannot be considered in isolation – settings and services must also follow the law and any associated guidance relating specifically to them. In some cases, the law will be more exacting than the values and principles below.

Core Values

- 3.3 National reports and guidelines from professional bodies over the years have identified some overarching core values expected from those supporting children and young people whose behaviour challenges:
- uphold children and young people's rights – children and young people with learning disabilities, autistic spectrum conditions, and mental health difficulties whose behaviour challenges have the same human rights as all children and young people and require additional help to overcome the difficulties their behaviour may present;
 - treat children and young people with learning disabilities, autistic spectrum conditions, and mental health difficulties whose behaviour challenges as full and valued members of the community whose views and preferences matter;
 - respect and invest in family carers as partners in the development and provision of support for children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties; and
 - recognise that all professionals and services have a responsibility to work together to coordinate support children and young people whose behaviour challenges and their families.

3.4 The following values relate specifically to the use of restraint. They were drawn up with reference to the Independent Restraint Advisory Panel's review of restraint systems used in secure children's homes¹⁵ but they are relevant to all of the settings and services to which this guidance applies:

- every child or young person deserves to be understood and supported as an individual;
- the best interests of children and young people and their safety and welfare should underpin any use of restraint;
- the risk of harm to children, young people and staff should be minimised. The needs and circumstances of individual children and young people, including their age, particular vulnerabilities, learning disability, medical condition or impairments, should be considered and balanced with the needs and circumstances of others. Decisions on whether or not to restrain or intervene with an individual, affect others, including staff; and;
- a decision to restrain a child or young person is taken to assure their safety and dignity and that of all concerned, including other children, young people or adults present.¹⁶

Key Principles

3.5 Restraint may be necessary to safeguard the individual and/or others from serious injury or harm, and sometimes it will be the only realistic option, for example to prevent a child from running into a busy road. The following key principles are offered to guide settings and services in developing their policies and practice in the context of the particular legal requirements that apply to them:

- promote a positive and proactive approach to behaviour, including de-escalation techniques appropriate to the child or young person, to minimise the likelihood of or avoid the need to use restraint (see examples in all of the case studies in Annex B);
- use of restraint is based on assessment of risk and to safeguard the individual or others;
- restraint should only be used where it is necessary to prevent risk of serious harm, including injury¹⁷ to the child or young person, other children or young people, to staff, the public or others,¹⁸ if no intervention or a less restrictive intervention were undertaken;

Reducing the Need for Restraint and Restrictive Intervention

- an intervention is in the best interests of the child or young person balanced against respecting the safety and dignity of all concerned, including other children, young people or adults present;
- restraint is not used to punish or with the intention of inflicting pain, suffering or humiliation;
- techniques used to restrain or restrict liberty of movement are reasonable and proportionate to the circumstances, risk and seriousness of harm; and are applied with the minimum force necessary, for no longer than necessary, by appropriately trained staff;
- use of restraint, reasons for it and consequences of its use, are documented¹⁹, monitored, open and transparent; and
- when planning support and reviewing any type of plan which references restraint (such as a behaviour support plan), children and young people, and parents, and where appropriate (for example, where the child or parent/carer wants it), advocates should be involved.

3.6 The nine principles underpinning the NHS England and Local Government Association guidance *Developing support and services for children and young people with a learning disability, autism or both* are also fundamental to ensuring community support for children, and young people with learning disabilities, autistic spectrum conditions, and mental health difficulties who display behaviour that challenges and to ensuring that they have the right to the same opportunities as anyone else to live satisfying and valued lives and to be treated with the same dignity and respect.²⁰

4. Key Actions for Settings and Services

4.1 All settings and services to which this guidance applies should follow the set of key actions described and summarised below. These are based on practices which have been shown to work well in supporting children and young people whose behaviour challenges.

Summary of Key Actions for Settings and Services

Have a clear policy for meeting children and young people's individual needs and promoting positive relationships and behaviour. This should include measures for understanding children and young people's needs and the causes of behaviour, anticipating situations that may cause distress and taking steps to address them, assessing, managing and reducing risk, thereby reducing the likelihood of restraint.

Know the law and relevant guidance and have clear governance and accountability arrangements for supporting children and young people whose behaviour challenges and for any use of restraint, including arrangements for working across settings and services.

Involve children, young people and their parents/carers as appropriate in decisions relating to behaviour and use of restraint, and in discussing restrictive interventions and their impact, including through the development of behaviour support plans.

Use evidence-based approaches to promoting positive behaviour and supporting individual children and young people whose behaviour challenges.

Have sound measures in place for training and developing staff, including training in understanding children and young people whose behaviour challenges, developing the skills to respond to their needs and understanding when expert help is required.

Have a system in place for continually improving assessment and management of risk.

Have a system for recording and reporting incidents (distinguishing between planned and unplanned interventions) which enables children and young people who have been restrained to express their feelings about their experience as soon as is practicable, to add their views and comments to the record of restraint and offers them the opportunity to access advocacy support to help them with this.²¹

Have a system in place for reviewing how restraint is used in individual cases and patterns or trends in its use to inform changes in approach where necessary.

Recognise the impact of environment on individuals, and critically review their environment and practices, better to support children and young people and the reduction of restraint in line with best practice.

A Clear Strategy

- 4.2 All settings and services will need to ensure policies on behaviour and use of restraint are consistent with relevant statutory duties and/or related guidance and standards; and will wish to ensure they are underpinned by the core values and key principles set out in Chapter 3 above.
- 4.3 Individual policies should be developed with regard to any wider local strategies which may have been developed in relation to use of restraint. For care and education services, this may include policies developed in response to ADCS guidance 2009.
- 4.4 It is good practice, and in some cases a legal requirement (see Annex A) for policies to set out:
- the measures taken to encourage effective communication and positive behaviour, including those to develop an environment which helps to reduce stress and anxiety and the likelihood of restraint being used for behaviour that challenges. This should include the ways staff interact/communicate with children and young people;
 - how support is provided for those whose behaviour challenges through creating a supportive environment – including strategies for prevention or de-escalation which can avert and reduce the need for restrictive intervention, and the development and regular review of behaviour support plans for individual children and young people;
 - how children, young people, parents/carers and other agencies are involved in supporting positive behaviour, including individual behaviour support plans;
 - circumstances in which it may be appropriate to use restraint as set out in a behaviour support plan;
 - how staff are trained in understanding behaviour, supporting positive behaviour, assessing and managing risk, and using restraint appropriately where it is necessary, including how training is maintained and reviewed;
 - arrangements for reporting and recording use of restraint, including informing parents or carers;

- details of how staff restraint practice will be reviewed and evaluated;
- arrangements for providing support (emotional and, where necessary, medical) to children and young people and staff following any use of restraint, including access to advocacy;
- arrangements for monitoring the use of restraint and patterns and trends in its use, including consideration of whether interventions were reasonable and proportionate to the risks they presented and whether changes can be made to practice to reduce the use of restraint;
- arrangements for considering complaints; and
- details of how the behaviour policy will be reviewed, evaluated and where necessary amended.

Governance and Accountability

- 4.5 To secure proper accountability and transparency, it is essential that those responsible for providing and commissioning services for children and young people whose behaviour challenges have clear arrangements governing the use of restraint.
- 4.6 Governance arrangements should include those for planning to support children and young people whose behaviour challenges and reducing the need to use restraint, and recording, monitoring and review. Aggregated information from reviews of the use of restraint should be used to consider future measures to avoid incidents which could lead to its use.
- 4.7 Settings and services will wish to consider identifying a lead person at governing body or executive board level with responsibility for their behaviour policy and strategy, including any specific programmes to reduce the need for restraint. They will also wish to consider appointing a member of staff to act as a champion and building networks with others pursuing such reduction programmes. It is good practice to inform children, young people, parents and carers of the role and functions of the lead person or champion.
- 4.8 Independent Visitors also play a useful role in residential special schools and in children's homes in supporting children and young people's interests, including in relation to support for behaviour issues. They should be sufficiently knowledgeable to explore how well communication and behaviour support meets children's needs.

Involving Children and Young People, Parents and Carers

- 4.9 For children and young people with special educational needs and disabilities, including those with learning disabilities, autistic spectrum conditions and relevant mental health difficulties, Part 3 of the Children and Families Act 2014 (section 19) requires local authorities, when carrying out their functions under that Part, to have regard to:
- the views, wishes and feelings of the child and his or her parent, or the young person;
 - the importance of the child and his or her parent, or the young person, participating as fully as possible in decisions relating to the exercise of the function concerned;
 - the importance of the child and his or her parent, or the young person, being provided with the information and support necessary to enable participation in those decisions; and
 - the need to support the child and his or her parent, or the young person, in order to facilitate the development of the child or young person and help him or her to achieve the best possible educational and other outcomes.
- 4.10 Involving children and young people in decisions about their education, health and care is essential in ensuring that their support meets their needs and enables them to achieve good outcomes. This could include giving them access to information in formats appropriate to their age and capacities; enabling guidance and support by their parents and/or advocates; and providing information and support which facilitates their involvement in decisions about plans for their support, including reviews of that support. Examples are given in Annex B of how settings and services have involved children, young people and parents in decision making, in particular case studies 2, 6, 9, 10 and 11.
- 4.11 It is important for children and young people to be well-informed about their rights in relation to decision-making on the use of force. This could be through an advocate where one is involved, for example in the care system, and it could be through the SEN and Disability Information, Advice and Support Services which local authorities are required to secure in order to make available information, advice and support to children and young people with SEN and/or disabilities, and their parents.
- 4.12 More specifically, the following advocacy is available in the health arena:

- independent mental capacity advocates (IMCAs) under the Mental Capacity Act 2005;
- independent mental health advocates (IMHAs) under the Mental Health Act 2007;
- independent complaints and advocacy services in the NHS; and
- independent advocates under the Care Act 2014.

4.13 Children and young people who have difficulties with speech, language and communication will use different ways of communicating such as augmentative and alternative communication. It is important that approaches to engaging them in decisions involve those means of communication (examples are given in Annex B – in particular case studies 6 and 12). Some children and young people may not have sufficiently developed language skills to communicate verbally and may not be able to understand or respond to verbal de-escalation. This may also occur if members of staff do not speak the child or young person's first language. Verbal and/or non-verbal strategies should be used to ensure the child or young person understands what is happening and has adequate time to process information and respond. Speech and language therapy support may be required for children and young people with speech, language and communication needs.

4.14 Involving parents, who have detailed knowledge and experience of their child, can help to improve understanding of what helps to support the child and contribute positively to the development of behaviour support plans (see case studies 6, 7, 9 and 10 in Annex B).

Evidence-Based Approaches

Behaviour Strategies

4.15 All settings should aim to develop proactive strategies which help reduce the likelihood of behaviours that challenge, leading to the use of restrictive interventions and focus on improving the safety and well-being of children and young people. Such strategies should be based on a good understanding of learning disabilities, autistic spectrum conditions and mental health difficulties and of how children and young people affected by them are at heightened risk of displaying behaviours that challenge. Strategies should be consistent with the core values and key principles in Chapter 3 and support the setting or service's own behaviour policy.

- 4.16 Children and young people, parents and carers should be asked for their views on the use of restraint and the development of any strategies for reducing its use. Settings and services should work with children, young people and parents to develop behaviour support plans for individual children and young people.
- 4.17 Effective behaviour strategies address how staff will be trained and developed in developing positive behavioural support and include provision for behaviour support plans to be made for individual children and young people whose behaviour challenges. It is essential that strategies and staff practice are kept under review so that changes can be made based on evidence of what has worked and what has not worked in practice. Settings and services should identify where expert help may be needed to inform their behaviour and support strategies for example, from a qualified behaviour specialist, a therapist with expertise in communication or sensory needs, or from a medical consultant on epilepsy.
- 4.18 It has been shown in some settings that it is possible to achieve significant reductions in the need to use restraint and restrictive intervention through specific reduction programmes. Many services are reducing the incidence of aggressive behaviour with less restrictive approaches. Settings and services should consider developing their own explicit restraint reduction programmes as part of their broader behaviour strategies and, as part of those programmes, should pay particular attention to securing appropriate training and development for staff. In implementing a restraint reduction strategy, settings and services will need to address concerns of staff who may feel that it would reduce their levels of safety. It may be helpful to share with staff evidence from other settings and services who have successfully implemented such a strategy that it results in a calmer environment for all. A range of examples in education and health contexts are given in Annex B - see case study 1 in particular.

Positive Behavioural Support

- 4.19 The term positive behavioural support is used here to describe a framework to better understand, and so reduce, behaviour that challenges among children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties. It is based on an assessment of the context in which behaviour occurs and uses that information to develop interventions to support children and young people. These may include practice changes such as changing their environment, developing their skills, providing focused support and developing reactive strategies for use where necessary. Evidence has shown that approaches using such a framework can:

Reducing the Need for Restraint and Restrictive Intervention

- build skills – for example communication skills, so that a child may learn a sign for ‘finished’ rather than throwing a cup, or resilience skills to gradually learn to cope with demands which were once too much for them;
- enhance quality of life – for example, by identifying pain and enabling medical intervention for an earache which is causing a child to bang their head on the wall or by changing the environment so that a child that needs to run around a lot is taken outdoors regularly, reducing the need for them to run away; and
- reduce the likelihood of behaviours that challenge – development of proactive strategies such as avoiding sensory overload for a child where this is known to increase anxiety by allowing them to move to the next session a few minutes before others, will reduce the need for reactive strategies such as trying to intervene in an incident in a crowded corridor when anxiety levels are high.

4.20 Positive behavioural support focuses on preventative strategies to ensure needs are met and secure improvements in quality of life. It also includes strategies to ensure that early signs of anxiety and agitation are recognised and responded to and strategies for when a child or young person’s agitation escalates to a point where they place themselves and/or others at serious risk of harm. Positive behavioural support involves:

- Person-centred planning – the needs of the child or young person are central to the development of plans for their support and their views should be obtained. Helping children and young people to develop personal relationships and helping staff to understand them as individuals supports better person-centred planning.
- Skilled assessment – to understand why a child or young person presents behaviours that concern or challenge; and what helps predict their occurrence or causes the child to continue presenting them or regularly reverting to them. This can help to identify areas of unmet need. Assessment requires consideration of a range of contextual factors including personal factors, mental and physical health, communication skills and the child or young person’s ability to influence the world around them. For children and young people displaying significant levels of behaviour that challenges, assessment should be conducted by a psychologist or behaviour specialist with relevant training and qualifications. Assessment should take account of the views of the child or young person and parents.
- *Behaviour support plans* – informed by the assessment, these describe how the child or young person is to be supported, address aspects of their environment which they find challenging, and support them in developing new skills and strategies better to communicate their needs and become more independent in meeting them. Plans should be developed with children and young people and parents.

4.21 Behaviour support plans should be based on a shared understanding of the reasons for a child or young person's behaviour and:

- identify proactive strategies designed to improve the child or young person's quality of life and seek to remove the conditions likely to promote behaviour that challenges, including changing the environment (for example, reducing noise and increasing predictability) and promoting active engagement through structured and personalised activities;
- identify adaptations to a child or young person's environment or routine and help them to develop alternatives to behaviour that challenges to achieve their goals, for example improved communication, emotional regulation or social interaction;
- identify preventative strategies to calm the child or young person when they begin to show early signs of distress, such as relaxation techniques and diversion into activities they find enjoyable and rewarding;
- identify reactive strategies to manage behaviours that are not preventable, including how family members, staff or carers should respond if a child or young person's agitation escalates and there is a significant risk of harm to themselves and/or others;
- be reviewed frequently – particularly if behaviour that challenges or use of restrictive interventions increases or quality of life deteriorates;
- identify any training to help family members, staff or carers improve their understanding of behaviour that challenges; and
- identify those responsible for delivering the behaviour support plan and the person responsible for coordinating it.

4.22 Behaviour support plans may form part of the provision specified in Education, Health and Care plans for children and young people with special educational needs; care plans and other forms of personalised planning for social care; and plans in Child and Adolescent Mental Health Services provided through the Care Programme Approach. The name of the plan is less important than the quality of assessment, intervention and review underpinning it which should, wherever possible, include involvement of the child or young person, and their family or advocates. Examples of successful positive behavioural support are given in Annex B, in particular case studies 3 – 6, 11 and 12).

Training and Development of Staff

- 4.23 Training and development play a crucial role in promoting positive behaviour and supporting those whose behaviour challenges. Settings and services should ensure they enable staff to develop the understanding and skills to support children and young people and help parents to secure a consistent approach (examples of effective training and development are given in Annex B – in particular case studies 3, 9, and 11). Guidelines from the National Institute for Clinical Excellence (NICE) recommend that local authorities and clinical commissioning groups jointly designate a lead commissioner to oversee strategic commissioning of health, social care and education services specifically for all children, young people and adults with a learning disability, including those who display, or are at risk of developing behaviour that challenges.²² Where local authorities and clinical commissioning groups have jointly designated a lead commissioner to strategically commission health, social care and education services for people with learning disabilities, or those who are at risk of developing behaviour that challenges, the commissioner might have a role in coordinating this staff development.
- 4.24 Training should be tailored to take account of the needs of the children and young people being taught and/or cared for and the role and specific tasks that staff will be undertaking. It should cover approaches to meeting children and young people's needs more effectively, preventing the escalation of crisis situations, and reducing and minimising the need for restraint through positive behavioural support. In children's homes, the registered person is responsible for ensuring that all their staff have been adequately trained in the principles of restraint and any restraint techniques appropriate to the needs of the children the home is set up to care for.
- 4.25 Staff should only use restraint techniques for which they have received training and can demonstrate competence. The setting or service should record the methods that a member of staff has been trained to use.
- 4.26 Training could usefully include knowledge, understanding and skills in relation to:
- considering the views and experiences of children, young people and their families;
 - communicating with (and listening to) children and young people whose way of communicating is non-verbal, including those with speech, language and communication needs;

Reducing the Need for Restraint and Restrictive Intervention

- identifying the causes of and triggers for behaviour that challenges, including those that may stem from medical conditions, sensory issues, or an unmet need or undiagnosed medical condition;
- the thoughts and feelings of staff on being exposed to behaviour that challenges;
- the assessment and management of risks, including dynamic risk assessment;
- building positive relationships, involving children, young people and parents in planning, developing individual behaviour support plans and reviewing support;
- alternatives to restraint, including effective use of techniques to calm a situation or de-escalate it and obviate the need to use restrictive options;
- safe implementation of restraint, including how to minimise associated risks, particularly in respect of the growth and development of children and young people;
- use of planning tools and advanced decision-making to promote safety in the use of restraint; and
- examples of effective practice in meeting the needs of children and young people whose behaviour challenges.

4.27 Settings and services will also wish to consider whether it would be helpful to provide appropriate training to parents alongside staff to promote consistent approaches and aid communication between home and the setting. This approach has been found to be beneficial in some contexts.

4.28 It is up to settings and services to commission the training they require to meet the needs of those they educate or care for and the training and development needs of staff. As employers, settings and services should conduct due diligence before commissioning any training, including checking that the training has been devised by experts with a successful track record of working in the relevant specialism. They should look for evidence that any restraint techniques promoted by the training have been medically assessed to demonstrate their safety for use with children who are still developing, physically and emotionally. Settings and services should routinely review the effectiveness of any training commissioned.

4.29 The British Institute of Learning Disabilities (BILD ACT) certifies training providers complying with the Restraint Reduction Network Training standards. The Restraint Reduction Network (RRN) – a charity and subsidiary of BILD – has worked with Health Education England to develop quality standards for training providers delivering training with a restrictive intervention component.²³ The standards offer

a benchmark for training which includes restrictive intervention in health settings and are mandatory in NHS commissioned services. Although primarily designed for health, the standards reference education and social care settings. The RRN framework sets out any specific considerations or adaptations to the standards that should be taken into account for different populations (including learning disabilities, autistic spectrum conditions and mental health difficulties) or settings (including schools and foster carers). The standards are designed to ensure that training improves staff skills and confidence in how to understand people's behaviour, keep them safe and better meet their needs. They aim to ensure that training is delivered by competent and experienced training professionals who can evidence knowledge and skills, goes beyond the application of restraint and restrictive interventions to focus on human rights, prevention, de-escalation of crisis situations and encourages reflective practice. The UK Accreditation Service (UKAS) accredits certification bodies against internationally recognised standards to demonstrate their competence, impartiality and performance capability. Bodies certifying compliance with RRN training standards, including BILD ACT, must be accredited by UKAS.

- 4.30 Other accrediting bodies have also expressed an interest in providing certificated accreditation schemes through universities. The Institute of Conflict Management (ICM) has also developed a Quality Award Scheme, established with the support of the Health and Safety Executive. Education and child care specialists are working with the ICM to produce national standards for providers of training in mainstream and special schools which take account of the particular circumstances and legislation that apply in those settings. All settings and services should ensure that any training and development commissioned is consistent with the core values and key principles in Chapter 3. When commissioning training, settings and services are advised to consider UKAS accredited training as UKAS is the government recognised national accreditation service.

Assessing and Managing Risks

- 4.31 In most settings where restraint takes place a child or young person is known and behaviours that challenge are often foreseeable, though it may be difficult to predict exactly when they will occur or the degree of challenge they will pose. Settings and services can seek to reduce risk and improve foresight by following the advice in this guidance and:
- exploring why children or young people behave in ways that pose a risk;
 - trying to understand the factors that underlie or influence the behaviour and the triggers for it – some of these may stem from the environment created by the service or setting itself;

Reducing the Need for Restraint and Restrictive Intervention

- recognising the early warning signs which indicate that the behaviour is beginning to emerge;
- developing the skills to manage difficult situations competently and sensitively; and
- understanding and developing alternatives to restrictive intervention such as de-escalation techniques.

4.32 A decision on whether or not to use restraint will always require consideration of individual circumstances and is a matter of professional judgement. Decisions should be made within the framework of core values and key principles in Chapter 3 and be subject to monitoring and review.

4.33 Any use of restraint carries risks. Risks may be to the child or young person whose behaviour challenges, other children and young people, staff, other adults or property. They may arise as a result of interactions between the child or young person and their environment, the direct impact of their behaviour that challenges, or measures and interventions used to limit or manage risks to the child or young person and/or others.

4.34 Those risks need to be balanced against the risks associated with other courses of action, including the risks of taking no action at all. Risks associated with applying restraint or deciding not to do so include causing physical injury, causing a flight response, psychological trauma, distress and emotional disturbance to the child or young person and to staff.

4.35 Assessing risk involves using what is known from experience to make rational judgements about risks and weighing up options. It is about trying to predict the situations in which risks may occur, estimating the likelihood of the risk and potential harm that may occur, and gauging the seriousness of any harm that could result.

4.36 Sound assessment of risks will enable decisions to be made which:

- respect children and young people's rights;
- limit the level of inherent risk to which the child or young person and others are exposed;
- avoid unreasonable risks for the child or young person and others; and
- ensure that an intervention is necessary, appropriate and proportionate to the risks that it presents. The end should justify the means. A fair balance has to be struck between the severity and consequences of the intervention for the child or young

person being restrained and the aim of the restraint. This requires consideration of the reasons why they may be particularly vulnerable to harm, such as their age, experience of trauma, health problems or disabilities. The means of restraint and its duration should be no more than necessary to accomplish its aim.

4.37 When considering whether to use restraint with a child or young person, staff should ask themselves: “At this moment what is in the best interests of the child and/or those around them, taking account of the risks presented?”.

4.38 In assessing risk, staff should take into account:

- the size, age and understanding of the child or young person;
- the specific hazards they face;
- their particular vulnerabilities, learning disabilities, medical conditions and impairments;
- the relative risks of not intervening;
- the child or young person’s previously sought views and experiences, and those of parents and carers, on strategies and approaches they considered might de-escalate or calm a situation;
- the method of restraint that would be appropriate in the circumstances; and
- the impact of the restraint on the future relationship with the child or young person

4.39 Options for reducing risks should be thoroughly explored, and the benefits and drawbacks of each considered and, where possible, recorded. Where there are concerns that the risk reduction options being considered may themselves give rise to risks to the child or young person or others, settings and services should consider whether to seek advice from others such as:

- local safeguarding partners and other relevant agencies;
- the Health and Safety Executive;
- medical advisers;
- legal advisers;
- local authority; and
- Local Health and Wellbeing Board.

- 4.40 Measures agreed for managing identified risks should be set out in an agreed behaviour support plan for the child or young person. The child and their parent or the young person should be fully involved in the process. The plan should be shared with all those with a role in implementing it and monitoring its impact. Appropriate training should be provided for staff to ensure that they have the competence and skills to implement it. In some cases, training may be required as a matter of urgency so that the plan can be implemented without delay.
- 4.41 Regular reviews of risk assessment and management measures, including arrangements for staff training and development should inform future planning and help to improve day-to-day practice.
- 4.42 *Minimising and Managing Physical Restraint*²⁴ is guidance intended for secure training centres (STCs) and under-18 young offender institutions (YOIs) but has valuable information on ensuring appropriate accountability for use of restraint.

Planned and Unplanned Interventions

- 4.43 Planned interventions are when staff employ, where necessary, planned and agreed approaches to behaviour that challenges that have been set out in a child or young person's behaviour support or care plan and detail any action to restrain a child or young person. Planned interventions will be based on a careful risk assessment, including an understanding of their needs (including their particular vulnerabilities, learning disabilities, medical conditions and impairments), their best interests and evidence about the risks faced.
- 4.44 Unplanned interventions require professional judgement to be exercised in difficult situations, often requiring split-second decisions in response to unforeseen events or incidents where trained staff may not be on hand. Such decisions, known as dynamic risk assessments, will include a judgement about the capacity of the child or young person at that moment to make a safe choice. Staff training and supervision of practice should support dynamic risk assessment. Unless the situation is urgent, staff should seek assistance from appropriately trained staff. If such assistance is not available, any response must still be reasonable and proportionate, and should use the minimum force necessary in order to achieve the aim of the decision to restrain.
- 4.45 When children and young people are known to the service or setting, they will have had their needs carefully assessed, and support for their behaviour should be in place through their individual behaviour support plans. Such plans should include planned and agreed approaches to managing behaviour that challenges and prevent it from escalating and, if appropriate, any agreed approaches to

restraint. An unplanned intervention for a child or young person with a support plan should prompt discussion about whether the plan needs to be changed.

Settings and Services where Children and Young People May Not Be Known

- 4.46 The core values and key principles in Chapter 3 above apply to the management of unforeseen behaviours that challenge, even in contexts where they cannot be anticipated or responses pre-planned such as Accident and Emergency departments, the ambulance service, or mental health services that admit patients with little or no knowledge of their background.
- 4.47 In services like these, where people's histories and care needs may not be known or understood, individual planning will not be possible. Nonetheless, a range of whole-service approaches can promote therapeutic engagement, avoidance of conflict situations and the safe support of people at times of behavioural crisis. These can address potential triggers for behaviour that challenges, including oppressive environments, the use of blanket restrictions such as locked doors, lack of access to outdoor space or refreshments and poor or confusing environmental design. At national level, the Mental Health Crisis Care Concordat²⁵ has brought a range of national organisations together to make a commitment to work together to support local systems to achieve continuous improvements for crisis care for people with mental health issues across England. The Concordat covers policy making and spending decisions, anticipating and preventing mental health crises wherever possible, and making sure effective emergency response systems operate in localities when a crisis does occur. The Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations containing commitments and actions to deliver services meeting the principles of the National Concordat.
- 4.48 There are a number of resources which support settings or services to adopt a whole-service approach to the reduction of the need for restraint. The NICE guideline *Violence and Aggression: short-term management in mental health, health and community settings*²⁶ contains guidance for specific settings including Accident and Emergency and primary care. Where the Safewards²⁷ model has been implemented in adult acute mental health settings, they have demonstrated significant reductions in conflict situations, use of physical restraint and restrictive intervention, seclusion and rapid tranquillisation. Settings and services may wish to consider whether similar approaches could be replicated in their own context.

- 4.49 A number of health and voluntary and community sector organisations have developed ‘hospital passports’ or ‘communication passports’ for people with learning disabilities or autistic spectrum conditions. These passports provide useful information for hospital staff who will not have previous knowledge of the person and can include information about managing and preventing behaviour that challenges.²⁸ Communication passports typically include information on who should be contacted, how the person communicates and shows pain, and what should be done if they become anxious. While these passports have been developed for use in health contexts, other settings and services may wish to consider this approach.

Escalation

- 4.50 Every behaviour support plan should have a process for supporting a child or young person to avoid crisis and a protocol for escalation. If the individual is at risk of admission as a mental health inpatient, or has been subject to an emergency admission, a Care Education and Treatment Review must be undertaken to identify the factors that are preventing adequate and safe support being provided where they live, or preventing their discharge. The Review is an essential element to ensuring children and young people with learning disabilities, autistic spectrum conditions or both, who are likely to be admitted to or stay too long in mental health / learning disability wards in hospitals, are supported to remain in the community. Detailed guidance on the review process has been issued by NHS England.²⁹
- 4.51 Police may exceptionally be called upon to help manage a dangerous situation and will use techniques and act in accordance with their professional training. Staff of the setting or service are responsible for alerting police officers to any specific risks or health problems that a child or young person may have (‘hospital passports’ may be helpful here), as well as monitoring the child or young person’s physical and emotional wellbeing and alerting police officers to any specific concerns. Staff of the setting or service and police officers have a responsibility to ensure that situations do not unnecessarily escalate. Staff should be alert to the risk of any health condition which could be exacerbated by restraint, continue to monitor the young person’s physical and psychological wellbeing throughout the incident of restraint, and respond to any signs of, for example, respiratory or cardiac distress.
- 4.52 Guidance for the police is available in the Association of Chief Police Officers and National Policing Improvement Agency’s Guidance on Responding to People with Mental Ill Health or Learning Disabilities.³⁰

Safeguarding the Welfare of Staff

4.53 Employers have a duty under section 2 of the Health and Safety at Work etc Act 1974 (1974 Act) to ensure, so far as is reasonably practicable, that the health, safety and welfare at work of their employees. Section 3 of the 1974 Act places a duty on employers to conduct their undertaking in such a way as to ensure, so far as is reasonably practicable, persons who are not their employees and who are affected by the employer's undertaking are not exposed to risks to their health and safety. Employers must:

- assess the risks to employees and others (including the risk of reasonably foreseeable violence) and implement steps to reduce these risks;
- provide adequate information, instruction, training and supervision to ensure the health and safety of employees;
- monitor and review arrangements put in place to reduce the risks to ensure they are effective; and
- establish transparent processes to acknowledge the hazardous nature of any foreseeable incidents and of any restrictive interventions.

The duty includes risks arising from both violence and the use of restrictive interventions.

Recording and Reporting

4.54 Settings and services will wish to consider when to record occasions where restraint is used, whether planned or unplanned. (Depending on the type of setting or service, this may be a requirement.) Information should be open and transparent and enable consideration to be given to the appropriateness of use of restraint.³¹

4.55 CQC and Ofsted will take into account the quality and impact of the recording of restraint in their inspection activity. Where this fails to meet the requirements or good practice expectations set out in the relevant regulations, guidance or standards they will take action as appropriate, including enforcement action.

4.56 In health services, record keeping should be consistent with the requirements of the Mental Health Services Dataset³² and the National Reporting Learning System.³³ Services must publish an annually updated, accessible report on their behaviour support planning and restrictive intervention reduction programmes. This must outline the training strategy, techniques used, with what frequency and

reasons why, whether any significant injuries resulted, and details of ongoing strategies for bringing about reductions in the use of restrictive interventions.

- 4.57 In children's homes, record keeping should be consistent with regulation 35 of the Children's Homes (England) Regulations 2015 which, amongst other things, requires reporting of restraint within set time periods. However, regulation 35(4) allows exemption from the recording requirement for specific types of restraint used within some children's day-to-day routine if that restraint is included as a provision in those children's Education, Health and Care plans.
- 4.58 In residential special schools, the National Minimum Standards require a written record for any use of reasonable force within 24 hours of the incident. Other non-residential special schools are not covered by such a specific statutory requirement but must have behaviour policies. It is good practice for all special schools to set out, in their behaviour policy, the circumstances in which force might need to be used. Any policy on the use of reasonable force should acknowledge schools' legal duty to make reasonable adjustments for disabled children. Any use of reasonable force should be followed by a post-incident review, with the child and parents and a staff debrief (see below).

Post-incident Support

- 4.59 After incidents, the child or young person and the staff involved should be given emotional support and basic first aid for any injuries as soon as possible. Immediate action should be taken to secure medical help for injuries that require other than basic first aid. All injuries should be recorded in accordance with the setting or service's procedures and reported as appropriate to the Health and Safety Executive. Action taken in respect of post-incident support could include trauma support for children, young people and their families affected by the use of restraint.

Reviewing Actions to Improve Support

- 4.60 Settings and services should ensure that appropriate lessons are learned from instances where restraint has had to be used, including any patterns and trends, and consider how use of restraint might be avoided in future. This will usually involve de-briefing and post-incident review and monitoring of the use of restraint and restrictive intervention. The process should consider all types of individual plans that reference behaviour support, including behaviour support plans, and wider policies.

- 4.61 It is good practice to involve the child or young person and, wherever possible, parents, advocates and other relevant representatives in planning, monitoring and reviewing how and when restrictive interventions are used. If the child, young person and parents are not involved this should be documented and reasons given.

De-briefing and Post-incident Review

- 4.62 As soon as possible after the use of restraint, the member of staff involved should be de-briefed by an appropriate manager to allow for reflection, and for the manager to deal with the emotions raised by the incident. This improves staff learning and contributes to professional development.
- 4.63 Whenever restraint has been used, staff and the child/young person should have separate opportunities to reflect on what happened, and wherever possible a choice as to who helps them with this. Those with cognitive and/or communication impairments may need specific help to engage in this process, for example, use of simplified language, visual imagery or Alternative and Augmentative Communication.
- 4.64 Wherever possible, the families of children and young people should have the opportunity to participate in post-incident reviews. Someone appropriate and trusted by the child/young person and their family or, where appropriate, the individual's advocate, could also play a role. Reviews could involve a facilitated staff team discussion about the warning signs of an impending incident, whether any previously agreed behaviour plans were followed, what de-escalation strategies were used and how effective they were, and what might be done differently in future.
- 4.65 Someone who was not involved in the incident should be involved in post-incident reviews in order to seek to understand – from the points of view of the child or young person and family – whether the setting or service did not understand what was needed, what upset the individual most, whether and how staff actions were helpful or unhelpful, and how things could be better in the future, including any changes which might be made, e.g. to the care environment.
- 4.66 If a pattern of persistent use of restraint emerges, and if a setting or service considers they do not have sufficient expertise themselves, an expert assessment should be sought, to identify the triggers for the behaviour that leads to use of restraint. The reviewer should consider, with the child or young person, and as appropriate, their parents and/or advocates, revising their individual support plan. Consideration should also be given to improving staff training and development as part of action to address the issue.

Monitoring

- 4.67 Managers or staff should use aggregated information from reviews to consider improvements to policies and practices, including the setting or service's approach to reducing potential triggers to behaviour that challenges or conflict situations. They should take action to change policies or practices where approaches have been used for some time but they have not been found effective. Such action may contribute to fulfilling a setting or service's duties under the Equality Act 2010. This process is especially important in services where young people's histories and needs may not be known or well understood and individual planning is not possible, such as Accident and Emergency departments or primary healthcare settings. To fulfil the Public Sector Equality Duty, settings and services should consider monitoring restraint practice and identifying any disproportionate use of restraint in relation to particular groups who share one of the relevant protected characteristics (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation). Such monitoring and reviewing enable continuous improvement of practice supporting children and young people whose behaviour challenges.

Transitions

- 4.68 Children and young people with learning disabilities, autistic spectrum conditions or mental health difficulties whose behaviour challenges face difficult transitions when moving from settings with which they have become familiar – in particular, those they have been attending daily or where they are resident. Settings and services should therefore cover expected transitions in children and young people's behaviour support plans. When young people are moving on to adult provision, for instance, early planning is essential to share approaches that work with the new service or setting, to enable familiarisation for the young person, involving them and where appropriate, their parents or carers.

5. Different Forms of Restraint

- 5.1 Any form of restraint must be lawful and based on individual circumstances. It should be consistent with the core values and key principles in Chapter 3, including an appropriate assessment of risks, be proportionate to those risks and be used for no longer than is necessary.
- 5.2 For children and young people detained under the Mental Health Act 1983, the Mental Health Act Code of Practice 2015 provides detailed statutory guidance on the different types of restraint and the relevant considerations that apply to the use of such techniques (Chapter 26). Where those that are bound by the Code are working with children and young people in any of the settings also covered by this guidance, such as Learning Disability Assessment and Treatment Units or a children and adolescent mental health ward, they must follow the procedures in that document.
- 5.3 Restraint can take different forms. Some forms of restraint may amount to a deprivation of liberty, although it should be noted that a restriction of liberty is not the same as a deprivation of liberty but depends on the degree or intensity of the restrictions.³⁴ Article 5 of the European Convention on Human Rights states that ‘everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law’. There are various routes to deprive individuals of their liberty. This includes when individuals aged 16 and above lack mental capacity, as defined by the Mental Capacity Act 2005, and are deprived of their liberty for care and treatment purposes.
- 5.4 Legislation and case law are currently evolving for 16 and 17-year olds who lack mental capacity and cannot consent to their care and treatment arrangements which give rise to a deprivation of liberty. Where settings think they may be depriving anyone in this group of their liberty, they should seek legal advice to ascertain the most up to date position and the processes they must follow so that this deprivation is necessary, proportionate and lawful.³⁵
- 5.5 For children aged 15 and below, the Mental Capacity Act does not generally apply and cannot be used to determine mental capacity, but the same legal tests apply for whether the arrangements amount to a deprivation of liberty as for those aged 16 and 17. For children aged 15 and below, those with parental responsibility can generally consent to deprivations of liberty on behalf of their child. Where parental consent cannot be used, local authorities and other bodies/individuals must apply to the High Court for authorisation under the Court’s inherent jurisdiction to deprive the child of their liberty. There is currently no central guidance to advise local authorities or others on decisions relating to deprivation of liberty orders.

Responsible bodies are expected to use their professional judgement, taking into consideration the individual needs of the child.

- 5.6 The independent review in 2018 of the Mental Health Act has made a series of recommendations intended to deliver a system which is more responsive to the wishes and preferences of the patient, which takes more account of a person's rights, and to improve as much as possible the ability of patients to make choices. It emphasises that care should be delivered safely in the least restrictive way.³⁶
- 5.7 The different forms of restraint described below apply generally and not only to children and young people detained under the Mental Health Act or subject to deprivations of liberty, including through the Mental Capacity Act.

Physical Restraint

- 5.8 Staff must not intentionally cause pain to a child or young person in an attempt to force compliance with their instructions. Any period of restraint can be dangerous, particularly where it occurs on the ground. People should not be deliberately restrained in a way that affects their airway, breathing or circulation, for example by covering the mouth and/or nose or applying pressure to the neck region or abdomen. If a child or young person is unintentionally held on the ground, staff should release their holds or reposition into a safer alternative or standing position as quickly as possible. For any form of restraint, including seated and standing, there is a risk of physical and psychological harm, and it should be avoided where possible. Staff should be aware of any specific regulations and guidance that govern the use of restraint in their settings.
- 5.9 A member of staff should take responsibility for communicating with the child or young person throughout any period of restraint in order to attempt continually to de-escalate the situation. Staff should also continue to monitor the child or young person for signs of emotional or physical distress following any such period of restraint.

Mechanical Restraint

- 5.10 Mechanical restraint involves use of a device to prevent, restrict, or subdue movement of a person's body with the aim of controlling their behaviour. Mechanical restraint may be used to manage extreme aggressive behaviour directed towards others or to limit self-injurious behaviour of extremely high frequency and intensity. This contingency is most notably encountered with small numbers of children and young people who have severe cognitive impairments, where devices such as arm splints or cushioned helmets may be required to

safeguard them from the consequences of their behaviour. Any such devices should only be put in place by people with relevant training, qualifications, skill and experience. Wherever mechanical restraint is used as a planned contingency, it should be identified within a support plan which aims to obviate the need for its continued use.

Medication (Chemical Restraint)

- 5.11 Chemical restraint refers to the use of medication prescribed and administered by health professionals for the purpose of quickly controlling or subduing disturbed/aggressive behaviour and inappropriate prescription of substances for non-medical reasons, where it is not prescribed for the treatment of a formally identified physical or mental illness. It should be used only for a child or young person who is both (a) highly aroused, agitated, overactive, aggressive, is making serious threats towards others or themselves, or is being destructive to their surroundings, and (b) when other therapeutic or restrictive interventions have failed to contain the behaviour. An antipsychotic, an antidepressant, or both should not be prescribed in response to behaviour that challenges without an appropriate clinical reason.
- 5.12 Chemical restraint should only be used by health professionals as part of an agreed support plan and should be delivered in accordance with evidence-based best practice guidelines and by staff with the relevant qualifications, skills and experience to administer it. Prescribers should provide information to those who provide care and support about any physical monitoring that may be required in addition to information about the medication to be used and how it should be administered (the route of medication).
- 5.13 *Stopping over-medication of people with a learning disability, autism or both (STOMP)* is a project led by NHS England which aims to reduce the use of medication, promoting non-drug therapies and making sure that people, families and staff are fully informed and involved. All health care providers who prescribe psychotropic medicine to people with a learning disability, autism or both are asked to adopt the STOMP health care pledge:
- We will actively explore alternatives to medication.
 - We will ensure people with a learning disability, autism or both, of any age and their circle of support are fully informed about their medication and are involved in decisions about their care.
 - We will ensure all staff within the organisation have an understanding of psychotropic medication including why it is being used and the likely side effects.

- We will ensure all people are able to speak up if they have a concern that someone is receiving inappropriate medication.
- We will maintain accurate records about a person's health, wellbeing and behaviour.
- We will ensure that medication, if needed, is started, reviewed and monitored in line with the relevant NICE guidance.
- We will work in partnership with people with a learning disability, autism or both, their families, care teams, healthcare professionals, commissioners and others to stop over medication.

5.14 The Voluntary Organisations Disability Group (VODG) has developed a similar pledge for social care organisations.³⁷

Withdrawal (Imposed and Autonomous) and seclusion

5.15 This section refers to withdrawal and isolation as a method of removing a child or young person from a situation which causes them anxiety or distress and taking them to a safer place where they have a better chance of composing themselves. It does not refer to actions which are intended as a disciplinary penalty. Such practice is outside the scope of this guidance.³⁸

5.16 Where withdrawal is against the individual's will ('imposed withdrawal'), it is a form of restraint carried out under a setting's duty of care to protect the child from harm, or risk of harm, to themselves and/or others. Any use of force by staff in those circumstances must be reasonable.

5.17 In some cases, because of the effects of their impairment or condition, a child or young person may actively choose to move to a quiet space for a period, for example when their anxiety levels rise and they become agitated, in order to calm down and 'self-regulate' their behaviour, averting the need for restraint. We describe this practice as 'autonomous withdrawal'. Staff should take steps to support them and monitor their progress. Where this is the case, appropriate provision should be made for this in the child or young person's support plan and kept under review with the child, parents and/or young person. This would not constitute restraint as the child or young person is free to leave the quiet space. Settings and services should take care to ensure that their use of language is clear regarding when withdrawal is autonomous or imposed.

5.18 Seclusion (which may be described alternatively in different settings, for example single separation in secure children's homes) is a form of restraint referring to the

supervised containment and isolation of a child or young person away from others, in a room/area from which they are prevented from leaving. It should only be used to contain severely disturbed behaviour, including which is likely to cause harm to others, and for the minimum time necessary. Staff would normally stay with the individual to support them and monitor their progress until they are ready to resume their usual activities.

- 5.19 Seclusion should never be used solely as a means of managing self-harming behaviour. It should only be used when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the individual's health or safety arising from their own self-harm and that any such risk can be properly managed.
- 5.20 All settings should adopt consistent, transparent, and fair procedures for the use of such measures. They should publish rules or policies setting out when measures will be used, what they consist of, and what will happen in case of non-compliance. Schools in particular should also consider whether parents and children could be given the opportunity to express views about these measures.
- 5.21 Schools could also ask parents to state explicitly that they are aware of these rules or policies, and to accept that sending their children to the school means their children will be subject to them, and that they have granted consent.
- 5.22 Parents can make decisions about their children's lives within certain bounds. This includes the power, within certain limits, to consent to their child being confined by others.³⁹ This consent must be reasonable. Schools should note that if a child or young person is being treated to greater levels of restriction than their peers, especially without parental consent, that is likely to be a deprivation of liberty. As a rule of thumb, case law suggests that from about age 12 onwards, extensive or total confinement is increasingly likely to be a deprivation of liberty and therefore unlawful (see Annex A for further detail).
- 5.23 If staff anticipate that withdrawal and seclusion are likely to be necessary, the circumstances and methods used should be discussed with the child or young person, their parents and other relevant adults as appropriate, and should be noted in the individual's support plan.
- 5.24 Any use of force to get the child or young person into, or prevent them leaving, a place must comply with the requirements of section 93 of the Education and Inspections Act 2006.
- 5.25 For children detained and treated under the Mental Health Act 1983 (MHA), the use of seclusion must follow the guidance in the MHA Code of Practice. If an emergency situation arises involving someone who is being treated for a mental

disorder and who is not detained under the MHA (an informal patient) and seclusion is necessary to protect themselves and/or others from risk of injury or harm, it should be used for the shortest possible period to manage the situation and an assessment for detention under the MHA should be undertaken immediately.

Long-term Segregation under the Mental Health Act 1983 in Hospital Settings

- 5.26 Long-term segregation, where a child or young person is prevented from mixing freely with other children or young people, should only be used in hospital settings; and by health professionals for those who present an almost continuous risk of serious harm to others and for whom it is agreed there would be benefit from a period of intensive care and support in a discrete area that minimises their contact with other children or young people. Particular attention should be paid to the potential risks of segregation as a form of restraint, considering the needs and behaviours of the child or young person. Segregation should not be undertaken for someone presenting, or at risk of, self-harm. Long-term segregation must never take place outside of hospital settings and should never be used with children or young people except those who are detained under the Mental Health Act 1983. It must only ever be undertaken in conjunction with the safeguards for its use in the MHA Code of Practice.
- 5.27 The Care Quality Commission thematic review has a particular focus on how hospital and residential care providers can protect the welfare and rights of those who are subject to prolonged seclusion or segregation. Its initial report, published in May 2019, focused on NHS and independent child and adolescent mental health wards, and NHS and independent sector wards for people of all ages with learning disabilities and or autism. Its recommendations include that 'all parties involved in providing, commissioning or assuring the quality of care of people in segregation, or people at risk of being segregated, should explicitly consider the implications for the person's human rights. This is likely to lead to both better care and better outcomes from care.' Blanket Restrictions
- 5.28 Oppressive environments and the imposition of blanket restrictions such as permanently locked doors, or removal of access to outdoor space or refreshments can have a negative impact on children and young people's behaviour and may breach requirements under the Human Rights Act 1998 or other legislation, for example relating to secure accommodation of children. Where, exceptionally, blanket restrictions are considered necessary, they should be governed by a clear policy which indicates how such restrictions comply with the Human Rights Act

1998 and other relevant legislation and the reasons for them should be explained to children and young people and to their families.

Summary

- 5.29 The negative impact that the use of restraint has on children and young people and those that care for them has been well documented.
- 5.30 The aim for all services and settings should be to improve the safety and well-being of children and young people in their care by developing proactive strategies to reduce the likelihood of behaviours that challenge and reduce and minimise use of restraint and restrictive intervention.
- 5.31 Settings and services covered by this guidance should know the law and relevant guidance that applies to them and:
- use evidence-based approaches to behaviour support;
 - have policies in place for promoting positive relationships and behaviours and eliminating unnecessary and inappropriate use of restraint;
 - have clear arrangements for governance and accountability in respect of behaviour and responses to behaviour that challenges;
 - involve children, young people and their parents/carers as appropriate in decisions relating to behaviour and use of restraint, including through the development and review of behaviour support plans;
 - ensure staff are suitably trained in understanding the range of communication used by children and young people, minimizing the need for, and safely and appropriately using, restraint where necessary and provide opportunities for regular staff development;
 - understand when expert help is required from specialists;
 - have a system in place for continually improving assessment and management of risk;
 - have a system for recording and reporting incidents where required, which enables children and young people who have been restrained on those occasions to express their feelings about their experience; and

Reducing the Need for Restraint and Restrictive Intervention

- have a system in place for reviewing how restraint is used in individual cases and patterns and trends in its use, changing practice where necessary to reduce and minimise its use.

6. Annex A. Legal Duties and Relevant Guidance

- 6.1 Alongside this guidance, readers will also need to be familiar with the law and good practice guidance that relates to their service or setting. In some cases this will set out requirements or expectations that go beyond the guidance in this document
- 6.2 The following is a summary of the purposes for which restraint or force may be used lawfully and the legislation relevant to their use. It does not give a precise statement of the law. That can only be found in the legislation and case law. Annex A does not provide an exhaustive list of legal requirements and provisions.
- 6.3 If organisations and staff use restraint on those in their care they must have a lawful basis for doing so. The law in respect of issues continues to evolve. Settings and services should review and update their local policies on an ongoing basis in light of legal developments.

Human Rights Act 1998

- 6.4 All services must abide by the Human Rights Act 1998 (HRA). The HRA imposes a duty on public authorities (including NHS Trusts, state-funded schools and colleges and local authorities) and other services exercising functions of a public nature not to act in a manner that is incompatible with the European Convention on Human Rights (ECHR).⁴⁰ The rights that are most likely to be infringed by improper use of restraint are:
- the prohibition of torture and inhuman or degrading treatment (Article 3);
 - the right to liberty and freedom (Article 5);
 - the right to a fair trial and no punishment without law (Article 6);
 - the right to respect for private and family life (Article 8);
 - freedom of thought, religion and belief (Article 9); and
 - no discrimination (Article 14).
- 6.5 Settings and services and their staff should help all children and young people and their families to understand the legal authority for any proposed action and their rights. No restrictive intervention should be used unless it is justified in all the

circumstances of the case and is in line with the legislation and relevant statutory guidance that applies to specific settings and services.

- 6.6 Article 8 of the ECHR protects the right to respect for private and family life. A restrictive intervention that does not meet the minimum level of severity for Article 3 may nevertheless breach Article 8 rights if it has a sufficiently adverse effect on the child or young person's private life, including their moral and physical integrity.
- 6.7 Restrictions that alone, or in combination, deprive children and young people of their liberty, without lawful authority, will breach Article 5 of the ECHR (the right to liberty).

Equality Act 2010

- 6.8 All settings and services must ensure that they comply with the Equality Act 2010 which requires that they do not discriminate against individuals in relation to protected characteristics (these are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation). The Act makes different provision for different settings, with the basic requirement that settings and services must ensure they do not:
- treat individuals less favourably because of a protected characteristic (direct discrimination);
 - apply a provision, criterion or practice that puts an individual with a given protected characteristic, and others who share that characteristic, at a disadvantage compared to someone who does not share that protected characteristic, for example by having a blanket behaviour policy that is applied in the same way to all but in practice causes special problems for disabled children (indirect discrimination);
 - behave in an unwanted way which relates to a relevant protected characteristic and which violates or is meant to violate the dignity of an individual or creates an intimidating, hostile, degrading, humiliating or offensive environment for that person (harassment); and
 - single out individuals for unfair treatment because they (or in some circumstances their parents or siblings) complain about discrimination or try to seek redress under the Equality Act (victimisation).
- 6.9 Public authorities are subject to the Public Sector Equality Duty. This means that they must have 'due regard' to the need to eliminate unlawful discrimination, to

advance equality of opportunity and to foster good relations between people who share a relevant protected characteristic and those who do not.

6.10 Having 'due regard' to the need to advance equality of opportunity is defined further in the Equality Act 2010 as including having due regard to the need to:

- remove or minimise disadvantages;
- take steps to meet different needs; and
- encourage participation when it is disproportionately low.

Deprivation of Liberty

6.11 The Mental Capacity Act 2005 empowers individuals to make their own decisions where possible and protects the rights of adults and young persons (aged sixteen and over) who lack the mental capacity to make a specific decision at a particular time. The Act provides a legal framework for others to act in the best interests, and make decisions on behalf, of persons who lack capacity to make a specific decision at a particular time and provides for Court authorisation of certain decisions and treatment. It also includes a system for authorising deprivations of liberty.

6.12 The [Mental Capacity Act Code of Practice](#)⁴¹ provides statutory guidance on the use of the Act, including issues around care and treatment (including restraint). Arrangements around deprivations of liberty for care and treatment purposes for individuals lacking mental capacity aged sixteen and over will change when the Liberty Protection Safeguards system is introduced. Where settings think they may be depriving anyone in this group of their liberty, they should seek legal advice to ascertain the most up to date position and the processes they must follow so that this deprivation is necessary, proportionate and lawful.

Health Services

6.13 Mental Health Act 1983 The Mental Health Act 1983 (as amended) covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provides the legislation by which people diagnosed with a mental disorder can be detained in hospital or police custody and have their disorder assessed or treated against their wishes.

6.14 Statutory guidance on the use of the Mental Health Act can be found in the *Mental Health Act 1983 Code of Practice 2015*. This includes the following definition of restrictive interventions:

‘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 action is undertaken; and
- end or reduce significantly the danger to the patient or others.

Restrictive interventions should not be used to punish or for the sole intention of inflicting pain, suffering or humiliation.’

6.15 Chapter 26 of the Code of Practice includes guidance on the use of such interventions, including guidance at paragraphs 26.52 – 26.61 on the use of restraint on children and specific guidance for those under 18 at Chapter 19. It also addresses who can consent to such treatment.

Mental Health Units (Use of Force) Act 2018

6.16 The aim of the Mental Health Units (Use of Force) Act 2018 is to reduce the use of force by increasing the oversight and management of use of force in mental health units. It identifies use of force as:

(a) the use of physical, mechanical or chemical restraint on a patient, or

(b) the isolation of a patient.

- “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—
 - (a) is intended to prevent, restrict or subdue movement of any part of the patient’s body, and
 - (b) 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.

- The Act is accompanied by statutory guidance from Department of Health and Social Care which sets out in more detail the requirements for health organisations, and their staff, that operate mental health units.

Health and Social Care

NICE Guidelines

6.17 NICE Guidelines make evidence-based recommendations on a wide range of topics and represent best practice. Settings and services will wish to have regard to the following NICE Guidelines:

- Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges
- Autism in under 19s: support and management
- Antisocial behaviour and conduct disorders in children and young people: recognition and management
- Violence and aggression: short-term management in mental health, health and community settings
- Looked-after children and young people
- Psychosis and schizophrenia in children and young people: recognition and management
- Managing Medicines in Care Homes
- Learning disabilities and behaviour that challenges: service design and delivery

Schools

Use of Restraint

6.18 Section 93 of the Education and Inspections Act 2006 allows the use of reasonable force to:

- prevent or stop the committing of any offence by a pupil;

Reducing the Need for Restraint and Restrictive Intervention

- prevent or stop personal injury to, or damage to the property of any person (including the pupil themselves) by a pupil; or
 - prevent or stop a pupil prejudicing the maintenance good order and discipline.
- 6.19 There are separate powers for schools to conduct a search for prohibited items and separate provisions governing the lawfulness of disciplinary penalties including detentions.
- 6.20 Guidance on the use of reasonable force by is provided by the non-statutory guidance *Use of reasonable force: Advice for head teachers, staff and governing bodies* (Department for Education, 2013).
- 6.21 The Department for Education’s guidance *Mental Health and Behaviour in Schools* (November 2018) provides non-statutory advice to help schools support pupils whose mental health problems manifest themselves in behaviour.
- 6.22 Residential special schools must also have in place policies on behaviour as set out in Standard 12 of *the Residential Special Schools: National Minimum Standards* (Department for Education, in force from April 2015). Those boarding schools also registered as children's homes also need to adhere to the *Children's Homes (England) Regulations 2015* (see below). Both these documents contain specific material on restraint which complements this document.

Use of Medicines

- 6.23 Many of the children and young people covered by this guidance will have known medical conditions. Under section 100 of the Children and Families Act 2014, governing bodies of community special and foundation special schools and proprietors of special academies are among the bodies that must ensure that arrangements are in place to support pupils with medical conditions. These arrangements may include drawing up individual healthcare plans for children and young people at the school. Staff undertaking risk assessment and planning for children at heightened risk of restraint should also refer to their individual healthcare plans for information about their medical condition, associated risks and agreed actions.
- 6.24 In implementing their duty under section 100 of the Act, relevant schools must have regard to the statutory guidance *Supporting pupils at school with medical conditions* (December 2015).

Children's Homes

- 6.25 Children's homes are governed by the Children's Homes (England) Regulations 2015 which cover:
- behaviour management and discipline (regulation 19);
 - use of restraint (regulation 20);
 - employment of suitably trained and qualified staff (regulation 32(3)(b)); and
 - behaviour policies including monitoring, reporting and recording (regulation 35).
- 6.26 The Care Planning, Placement and Case Review (England) Regulations 2010 are relevant to children placed in children's homes and in foster care (see below). They confirm that the care plan should be provided to the relevant persons. Those making decisions about the use of restraint should therefore be in possession of the circumstances around a particular child, including where the care plan may refer to restraint.
- 6.27 Guidance for services on meeting the regulations are set out in the Guide to the Children's Homes Regulations including the quality standards (Department for Education, April 2015). This contains specific material on restraint to which children's homes must have regard. In addition, secure children's homes may use restraint for preventing a child or young person from running away from the home.

Fostering Services

- 6.28 Fostering service providers are governed by the Fostering Services (England) Regulations 2011. Regulation 13 requires fostering services to have a written policy about acceptable measures of control, restraint and discipline. The regulations are complemented by statutory guidance, including the [National Minimum Standards in Fostering Services \(the NMS\)](#). Together these form the basis of the regulatory framework under the Care Standards Act 2000 (CSA).
- 6.29 NMS 3 sets out how fostering services should support foster parents to manage appropriately and de-escalate challenging behaviour, including the provision of specialist training where necessary. All fostering service providers are expected to follow the NMS. Compliance is monitored via Ofsted's inspection regimes (the Social Care Common Inspection Framework for independent fostering providers and the ILACS framework for local authority fostering services).

- 6.30 Private fostering differs from most other forms of fostering in that the local authority has no role in choosing who will accommodate the child. In most cases the child will not have a care plan and is not a looked after child. There are, however, [national minimum standards](#) with which authorities must comply. There is no expectation that someone accommodating a child under private fostering arrangements should have a written policy about restraint.

Residential Holiday Schemes for Disabled Children

- 6.31 These schemes are governed by the Residential Holiday Schemes for Disabled Children (England) Regulations 2013 which include:
- use of restraint (regulation 15); and
 - behaviour management policy, recording of restraint and reviews (regulation 16).

Relevant Guidance

- 6.32 For completeness, a list of the guidance applicable to the settings to which this guidance applies is set out below and in the section above on NICE guidelines:
- [Mental Capacity Act Code of Practice: Protecting the Vulnerable \(2007\)](#)
 - [Protocol for Local Children's Services Authorities on Restrictive Physical Interventions in Schools, Residential and Other Care Settings for Children and Young People \(Association of Directors of Children's Services, 2009\).](#)
 - [The Children Act 1989 Regulations and Guidance – Volume 2: Care planning, placement and case review \(2015\)](#)
 - [Working Together to Safeguard Children \(2015\)](#)
 - [0-25 Special Educational Needs and Disability Code of Practice \(2015\)](#)
 - [The National Minimum Standards for Residential Special Schools \(2015\)](#)
 - [Behaviour and Discipline in Schools \(2016\)](#)
 - [Use of reasonable force \[in schools\] \(2013\)](#)
 - [Guide to the Children's Homes Regulations including the quality standards \(2015\)](#)
 - [Positive and Proactive Care: reducing the need for restrictive interventions \(2015\)](#)

Reducing the Need for Restraint and Restrictive Intervention

- [The Children Act 1989 Guidance and Regulations Volume 4: Fostering Services \(2011\)](#)
- [Supporting pupils at school with medical conditions \(2015\)](#)
- [Residential holiday schemes for disabled children: National minimum standards \(2013\)](#)
- [Mental Health and Behaviour in Schools \(2018\)](#)
- [Positive environments where children can flourish: a guide for inspectors about physical intervention and restriction of liberty – Office for Standards in Education \(March 2018\)](#)
- [NHS England: Developing support services for children and young people with a learning disability, autism or both \(2017\)](#)
- [Mental Health Services Data Set \(MHSDS\) v3.0 User Guidance](#)

7. Annex B. Positive and Proactive Approaches to Supporting Children and Young People Whose Behaviour Challenges

- 7.1 The following case studies illustrate essential features of good practice, thorough assessment, understanding behaviour in context, consultation with children and their families, multi-disciplinary planning and review. They demonstrate how to reduce the chances of an incident occurring which may trigger use of a restrictive intervention.

Case Study 1. A whole school approach to reducing restraint and risk - from the Principal of a Special School

How a whole-school policy change is reducing use of restraint.

- 7.2 At our school we made the decision to change our practice after I attended a conference where HMI was explaining the new inspection process and the need for special schools to think about the number of interventions that had been taking place in our schools. We were also told about the impact that the use of intervention rooms/quiet rooms or time out rooms on can have on the child and the member of staff.
- 7.3 On returning to school I was faced with quite a difficult task as staff felt, initially, that by removing Ground Recovery holds and informing staff that the holds should be the absolute minimum, I was not keeping them safe. The removal of our intervention areas also caused some consternation as again there was, perceived, no place of safety. However, this is something that I had struggled with for a long time. Why should we have intervention areas? What does that tell the child? The debates were quite wide-ranging and, for a short period, staff were in turmoil about whether they should or should not intervene.
- 7.4 However, I removed Ground Recovery straightaway and started to investigate the reasons for interventions as a formal process, internally, so that we could understand the mechanisms and choices that had been made prior to any incident taking place. We quickly realised, through this analysis, that we could identify incidents that could have been handled in a different way and that staff reactions

could have resulted in a more positive outcome for the child. Amazingly, staff were accepting of the outcomes and fully participated in the process.

- 7.5 At first the children also found this difficult because we had removed their sense of safety. That is the safety they felt when they knew staff would intervene. In fact, some of the children advised that the staff had 'gone soft'. I gave the children a small budget and asked them to design a chill out zone for themselves. As it turned out, we did not need this for our children and now have reading areas, sensory rooms and phonic suites. We have also developed a therapy suite where our Speech and Language Therapists, School Counsellor and Massage Therapists work. We have developed Thrive across the school and use different interventions such as fishing and horse riding for children when they find the curriculum difficult, but again, these are now used as forms of accreditation for the children so they serve a purpose.
- 7.6 We worked extensively with the staff teams to ensure that they understood why the changes were being made. I shared lots of examples of cases where issues had arisen and resulted in litigation. I also worked with parents at parents' meetings and coffee mornings explaining the new ethos. Parents were relieved that we had taken this stance as they did not like the idea of staff holding their child.
- 7.7 We continue to analyse interventions and staff are readily open to questions and answers about their reactions and the outcomes. The numbers of interventions are very low and rare and the children no longer expect this to be the first reaction from staff. As a result of all of the action we have taken the school is now a much calmer and happier place and in fact both staff and children have commented on the positive ethos here. We have also had a lot of positive comments from visitors about how happy the children look.

Case Study 2. Open-Door: patient involvement to reduce admissions due to crisis

The following shows action taken in respect of adults, but the approach for better patient involvement to manage hospitals could, if suitably adapted, be used in relation to children and young people.

- 7.8 Cambridge and Peterborough NHS Foundation Trust, with Promise Global Initiative, have developed a 'bottom-up' approach to reducing the need for restraint and restrictive intervention. This involves over 200 initiatives in their wards, themed around the concept of space and enhancing the physical environment.

- 7.9 Changes range in scale from small to large - from replacing the traditional 'mug shots' of staff on wards with 'know me profiles' using informal photos and including short personal notes to encourage dialogue between patients and staff, to the Open Door initiative which aims to encourage patients to have more control over their care.
- 7.10 Open Door is a mutual agreement made in advance with patients who are identified as 'frequent attenders' at Accident and Emergency Units, Crisis Teams or out of hours GPs. Mostly these patients will have a diagnosis of personality disorder. Their repeat attendance is associated with going through an extremely difficult phase, with high levels of distress. Traditionally, services spent considerable energy trying to keep such patients out of hospitals since this has usually escalated risk in the long run as patients learn to seek help in distress through self-harm or crisis presentations.
- 7.11 Open Door seeks to put patients in the driving seat. Through prior agreement, patients are offered a two to three-night stay in an assessment unit. This can be requested at any time, the only condition being that they must not have self-harmed in the previous 48 hours. Personalised plans are drawn up following positive risk assessment which seeks to understand the specific drivers for their behaviour. Plans can factor in conditions such as the patient engaging with the community PD (Personality Disorder) service. The service must also uphold its commitment.
- 7.12 Patient feedback has been positive. Admissions have decreased since the introduction of the initiative and the relationships between patients and services have changed. Patients have reported that it is helpful when thinking about potential future crisis points to know that admission is possible. One patient said, "It has helped me to see that I don't need to be in hospital for every crisis I experience".

Case Study 3. In-depth needs analysis and staff training support a child in school and hospital

A multi-disciplinary approach to planning for behaviour.

- 7.13 J came to his current special school at age fourteen on a 52-week residential placement, having previously been in a local authority special school for children with emotional and behavioural difficulties. He has an autistic spectrum condition and foetal alcohol syndrome.

Reducing the Need for Restraint and Restrictive Intervention

- 7.14 J is a very affectionate boy who thrives on positive attention from adults. He enjoys creative role play, football, video games, cookery and art. He also shows interest and care in animals.
- 7.15 J experienced trauma and neglect from a very young age. During his first few months at his current school, J was very withdrawn and aggressive and had difficulty in forming trusting relationships, struggling to regulate his emotions, feeling anxious and angry at times.
- 7.16 The school took a systematic approach involving:
- A review of J's history and background information
 - Discussion and review with residential staff and his social worker regarding family contact
 - A multi-disciplinary approach, with early observation and identification of need
 - Direct work with education and residential staff to increase understanding of needs and share effective strategies and approaches
 - Development of a detailed support plan, including individual therapeutic work with consistent structure and staff
 - Regular discussion with a behaviour analyst regarding any incidents, triggers and outcomes
 - Review and update of support plans – including a personal handling plan (PHP)
- 7.17 The school's Therapy Team reviewed J's history and background information, before providing initial advice and strategies to relevant staff. Initial assessments of J were carried out, including observations, baseline screening for emotional development, review of information from previous placements and consultation with staff. Assessments concluded that staff would benefit from training in Attachment Disorder. This was subsequently delivered to residential and key education staff by an Educational Psychologist (EP) and Assistant Psychologist (AP).
- 7.18 The EP and AP discussed J's needs with staff and agreed ongoing strategies, the key to which was building trusting relationships with him and boosting his own self-esteem and self-worth through positive praise and nurturing approaches.
- 7.19 Staff became able to read non-verbal signs of anxiety and intervened early with positive interaction and reinforcement of positive behaviours. They built

relationships with J, allowing him to share his feelings and validating them. Use of Social Story for hospital appointments reduced anxiety, and adults working with J modelled calm and verbal and visual prompting which enabled him to be calm. A multi-disciplinary approach was adopted, including Occupational Therapy and drama therapy input. J had an individual programme which allowed him to explore narratives through drama, use of puppets and creative materials. Through drama therapy J's confidence and self-expression developed and he gained a greater sense of trust and confidence to share his ideas. His personal handling plan was regularly updated to increase staff awareness of triggers and reflect changes to the strategies and approaches to be used.

- 7.20 J is now much more settled and appears much happier. There has been a significant reduction in instances of physical aggression and he has formed positive relationships with staff, becoming less reliant on one or two key adults. His engagement in lessons has improved and he is more willing to accept positive praise. His English and Mathematics have improved and the number of incidents of physical aggression fell from twelve to none in just three months.

Case Study 4. A local authority meeting needs through positive behavioural support

How a positive behavioural needs-approach and analysis uncovers unspoken needs.

- 7.21 L is a 9 year old boy with an autistic spectrum condition and a learning disability. It was getting difficult for L to live at home as he was displaying a number of high-risk behaviours, including regularly running away. He was also displaying a lot of self-injury and some aggression. L travelled to and from school via a taxi and would often escape when leaving the taxi.
- 7.22 A functional assessment showed that L's life was very limited; and the more he ran away, the more he was restricted. L had limited communication skills with which to express his needs. The function of his behaviour was to escape from the boredom and social isolation the restrictions created; the ability to be outdoors and to run, which was not available to him in his everyday life was therefore very valuable to him.
- 7.23 Following intervention from the Halton Positive Behaviour Support Service, L stopped running away altogether and his other behaviours have reduced. He is now able to move freely around and his functional communication skills and activity have increased. [Case study adapted from material published by the Challenging Behaviour Foundation]

Case Study 5. Multi-disciplinary team around the child to plan routine medical visits

Multi-disciplinary team working around the child.

- 7.24 B is fourteen and weighs thirteen stone. He has an autistic spectrum condition, a severe learning disability, and does not speak. He is fearful of new situations and being touched. As he becomes more frightened and is confronted by events he does not understand, he becomes aggressive and may injure himself and others. This inhibits his access to health procedures such as visits to the dentist, blood tests or X-rays.
- 7.25 The multi-disciplinary team working with B provides a range of interventions to address this. B's keyworker, the learning disability nurse, is advised in advance of any procedures he requires. She ensures that the family and the team are fully aware of the nature of the intervention and the practicalities involved in enabling B to be treated.
- 7.26 B has a Positive Behavioural Support plan which includes provision to help accustom him to essential procedures such as blood tests, dental checks and X-rays. This has reduced his anxiety. The team working with B communicates with those carrying out any procedures about the most suitable venue, time of day, and people who should be present. Adjustments are agreed in advance to help B to access the tests. Even with such preparation, there are times when B will be distressed. The strategy for managing these is planned and agreed in advance, with the family, clinicians and therapists. Options considered included undertaking the procedure with the use of distraction or behavioural strategies or whether restraint or sedation is acceptable and, if so, how to ensure sufficient and appropriately trained staff are available and supported in order to administer this.
- 7.27 In practice, use of general anaesthetic has rarely needed to be considered. Full paediatric/anaesthetic assessment is arranged in advance of the procedure with risks assessed and understood by all involved.

Case Study 6. Positive behavioural support helps a child to communicate their needs

How a child or young person can learn to express needs without aggression.

- 7.28 A is an 11 year old boy with a severe learning disability. He likes watching videos and practical tasks such as gardening or DIY with his father. Placing demands on A could lead to aggressive incidents, particularly at school. As aggressive

incidents increased, A was permanently excluded from school. His mother had to leave work and his aggression at home increased.

- 7.29 A functional analysis of A's behaviour was carried out and a Positive Behavioural Support programme, developed with the Bristol Positive Behaviour Support Service, was used to help A label his emotions so he could express his feelings through Makaton signs rather than aggression. A was supported to develop his emotional literacy and to reintegrate into school.
- 7.30 A's family learned new skills so they could help him with his emotional literacy and communication skills. A was much calmer and happier by the time he was discharged from the Bristol Positive Behaviour Support Service and staff described him as "a joy to work with". [Case study adapted from material published by the Challenging Behaviour Foundation]

Case Study 7. Preparing an accessible environment and practice for a medical examination

Adapting the environment and the approach taken by practitioners.

- 7.31 D, a twelve year old child with moderate learning difficulties and an autistic spectrum condition, is referred as part of his Education, Health and Care needs assessment to his local paediatrician because of concerns over physical aggression.
- 7.32 D and his parents arrive on time for his appointment and sit in a very busy waiting room. The clinic is running late and after thirty minutes, when they get into the clinic room, D is highly agitated. The doctor starts asking D questions. He gets up and tries to leave the room, rattling the door knob, then escalates to throwing furniture before starting to strip off his clothes. The doctor cannot examine him and the appointment ends.
- 7.33 D is then referred to a child psychiatrist for children with learning difficulties. Knowing that he has autistic spectrum conditions and finds clinics difficult, she arranges for him to be directed to a quiet waiting area on arrival and makes sure that the appointment starts on time.
- 7.34 On entering the room, the doctor focusses initially on talking to parents and allows D to settle before trying to engage him. D initially goes to the back of the room but after ten minutes comes and sits with his parents. The doctor gently tries to engage D, but stops if he seems disengaged or anxious.

- 7.35 She is eventually able to explain that she would like to examine him and shows what she is going to do by examining his dad. D then allows himself to be examined.
- 7.36 Arrangements are then made for members of the community learning disability team to visit the family at home to follow up to discuss their concerns about D's behaviours.

Case Study 8. A multi-disciplinary therapeutic team prepare a child for complex medical tests

How a hospital multi-disciplinary team share strategies to manage treatments.

- 7.37 O is a ten year old child with Downs Syndrome, an autistic spectrum condition and severe learning disability. He attends a special residential educational placement and is known to a highly specialist Multi-disciplinary Behaviour Team for children with learning disabilities. O has complex medical difficulties and ongoing medical needs. In the past he has experienced painful and invasive medical procedures and has been held down to have blood tests or injections. His mother is taking him to a large hospital for an eight hour specialist assessment of bladder and kidney function involving an injection, drinking a lot, a series of blood tests at hourly intervals, regular scans and a special X-ray and bladder pressure assessment.
- 7.38 O will need to move between the children's ward to the urology department ten times, going in lifts, walking in corridors with other patients and visitors and meeting a new team of professionals. O is able to talk, but finds it difficult to express his feelings verbally or process information unless it is presented using a Total Communication Approach (signing, visual support and single to two word level verbal communication). He has a range of behaviours that challenge, including self-injury. He is highly sensitive to the sensory environment and is often chaotic.
- 7.39 Multi-disciplinary assessment – involving input from highly specialist Speech and Language Therapy, Specialist Occupational Therapy, Psychiatry and Learning Disabilities staff – has identified strategies to support O. A member of the team will accompany O throughout the day. Considerable discussion and planning takes place between the team and named nurse at the hospital, including sharing behaviour plans and strategies, to support the appointment.
- 7.40 O is given a day room as his base away from the ward and other children to reduce unpredictable occurrences and provide a quiet environment. He has a Social Story, using symbols the night before, which is referred to across the day.

The use of schedules within schedules shows O what is happening, and what he is doing now and next. Reduced verbal input, consistent scripting, a Total Communication Approach with ample time for processing information, and the use of therapeutic sensory strategies achieve the right level of arousal for each activity. This allows O to undergo the whole assessment in a single day without need of restraint.

Case Study 9. Adapting the classroom and lessons to help a child with acquired brain injury remain in school

Adapting communications to suit individual needs.

- 7.41 T is fourteen. He sustained a brain injury at age eleven following treatment for a brain tumour. T attended a local school. Occupational Therapy (OT) worked together with T, his family and school staff to prevent his behavioural challenges and keep him in school.
- 7.42 T could not remember the school or home routine. This made him extremely anxious and led to him lashing out at his teachers and parents as he could not verbalise how he was feeling. This led to frequent restraint. He was excluded from school and had regular involvement with the police.
- 7.43 The OT worked with T, his parents and school staff to help them to recognise that T's needs from his brain injury were often 'hidden'. Discussion highlighted how T required a lot of energy to remember what was happening in a day and how to organise himself to be able to do the things he needed to do. Greater understanding of T's needs changed the way people interacted with him as they could see his behaviour as a response to his challenges, rather than a deliberate way to get attention.
- 7.44 T used a personal calendar on his mobile phone which he, his teachers and his parents updated to ensure he had a reminder of what was happening in his day. This reduced his anxiety, improved his behaviour and supported his participation in school.
- 7.45 School staff scheduled in some 'down time' for T during the school day, where he used a specific space created in the back of a classroom when he needed to rest for a few minutes; and a 'pass card' signed by the head teacher which he could show to his teacher to give him permission to do so.

- 7.46 Class instructions were given orally and in writing so T could refer back to them. Some activities were broken down into manageable sections so he could focus on one thing at a time. T created a checklist, which he attached to his bag so that he would remember the items he needed to take with him. The teacher also placed T to the side of the classroom and towards the front, so that he was less distracted by the other pupils.
- 7.47 T's behaviour improved significantly, enabling him to remain in full-time education. Preventative strategies and the increased understanding of teachers and parents meant that restrictive interventions were no longer necessary.

Case Study 10. Short breaks provider working with parents for greater stability of support

How working with parents can help with behavioural support.

- 7.48 T is a fifteen year old boy with complex learning and behaviour needs and has been diagnosed with severe autistic spectrum condition. T has been coming to the short break project since 2011 and generally enjoys his visits. His package is 24 overnight and 49 sessions throughout the year. He currently attends a special school and is thriving with their support.
- 7.49 At his previous school T was in a classroom with other young people and attending classes such as English, Maths and Science.
- 7.50 The structured environment started to become a problem for T and his behaviour began to break down. He started to display unusual behaviour such as hair pulling and biting, often without any known triggers. Eventually his behaviour became too difficult for his previous school to support.
- 7.51 As a short break service it is good practice for Key Workers to be in contact with parents.
- 7.52 The short break service were aware of what had been going on at school, but had never seen any of these behaviours and decided to continue with T's visits. Unfortunately, T's behaviour began to break down and he had a couple incidents involving staff. He was provided with 2:1 staffing to help support him.
- 7.53 Staff knew how much the service meant to T and his family; not only did it provide T with somewhere to go other than school or home, but it allowed his parents to spend time with their daughter. So, rather than stopping service completely they asked the family about the best course of action. They decided to get T enrolled into his current school, a special school for children with autistic spectrum

conditions. While he was settling in, T's Keyworker also looked at his behaviour support plan and decided on the best way to support him during this time. It was decided that phasing T back into his visits would allow him to gain confidence within the project.

7.54 This was achieved by:

- having T's mum come in with him for the first few visits and allowing T to decide how long he wanted to stay;
- moving on to have T's mum sitting in another room while he played;
- arranging for T's mum to begin bringing him into the project and leaving him with staff to play;
- after a while, arranging for T's mum to drop him at the door; and
- eventually working up to T having transport to and from school, with overnight visits.

7.55 The service is now continuing routinely on this basis for T and his family.

Case Study 11. Art-Psychotherapy and multi-disciplinary team involvement help a child in care with Attachment disorder

A multi-agency approach to in-depth behaviour planning.

7.56 S was in Year 5 when she was admitted to her current school as a day pupil and is now in Year 8. The school is a special day and residential school for boys and girls aged eight to eighteen with behavioural, emotional and social difficulties who may also have a high functioning autistic spectrum condition. S is looked after by the local authority. Prior to admission she had been living in a local authority children's home with significant levels of support, including a behaviour support plan in which front Ground Recovery physical intervention was a main form of intervention. S's behaviour had resulted in exclusions, absences and time out of class.

7.57 S presented as extremely challenging, with high levels of aggression. The school took immediate steps to better understand why, speaking with the NHS Clinical Psychologist involved with her, to get an insight into the underlying causes of her behaviour. It became apparent that she had a significant Attachment Disorder, so the school focussed on addressing Attachment issues as a means of de-

escalating aggressive behaviours. This helped staff to understand S better and S to understand herself and her circumstances more clearly.

- 7.58 The school developed and agreed with S a behaviour support plan to build her self-esteem and self-confidence. It was clear and unambiguous, with definite strategies and identified personnel to implement them. It included significant levels of support, promoted consistency and security and was reviewed regularly. Her Keyworker was carefully chosen to ensure S could identify with her and form a trusting relationship.
- 7.59 The support plan enabled S to improve her learning and her attainments in both literacy and numeracy and had an extremely positive impact on her self-esteem and self-confidence. From the start the school ensured that S felt very much part of the school. She was encouraged to join after-school clubs and this has enhanced her relationships with other pupils and staff. The improvements led to significant reductions in aggressive outbursts in school. In her time at school, front Ground Recovery holds have never been used and physical intervention has only been used with her on two occasions, neither of them in the last twelve months.
- 7.60 Multi-agency working was very important. An Art Psychotherapist with specialism in Attachment Disorders worked under the supervision of the NHS Clinical Psychologist, who spent a day at the school evaluating her practice. The Art Psychotherapist worked directly with S and spent time with her Form Tutor, Classroom Support Assistant and Keyworker, providing them with valuable insight into her emotional wellbeing and undertaking extensive training with them. This enabled staff who worked with S on a daily basis to adapt and alter their approaches, creating a warm and secure environment with low anxiety; and helped them deal with aggressive behaviour without raising the stakes and de-escalate situations.

Case Study 12. Community facing therapeutic school: improving transition from school to work

Creating a therapeutic environment from school to work.

- 7.61 St. John's comprises a special school in Seaford, East Sussex and an Independent Special Further Education College in Brighton supporting the educational, residential and therapeutic needs of a wide range of young people (aged 5-25) with complex communication and behaviour needs.
- 7.62 Action to reduce use of restraint and restrictive interventions is based on the premise that behaviour is a form of communication and involves a strong focus on

staff training and development and a positive response to complex and challenging behaviours. Resources, time and energy have been invested in five key priorities:

1. Developing a repertoire of communication strategies

A lead practitioner has been appointed to the teaching staff to increase the education team's skill base in communicating with non-verbal learners and to work alongside the Speech and Language Therapy Team. A therapy outcomes measure approach to interventions improves the communication skills of learners through clearly defined and measured time-limited outcomes.

2. Investing heavily in Positive Behavioural Support (PBS)

Each Monday morning all learner facing staff, middle and senior leaders and the chief executive take an hour to plan, write and review behaviour support plans for every learner in the college. Those plans are reviewed six weeks later. A Level 5 trained PBS Leader has been appointed to be a key member of the charity's senior leadership team to give behaviour the status it deserves within the strategic development of our work.

3. Developing a mental health team to sit alongside therapists and counsellors

Many learners have undiagnosed mental health needs or needs that have been over-ridden by their learning difficulty and increased numbers have mental health as a primary or secondary need. Three assistant psychologists with oversight from clinical psychologists have been appointed to improve medical support and improve liaison with local CAMHS and Adult Mental Health Services. The work of the pre-existing counselling team has also been refocused around an outcomes and shorter-term intervention model.

4. Making significant adaptations to learning environments

Much of St. John's learning is community learning and a small group of behaviourally complex learners have programmes which are solely community-based. Where classrooms don't work for specific learners purpose-built safe spaces have been created in the grounds that meet their specific needs. The Employability Team has worked closely with employers to ensure that work placements are available for the most complex learners, as well as those for whom conventional employment is the destination. For the last six years an annual city-centre conference has been held with local employers to take learners with complex behaviours into the heart of the tourist hot spots of the city and enable them to develop their adaptive skills in situ.

5. Simplifying the curriculum offer to focus on five placement outcomes

The whole curriculum is based around five sequential placement outcomes:

well-being > communication > skills > independence > employability

Through consistent and unrelenting focus on these outcomes the aim is to reduce restrictive physical interventions by 90% by 2020. The overall aim is to enable learners with complex and challenging communication methods to take more control and ownership of their own behaviours.

Since learner behaviours affect the well-being of staff a rich and varied programme of staff support is in place, including morning meditation.

Endnotes

¹ Children's Views on Restraint, reported by the Children's Rights Director for England (Ofsted, 2012); *Mental health crisis care: Physical Restraint in Crisis* (MIND, 2012). https://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf

² *The Business Case for Preventing and Reducing Restraint and Seclusion Use* (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2011). <https://edsources.org/wp-content/iframe/seclusion-restraint/Businesscaseagainstrestraint.pdf>

³ A learning disability is defined by three core criteria: lower intellectual ability (usually an IQ of less than 70), significant impairment of social or adaptive functioning, and onset in childhood. Learning disabilities are different from specific learning difficulties such as dyslexia, which do not affect intellectual ability (*Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges*, NICE Guideline 11, 2015) <https://www.nice.org.uk/guidance/ng11>

⁴ Autism is defined as a lifelong developmental disability that affects how a person communicates with and relates to other people, and how they experience the world around them. A term often used to cover a range of conditions on the autistic spectrum (and the one used in this guidance) is autistic spectrum conditions (ASC).

⁵ Mental health difficulties could include emotional disorders, e.g. phobias, anxiety states and depression; conduct disorders, e.g. stealing, defiance, fire-setting, aggression and antisocial behaviour; hyperkinetic disorders, e.g. disturbance of activity and attention; developmental disorders, e.g. delay in acquiring certain skills such as speech, social

ability or bladder control, primarily affecting children with ASC and those with pervasive developmental disorders; attachment disorders, e.g. children who are markedly distressed or socially impaired as a result of an extremely abnormal pattern of attachment to parents or major care givers; and other mental health problems including eating disorders, habit disorders, post-traumatic stress syndromes, somatic disorders and psychotic disorders e.g. schizophrenia and manic depressive disorder.

⁶ See *Behaviour and Discipline in Schools. Advice for head teachers and school staff* (Department for Education, 2016).

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488034/Behaviour and Discipline in Schools - A guide for headteachers and School Staff.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488034/Behaviour_and_Discipline_in_Schools_-_A_guide_for_headteachers_and_School_Staff.pdf)

⁷ See *Behaviour and Discipline in Schools. Advice for head teachers and school staff* (Department for Education, 2016).

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488034/Behaviour and Discipline in Schools - A guide for headteachers and School Staff.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488034/Behaviour_and_Discipline_in_Schools_-_A_guide_for_headteachers_and_School_Staff.pdf)

⁸ Under section 33 of the Children Act 1989.

⁹ This includes unpaid volunteers or parents accompanying students on a school organised visit whom the head teacher has temporarily put in charge of pupils.

¹⁰ *Positive environments where children can flourish: A guide for inspectors about physical intervention and restrictions of liberty* (Ofsted, 2018).

<https://www.gov.uk/government/publications/positive-environments-where-children-can-flourish>

¹¹ <https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

¹² *R(c) v Secretary of State* [2009] QB 657 at [58]

¹³ Relevant legal duties and guidance are set out for each sector in Annex A of this guidance.

¹⁴ The core values and principles apply to the settings and services listed in paragraph 1.13 and will be of interest to those listed in paragraph 1.16.

¹⁵ *A review of restraint systems commissioned for use with children who are resident in secure children's homes* (Independent Restraint Advisory Panel, 2014).

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/376933/irap-restraint-in-youth-custody-report.pdf

¹⁶ Legislation covering schools, children's homes and fostering services allows restraint to protect property under specified circumstances, schools to use reasonable force to stop pupils compromising good order and discipline, and children's homes to prevent children from running away from the home.

¹⁷ Terminology varies according to the different pieces of legislation.

¹⁸ Legislation covering schools, children's homes and fostering services also allows restraint to protect property under specified circumstances, schools to use reasonable force to stop pupils compromising good order and discipline, and secure children's homes to prevent children from running away from the home.

¹⁹ The law and guidance on the recording of restraint differs depending upon the setting or service concerned. See Annex A.

²⁰ <https://www.england.nhs.uk/publication/developing-support-and-services-for-children-and-young-people-with-a-learning-disability-autism-or-both/>

²¹ *The Children's Home Regulations 2015*. Regulations 35(3) and 7(2)(b)(iii)) and associated guidance.

²² *Learning disabilities and behaviour that challenges: service design and delivery*, NICE guideline 93 (NICE, 2018). <https://www.nice.org.uk/guidance/ng93>

²³ James Ridley, Sarah Leitch, Restraint Reduction Network. Training Standards 2019, (British Institute for Learning Disabilities, 2019) http://restraintreductionnetwork.org/wp-content/uploads/2016/11/BILD_RRN_training_standards_2019.pdf

²⁴ *Minimising and Managing Physical Restraint. Safeguarding Processes, Governance Arrangements, and Roles and Responsibilities* (National Offender Management System, Ministry of Justice *et al*, 2012). <https://www.gov.uk/government/publications/minimising-and-managing-physical-restraint>

²⁵ *The Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis* (HM Government, 2014).

https://www.crisiscareconcordat.org.uk/wp-content/uploads/2014/04/36353_Mental_Health_Crisis_accessible.pdf

²⁶ <https://www.nice.org.uk/guidance/ng10>

²⁷ <http://www.safewards.net/>

²⁸ For an example of a hospital passport for children with lifelong conditions, see <http://www.uhbristol.nhs.uk/hospital-passport>.

²⁹ <https://www.england.nhs.uk/learning-disabilities/care/ctr/care-education-and-treatment-reviews/>

³⁰ <http://library.college.police.uk/docs/acpo/Guidance-mental-ill-health-2010.pdf>

³¹ The law and guidance on the recording of restraint differs depending upon the setting or service concerned. See Annex A.

³² <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set>

³³ <https://report.nrls.nhs.uk/nrlsreporting/>

³⁴ *Guzzardi v Italy* (1980) 3 EHRR 333

³⁵ See further <https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance>

³⁶ *Modernising the Mental Health Act. Increasing choice, reducing compulsion Final report of the Independent Review of the Mental Health Act 1983* (December 2018). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/762206/MHA_reviewFINAL.pdf

³⁷ <https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/how-to-support-stomp/#health-care>

³⁸ See *Behaviour and Discipline in Schools. Advice for head teachers and school staff* (Department for Education, 2016). [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488034/Behaviour and Discipline in Schools - A guide for headteachers and School Staff.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/488034/Behaviour_and_Discipline_in_Schools_-_A_guide_for_headteachers_and_School_Staff.pdf)

³⁹ *Nielsen v Denmark* (1988) 10929/84, as discussed in *HL v United Kingdom* (2004) 45508/99, *P v Cheshire West and Chester Council* [2014] UKSC 19, *Re D (Parental Responsibility: Consent to 16-Year-old Child's Deprivation of Liberty)* [2017] EWCA Civ 1695.

⁴⁰ http://www.echr.coe.int/Documents/Convention_ENG.pdf

⁴¹ *Mental Capacity Act 2005 Code of Practice* (Department of Health, 2016). <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice> Useful information on the Mental Capacity Act is also available at <http://www.scie.org.uk/mca-directory/>

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