Salford
Safeguarding
Children Board

Managing Challenging Behaviour – Minimisation of and Alternatives to the use of Restrictive Physical Practices in health, schools and children's social care settings.

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Contents

Managing Challenging Behaviour – The Minimisation of and Alternatives to the use of Restrictive Physical Practices in health, schools and children's social care settings.

1. Policy Statement

1.1 All children and young people are entitled to lead fulfilling lives, and all agencies providing services are committed to supporting them to be healthy, stay safe, enjoy and achieve, make a positive contribution, and achieve economic well-being (Every Child Matters 2003).
Some children and young people may engage in behaviours that impact upon their opportunities to lead fulfilling lives. For some children and young people challenging behaviour is often an attempt to communicate. Challenging behaviour is defined as:

1.2 "Behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy or behaviour which is likely to seriously limit or deny access to the use of community facilities" (Emerson, 1987).

1.3 Challenging behaviours often form a chronic pattern, in which episodes of behaviour may become out of control, requiring professionals to intervene to prevent injury or serious property damage. It may be necessary for individual solutions to challenging behaviours to include some form of physical force. This use of physical force is referred to as Restrictive Physical Intervention (RPI). The use of RPI to manage behaviours carries risks. These risks are there whether the techniques are applied appropriately or inappropriately, in both cases it can result in pain, physical injury and emotional distress to all concerned, the likelihood of this happening is increased if it is applied inappropriately.
The inappropriate use of physical force may be unethical and in some instances, illegal.

1.4 As intervention strategies, RPI's aim to gain rapid, safe and effective control of aggressive situations or to reduce risks. RPI's should only be used in the context of an overall proactive and preventative plan for challenging behaviour. It has been estimated that 1/1000 young people in the General Population has a learning disability and that of these 10-15% will develop challenging behaviour. It is acknowledged that children and adolescents with learning disabilities are at high-risk of developing emotional and behavioural difficulties.

2. Key principles

2.1 This strategy is founded on a number of key principles. They underpin the need to understand the use of restrictive practices in Salford and to ensure that when, as a last resort they have to be used, it is in the least damaging manner.

2.2 As a Safeguarding Children Board we believe that:

- Children and Young People's **human rights** must be protected and honoured at all times.
- Understanding people's behaviour allows their unique and individual needs to be identified and **quality of life** enhanced.
- Involvement **and participation** of service users, their families, carers and advocates is essential.
- People must be treated with **compassion**, dignity and kindness.
- Education, health and social care services must keep people safe and **free from harm**.

- Positive **relationships** between the people who deliver services and those they serve must be protected and preserved.

2.3 The broad aims of the policy are:

- the prevention / minimisation of challenging behaviours;
- that, where used, restrictive physical interventions promote the best interests of children and young people;
- that where used, restrictive physical interventions are used for the safety of all.
- that all risks associated with the use of restrictive physical interventions are
- continuously assessed and understood;
- to maintain the safety and dignity of children, young people and staff;
- that managers and employers discharge their responsibilities effectively;
- to highlight the training needs of staff in the use of restrictive physical interventions.

3. Executive Summary

3.1 This strategy follows the format of the Royal College of Nursing Guidance, Positive and Proactive Care: reducing the need for restrictive interventions but applied it to a children's context. It incorporates the previous Salford Safeguarding Children's Board Positive Behaviour Support Policy and the DFE policy 'Use of Reasonable Force' In order to ensure that the ethos and language of the RCN Guidance translates into the Salford Policy it is critical that the three documents are used simultaneously in all contexts.

3.2 SSCB recognises the importance of a consistent and transparent approach to managing challenging behaviour which is built on solid ethos, philosophy and principles and is shared with all stakeholders and partners.

3.3 SSCB wishes to ensure that the key elements of ensuring a commonality of language and transparency of recording are enshrined in all policies produced locally which sit under the umbrella of this policy.

4. Overarching Required Actions under this Strategy

- To develop a policy incorporating the ethos and philosophy of the board strategy but that which reflects local need and practice.
- To fully implement the local policy by December 2014.
- To develop through the policy a consistent and transparent recording and reporting methodology with initial reports submitted by July 2015.
- To maintain a register in each establishment of children and young people on whom RPI may be used.
- To ensure a commonality in the use of language across both the SSCB and local policy.
- To develop a training programme for staff in the school, setting or establishment which is subject to regular update, review and scrutiny?

5. Who is this Strategy for?

5.1 This strategy applies across all education, health and social care settings. It has important implications for all such services and to all staff, practitioners, families and carers who support people who are either exposed to restrictive physical interventions, or are at risk of being so. It is of particular significance for individuals working with people with autistic spectrum conditions, learning disability, mental health conditions associated with challenging behaviour (ADHD, OCD, ODD), but it is not limited to individuals with these conditions.

5.2 This updated SSCB strategy is fully applicable to the care and support delivered by education, health and social care staff outside of traditional care settings, including in children and young people's own homes, in the community, in custody.

5.3 The strategy requires important actions to be taken by:

- commissioners of health and social care services
- directors of children's services
- directors of nursing
- directors of public health
- service managers, governance leads and executive quality leads in health and social care services, across both statutory and third sectors
- staff of all disciplines and degrees of seniority working in health and social care services
- chairs (and members) of local safeguarding adults boards and safeguarding children boards
- enforcement and inspection staff
- those who provide training to staff on the use of physical interventions
- lecturers and teaching staff who deliver professional training to health and social care staff; and
- academic and research staff.
- head teachers
- chairs of governors and management committees
- academy sponsors
- Youth workers
- owners of PVI settings for preschool children
- third sector organisation providing services to the relevant client groups

5.4 The guidance will also be of interest to:

- family carers and parents of people receiving services
- people who use services
- independent advocates and organisations
- legal advocates
- Security staff working in schools, health and social care settings.

Police and the Secure Estate

5.5 This strategy is intended to be guidance for workers in the secure estate. However it is recognised that the control and order of young people who are detained is the responsibility of the governor or director of the establishment.

5.6 Strategy users should have a clear local protocol about when the police are called in to support the handling of any crisis, however during such an intervention the educational establishment, social care or health setting retains the duty of care for the child or young person. It is expected that the local protocol will clearly state that the police will only be called as a last resort and therefore the police will use appropriate methods for the situation.

6. Introduction

6.1 In 2012 the Department of Health published *Transforming Care: A national response to Winterbourne View Hospital* and in July 2013 the Department for Education published 'Use of Reasonable Force'. Together with the existing SSCB strategy these documents provide the basis for this revised strategy.

6.2 All children and young people are entitled to lead fulfilling lives, and all agencies providing services are committed to supporting them to be healthy, stay safe, enjoy and achieve, make a positive contribution, and achieve economic well-being (Every Child Matters 2003). Some children and young people may engage in behaviours that impact upon their opportunities to lead fulfilling lives. For some children and young people challenging behaviour is often an attempt to communicate. Challenging behaviour is defined as,

"Behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy or behaviour which is likely to seriously limit or deny access to the use of community facilities" (Emerson, 1987).

6.3 Failure of services to apply regulated Positive Behaviour Management Strategies, places children and young people who present with challenging behaviours at heightened risk of detrimental responses and experiences such as:

a. exclusion from local services
b. people being moved to 'out of area placements'
c. restricted access to meaningful daytime activities, employment, education or home support
d. exposure to seclusion, restrictive physical interventions, locked environments and in some cases abuse
e. hazardous clinical approaches such as inappropriate prescribing of medication, punitive responses to behaviour and management regimes that are so restrictive as to significantly impair an individual's quality of life; and
f. direct or indirect harm.

6.4 Reducing RPI and managing behaviour is fundamentally about improving quality of life as well as meeting needs and reducing distress; it recognises that people engage in challenging behaviours because they have unmet needs, are exposed to environments and interactions which they find challenging and often have a generally impoverished quality of life. Much of the time, people's behaviours represent a desperate attempt to meet their own otherwise unmet needs.

6.5 In response to growing concerns about physical interventions across all sectors, the coalition Government committed the Department of Health (DH) to work with the CQC and external partners to review how providers record and monitor the use of restrictive interventions and to publish guidance on PBS with the aim of ensuring that physical interventions are only ever used as a last resort.

6.6 This document incorporates the statutory guidance given to Schools by the DFE in July 2013 and February 2014.
http://www.education.gov.uk/schools/pupilsupport/behaviour/behaviourpolicies

6.7 This new document replaces the 2011 SSCB strategy on the management of Challenging Behaviour by using restrictive physical interventions and widens it to include mainstream schools, special schools, social and health care settings for people with learning disabilities and/or autistic spectrum conditions or any school or setting providing for or educating Children and young people who demonstrate challenging behaviour. It provides a road map by which to reduce inappropriate reliance on unnecessary and restrictive reactive management approaches through the delivery of recognised responses to Challenging behaviour and organisational Restrictive Practice Reduction Programmes. Its scope is broader than the document it replaces in that it applies to:

- all health and social care settings
- all health staff working with children and young people
- educational staff working in mainstream and special schools; and
- all service user groups regardless of health conditions and support needs.

6.8 Whilst the national guidance separates Health, Social care and Education this Salford document linked to the requirements of the Children and Families legislation 2014 is more wide ranging. . It should be read in conjunction with *Use of Reasonable Force. Advice for head teachers, staff and governing bodies* which provides guidance for mainstream schools and the Departments of Health 'Positive and Proactive Care: reducing the need for restrictive interventions'

7. Aims of the Strategy

7.1 This strategy aims to;

- Reassure children, young people and their families that provisions are well informed regarding good practice with regard to the use of restrictive physical interventions and that where these are required they are delivered through a partnership approach, in which the child or young person's best interests are paramount at all times
- provide guidance on the use of organisational models of restrictive practice reduction and Positive Behavioural Management Strategies in order to bring about lasting reductions in the use of restrictive practices
- ensure that when, as a demonstrable last resort, such interventions are required, that they are used in a transparent, legally valid and ethically stringent manner
- assist education, health and social care staff, across a range of settings by promoting best practice principles; and
- prevent the misuse and misapplication of restrictive Behavioural Management Strategies.

8. Equalities Statement

8.1 This SSCB Strategy supports the SSCB requirement to comply with the Equalities Act 2010 and to do the Equalities Duty.

8.2 The Equality Duty has three aims. It requires public bodies to have ***due regard*** to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and

- **foster good relations** between people who share a protected characteristic and people who do not share it.

8.3 Because we have ***due regard*** this means that we have consciously thought about the three aims of the Equality Duty as part of the process of developing this strategy. Equality issues have influenced the way we have developed and will evaluate and review this policy; it will influence how local providers design, deliver and evaluate services, and how we commission and procure from others.

8.4 Having due regard to the need to **advance equality of opportunity** means that in developing this strategy and supporting local policy development consideration has been given to the need to:

- remove or minimise disadvantages or over usage of RPI suffered by people due to their protected characteristics;
- meet the needs of people with protected characteristics; and
- encourage people with protected characteristics to participate in decision making about their own care

8.5 To ensure that the strategy and subsequent policy complies with the Equality Duty may involve treating some people better than others, as far as this is allowed by discrimination law. For example, it may involve making use of an exception or the positive action provisions in order to provide a service in a way which is appropriate for people who share a protected characteristic.

8.6 Doing the equalities duty through this strategy and subsequent policies also explicitly recognises that disabled people's needs may be different from those of non-disabled people. Therefore we take account of disabled people's impairments when making decisions about the implementation of these policies. This might mean making reasonable adjustments or treating disabled people better than non-disabled people in order to meet their needs.

8.7 The Equality Duty and therefore this strategy covers the following protected characteristics:

- age
- disability
- gender reassignment
- pregnancy and maternity
- race – this includes ethnic or national origins, colour or nationality
- religion or belief – this includes lack of belief
- sex
- sexual orientation

9. Statements of Intent

This strategy requires all service providers and commissioners to take action.

The key actions are set out below as Statements of Intent.

Statements of Intent.

9.1 It is inherent to the nature of some services that they support people whose needs and histories mean that it can reasonably be predicted that they may present with behaviours that place themselves and/or others at risk of harm. Examples of such services might include acute psychiatric settings (including secure services), residential units specialising in working with people who present with challenging behaviour, residential or day special schools for

children with severe learning difficulties and challenging behaviour, enhanced resource units in mainstream schools, Children's Homes and the secure estate etc.

9.2 It is the intention of the Salford Safeguarding Children's Board through this strategy to clarify the expectations for all service delivery points in Salford through a series of statements of intent, which need to be interpreted by such services and settings into a locally applied working policy, which is accountable, can be reported on and can be evaluated:

1. Schools and settings will ensure that Individuals who use services have Behaviour Support Plans which include the full range of strategies to be used with that child or young person and which aim to prevent the use of restrictive practices.
2. Schools and settings will ensure that Behaviour Support Plans are put together in partnership with users of services and the people who know the person best.
3. Schools and settings will ensure that Behaviour Support Plans include details of individualised, bespoke proactive strategies, as well as reactive management strategies which possibly include restrictive practices. These must take account of service users' unique circumstances.
4. Schools and settings will ensure that Behaviour Support Plans include broader consideration of the support/training needs of the person's wider circle of support. At the point of creation the support plan should identify all who may be involved but also define the scope of the plan and who it involves.
5. Schools and settings will ensure that wherever restrictive practices are included in a Behaviour Support Plan, it must be clear that:
   a) there must be a **necessity** to act in order to avoid harm to the person
   b) the nature of restrictive practices must be **proportionate** to the potential harm to the person
   c) the practice must be the **least restrictive option** that will meet the need
   d) any restriction should be imposed for **no longer than absolutely necessary**
   e) what is done, why and with what consequences must be recorded in an **open and transparent** manner.
6. Schools and settings will ensure that in the event that a child or young person presenting with an unpredicted behaviour that places themselves or others at risk, and an unplanned restrictive practice may having to be used, the Behaviour Support Plan should subsequently be promptly updated to include contingencies in case of any recurrence as well as any necessary amendments to preventative strategies.
7. Schools and settings must ensure that reviews of Behaviour Support Plans are included within their internal audit / monitoring / evaluating and reporting programmes. Schools and settings will ensure that the recording of RPI is in line with that expected by the body authorising the particular methodology of RPI used, is reported annually to the governing body and where requested to the Local Authority. All recording of RPI should be transparent and available for inspection by those persons with an interest in a specific Behaviour Support Plan.
8. The Local Authority in its role as a commissioner of such services and placements must ensure that service providers have access to the knowledge and skills required to develop and deliver Behaviour Support Plans.
9. The Local Authority and the Safeguarding Children Board must seek assurances during visits and reviews that people who are subjected to restrictive practices are supported by Behaviour Support Plans.
10. Schools and settings must have local policies that minimise the use of restrictive practices, as well as to ensuring that when they are used it is in a safe and ethically acceptable manner.

11. For the purposes of consistency, all policies should use the terminology contained in this document, in accordance with the definitions provided.
12. Schools and settings where staff is trained in the delivery of restrictive practices must have an overarching multi-component strategy to minimise their use.
13. Schools and settings must provide an annually updated, accessible document which summarises the use of restrictive practices in the schools or settings and which outlines their training strategy, techniques used and reasons why. This must be available to the Governors / Management Committees / setting owners / managers / The Local Authority and users of services and their family carers.
14. Schools and settings must publish a report on the use of restrictive practice at least annually on their website.
15. Governors, Management Committees, setting owners, managers and The Local Authority should at least annually, review the incidences of restrictive practices, agree the training strategy and plans for reduction of restrictive practices, and monitor progress made.
16. Governors, Management Committees, setting owners, managers and The Local Authority should decide as to what restrictive practices should be used; this decision should take account of the individual context of the school or setting.
17. Governors, Management Committees, setting owners, managers and The Local Authority should ensure that whenever restrictive practices have been used the staff involved, the service user, and those most closely involved in the plan should be invited to take part in a supportive debriefing and post incident review process.
18. In order to deliver the recommendations of this guidance all staff in schools and settings will require training, this must include:
    a) A focus on skills in crisis management, including alternatives to restrictive practices.
    b) Promoting attitudinal change among staff.
    c) Implementation / refreshing of new models of delivery as agreed by Governors, Management Committees, setting owners, managers and The Local Authority and the Safeguarding Children Board

10. The Salford Safeguarding Children Board View of Managing Challenging Behaviour

10.1 The approaches which are used in the area covered by the Salford Safeguarding Children Board recognise that there are certain underpinning assumptions which need to be made in order to ensure that principles and aspirations can be converted to practice.

In writing local policies, which sit underneath this strategy it is incumbent upon each organisation to ensure that their local policy fits within the wider assumptions of the strategy and encompasses:

i) an understanding of the fact that *challenging behaviour which is displayed by an individual, is based on the social and physical environment and broader context within which it occurs, and any response should be based on an assessment of that context.*

ii) stakeholder perspectives and involvement

and

iii) *uses this understanding to develop, implement and evaluate the effectiveness of a personalised and enduring system of support that enhances quality of life outcomes for the focal person and other stakeholders'.*

To understand the wider approaches needed policies across all schools and settings need to:

- Use **person centred, values based, approaches** to ensure the child or young person is being educated and living the best life they possibly can. This may involve assisting a person to develop personal relationships, improve their health and education, to be more active in their community and to develop personally, at whatever age or stage. When done properly this approach ensures that individual needs are appreciated and met and those formulating plans around those needs know the child or young person as an individuals. For many children and young people this approach will be familiar as it is the one used in their Education Care and Health Plan. (EHCP).

- Use skilled assessment in order to **understand probable reasons why a person presents behaviours of concern**; what predicts their occurrence and what factors maintain and sustain them (this is area of assessment is often referred to as a functional assessment). This requires consideration of a range of contextual factors including personal constitutional factors, educational needs, mental and physical health, communication skills and the child or young person's ability to influence the world around them. Patterns of behaviour provide important data, skilled analysis of which enables key areas of unmet need to be elucidated.

- Direct the use of written **Behaviour Support Plans** which have been informed by a robust assessment in order to ensure a consistent and shared proactive approach to meeting the child or young person's needs, that challenging environments are remediated, that quality of life is enhanced and that wherever possible people are supported to develop alternative approaches by which they can better meet their own needs. These are sometimes referred to as **primary preventative strategies**.

- Require that the Behaviour Support Plan also details the responses such as **de-escalation techniques**, to be used by carers/supporters when a person starts to become anxious, aroused or distressed. These aim to promote relaxation and avert any further escalation or crisis.

- Ensure that the Behaviour Support Plan also details those **reactive strategies** to be used when the person's agitation further escalates to the point where behaviours are presented which place either themselves or others at significant risk of harm. These may include the use of restrictive practices.

11. Developing a graduated approach to the management of challenging behaviour

11.1 SSCB believe that all establishments covered by the board should have a local policy which describes a graduated approach to managing challenging behaviour. This policy will be firmly embedded in a recognised accredited technique which shares the values and philosophy of the SSCB strategy.

11.2 It is expected that the policy will clearly demonstrate an approach which fits the requirements of all current legislation.

12. The Lawful Application of Restrictive Practices

12.1 It is essential that organisations and practitioners who impose restrictions on those in their care have a legal basis for doing so.

12.2 The application of restrictive practices could breach the European Convention on Human Rights. Applying a restrictive practice without consent, or lawful authority or excuse, could make individuals and their employers liable to civil and criminal actions for assault, battery, breach of contract, negligence, false imprisonment, ill treatment or neglect.

12.3 Statutory and common law defences may apply to the application of restrictive physical interventions. Reasonable force may be used for the purposes of self-defence, the defence of others, prevention of crime, lawful arrest or to protect property.

12.4 In order to be 'reasonable' in the circumstances, the force used should be both necessary and proportionate. The strategies advocated for use in applying restrictive physical intervention if applied consistently and in line with the relevant training and reporting requirements will support staff that are required to use RPI who face challenges. The Department for Education Document, Use of Reasonable Force – July 2013 explains how this applies to schools.

13. The Human Rights Act

13.1 The use of restrictive practices must not breach a person's rights under the ECHR, particularly:

- Article 5: right to liberty
- Article 3: prohibition on inhuman and degrading treatment; and
- Article 8: right to private life.

13.2 **Article 5** is triggered when there is a deprivation of liberty. Restrictive practices restrict a person's liberty, but may not necessarily be of a degree or intensity amounting to a deprivation of liberty. The difference between deprivation of and restrictions upon liberty is one of degree or intensity, and not one of nature or substance. Whether or not there is a deprivation of liberty turns on the individual circumstances of each case. The interpretation of 'deprivation of liberty' is evolving through judgments made by the European Court of Human Rights and UK courts.

13.3 **Article 5(1)** of the ECHR guarantees that a person may only be deprived of their liberty in certain circumstances, which include the lawful detention of a person of 'unsound mind', and only if the deprivation of liberty has been authorised by a procedure prescribed in law.

13.4 **Article 5(4)** requires that a detained person must be able to challenge the lawfulness of that detention before a court or tribunal.
A person can be lawfully detained for the purposes of Article 5 if:

- they are compulsorily detained under the Mental Health Act 1983; or if the person lacks capacity to consent to their admission or treatment, and will be kept in a hospital or care home, the deprivation of liberty has been authorised by the Mental Capacity Act 200517 under an authorisation given under Schedule A1 to that Act, or a Court of Protection order.

13.5 **Article 3** of the ECHR prohibits inhuman or degrading treatment. The ill-treatment must reach a certain level of severity to fall within the scope of Article 3 – this level depends on all the circumstances of the case, such as the duration of the practice, its effects and the patient's particular characteristics. The use of forcible measures in respect of a detained hospital patient, which are not medically necessary, could amount to ill-treatment that

breaches Article 3.28. Local policies will need to clearly reflect and describe strategies which if applied inappropriately could be construed as coming under the Human Rights Act and give cause to challenge under that act. E.g. the use safe spaces or seclusion rooms.

14. The Mental Health Act (1983) (MHA)

14.1 The MHA Code of Practice is clear that the purposes of applying restrictive interventions (where lesser interventions such as de-escalation have proved ineffective), are to:

- take immediate control of a dangerous situation
- end or reduce significantly the danger to the service user or others; and
- contain or limit the person's freedom for no longer than is necessary.
- The five key guiding principles established within the MHA Code are:
- **Purpose** principle – the Act must be used to minimise the undesirable effects of mental disorder by maximizing their safety and wellbeing (mental and physical) of patients, promoting recovery and protecting others from harm.
- **Least restrictive** principle – people taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty.
- **Respect** principle – people taking decisions under the Act must recognize and respect each patient including their race, religion, gender, age, sexual orientation and any other disability.
- **Participation** principle – patients must be involved in their care as much as is practicable. The person's family and other carers should be involved unless the service user does not want them to be (or there are other specific reasons as outlined in the Act).
- **Effectiveness, efficiency and equity** principle – this refers to the most appropriate use of resources to meet the needs of patients.

15. The Mental Capacity Act 2005 & The Mental Capacity Regulations 2014

15.1 The MCA provides a legislative framework for decision-making for people aged 16 and over who lack the capacity to make specific decisions. A person is assumed to have the capacity unless it is established they do not.

15.2 In relation to the type of physical interventions outlined in this strategy:

- The person proposing to apply the physical intervention must reasonably believe the service user lacks capacity to consent to the intervention, and that the intervention is in the service user's best interests. A service user's best interests must be assessed in accordance with section 4 of the MCA; and
- The person applying the physical intervention must reasonably believe that it is necessary in order to prevent harm to the service user; and
- The physical intervention is a proportionate response to:
- The likelihood of the service user suffering harm, and
- The seriousness of that harm.

15.3 Below are some examples of restrictive practices which should be taken into account when considering whether, in all the circumstances of the case, there is likely to be a deprivation of liberty that will need to be authorised under the MHA or MCA and whether the restrictive practice is reasonable and proportionate.

Restriction of movement:

- Using disproportionate physical intervention techniques.
- Tying limbs to chairs and beds.
- Arm splints
- Strategic placing of furniture.
- Use of chairs or commodes with trays/tables.
- Tip back, or low bean bag type chairs.
- Mattresses on floors to prevent people getting up.
- Harnesses

Environmental

- Seclusion rooms.
- Locked care environments.
- Stair gates.
- Long term segregation

Medical Management

- Under or over use of medication to control behaviour.

16. Unacceptable de Facto Detention

16.1 De Facto Detention is where a culture persists where control and containment are prioritised over treatment and support, in this kind of service, users have been locked in, told that they would be detained if they attempted to leave, exposed to rigid and institutional 'blanket rules' (such as those around access to meals, opportunities to smoke, being allowed access or leave bedrooms only at specific times of day), not made aware of their liberties and the choices open to them and exposed to other unwarranted and unnecessary restrictions.

16.2 This type of de facto detention is ethically unacceptable and can amount to an unlawful deprivation of liberty, which would be a violation of a service user's human rights.

16.3 Professionals of any discipline who are complicit in implementing such practices risk being removed from their respective professional registers and potential prosecution.

16.4 All professionals have a duty to challenge such practices.

16.5 The Safeguarding Children's Board, Governing Bodies and the local authority have a responsibility to develop open and safe cultures through which all workers can execute their duty of care to speak up if they have concerns (Whistle blowing). This guidance promotes the lawful and ethical use of restrictive practices alongside governance driven strategies to reduce organisational reliance on restrictive physical intervention strategies.

17. Definitions of Types of Restrictive Practices

In order to help establish a commonality of language some basic definitions of types of restrictive practices are included below. In using these terms in the preparation of local policies it is expected that where these terms are used the foolowing definitions are assumed.

17.1 Restraint

The use of force, or the threat to use force, to make someone do something that they are resisting, or restrict a person's freedom of movement, whether they are resisting or not.

17.2 Restrictive physical interventions

The use of force to control a person's behaviour and can be employed using bodily contact or mechanical devises. The DFE document 'Use of Reasonable Force' gives a working definition of 'What is reasonable force' this should be referred to in school policies and clearly articulated to both those who are likely to need to use force and those on whom it may be used their parents and carers.

Restrictive Physical Intervention (RPI) describes a wide range of strategies which can be used to manage children and young people who put hemselves and others in danger or are likely to cause significant damage to property. It does not just refer to hands on contact by one person on another. In developing policies which sit underneath this strategy schools, settings and health service providers need to be clear about the type of intervention which they would use in their context and why. These should then be transfered to individual planning mechanisms as appropriate and shared with all concerned.

In a school / setting context restraint generally comes into the categories of, physical restraint, mechanical restraint and chemical restraint. In a health service context psychosocial restraint may also be considered as an option.

Other Restrictive Practices which could be described as environmental restraint include seclusion and long term segregation.

17.3 Physical restraint

Any direct physical contact, with or without resistance, where the intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

17.4 Clinical holding (sometimes known as therapeutic holding)

The use of physical holds to assist or support a person to receive medical care or treatment in situations where their behaviour may otherwise limit the ability to meet the person's clinical needs, or where the person's behaviour may present a safety risk to themselves, members of the care team or other accompanying persons.

17.5 Mechanical restraint

The use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

17.6 Chemical restraint

The use of medication to control or subdue a person's behaviour, be it regularly administered or 'prescribed as required' and where it is not prescribed by a registered medical practitioner for treating a formally identified physical or mental illness. Schools and setting should have policies which clearly relate to the administration of medication in a school or setting and the relevant plans should be in place for identified individuals.

17.7 Seclusion

This is where a child or young person is confined alone as a direct response to inappropriate or disturbed behaviour.

18. The Safer Application of Restrictive Practices

18.1 By the nature of Restrictive Practices there is a significant danger that they could be used 'unsafely' the aim of this strategy is to minimise the use of RPI and to ensure that where RPI is used it is a values based approach which is operated in a safe and controlled manner.

18.2 In schools the DFE document 'Use of Reasonable Force' describes the key points for the safe use of reasonable force.

- School staff has the power to use force and the lawful use of the power will provide a defence to any related criminal prosecution or other legal action.
- Suspension should not be an automatic response when a member of staff has been accused of using excessive force.
- Senior school leaders should support their staff when they use this power.

18.3 In order to remain safe and stay within the ethos and philosophy of this strategy school staff will need a consistent approach in which they at confident and a significant amount of ongoing training.

18.4 A key part of staying safe within the operation of any RPI policy is open and transparent recording and reporting.

19. Recording and Reporting

19.1 More open and transparent recording of incidents will help organisations better understand local risks and learn from them through thorough review processes. It will enable governance boards in schools and local authorities to establish baselines for the use of RPI and to engage in open and transparent conversations with schools and settings about the use of RPI. Records of the use of RPI should be presented at least annually to the Governors in a school setting, to the managers in a private setting or the appropriate governance board in a health or social care setting.

19.2 Incidents of RPI in Salford Schools should be recorded on SIMS so that an annual report can be taken to the Challenging behaviour sub group of the Salford Safeguarding Children's Board and scrutinised by the Local Authority Designated Officer.

19.3 In order to stay safe head teachers, governors and senior managers of services allowing/using restrictive practices to be used must understand the extent of their application and this should to be founded on accurate and transparent data:
Services must monitor the incidence of the restrictive practices defined in this guidance. Data informed practice is a key factor in reducing reliance on and perpetuating the need for restrictive practices.

19.4 Schools, settings and services using RPI should maintain a register of children and young people's whose behaviour support plans indicate that RPI may be used. These registers should be available for inspection by regulatory bodies may be scrutinised by governors / proprietors at any time.

19.5 Whilst not currently sitting within regulatory frameworks it is the view of SSCB that where any plan including RPI is not included in the register it is a serious issue and could be judged a cause for concern. Similarly the use of RPI without a clear plan would indicate concerns at a similar level.

20. Practice following the use of RPI

20.1 Following any use of RPI, whether planned or unplanned, a full record should be made. This should be recorded as soon as practicable (and always within 24 hours of the incident). The record should allow aggregated data to be reviewed and should indicate:

- the names of the staff and service users involved
- the reason for using the specific type of restrictive practice (rather than an alternative less restrictive strategy)
- the type of intervention employed
- the date and the duration of the intervention
- whether the service user or anyone else experienced injury or distress; and
- if they did, what action was taken
- The outcome of the debrief session

20.2 A clear common format should be used to record RPI and RPI should be recorded in such a way that there is not possibility of any amendment to the record at a future date.

20.3 It is incumbent upon the head teacher/governors/managers /proprietors of an establishment to maintain the integrity of this recording.

20.4 Good practice interrogation of this data would enable those who have accountability in the establishment to look at patterns and trends and identify further action at an individual level, whether that individual is a child or young person or a member of staff.

20.5 All staff involved in the reviewing of placements should have access to this data set.

21. Commissioning Services where RPI might be used

21.1 SSCB is clear that services which are commissioned and where RPI may be used should follow the requirements of this strategy.

21.2 Commissioners should ensure that the services they commission can deliver high quality support to people who have complex and at times challenging needs. Commissioners should ask for copies of any policy / strategies documents relating to the use if RPI prior to placement of a child or young person. Where practicable commissioners should have the opportunity to see the types of restraint and RPI used to enable them to understand what that might mean for the child or young person's experience.

21.3 Commissioners will need to ensure that placements are only made and sustained on the basis of a full understanding of a person's needs and any associated risks. They will also be required to assure themselves, on an ongoing basis, of the competence of provider organisations to meet users' needs. This will mean interrogating the available proactive therapeutic approaches as well as organisational strategies to maintain appropriate competencies across the workforce. Special attention should be paid to the ability of the service to deliver where needed, values based RPI and to the availability of high quality assessments and support in order to develop relevant plans. Commissioners should request

to see records of the use of RPI when reviewing contract placements to reassure them as to the compliance with the SSCB strategy.

22. Staff Training and Development

22.1 Staff who are expected to use RPI or see RPI in use will require specialised training. The precise nature of the interventions and techniques used will be predicated by the age and phase of the children and young people, the amount of training and the frequency of refresher courses needed will also be linked to context.

22.2 Managers should be trained on the observable effects of training staff in the use of RPI.

22.3 The SSCB require the use of recognised and accredited methodology and currently support the use of the Team Teach methodology http://www.team-teach.co.uk/ with training sessions being coordinated via New Park High School. The training team at new Park High School can be contacted on 0161 921 2000. Other recognised methodologies are available and can be found at http://www.bild.org.uk/.

22.4 All local policies should include links to the accredited training strategies which have clear learning outcomes related to:

- The experience of service users
- Trauma informed care
- Core skills in building therapeutic relationships
- The principles of a values based approach to RPI
- Legal and ethical issues
- Risks associated with restrictive practices
- Seclusion
- Staff thoughts and feelings on being exposed to disturbed behaviour
- The use of safety planning tools and advance decisions
- Alternatives to restrictive practices
- Effective use of de-escalation techniques
- Training in the risks associated with RPI
- The use of breakaway techniques
- Post incident debriefing

22.5 SSCB promotes workforce development which leads to attitudinal change to use the use of RPI. To ensure that this is a key component of new policies and procedures a significant weight should be given to the skills required within any school, setting or establishment to resolve challenges and problems prior to the use of RPI. All staff need to be supported to develop skills so that RPI is the last resort, and when that last resort is used physical and emotional trauma for the child / young person or member of staff are minimised.

23. Local Policies

23.1 Local policies developed under this SSCB strategy need to take account of the actions required and to reflect the current legislation, case law and evidence of best practice.

23.2 Policies should outline the organisational approach to restraint / seclusion reduction, including training strategies. This section of the policy must also include arrangements for the provision of high quality Behavioural Support Plans for people who are likely to present behaviours that may require the use of restrictive practices. Employers and managers are responsible for ensuring that staff receive training, including updates and refresher courses, appropriate to their role and responsibilities within the service.

23.3 Policies should include information on Risk Management in both predictable and unpredictable circumstances.

23.4 Policies should include the reporting, recording and accountability arrangements and how data collected will be used to inform practice.

23.5 Local policies should be clear about how children, young people, their families and carers, and wider stakeholders will be kept informed about the application of the policy and any changes it that policy.

24. Conclusion

24.1 Children and Young People who have RPI as part of their life experience are likely to experience both physical and emotional harm as a result of that experience.

24.2 Staff who need to use RPI as part of their working pattern are also more likely to experience both physical and emotional harm as a result of that experience.

24.3 Therefore the reduction of the use of RPI by the application of a series of de-escalation techniques, good training to ensure that when used it is for the minimum amount of time required and with the least possible physical force and the development of a recording, reporting and accountability process will benefit both service users and service operators equally.

24.4 This approach needs to be consolidated through training, embedded into practice and enshrined in the governance of all schools; settings and establishments who use or may in the future use RPI.

25. Sharing Your Concerns

If you are worried about the safety of a child contact the Multi-agency Safeguarding Hub (MASH) on 0161 603 4500 as soon as possible. If a child is in immediate danger of being harmed, or if a child is home alone, the police should be called on 999.
For any other concern or information this section provides signposts to help you find what you want.

There are many ways in which you can share your concerns, this will depend on the nature of your concern, your position / relationship with the organisation you are complaining about and your preference as to how you wish to share that concern.

25.1 Schools

If your concern is about a school:

You should:
Talk to your child's school and follow their complaints procedure. Try to resolve the problem with them before taking your complaint further.

Ask for a copy of your school's complaints procedure if you've spoken to a member of staff and you're still not satisfied. All schools in England must have a complaints procedure and many publish it on their website.

The councils website www.salford.gov.uk may also have information about the school complaints procedure.

You can't complain to your council about private schools or colleges - contact the organisation that inspects them instead.

How to take your complaint further

You can take your complaint further once you've been through all the steps in the school's complaints procedure and you're still not satisfied. Who you need to contact depends on the type of complaint.

You should include any relevant documents.

Complain to DfE

Contact DfE using the online form if you're unhappy with a state school. They'll deal with most complaints relating to your child, e.g. decisions about their education. There's a list of the types of complaints they handle on the form.

DfE will contact you to tell you what will happen next. You should get an initial response to your complaint within 15 working days.

Complaints or concerns about child protection are looked at within 24 hours.

You can also contact DfE to complain about free schools and academies if:

- there's a problem with their complaints procedure
- they're not following the terms of their funding agreement

Complain to Ofsted

Contact Ofsted for complaints about 'maintained schools' (schools funded by the local authority) that affect the whole school. This includes problems with the quality of education or poor management.

You should get a response within 20 working days. You'll be told if or when they will investigate, what they'll do or why they're unable to help.

Ofsted
Online form
enquiries@ofsted.gov.uk
Telephone: 0300 1234 234
Monday to Friday, 8am to 8pm

25.2 Salford City Council Corporate Complaints Procedure

You can complain in a number of different ways - face to face, by letter or email and via the website.

The single complaints hotline, 0161 909 6540, will make it much easier for you to tell us when we get things wrong.

When you contact us at Salford your call will be logged centrally and the information will then be sent to the right department. The appropriate complaints officers will deal with the complaint as before.

Complaints procedure

Customers register complaint, comment or compliment, by:

- Phone
- In writing
- Online form
- By a member of staff completing an intranet form on the customer's behalf

Step one
Details logged and forwarded to directorate complaints officer. Where a member of staff registers a complaint, if possible, the service element is also dealt with.

Step two
Complaints officer categories using definitions and allocates to self or other appropriate person for action, responding to the customer where necessary within three working days.

Step three
All complaints will be resolved within ten working days.

Step four
You may wish to appeal.

Step five
The complaints officer takes the most appropriate course of action.

Appeal

If you are dissatisfied with the results of the investigation, you can write to the directorate complaints officer and request for the matter to be considered by a review committee of elected members. You need to do this within 28 calendar days of getting our response to your complaint, stating the grounds of your appeal.

Compensation

It may, in some cases, be appropriate to award compensation in order to settle a matter satisfactorily. In agreeing the amount of compensation guidance from the Local Government Ombudsman on compensation will be followed.

Other actions you may wish to take

If we fail to resolve your complaints, there are other options available to you. You can contact:

- your local councillor - a list of city councillors and their wards is available
- your constituency MP - a list of Salford's Members of Parliament is available
- the Local Government Ombudsman

The Local Government Ombudsman website will provide you with detailed information on their role when investigating complaints about councils. You can download information which explains the ombudsman's role in the complaints process.

25.3 Whistle blowing
If you are a member of school staff you may feel the need to consider using the Salford City Council Whistle Blowing procedure details of this procedure can be found under the Schools HR policies and procedures at http://intranet.salford.gov.uk/sch-hrpolicies.htm

25.4 General Safeguarding Concerns

If you have a general safeguarding concern about this policy you can share these by contacting:

Salford Safeguarding Children Board, Sutherland House, 303 Chorley Road
Swinton, M27 6AY
Tel: 0161 603 4322

26 Key Links / websites of interest.
http://www.partnersinsalford.org/sscb/documents/Guidance_for_Safer_Working_Section_1.pdf
http://www.partnersinsalford.org/sscb/documents/Managing_Allegations_Against_Professionals.pdf
http://www.education.gov.uk/schools/pupilsupport/behaviour/behaviourpolicies
http://www.bild.org.uk/?event_id=&org_id=223
http://www.team-teach.co.uk/
http://www.proact-scipr-uk.com/
http://www.autism.org.uk/
http://www.sebda.org/
http://www.rcn.org.uk/
http://www.salford.gov.uk/complaints.htm
www.ofsted.gov.uk
http://www.ofsted.gov.uk/resources/deprivation-of-liberty-guidance-for-providers-of-childrens-homes-and-residential-special-schools