



Department  
of Health



Department  
for Education

# Reducing the Need for Restraint and Restrictive Intervention

Children and Young People with Learning  
Disabilities, Autistic Spectrum Disorder and Mental  
Health Difficulties

DRAFT

*DRAFT GUIDANCE – FOR CONSULTATION*

November 2017

<p><b>Title: Reducing the Need for Restraint and Restrictive Intervention – Children and Young People with Learning Disabilities, Autistic Spectrum Disorder and Mental Health Difficulties</b></p>
<p><b>Author: Community Care / Mental Health, Dementia and Disabilities/ DDU / 18277</b></p>
<p><b>Document Purpose:</b> Draft Guidance for Consultation</p>
<p><b>Publication date:</b> January 2017</p>
<p><b>Target audience:</b> Professionals, health providers, social care providers, local authorities, clinical commissioning groups, special schools</p>
<p><b>Contact details:</b> Dementia and disabilities unit 2E56, Quarry House, Quarry Hill, Leeds LS2 7UE <a href="mailto:ddu@dh.gsi.gov.uk">ddu@dh.gsi.gov.uk</a></p>

You may re-use the text of this document (not including logos) free of charge in any format or medium, under the terms of the Open Government Licence. To view this licence, visit [www.nationalarchives.gov.uk/doc/open-government-licence/](http://www.nationalarchives.gov.uk/doc/open-government-licence/)

© Crown copyright

Published to gov.uk, in PDF format only.

[www.gov.uk/dh](http://www.gov.uk/dh)

# Reducing the Need for Restraint and Restrictive Intervention

Children and Young People with Learning  
Disabilities, Autistic Spectrum Disorder and Mental  
Health Difficulties

**Prepared by the Department of Health and the Department for Education**

# Contents

Contents.....	4
Chapter 1: Introduction.....	5
Chapter 2: A Positive and Proactive Approach to Behaviour .....	10
Chapter 3: Values and Principles.....	12
Chapter 4: Key Actions for Settings and Services.....	14
Chapter 5: Different Forms of Restraint .....	27
Summary of Actions.....	30
Annex A .....	31
Annex B .....	39
References.....	49

# Chapter 1: Introduction

## Definitions

1. This guidance is about:

- ‘Restraint’ – using force or restricting liberty of movement
- ‘Restrictive intervention’ – a deliberate act to restrict a person’s movement, liberty and/or freedom to act independently

Generally, the first term is used in legislation and guidance applicable to children’s homes and foster placements, and the second is used in relation to health and care settings. Throughout the guidance that follows we use the term ‘restraint’ to cover all services and settings.

The relevant provisions in legislation also 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.<sup>1</sup>

## Aims of this Guidance

2. This guidance aims to help special education, health and care settings to develop plans to support children and young people whose behaviour challenges, in order to reduce the incidence and risk associated with that behaviour; and to promote and safeguard the welfare of children and young people in their care. Eliminating inappropriate use of restraint is vital in this. It is particularly important in relation to children, who are still developing both physically and emotionally and for whom any trauma at this formative stage in their development could be very damaging and have long term consequences.
3. The personal costs to children and young people’s development and welfare and to staff from the use of restraint are well documented<sup>2,3</sup>. Research<sup>4</sup> has shown that restraint and seclusion increases the daily cost of care and contributes to significant workforce turnover. 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.

---

<sup>1</sup> Mental Health Act 1983 Code of Practice, 2015 [Chapter 26]

<sup>2</sup> Children’s Views on Restraint, reported by the Children’s Rights Director for England (Ofsted, 2012)

<sup>3</sup> Mental health crisis care: Physical Restraint in Crisis: London (MIND, 2012)

<sup>4</sup> The Business Case for Preventing and Reducing Restraint and Seclusion Use, US Department of Health and Human Services Substance Abuse and Mental Health Services Administration (2011)

## Chapter 1: Introduction

4. Children and young people with learning disabilities<sup>5</sup>, autistic spectrum disorders (also referred to as autism in this document) and mental health issues may often respond with challenging behaviour (verbal or non-verbal) when they are confronted with situations they do not understand, which cause anxiety or fear, and for which they have not been prepared. The likelihood of such behaviour can often be anticipated by those who know the child best. Measures to prevent or address it can be developed with the involvement of the child or young person and their family, careful assessment and multi-agency planning and support.
5. 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 planning, the assessment and management of risks and the use of evidence-based practice so that restraint is used appropriately, only where necessary, by trained staff and in line with the law, core values and ethical principles.

## Status of this Guidance

6. This guidance is non-statutory and advisory. It applies to the following settings:
  - Maintained special schools
  - Special academies and special free schools
  - Non-maintained special schools
  - Special post-16 institutions
  - Special schools or PRUs delivering hospital education (i.e. education provided at a community special school or foundation special school established in a hospital, or under arrangements made by a local authority under section 19 of the 1996 Education Act as 'exceptional provision of education').
  - Those independent educational institutions which could apply/have applied to the Secretary of State for Education for approval (under section 41 of the Children and Families Act 2014) to be named in an Education, Health and Care plan. Once approved, such institutions are legally obliged to admit a child whose plan names them as the appropriate placement.
  - Children's homes (including secure children's homes)
  - Residential holiday schemes for disabled children
  - Local authority approved foster care placements (which includes independent foster agency placements) and
  - All settings providing health care commissioned by the National Health Service

---

<sup>5</sup> 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 2015)

## Chapter 1: Introduction

(All types of special school listed above include residential and non-residential).

7. It 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 Disorder and mental health issues, in these settings. These are children and young people who have presented challenging behaviour which has, to date, led to use of restraint and restrictive intervention at a greater frequency, or to a greater degree, than for the majority of children and young people of a similar age.
8. The guidance will be of interest and relevance to local authority and health service commissioners and managers; special educational needs and disability teams; social care and looked after children teams; special school proprietors and governing bodies, head teachers and staff in special schools; and management teams and staff in health and social care settings listed above. It will also be of interest but does not apply to:
  - Mainstream schools (including Academies and Free Schools)
  - General further education colleges
  - Independent mainstream schools and colleges
  - Pupil Referral Units (with the exception of those providing hospital education) and all providers of Alternative Provision (AP), including AP Academies and AP Free Schools, with the exception of hospital schools or
  - The police and staff working within Young Offenders Institutions and Secure Training Centres, for whom other guidance applies.

## The Legal Framework

9. The use of all forms of physical intervention and physical contact are governed by criminal and civil law. The unwarranted or inappropriate use of force may constitute an assault and may also infringe a child or young person's rights under the Human Rights Act 1998. The use of restraint can be justified for purposes set out in relevant legislation and 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.

## Relationship to other Advice and Guidance

10. The guidance replaces:
  - *Guidance for Restrictive Physical Interventions: How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder (2002, DfES and DH)*; and

## Chapter 1: Introduction

- *Guidance on the Use of Restrictive Physical Interventions for Pupils with Severe Behavioural Difficulties (2003, DfES and DH).*

11. It 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).*

12. It does not replace other current and relevant guidance for schools, health services and settings and social care services and should be read alongside that guidance referred to at Annex A.

## Inspections

13. CQC and Ofsted will have regard to this guidance when assessing whether institutions and service providers are providing safe and appropriate education and care. The CQC's new system of registration, regulation and inspection holds corporate and NHS boards to account for failings in care. In extreme circumstances the CQC has the power to prosecute providers without issuing prior warning notices.

14. During service visits and routine reviews, the CQC will make sure that children who are exposed to restrictive interventions have access to high quality care and support plans, designed, implemented and reviewed by staff with the necessary skills; and that restrictive interventions are undertaken lawfully.

15. Ofsted will review the use of any restraint or restrictive practice during inspection and take appropriate enforcement action if they consider that there has been a breach of the Children's Home Regulations or the National Minimum Standards in a Residential Special School.

## Role of Commissioners

16. 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 effectively support those whose behaviour challenges and have arrangements in place to promote positive behaviour and reduce risk, and eliminate the unnecessary use of restraint.



## Chapter 1: Introduction

This includes assuring themselves that providers of care and/or education services meet the needs of the children and young people concerned; 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.

## Chapter 2: A Positive and Proactive Approach to Behaviour

17. Eliminating inappropriate use of restraint and minimising its use calls for settings and services to have a positive and proactive approach to behaviour with:

- Policies, strategies and practices which promote a positive culture and positive behaviour.
- Arrangements which identify, assess and manage risk well.
- High quality training for staff.
- Involvement of children and young people, parents and carers.
- Tailored support for individual children and young people that takes account of their impairments and their interaction with the environment in which they are taught and cared for and responds to their growth and development over time.
- Clear arrangements for governance and accountability.

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

- Adjustments to the environment in which children and young people are taught, treated and cared for to address factors that are likely to increase or decrease the likelihood of restraint.
- Deployment of approaches and techniques to de-escalate or calm situations that are appropriate to the child or young person and take account of their views.
- Use of appropriate external expertise when needed.

19. In considering their 'hierarchy of responses' settings and services will need to ensure they fulfil their duties under the Equality Act 2010 towards disabled children and young people. They must think ahead and make reasonable adjustments to avoid discriminating against disabled people. This involves adjustments to 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. Further information on the Equality Act can be found at Annex A.

20. Behaviour is a means of communication and all behaviour has a purpose. Behaviour that challenges may signal a need for support. Behaviour policies and practice should recognise this and support children and young people to develop alternative ways of expressing themselves that achieve the same purpose but in more appropriate ways.

## Chapter 2: A Positive and Proactive Approach to Behaviour

21. Special schools, children's homes, NHS commissioned health services and local authority approved providers of foster care have responsibilities to protect the welfare and safety of children and young people in their care.
  
22. Sometimes restraint will be necessary. Staff must have reasonable grounds for believing that restraint is necessary in order to justify its use. Staff will need to use their professional judgement in each case, assessing the risks involved and taking account of the needs and circumstances of the child or young person (as set out in relevant support plans drawn up for them).

## Chapter 3: Values and Principles

23. The use of restraint should be consistent with clear values and sound ethical principles, as well as complying with the relevant legal requirements.

### Core Values

24. The following core values, drawn up with reference to the Independent Restraint Advisory Panel's review of restraint systems used in secure children's homes<sup>6</sup>, are relevant to all of the settings and services to whom this guidance applies:

- A focus on the child or young person's safety and welfare should underpin any use of restraint.
- Children, young people and staff, should be treated fairly and with dignity and respect.
- Minimising the risk of harm to children, young people and staff should be a key priority.
- The needs and circumstances of individual children and young people should be considered and balanced with the needs and circumstances of others because decisions on whether or not to restrain or intervene with an individual affect others, including staff.
- Where possible, a decision to restrain a child or young person should be based on their best interests balanced against respecting the safety and dignity of all concerned, including other children, young people or adults present.

### Key Principles

25. The following key principles are offered to guide settings and services in developing their policies and practice on behaviour and the use of restraint:

- There will be times when restraint is needed to safeguard the individual or others but, broadly speaking, restraint should be the last response to behaviour that challenges. De-escalation techniques, appropriate to the child or young person, set within a positive and proactive approach to behaviour, should always be used to try and avoid the need to use restraint.
- Use of restraint should be based on assessment of risk.

---

<sup>6</sup> A review of restraint systems commissioned for use with children who are resident in secure children's homes (June 2014).

### Chapter 3: Values and Principles

- There would be a real possibility of injury or harm<sup>7</sup> to the child or young person, other children or young people, to staff, the public or others<sup>8</sup> if no intervention or a less restrictive intervention were undertaken.
- An intervention should be in the best interests of the child or young person and balanced against respecting the safety and dignity of all concerned, including other children, young people or adults present.
- Restraint should not be used to punish or with the intention of inflicting pain, suffering or humiliation.
- The techniques used to restrain or restrict liberty of movement must be reasonable and proportionate to the circumstances, risk and seriousness of harm; and be 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, must be subject to audit and monitoring and be open and transparent.
- When reviewing plans for restraint with children and young people, those with parental responsibility or, where appropriate, advocates should be involved.

---

<sup>7</sup> Terminology varies in the relevant pieces of legislation.

<sup>8</sup> Regulations covering schools, children's homes and fostering services also allow restraint to protect property under specified circumstances.

# Chapter 4: Key Actions for Settings and Services

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

## Summary of Key Actions for Settings and Services

- Have a clear policy for promoting positive relationships and behaviour, including measures for understanding the causes of behaviour, assessing, managing and reducing risk, and reducing the need for restraint.
- Have clear arrangements for governance and accountability for supporting children and young people whose behaviour challenges and for use of restraint, including arrangements for working across services.
- Involve children, young people and their parents/carers as appropriate in decisions relating to behaviour and use of restraint.
- 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.
- Have a system in place for improving assessment and management of risk.
- Have a system for recording and reporting incidents (distinguishing between planned and unplanned interventions).
- Have a system in place for reviewing how restraint is used in individual cases to inform changes in approach where necessary.

## A Clear Policy

27. All settings and services will need to ensure policies on behaviour and 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 paragraphs 25 and 26 above.

28. Individual policies should be developed with regard to any wider local restraint strategies which may have been developed. For care and education services, this may include policies developed in response to ADCS guidance 2009<sup>9</sup>.

---

<sup>9</sup> A protocol for local children's services on restrictive physical interventions in schools, residential and other care settings (Association of Directors of Children's Services Health, Care and Additional Needs Task Group, 2009)

29. It is good practice, and in some cases a legal requirement, for policies to set out:

- The measures taken to encourage effective communication and positive behaviour, including adjustments to the environment which help to reduce stress and anxiety and the potential for challenging behaviour. This should include the way staff interact/communicate with children and young people.
- How support is provided for those whose behaviour challenges – including strategies for prevention, de-escalation or defusion which can avert and reduce the need for restrictive intervention, and the development and regular review of support plans for individual children and young people.
- How children, young people and parents/carers and other agencies are involved in supporting positive behaviour, including individual support plans.
- Circumstances in which it may be appropriate to use restraint.
- How staff are trained in supporting positive behaviour, assessing and managing risk, and using restraint appropriately where necessary, including how training is maintained and reviewed.
- Arrangements for reporting and recording use of restraint.
- Arrangements for providing support (emotional and, where necessary, medical) to children and young people and staff following use of restraint.
- Arrangements for monitoring the use of restraint.
- Arrangements for considering complaints.
- Details of how the behaviour policy will be reviewed, evaluated and where necessary amended.

## Governance and Accountability

30. 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.

31. Governance arrangements should include 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.

32. Settings and services should 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 inappropriate 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.

## Involving Children and Young People, Parents and Carers

33. For children and young people with special educational needs and disabilities, including those with learning disabilities, Autistic Spectrum Disorder and mental health difficulties, Part 3 of the Children and Families Act 2014 (section 19) requires local authorities, when carrying out their functions, to have regard to:
- The views, wishes and feelings of the child and his or her parent.
  - 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 where his or her parent, or the young person, being provided with the information and support necessary to enable participation in those decisions.
  - 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.<sup>10</sup>
34. Involving children and young people in decisions about their education, health and care is central to ensuring that support meets their needs and enables them to achieve good outcomes.
35. Children and young people who have difficulties with speech, language and communication, have limited speech, or physically cannot speak will use different ways of communicating. It is important that approaches to engaging them in decisions involve those means of communication. 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.

## Evidence Based Approaches

### Behaviour strategies

36. Strategies for promoting positive behaviour and managing behaviour that challenges should be consistent with the core values and key principles in paragraphs 25 and 26 above and support the setting or service's own behaviour policy.

---

<sup>10</sup> For some children in care it may not be appropriate to involve the birth parents but instead involve those with corporate parental responsibility or a suitable advocate or representative who knows the child or young person. This applies to references to parents and parental involvement throughout this guidance.



## Chapter 4: Key Actions for Settings and Services

37. Effective behaviour strategies address how staff will be trained and developed and include provision for behaviour support plans to be made for individual children and young people whose behaviour challenges. It is essential that strategies are kept under review so that changes can be made based on evidence of what has worked and what has not worked in practice.
38. It is possible to achieve significant reductions in the need to use restrictive intervention through specific reduction programmes. Many services are reducing the incidence of violence and aggression with less restrictive approaches. Settings and services will wish to consider developing their own explicit restraint reduction programmes as part of their behaviour strategies. Examples in education and health contexts are given in Annex B.

### Positive behavioural support

39. The term positive behavioural support is used here to describe a framework for understanding the context and meaning of behaviour and developing interventions to support individual children and young people. Evidence has shown that approaches using such a framework can enhance quality of life and reduce behaviours that challenge. This can, in turn, reduce the need for restraint.
40. Different approaches are available which use a positive behavioural support framework. Settings and services will wish to select those which best meet their needs and circumstances.
41. Approaches using the positive behavioural support framework typically involve:
- Person-centred planning – assisting the child or young person to develop personal relationships and for staff to understand them as individuals.
  - Skilled assessment – to understand why a child or young person presents behaviours that concern or challenge; what predicts their occurrence or causes the child to continue presenting them or regularly reverting to them. This can help to identify areas of unmet need.
  - Behaviour support plans – to describe how the child or young person is to be supported, addressing aspects of their environment which they find challenging and support to help them develop strategies to better meet their own needs.
42. Behaviour support plans will typically detail the responses used by staff when a child or young person starts to become anxious, aroused or distressed and which aim to prevent the situation escalating into a crisis, for example, distraction or diversion. They will also include guidance on how people should react when a child or young person's behaviour further escalates to a point where they place themselves and/or others at significant risk of harm. Plans should be kept under review as the child or young person grows and develops.

43. Behaviour support 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, and their family or advocates. Examples of successful positive behavioural support are given in Annex B.

### Training and Development of Staff

44. Training and development play a crucial role in promoting positive behaviour. They enable staff to develop the understanding and skills to support those whose behaviour challenges and helps parents to secure a consistent approach to behaviour in school and at home.

45. Training should be tailored to take account of the needs of the children and young people being taught and/or cared for and to the role and specific tasks that staff will be undertaking. It should cover approaches to reducing and minimising the need for restraint through 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.

46. 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.

47. Training could usefully include knowledge, understanding and skills in relation to:

- The experience of children, young people and their families
- Techniques for understanding non-verbal communications of children
- The thoughts and feelings of staff on being exposed to challenging behaviour
- The assessment and management of risks
- Building positive relationships and developing individual support plans
- Alternatives to restraint, including effective use of techniques to calm a situation or de-escalate potentially restrictive options
- Safe implementation of restraint, including how to minimise associated risks, particularly in relation to 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.

48. There are no universally accepted standards for the use of restraint or training, in this field. The British Institute of Learning Disabilities (BILD) offers voluntary quality accreditation schemes for training providers and has produced a range of publications and materials on

## Chapter 4: Key Actions for Settings and Services

support for those whose behaviour challenges. The Institute of Conflict Management has also developed a Quality Award Scheme, established with the support of the Health and Safety Executive.

49. 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 will wish to ensure that any training and development commissioned is consistent with the core values and key principles in paragraphs 25 and 26 above and 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.

## Assessing and Managing Risks

50. 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 improve foresight by:

- Exploring why children or young people behave in ways that pose a risk
- Trying to understand the factors that underlie or influence the behaviour
- Recognising the early warning signs which indicate that the behaviour is beginning to emerge
- Developing the skills to manage difficult situations competently and sensitively.

51. A decision on whether or not to use restraint will always require a consideration of the individual circumstances and is a matter of professional judgement.

52. 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 the child or young person's challenging behaviour, or measures and interventions used to limit or manage risks to the child and/or others.

53. 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.

## Chapter 4: Key Actions for Settings and Services

54. 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.
55. This will enable decisions to be made which:
- 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.
  - Ensure that an intervention is reasonable and proportionate to the risks that it presents.
56. When considering whether to use restraint with a child or young person, staff should ask themselves: “What would I want somebody to do in similar circumstances if this was my child?”
57. In assessing risk staff should take into account:
- The size, age and understanding of the child or young person
  - The specific hazards they face
  - Any relevant disability, health problem or medication
  - The relative risks of not intervening
  - The child or young person’s previously sought views, 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
  - The impact of the restraint on the future relationship with the child or young person
58. Options for reducing risks should be 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 will wish 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
  - Health and wellbeing Board
59. Measures agreed for managing identified risks should be set out in an agreed support plan for the child or young person. The child and their parent/carer or the young person should

## Chapter 4: Key Actions for Settings and Services

be fully involved in the process as appropriate. 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.

60. Regular reviews of risk assessment and management measures, including arrangements for staff training and development, inform future planning and help to improve day-to-day practice.

## Planned and Unplanned Interventions

61. Planned interventions are when staff employ, where necessary, planned and agreed approaches to challenging behaviour set out in a child or young person's support plan or care plan. Action to restrain a child or young person will be based on a careful risk assessment, including an understanding of their needs and evidence about the risks faced.
62. 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 be reasonable, proportionate and use the minimum force necessary in order to prevent injury and maintain safety.
63. 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 plans. Plans should include, where appropriate, planned and agreed approaches to restraint to be applied in the day to day routine of the child. An unplanned intervention for a child or young person with a support plan should prompt discussion about whether the plan needs to be changed.

## Services and Settings where Children and Young People may not be known

64. The core values and key principles in paragraphs 25 and 26 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.

65. In services like these, where people's histories and care needs may not be known or understood, individual planning will not be possible, but 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 challenging behaviour, 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.
66. 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*<sup>11</sup> contains guidance for specific settings including A&E (accident and emergency) and primary care. Where the Safewards<sup>12</sup> 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. Services and settings may wish to consider whether similar approaches could be replicated in their own context. NHS protect provides useful guidance<sup>13</sup> on understanding and responding to behaviour that challenges, whether or not it was anticipated.
67. A number of health and voluntary and community sector organisations have developed 'hospital passports' for people with learning disabilities or autism. 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<sup>14</sup>. 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

68. There should be a clear local protocol about the circumstances when, exceptionally, police may be called to manage a young person's behaviour within a setting. Staff should be alert to the risk of any respiratory or cardiac distress and continue to monitor the young person's physical and psychological wellbeing throughout the incident of restraint.

---

<sup>11</sup> <https://www.nice.org.uk/guidance/ng10>

<sup>12</sup> <http://www.safewards.net/>

<sup>13</sup> <http://www.nhsprotect.nhs.uk/reducingdistress/>

<sup>14</sup> For an example of a hospital passport for children with lifelong conditions see <http://www.uhbristol.nhs.uk/hospital-passport>.

## Chapter 4: Key Actions for Settings and Services

69. NHS Protect guidance indicates trigger points for seeking further assistance from the police. Police called upon to help manage a dangerous situation will use techniques and act in accordance with their professional training. Care and support staff are responsible for alerting police officers to any specific risks or health problems that a young person may have as well as monitoring the young person's physical and emotional wellbeing and alerting police officers to any specific concerns.
70. 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.<sup>15</sup>

## Safeguarding the Welfare of Staff

71. Where settings and services are employers, they have a duty under the Health and Safety at Work Act 1974 to ensure, so far as is reasonably practicable, that the health, safety and welfare at work of their employees and the health and safety of others affected by the employer's undertaking is safeguarded. 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.
  - 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

72. Settings and services are expected and depending on the type of setting or service may be required to record occasions where restraint is used, whether planned or unplanned.
73. Ofsted and CQC will review the recording or failure to record any use of restraint and determine if this meets the requirements of the relevant regulations, guidance or standards as appropriate.

---

<sup>15</sup> <http://library.college.police.uk/docs/acpo/Guidance-mental-ill-health-2010.pdf>



## Chapter 4: Key Actions for Settings and Services

74. In health services, record keeping should be consistent with the requirements of the Mental Health and Learning Disability Minimum Dataset and the National Reporting Learning System. Services must publish, annually updated, accessible report on their behaviour support planning and restrictive intervention reduction programmes, which outlines the training strategy, techniques used (how often) and reasons why, whether any significant injuries resulted, and details of ongoing strategies for bringing about reductions in the use of restrictive interventions.
75. 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.
76. 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 a specific statutory requirement but must have behaviour policies in which the school should set out procedures for record keeping and reporting of incidents involving reasonable force.

## Post-incident Support

77. 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.

## Reviewing Actions to Improve Support

78. Settings and services should ensure that appropriate lessons are learned from instances where restraint has had to be used. This will usually involve de-briefing and post-incident review and monitoring of the use of restraint and restrictive intervention. The process should consider individual plans and wider policies.
79. 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

80. 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 the manager to deal with the emotions raised by the incident. This improves staff learning and contributes to professional development.
81. Whenever restraint has been used, staff and children and young people 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.
82. Wherever possible, the families of children and young people should have the opportunity to participate in post-incident reviews – though this may not always be appropriate, for instance when the child is looked after by a local authority. Someone appropriate and trusted by the child and their family or, where appropriate, a child'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.
83. 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 and family - whether the setting or service did not understand what was needed, what upset the child most, whether and how staff actions were helpful or unhelpful, and how things could be better in the future.
84. If there is a pattern of persistent use of restraint, the reviewer should consider, with the child or young person, and as appropriate their parents/carers and/or advocates, revising their individual support plan.

## Monitoring

85. 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 challenging behaviour 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.

## With a View to the Future

86. Children and young people with learning disabilities, autism or mental health difficulties and challenging behaviour face difficult transitions when moving from settings that they have become familiar with, in particular, those which they have been attending daily or where they are resident. Services and settings should therefore cover expected transitions in children's behaviour plans. When young people are moving on to adult provision, for instance, early planning is essential to share what works with the new service or setting, to enable familiarisation for the young person, involving them and where appropriate, their parents or carers.

## Chapter 5: Different Forms of Restraint

87. Restraint can take a number of forms. There are particular considerations with each but use of any form of restraint must be lawful and based on individual circumstances. It should be consistent with the core values and key principles in paragraphs 25 and 26 above, including an appropriate assessment of risks.
88. For children and young people detained under the Mental Health Act 1983, the Mental Health Act Code of Practice 2015 (see footnote 1) 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.

The different forms of restraint apply generally and not only to those detained under the Mental Health Act:

### Physical restraint

89. Staff must not cause deliberate 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. Care should be taken to avoid restraining children and young people in a way that impacts on their airways, 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, exceptionally, held on the ground, staff should release their holds or reposition into a safer alternative or standing position as soon as possible.
90. 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

91. 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 should not be a first response to managing challenging behaviour but may be used to manage extreme violence directed towards others or to limit self-injurious behaviour of extremely high frequency and intensity. This contingency is most notably encountered with small numbers

## Chapter 5: Different Forms of Restraint

of children 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. Devices must be put in place by people with relevant qualifications, skill and experience. Wherever mechanical restraint is used as a planned contingency it must be identified within a support plan which aims to create circumstances where continued use of mechanical restraint will no longer be required.

### Medication (chemical restraint)

92. Chemical restraint refers to the use of medication prescribed and administered for the purpose of quickly controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness. It should not be used routinely or as a first response, but only for a child or young person who is highly aroused, agitated, overactive, aggressive, is making serious threats towards others, or is being destructive to their surroundings and 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 challenging behaviour without an appropriate clinical reason.
93. Chemical restraint should be used only 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).

### Withdrawal and Seclusion

94. Withdrawal involves removing a child or young person from a situation which causes anxiety or distress and taking them to a safer place where they have a better chance of composing themselves. Staff would normally stay with the child to support them and monitor their progress until they are ready to resume their usual activities. This form of restraint could be regarded as a restriction of liberty but one taken under a setting's duty of care in order to protect the child from harm, or risk of harm, to themselves and/or others. Reasonable force can be used by staff in those circumstances, where it is necessary. An example is given in Annex B.
95. 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. Staff should take steps to support them and

## Chapter 5: Different Forms of Restraint

monitor their progress. Where this is the case, appropriate provision should be made in their support plan and kept under review. It is unlikely that this would constitute restraint.

96. Seclusion refers 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 is designed to contain severely disturbed behaviour which is likely to cause harm to others. The courts have found that seclusion could be used with a young person where it was necessary in order to control aggressive behaviour but only for so long as was necessary, proportionate and the least restrictive option likely to succeed, and in accordance with a risk and restraint reduction plan and support plan designed to safeguard their psychological and physical health. For young people over 16, without mental capacity, use of seclusion which amounts to a deprivation of liberty must be authorised under the Mental Capacity Act 2005.
97. As noted above, for children detained under the Mental Health Act (MHA) 1983 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 Mental Health Act (an informal patient) and, as a last resort, seclusion is necessary to protect 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

98. Long-term segregation, where a child or young person is prevented from mixing freely with other children or young people, should only be used 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. Long-term segregation must never take place outside of hospital settings and should never be used with children who are not detained under the MHA. It must only ever be undertaken in conjunction with the safeguards for its use in the MHA Code of Practice.

## Blanket Restrictions

99. Oppressive environments and the use of blanket restrictions such as locked doors, lack 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 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 and other relevant legislation and the reasons for them should be explained to children and young people and to their families.

# Summary of Actions

101. The negative impact that the use of restraint has on children and young people and those that care for them has been well documented<sup>16</sup>.
102. Children and young people with learning disabilities, autism or mental health issues who have previously exhibited challenging behaviour are at particular risk of restraint and steps should be taken to ensure that the need for restraint is minimised.
103. Health and care services and special schools wishing to minimise the need to use restraint should:
  - Have policies in place for promoting positive relationships and behaviours and eliminating unnecessary restraint
  - Have clear arrangements for governance and accountability
  - Involve children, young people and their parents/carers as appropriate in decisions relating to behaviour and use of restraint
  - Use evidence based approaches to promoting positive behaviour
  - Ensure staff are suitably trained in minimizing and safely using restraint and provide opportunities for regular staff development;
  - Have a system in place for continually improving assessment and management of risk
  - Have a system for recording and reporting incidents
  - Have a system in place for reviewing how restraint is used in individual cases

---

<sup>16</sup> References to two relevant publications are at footnotes 2 & 3 above

# Annex A

Alongside the core values and principles set out in this guidance, readers should also refer to current relevant guidance for schools, health services and settings and social care services.

## Legal Duties and Relevant Guidance

1. 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.
2. It includes references to the legislation which is applicable to each service and setting which this guidance addresses and also information on the guidance applicable to particular services. Where there are specific duties relevant to particular types of setting or services these are set out under the section headings used in this guidance.
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 relevant to restrictive interventions, and the degree of restriction that might amount to an unlawful deprivation of liberty, continues to evolve and services should review and update their local policies on an on-going basis in light of legal developments.

### Human Rights Act 1998

4. All services must abide by the Human Rights Act (HRA). The HRA imposes a duty on public authorities (including NHS Trusts, schools and Local Authorities) and services, exercising functions of a public nature, not to act in a manner that is incompatible with the European Convention on Human Rights (ECHR)<sup>17</sup>. 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).

---

<sup>17</sup> [http://www.echr.coe.int/Documents/Convention\\_ENG.pdf](http://www.echr.coe.int/Documents/Convention_ENG.pdf)

## Annex A

5. Services and settings 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 guidance that applies to specific services and settings. Action that is not justified may well breach article 3 of the ECHR, which prohibits inhuman or degrading treatment.

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.

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

8. All settings and services must ensure that they comply with the Equality Act 2010 which requires that they do not discriminate against individuals with protected characteristics (these include gender, sexual orientation and disability). 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 they have a protected characteristic (direct discrimination);
- Apply a provision, criterion or practice that puts an individual with a protected characteristic at a disadvantage compared to someone without a protected characteristic, for example by having a blanket behaviour policy that is applied in the same way to all (indirect discrimination);
- Behave in a way which violates the dignity of an individual with a protected characteristic or creates an intimidating, hostile, degrading, humiliating or offensive environment (harassment); and
- Single out individuals with protected characteristics for unfair treatment, for example if they or their parents complain about how support has been provided or not provided (victimisation).

## Restriction and deprivation of liberty

9. The Mental Capacity Act 2005 protects the rights of adults and young persons (those aged 16 and over) who lack the mental capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken. In general,



## Annex A

it allows certain actions to be taken if they are in the best interests of the person who lacks capacity, and provides for Court authorisation of certain decisions and treatment.

10. The Mental Capacity Act Code of Practice<sup>18</sup> provides statutory guidance on the use of the Act, including issues around care and treatment (including restraint). There is a separate Code of Practice on the deprivation of liberty of those who lack capacity. It should be referred to by those working with and/or caring for young people (16 and 17 olds) who may lack capacity to make particular decisions. It describes their responsibilities when acting or making decisions on behalf of individuals who lack the capacity to act or make these decisions for themselves.

11. The Act does not apply in cases where a person is under 16 years of age and/or does not lack capacity as defined in the Act. In those circumstances, valid consent must be obtained (from the person or someone with parental responsibility, as appropriate), or the action will need to be authorised by a Court. Whether parental consent can validly authorise a deprivation of liberty for children under 16 or with capacity has been subject to developing case law<sup>19</sup>. Practitioners should therefore seek legal advice before deciding whether consent is appropriate or whether a court order will be needed. The Codes of Practice on the Mental Health Act and Mental Capacity Act provide further information about when children and those with parental responsibility can give valid consent to the use of restrictive practices for children (where applicable) and young people (references to these Codes of practice for the Mental Health Act and Mental Capacity Act are at footnotes 1 and 18 respectively).

12. Useful information on the Mental Capacity Act and the DoLS is also available at <http://www.scie.org.uk/mca-directory/>.

## Health Services

### Mental Health Act 1983

13. 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.

---

<sup>18</sup> Mental Capacity Act 2005 Code of Practice, 2007

<sup>19</sup> AB (a child) [2015] EWHC 3125 (Fam); and Birmingham City Council and D [2016] EWCOP 8

## Annex A

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.’*

15. Chapter 26 of the Code of Practice includes guidance on the use of such interventions, including guidance at paras 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.

## Health and Social Care

### NICE Guidelines

16. NICE Guidelines make evidence-based recommendations on a wide range of topics and represent best practice. Services and settings 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 under19s: 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

## Schools

### Use of restraint

17. Section 93 of the Education and Inspections Act 2006 allows the use of **reasonable** force:

- To prevent the committing of any offence;
- To prevent personal injury to, or damage to the property of any person (including the pupil themselves); or
- To maintain good order and discipline.

There are separate powers for schools to conduct a search for prohibited items and to issue detentions.

18. Guidance on the use of reasonable force is provided by the non-statutory guidance *Use of reasonable force: Advice for head teachers, staff and governing bodies* (DfE, July 2013).

19. In developing policies on behaviour, schools should also have regard to the DfE guidance *Behaviour and Discipline in Schools* (January 2016).

20. Special schools must have policies on behaviour and the measures of control, discipline and restraint that may be used. They must make their policies known to staff, parents and pupils. (As set out in *Behaviour and Discipline in Schools* (January 2016)).

21. 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* (DfE, 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 paragraph 27 below).

### Use of Medicines

22. 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 school governing bodies and proprietors of academies must ensure that arrangements are in place to support pupils with medical conditions; these may include drawing up individual healthcare plans for children and young people at the school. Staff undertaking risk assessment and planning for children at higher risk of restraint should also refer to their individual health care plans for information about their medical condition, associated risks and agreed actions.

## Annex A

23. In implementing section 100, schools must have regard to the statutory guidance *Supporting pupils at school with medical conditions (December 2015)*

### Children's Home

24. Children's Homes are governed by the *Children's Homes (England) Regulations 2015*. These cover:

- Use of restraint (regulation 20);
- Behaviour policies including monitoring, reporting and recording (regulation 35); and
- Employment of suitably trained and qualified staff (regulation 32(3)(b)).

25. Guidance for services on meeting the regulations are set out in the *Guide to the Children's Homes Regulations including the quality standards (DfE, April 2015)*.

26. In addition, secure children's homes will also be justified in preventing a child or young person from running away from the home as long as the placing local authority has obtained a court order under section 25 of the Children Act 1989<sup>20</sup> and, for a child under 13 years of age, the consent of the Secretary of State for Education (see also *Guide to the Children's Homes Regulations including the quality standards (DfE, April 2015)- Annex B – Additional information for secure children's homes*).

### Foster Services

27. Foster Services are governed by the *Fostering Services (England) Regulations 2011*. These cover:

- Control, restraint and discipline
- Preparation of policies; and
- Monitoring and Reporting.

28. Guidance on fostering service regulations can be found in *The Children Act 1989 Guidance and Regulations Volume 4: Fostering Services (2011)*.

### Residential Holiday Schemes for Disabled Children

29. These schemes are governed by the *Residential Holiday Schemes for Disabled Children (England) Regulations 2013* which include:

---

<sup>20</sup> After an initial period of 72 hours where the criteria in section 25 must apply, but a court order is not needed.

## Annex A

- Use of restraint (Regulation 15); and
- Behaviour management policy, recording of restraint and reviews (Regulation 16).

### Relevant guidance

For completeness, a list of the guidance applicable to the settings to which this guidance applies is set out below:

- Mental Capacity Act Code of Practice: Protecting the Vulnerable 2007:  
<http://tinyurl.com/MCA-CodeOfPractice2007> [NB this covers guidance on deprivation of liberty]
- The Children Act 1989 Regulations and Guidance – Volume 2: Care planning, placement and case review (2015)  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/441643/Children\\_Act\\_Guidance\\_2015.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/441643/Children_Act_Guidance_2015.pdf)
- Supporting pupils at school with medical conditions  
[www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3](http://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3)
- Working Together to Safeguard Children 2015  
[www.gov.uk/government/publications/working-together-to-safeguard-children](http://www.gov.uk/government/publications/working-together-to-safeguard-children)
- 0-25 Special Educational Needs and Disability Code of Practice  
[www.gov.uk/government/publications/send-code-of-practice-0-to-25](http://www.gov.uk/government/publications/send-code-of-practice-0-to-25)
- The National Minimum Standards for Boarding Schools  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/416186/20150319\\_nms\\_bs\\_standards.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416186/20150319_nms_bs_standards.pdf)
- The National Minimum Standards for Residential Special Schools  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/416188/20150319\\_nms\\_rss\\_standards.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416188/20150319_nms_rss_standards.pdf)
- Behaviour and Discipline in Schools  
<https://www.gov.uk/government/publications/behaviour-and-discipline-in-schools>
- Use of reasonable force <https://www.gov.uk/government/publications/use-of-reasonable-force-in-schools>
- Guide to the Children's Homes Regulations including the quality standards  
<https://www.gov.uk/government/publications/childrens-homes-regulations-including-quality-standards-guide>
- Positive and Proactive Care: reducing the need for restrictive interventions (2015)  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/300293/JR\\_A\\_DoH\\_Guidance\\_on\\_RP\\_web\\_accessible.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JR_A_DoH_Guidance_on_RP_web_accessible.pdf)
- The Children Act 1989 Guidance and Regulations Volume 4: Fostering Services 2011  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/274220/Children\\_Act\\_1989\\_fostering\\_services.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/274220/Children_Act_1989_fostering_services.pdf)
- Supporting pupils at school with medical conditions (December 2015)  
<https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3>

## Annex A

- Residential holiday schemes for disabled children: National minimum standards (August 2013)

<https://www.gov.uk/government/publications/residential-holiday-schemes-for-disabled-children>

# Annex B

## Examples of Positive and Proactive Approaches to Behaviour that Challenges

The following examples 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 restraint.

### Case Study Index

1. Ratcliffe, a whole school approach to reducing restraint
2. Dentist visit a multi-disciplinary team approach around the child
3. Adapting the environment and practitioner approach for a medical examination
4. Hospital multi-disciplinary team share strategies
5. Better patient involvement to manage hospital visits
6. Residential school multi-disciplinary approach improves behaviour
7. Special school effective use of a safe space to ease anxiety
8. Multi-agency approach in a special school
9. A school adapting communications to suit individual needs
10. Short breaks provider working with parents

### **1. A whole school approach to reducing risk, restraint and restrictive intervention – from the Principal of Ratcliffe Special School, Devon**

*Illustrates a whole school policy change to reduce use of restraint*

At Ratcliffe we made the decision to change our practice in 2013 after I attended a conference in London 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 use of intervention rooms/quiet rooms or time out rooms and the trauma this causes for the child and the member of staff.

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.

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.

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.

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.

We continue to analyse interventions and staff are readily open to questions and answers about their reactions and the outcomes. Our 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.

## **2. Preparing a child with learning disabilities for visits to the dentist, for blood tests or X-rays**

*Illustrates multi-disciplinary team around the child*

Billy is 14 and weighs 13 stone. He has autistic spectrum disorder, 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.

The multi-disciplinary team working with Billy provides a range of interventions to address this. Billy'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 Billy to be treated.

Billy 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 Billy 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 Billy to access the tests. Even with such preparation, there are times when Billy will be distressed. The strategy for managing these is planned and agreed in advance, with the family, clinicians and therapists. Discussion considers 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.

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.

### **3. Preparing a child with autism for a medical examination**

#### *Illustrates adapting the environment and practitioner approach*

David, a 12 year old boy with moderate learning difficulties and autism, is referred to his local paediatrician because of concerns over physical aggression as part of his education, health and care needs assessment.

David and his parents arrive on time for his appointment and sit in a very busy waiting room. The clinic is running late and 30 minutes later, by the time they get into the clinic room, David is highly agitated. The doctor starts asking David 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.

David is then referred to a child psychiatrist for children with learning difficulties. Knowing that he has autism 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.

On entering the room, the doctor focusses initially on talking to parents and allows David to settle before trying to engage him. David initially goes to the back of the room but after 10 minutes comes and sits with his parents. The doctor gently tries to engage David but stops if he seems disengaged or anxious.

She is eventually able to explain to him that she would like to examine him and shows what she is going to do by examining his Dad. David then allows himself to be examined.

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 David's behaviours.

#### 4. Preparing a child with learning disabilities for blood tests, scans and X-rays

##### *Hospital multi-disciplinary team share strategies to manage treatments*

Oliver is a 10 year old boy with Downs Syndrome, Autism Spectrum Disorder and Severe Learning Disability. He attends a specialist residential educational placement and is known to a highly specialist Multi-disciplinary Behaviour Team for children with Learning Disabilities. Oliver 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 8 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.

Oliver will need to move between the children's ward to the urology department 10 times, going in lifts, walking in corridors with other patients and visitors and meeting a new team of professionals. Oliver 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.

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 Oliver and it is agreed that a member of the team will accompany Oliver 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.

Oliver 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 symbolised written information the night before which is referred to across the day. The use of schedules within schedules shows Oliver what is happening, what he is doing now, and next. Reduced verbal input, consistent scripting and a Total Communication Approach with ample time for processing information, and the use of Therapeutic sensory strategies achieves the right level of arousal for each activity. This allows Oliver to undergo the whole assessment in a single day without need of restraint.

#### 5. Reducing use of restraints in health settings

*The following shows action taken in respect of adults. The general approach for better patient involvement to manage hospitals could, suitably adapted, be used in relation to children.*

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 involving over 200 initiatives in their wards themed around the concept of space and enhancing the physical environment.

Changes range from small to large in scale 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.

Open Door is a mutual agreement made in advance with patients who are identified as “frequent attenders” at Accident and Emergency Units, 136 Suite, Crisis Teams or out of hours GPs. Mostly these patients will have a diagnosis of personality disorder and 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.

Open Door seeks to put patients in the driving seat. Through prior agreement patients are offered a 2 to 3 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. 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”.

## 6. Support for a pupil in a residential school

*Illustrates a multi-disciplinary approach to plan for behaviour*

James came to Tadley Court in April 2015 at age 14 on a 52 week residential placement having previously been in a local authority special school for children with emotional and behavioural difficulties. He is autistic and has foetal alcohol syndrome. He has an Education, Health and Care plan.

James 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.

James experienced trauma and neglect from a very young age and during his first few months at Tadley Court was very withdrawn and aggressive and had difficulty in forming trusting relationships, struggling to regulate his emotions, feeling anxious and angry at times.

The school took a systematic approach involving:

- A review of James’s history and background information
- Discussion and review with residential staff and social worker regarding family contact
- A multi-disciplinary approach with early observation and identification of need

## Annex B

- Direct work with education and residential staff to increase understanding of needs and share effective strategies approaches
- Development of a detailed support plan, including individual therapeutic work with consistent structure and staff
- Regular discussion with a behavior analyst regarding any incidents, triggers and outcomes
- Review and update of support plans – including a personal handling plan (PHP)

The school's Therapy Team reviewed James's history and background information before providing initial advice and strategies to relevant staff. Initial assessments of James 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 and this was subsequently delivered to residential and key education staff by an Educational Psychologist (EP) and Assistant Psychologist.

The EP and Assistant Psychologist discussed James'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.

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 James, allowing him to share his feelings and validating them. Use of social story for hospital appointments reduced anxiety and adults working with James 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. James had an individual programme which allowed him to explore narratives through drama, use of puppets and creative materials. Through drama therapy James's confidence and self-expression developed and he gained a greater sense of trust and confidence to share his ideas. His personal support plan was regularly updated to increase staff awareness of triggers and reflect changes to the strategies and approaches to be used.

James 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 there has been a significant reduction in the number of incidents of physical aggression from 12 to none in just 3 months between November 2015 and January 2016.

### **7. Use of a 'safe space' with Ginny, a young person in a residential special school**

*Illustrates effective use of a safe space to ease anxiety*

Ginny is 19 years old and has lived in a 52 week residential setting since she was 9 years old. She is blind, has a severe learning disability, profound autism, and mental health problems and

## Annex B

does not speak. Ginny has always struggled with anxiety and excess energy, linked to attachment difficulties. Her impairments make it very difficult for her to find positive ways to 'burn off' energy. She wakes positively but anxiety and tension build throughout the day, leaving her feeling frustrated. Ginny struggles to process all forms of sensory information and regularly experiences 'overloading' usually resulting in loss of control and aggression towards herself and others.

Ginny's residential school has developed a tailored approach for supporting her with a 1:1 member of staff who will remain with her for each shift. The member of staff uses minimal speech, sometimes just one word instructions: 'coat', or a tactile cue and minimal contact, only making physical contact if completely necessary, and always making it in a definite, firm way, to avoid the more difficult 'light touch' that Ginny finds difficult to process. She keeps a very close eye on Ginny, looking out for the smallest movement or sign (which can be attempts to communicate), or change in mood. Responses are led by Ginny, who is offered basic choices and allowed to choose what she does next and when.

Ginny's behaviour would typically be 'flight' or 'fight'. As her visual impairment compromised flight, she would fight, hitting out, grabbing things and throwing them, biting, scratching, kicking and head-butting. She was a considerable risk to herself and others. Attempts to manage, reduce or prevent these outbursts were largely unsuccessful. All physical intervention with Ginny at those times caused her problems. She chooses cuddles and massage on her own terms but once tension builds up any physical contact from another person is very difficult for her and may feel uncomfortable or distressing.

Avoiding physical interventions, two person touch support and anything that approaches a physical restraint with Ginny was paramount. The school changed its approach and developed the idea of a safe space – a place where she could safely 'lose control', minimally furnished with mats, large items, sensory items and toys that she can throw around, safely bounce against and burn off energy and frustration.

When tension builds in Ginny (evident from faster breathing, increased twitching of legs and hands and tension in her body) staff encourage her to go to her safe space. Once there they stay outside and encourage her to dance and let off steam. Once Ginny has 'let go' she will dance, throw her body round the space, sometimes throw things, shout, laugh, cry - to release the tension. Staff stay outside the space and make clear to Ginny that she "has permission" to do this. Once she has finished she is calm and relaxed.

Ginny took time to learn about the safe space and to trust staff. Initially she would come outside of the safe space and throw things or hurt people. Staff felt it was in Ginny's best interests for them to hold the door on these occasions and monitor her safety via CCTV (the monitor also being outside the door). This would last for a few seconds but there were times when Ginny would remain out of control and this would need to be done several times over the course of a few hours.

The school pursued the safe space strategy because Ginny *felt* safer if she knew that her loss of control was containable and that staff would support her to prevent it from spilling over into the rest of the school. Ginny tested the boundary many times over a period of months. Now she very rarely does. She still needs encouragement to use the safe space when tension builds up

and understands when staff encourage her to 'hold it until you get to your room'. This has allowed her to develop more self-control.

### 8. Positive Behaviour Support for a pupil in a special school

#### *Illustrates multi-agency approach for in-depth behaviour planning*

Sandra was in Year 5 when she was admitted to Rossendale School as a day pupil and is now in Year 8. Rossendale is a specialist day and residential school for **boys** and **girls aged 8 to 18** with behavioural, emotional and social difficulties who may also have a high functioning autism spectrum disorder. Sandra is looked after by the local authority and prior to admission 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. Sandra's behaviour had resulted in exclusions, absences and time out of class.

Sandra 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 focused on addressing attachment issues as a means of de-escalating aggressive behaviours. This helped staff to understand Sandra better and Sandra to understand herself and her circumstances more clearly.

The school developed and agreed with Sandra 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 Sandra could identify with her and form a trusting relationship.

The support plan enabled Sandra 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 Sandra felt very much a 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 which was in the last 12 months.

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 Sandra 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 Sandra 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.



## 9. Supporting a child with acquired brain injury to remain in school

### *Adapting communications to suit individual needs*

Isaac is a 14 year old boy who sustained a brain injury at age 11 following treatment for a brain tumour. Isaac attended a local school. Occupational therapy worked together with Isaac, his family and school staff to prevent his behavioural challenges and keep him in school.

Isaac 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 and he was excluded from school and had regular involvement with the police.

The occupational therapist worked with Isaac, his parents and school staff to help them to recognise that Isaac's needs from his brain injury were often 'hidden'. Discussion highlighted how Isaac 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 Isaac'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.

Isaac used a personal calendar in 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.

School staff scheduled in some 'down time' for Isaac 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.

Class instructions were given verbally and in writing so Isaac could refer back to them. Some activities were broken down into manageable sections so he could focus on one thing at a time. Isaac 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 Isaac to the side of the classroom and towards the front so that he was less distracted by the other students in the class.

Isaac'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.

## 10. Short breaks provider working with parents for greater stability

### *Illustrates how working with parents can help behavioural support*

TC is a 15 year old boy with complex learning and behaviour needs and has been diagnosed with severe Autism. TC has been coming to The Pines since 2011 and generally enjoys his visits to us. His package is 24 overnight and 49 sessions throughout the year. He currently attends Treehouse School in Muswell Hill and is thriving with their support.

TC used to attend Amwell View School in Stansted Abbots, he was in a classroom with other young people and attending classes such as English, Maths and Science.

## Annex B

The structured environment started to become a problem for TC and his behaviour began to breakdown. He started to display unusual behaviour such as hair pulling and biting often without any known triggers. Eventually his behaviour became too difficult for Amwell to support TC effectively and he was expelled.

As a service its good practice for key workers to be in contact with parents.

So we were aware of what had been going on at school, we had never seen any of these behaviours from TC and decided to continue with his visits. Unfortunately, TC's behaviour began to breakdown with us also and he had a couple incidents involving staff. We provided TC with 2:1 staffing to help support him.

We know how much the service meant to TC and his family, not only did it provide TC with somewhere to go other than school or home but it allowed TC's parents to spend time with their daughter, so rather than stopping service completely, we asked the family what the best course of action was. They decided to get TC enrolled into Treehouse School which is a specialist school for Autism. While he was settling in TC's keyworker also looked at his behaviour support plan and decided on the best way to support him during this time, we felt that phasing TC back into his visits would allow him to gain confidence within the project. The way we achieved this was by having TC's mum come in with him for the first few visits and allowing TC to decide how long he wanted to stay, then we moved on to TC's mum sitting into another room while he played. Then mum bringing him into the project leaving him in with staff to play. Then she just dropped him at the door and eventually we have worked it up to TC having transport to and from school again with overnight visits with us. Service is now continuing as normal for TC and his family.



## References

Children's Views on Restraint, reported by the Children's Rights Director for England (Ofsted, 2012)

Mental Health Crisis Care: Physical Restraint in Crisis London (MIND, 2012)

The Business Case for Preventing and Reducing Restraint and Seclusion Use (US Department of Health and Human Services Substance Abuse and Mental Health Services Administration, 2011)

Challenging Behaviour and Learning Disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (NICE, 2015)

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

A protocol for local children's services on restrictive physical interventions in schools, residential and other care settings (Association of Directors of Children's Services Health, Care and Additional Needs Task Group, 2009)

Safewards – <http://www.safewards.net>

NHS Protect: Meeting Needs and Reducing Distress – Guidance on the prevention and management of clinically related challenging behaviour in NHS settings London (Department of Health, 2013)

Mental Health Act 1983: Code of Practice (Department of Health, 2015)

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

Guidance on responding to people with mental ill health or learning disabilities (Association of Chief Police Officers and National Policing Improvement Agency, 2010)