Outcomes First Group

RESTRAINT REDUCTION & TERMS OF REFERENCE POLICY

Outcomes First Group

THE USE OF RESTRICTIVE PRACTICESAND RESTRAINT TERMS OF REFERENCE

Page

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1.0 INTRODUCTION

The term organisation(s) is used to describe all services under the Outcomes First Group umbrella - Acorn Education and Options Autism, these are also described as the group.

Throughout these terms of reference the children, young people and adults the Outcomes First Group care for and/or educate are termed as individual(s), service user(s), person(s) or people.

These terms of reference are to inform, support, guide and provide insight to organisations within the Outcomes First Group on the use of restrictive practices and restraint and the group's desired behavioural approaches.

2.0 GENERAL INFORMATION

The Outcomes First Group have a dedicated board, known as the Reducing Restrictive Practices Board. The board's objectives are to manage the group's affiliations and memberships, set and reinforce guidelines, monitor and sporadically audit the use of restrictive practices and restraint across all organisations. However, even though the board holds the responsibility of authorising the use of certified restraint training programmes beyond the agreed standard offer e.g. foundation and advanced programmes, the local leadership team of each organisation remain responsible for the policy of restrictive practices and restraint within the service and ensuring they remain fully compliant with the Restraint Reduction Network (RRN) Training Standards. The board will monitor the use of restrictive practices and restraint and compliance to the RRN Training Standards through data collection and analysis and apply board approved support visits when necessary.

The board's objectives are achieved by working to the group's board approved Reducing Restrictive Practices and Restraint Plan, the purpose of this plan is to provide regulation that aligns to the Outcomes First Group's affiliations, accreditations and ongoing memberships.

Each organisation within the Outcomes First Group must have a designated individual titled as the Reducing Restrictive Practices Lead. This individual will be the organisations main person of liaison, connecting the board and its monitoring and auditing approaches to each organisation. These approaches provide the board with insight and awareness of both exemplary practice and practices that require improvement and development in complying with the Six Core Strategies.

The Outcomes First Group is a member of the Restraint Reduction Network (RRN).

3.0 SECTION 1 – RECOMMENDED CONTENTS OF POLICY

- INTRODUCTION
- NOMINATED REDUCING RESTRICTIVE PRACTICES (RRP) LEAD, GROUP PLEDGE AND PLAN
- TRAINING – UNDERSTANDING INDIVIDUALISED PRINCIPLES, VALUES AND BELIEFS
- AN INDIVIDUALISED APPROACH IN ENCOURAGING POSITIVE BEHAVIOUR SUPPORT (PBS)
- PRIMARY, SECONDARY AND TERTIARY INTERVENTIONS
- AN INDIVIDUALISED APPROACH IN ENCOURAGING THE USE OF REWARDS
- AN INVIDUALISED APPROACH IN RESPONDING TO RISK BEHAVIOURS
- INDIVIDUALISED SUPPORT PLANS AND RISK ASSESSMENTS

4.0 SECTION 2 - STAFF TRAINING AND MODELS OF RESTRAINT REDUCTION

Outcomes First Group have been approved as a 'Crisis Prevention Institute (CPI) Affiliated Organisation' by the British Institute of Learning Difficulties Association of Certified Training (BILD ACT). Affiliation requires organisations to meet the Restraint Reduction Network (RRN) Training Standards. The group deliver CPI's Certified Training programmes - Safety Intervention (SI) Foundation, Advanced and if approved by the Reducing Restrictive Practices Board Advanced and Emergency.

CPI SI programmes incorporate Positive Behaviour Support (PBS), trauma informed and person centred approaches. The programmes are the perfect solution for staff working in health, social care and education who need to prevent and/or intervene with presented risk behaviours. CPI SI has a focus on prevention and

reduction, it also trains staff in de-escalation skills, non-restrictive and restrictive interventions.

'What does good Positive Behaviour Support look like?'

CPI Training and Positive Behaviour Support (PBS) - the overall aim of PBS is to improve the quality of a person's life and that of the people around them by delivering the right support to help people lead a meaningful life. PBS is a person-centred approach for providing long-term support to people who have, or may be at risk of developing, behaviours that challenge. It is a blend of person- centred values and behavioural science and uses evidence to inform decision making. PBS is based on a set of overarching values which include the commitment to providing support that promotes inclusion, choice, participation and equality of opportunity.

Fundamental to the PBS approach is the belief that all behaviour is communication and all behaviour happens for a reason. Distressed behaviour or behaviour that challenges others may be a person's only way of communicating an unmet need. PBS helps us understand the reason for the behaviour so we can better meet people's needs, enhance their quality of life and reduce the likelihood of distressed or challenging behaviour.

PBS has several primary, secondary and tertiary approaches which include:

- Considering the person and their life circumstances including physical health and emotional needs,
- e.g. the impact of any traumatic or adverse life events and mental illness, physical ill health or disability.
- Reducing the likelihood of behaviours that challenge by creating physical and social environments that are supportive and capable of meeting people's needs.
- Being proactive and preventive by teaching people new skills to replace behaviours that challenge.
- Developing other skills and enhancing the opportunities people have for independent, interesting and meaningful lives.
- Agreeing tertiary (crisis/reactive) strategies which help keep everyone safe if the behaviour presents a risk to self or others, provided any restrictive practices agreed are the least restrictive and most appropriate to the person.

One core part of PBS involves assessing the individual and their behaviour to help understand why the behaviour happens, how the behaviour has been learned and how it is maintained. This process is called functional assessment. Once the reason, e.g. Function of Behaviour (FoB) has been identified, a personal plan is co-produced with the individual and their staff/carers and followed by everyone involved in supporting the person.

A Health Promotion or Public Health Model

Such a model can be used to eliminate or minimise restrictive practices by addressing three levels of need for people who present behaviours that challenge services or who put themselves or others at risk of harm. The health promotion model has three stages:

1) Primary prevention - these strategies aim to enhance a person's quality of life and meet their unique needs, thereby reducing the likelihood of behaviours of concern arising.

2) Secondary prevention - these strategies focus on the recognition of an individual's early behavioural signs (physical, emotional, communicative, etc.) which can indicate an increase in behavioural disturbance. Strategies are developed to identify how to respond to a person's behaviours or support the person to self-manage. Secondary strategies are likely to include approaches to de-escalation. These may be referred to as reactive strategies, secondary

preventative strategies or active interventions. Secondary strategies can be restrictive (such as use of PRN at an early stage) or non-restrictive. Such strategies are designed to be used when staff recognise signs of a developing behavioural disturbance, and are aimed at reducing or removing the underlying causes of the behaviour, including issues such as pain, distress or frustration.

3) Tertiary intervention - these strategies are used when an actual behaviour of concern is presenting, with the primary aim to bring the incident to an end in a timely and safe manner, with due regard to the persons rights and dignity.

Even though post crisis support and learning is not traditionally recognised as an official stage of the Health Promotion or Public Health Model, the group emphasise the importance of this stage to connect the approach with person-centered, trauma informed support – ensuring that:

(i) support is offered to people after times of distress.
(ii) a restorative and reflective approach is taken to help staff learn more about the person and how effective strategies that work for the person can be reinforced and/or ineffective strategies changed or adapted to avoid future distress.

Primary Prevention (Universal Precautions)

This stage involves activities or approaches designed to impact on the incidence of a condition to reduce or alter the factors that cause it. In terms of reducing restrictive practices, primary prevention aims to reduce the likelihood of the behaviour occurring in the first instance by reducing exposure to known triggers.

Primary prevention includes:

- Delivering services that focus on person-centred,trauma-sensitive care and support.
- Providing positive and rewarding social environments to reinforce desired behaviour.
- Giving a structure to the day and providing meaningful occupation and activities.
- Addressing health inequalities.
- Improving levels of independence.
- Enhancing quality of life.
- Improving communication skills.
- Helping people manage their own conditions by enhancing coping skills or adapting their environment.

Primary prevention is often part of a specific approach within an organisation and may include formalised models. Primary prevention may also include therapeutic interventions. Fundamentally, primary prevention is based on person-centred approaches which aim to provide the ‘right fit’ between the services available and the needs of the individual and captured within the person’s personalised plan and/or risk assessment.

Secondary Prevention (Selected Interventions)

Secondary prevention focuses on early intervention and aims to minimise escalation in behaviour which may lead to the use of restrictive practices. Secondary interventions include:

- An assessment of the presenting behaviour so that a targeted approach can be used which may include the removal of immediate triggers.
- Making changes to the environment.
- Self-regulation techniques such as relaxation, breathing exercises, mindfulness and meditation techniques.
- Effective verbal and non-verbal approaches such as limit setting and distraction techniques.
- Reinforcement of alternative positive behaviours (positive reinforcement).
- The use of appropriate medication either to address underlying psychiatric symptoms or to help alleviate anxiety.

All secondary prevention interventions must be collaboratively agreed and captured within the person's personalised plan and/or risk assessment.

Tertiary Intervention (Indicated Interventions)

These are reactive strategies aimed at addressing the needs of individuals where primary and secondary prevention has failed, or were assessed as ineffective, in order to help the individual to regain control. Tertiary strategies can be non-restrictive or restrictive. They aim to bring about immediate behavioural change in the individual by enabling staff to manage the situation and eradicate or minimise the risks. It is important to recognise that tertiary approaches are risk management responses and not designed or intended to achieve any long-term or lasting behavioural change.

The Six Core Strategies

The Six Core Strategies were developed using the health promotion model as an organisational approach for eliminating or minimising physical restraint and seclusion and is now more widely used to eliminate or minimise all forms of restrictive practice. The Outcomes First Group advocates the adoption of this model, and audits organisations in line with its six elements of organisational performance.

1. Leadership

Leadership strategies include defining and articulating a vision, values and philosophy that expect to eliminate restrictive practices where possible, minimise the use to manage risk behaviour and ensure such practices maximise safety and minimise harm. To achieve this vision, leaders need to develop and implement a targeted action plan to improve performance and hold everyone to account.

Leadership includes the oversight of every event when restrictive practices are used, investigating causality, reviewing and revising policy and procedures that may instigate conflicts, and monitoring and improving workforce development based on the principles of continuous quality improvement. This element is achieved by the group's universal expectation that all events of restrictive practice are to be recorded in a uniform way which supports inclusion of all parties involved and leadership oversight.

2. Use of Data

This core strategy suggests that successfully reducing restrictive practices requires the collection and use of data

at different levels, e.g. individual user, individual unit/department, wider service to identify baseline measures. These include data review by unit, shift, day, individual staff members involved in events and user; as well as tracking injuries and complaints related to restrictive practices in both service users and staff. The group encourages organisations to analyse the collection of data on a regular basis, e.g. weekly/biweekly. However, the Reducing Restrictive Practices Board complete an extraction of data, which is analysed and responded to, on a quarterly basis.

3. Workforce Development

This strategy ensures the workforce has the knowledge and skills to deliver services based on the principles of person-centred approaches, recovery and the characteristics of trauma-informed systems of care. The purpose of this strategy is to create an environment that is less likely to be coercive or trigger conflicts and is implemented through ongoing staff training. This strategy ensures staff implement a wide range of primary prevention, person-centred approaches designed to teach users emotional self-management of symptoms and individual triggers that lead to loss of control. A high quality of workforce development is maintained through the group's selection of certified training providers and ongoing tailored training programmes provided by the learning and talent department.

4. Prevention of Tools

This strategy reduces the use of restrictive practices through tools and assessments integrated into organisational policy and for each user via individual safety and support plans. This strategy relies heavily on the concept of individualised approaches and includes assessment tools to identify risk for violence, universal trauma assessment, person-first, non-discriminatory language in speech and written documents, environmental changes to include comfort and sensory rooms, sensory modulation interventions, and other meaningful treatment activities designed to teach people emotional self- management/regulation skills. More clinically informed tools are accessible and clinical services are used to support organisations in identifying a person's specific needs.

5. Consumer Involvement

This fully and formally includes service users, children, families and external advocates in various roles and at all levels in the organisation to help reduce restrictive practices. It includes monitoring, debriefing, and peer support services. The groups uniformed recording systems and procedures are designed to involve the person, however the group recognises a diverse range of needs and differences which may impact a person's capacity to engage in this process. As a solution organisations are encouraged to create adapted ways of engaging with the person post incident e.g. an observational assessment, social story etc.

6. Debriefing Techniques

This core strategy recognises the usefulness of a thorough analysis of every instance of restrictive practices. Reducing restrictive practices occurs through knowledge gained from a rigorous analysis of events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future. A secondary goal of this intervention is to attempt to mitigate, as much as possible, the adverse and potentially traumatising effects of restrictive practices for those involved.

How CPI Training Integrates These Approaches Into Their Training

CPI training is based on a review of the current research in best practice and teaches participants a range of

interventions within the primary, secondary and tertiary model. The curriculum includes practical approaches to reduce and manage conflict to minimise restrictive practices. Should behaviour escalate, CPI training includes the option of non- restrictive and restrictive tertiary/reactive strategies using a risk- based approach to ensure risk behaviour is managed as safely as possible.

In line with the Six Core Strategies, CPI programmes include a Safety and Support Plan to enable staff to work with the person to develop a person-centred, trauma-informed, Positive Behaviour Support intervention plan which identifies everyday practices to get the 'right fit' between the individual's personal support and needs in order to avoid potential conflict and crisis situations. The Safety and Support Plan also ensures that the use of any restrictive practices is assessed and agreed individually with each individual so interventions take account of the person's characteristics, history and specific risk behaviour.

CPI Four-Stage Model

Based on a health promotion model, the CPI framework outlines a cycle of continuous assessment, intervention and learning based on Primary and Secondary preventive interventions; non-restrictive and restrictive Crisis (Tertiary) Intervention; and a fourth stage of Post-Crisis Support and Learning. This final stage helps staff implement a range of interventions to ensure that debriefing is offered to all those involved in the use of restrictive practices. This stage also ensures effective learning to prevent or minimise restrictive practices.

5.0 SECTION 3 – THE OUTCOMES FIRST GROUP RESTRAINT TRAINING PACKAGES

The Outcomes First Group is affiliated to the Crisis Prevention Institute (CPI) and our organisations subscribe to either one of the below Safety Intervention (SI) packages – Foundation, Advanced or Advanced and Emergency. The market of education also covers residential (care) and health/human caters to the group's adult division.

Safety Intervention - Foundation ™

Table 1: Disengagement

Name & Sequence / Market	Strike	Wrist	Clothes	Hair	Neck	Body	Bite	Interventions (1 staff)		
								Low	Medium	High
Education	√	√	√	√	√	√	√	√	√	√
Health/Human	√	√	√	√	√	√	√	√	√	√
Timings (minutes)	90									

KEY
Green √ = Foundation Safety Interventions included
Red x = Skills not included

Table 2: Holding

Name & Sequence / Market	Seated			Standing			Team Interventions (2 staff)	Transitions (2 staff)	Children Holds		
	Low	Med	High	Low	Med	High			Seated (chair)	Seated (floor)	Standing
Education	√	√	√	√	√	√	√	√	√	√	√
Health/Human	√	√	√	√	√	√	√	√	x	x	X
Timings (minutes)	150										

CPI SI Foundation Training incorporates trauma informed and person centred approaches. The programme has a focus on prevention, it also teaches staff de-escalation skills as well as non- restrictive and restrictive interventions. The programme is Restraint Reduction Network (RRN) certificated training curricula.

A programme of Verbal Intervention can be delivered to organisations, this programme provides participants with theoretical units only.

6.0 SECTION 3 – STATEMENT ONE TO ONE HOLDING

As presented in the graphic above the foundation programme offers one to one holding skills at a low, medium and high level of intervention. To support each organisations understanding the group and CPI have compiled the following statement:

Outcomes First Group Clarification Regarding One to One Holding

The Outcomes First Group have permitted, as part of the Safety Intervention Foundation Programme, the use of one to one restrictive physical interventions at a low and medium level only. The group requires organisations to follow the emergency application process to request the use of high level one to one holding.

Using Restrictive Interventions

The legal and professional justification to use a restrictive physical intervention (physical restraint) assumes that such action represents a last resort response to maximise safety and minimise harm, and as such, is a reasonable, proportionate and least restrictive course of action when there is an imminent or immediate risk of harm to self or others.

In order to ensure staff fulfil their legal and professional responsibilities in relation to the use of restrictive interventions, CPI advises that the workplace application of the restrictive physical interventions taught within the CPI 'Safety Intervention' training programme (a Restraint Reduction Network Certified programme), require a minimum of two staff. However, there may be situations where an assessment of the risk is such that staff are able to justify intervening alone (one to one restraint). As a risk-based approach, such circumstances may include, but are not limited to:

1. One member of staff guiding someone who is distressed who presents a low risk to self or others, to or from a particular area e.g. guiding someone back into a building.
2. One member of staff holding a child because the disparities in physical size and physical maturity of the child. Where there are such disparities between the adults and the child, an intervention with one member of staff may be more appropriate and less traumatic for the child.
3. Emergency situations where a member of staff assesses the risk and determines that a one to one restraint represents less harmful course of action than not intervening e.g. a member of staff without the immediate help and support from colleagues, intervenes using a one to one restraint with someone who is head-butting a window with the intention to harm self.

When deciding to intervene in a one to one restraint, staff should determine whether they need to use a physical intervention immediately due to the risks to the person in distress, themselves or others, or wait for a second member of staff to arrive before intervening.

In any situation where any physical interventions are used, staff will need to be able to justify their decisions and subsequent actions ensuring the intervention is compatible with organisational policy as well as legal and professional responsibilities.

Holding young children using the CPI Restrictive Physical Interventions

The physiological principles taught within the CPI 'Safety Intervention' programme have been adapted and

independently risk assessed as suitable for staff to use on a 'one to one' basis for young children of primary school age (up to 11 years) in situations outlined in point 2 above.
However, even with this age group, the physical size and maturity of one child may vary significantly to another meaning a one to one intervention for some may not be appropriate or safe for both the child and/or member of staff. Similarly, a child of secondary school age (over 11 years) may lack physical size and maturity and a one to one intervention may be considered more appropriate than two staff.

Given these variations the physical size and maturity of children, organisations should outline reasonable parameters for practice in relation to one to one use of restrictive physical intervention within their policy and guidance. While general policy guidelines are written to set parameters of practice for staff, all interventions should be supported by an individual risk assessment and support plan for the child which determines the specific interventions that are appropriate. In circumstances where a risk assessment and support plan is not in place, staff must fulfil their duty of care and act reasonably, proportionately and responsibly in accordance with organisational policy.

In school or residential settings for children and young people, there may not always be a colleague immediately available to support a physical intervention or to act as an observer, however, every effort should be made to ensure any physical intervention is undertaken using a team approach. Calling for assistance and having an observer present and ready to assist helps to maintain the Care, Welfare, Safety, and Security of everyone—the child as well as the adult.

Where a one to one restraint is used in an emergency outside of any agreed safety and support plan, an immediate review of the incident should take place which should include a review of the risk and circumstances which took place as well as a review of the child/young person's safety and support plan to determine if such an approach should or should not be authorised and approved for similar future circumstances.

7.0 SECTION 3 – ADVANCED AND EMERGENCY TRAINING APPLICATION PROCESS

Safety Intervention - Advanced™

CPI

Table 1: Disengagement

Name & Sequence / Market	Strike	Wrist	Clothes	Hair	Neck	Body	Bite	Interventions (1 staff)			Neck (high risk)
								Low	Medium	High	
Education	√	√	√	√	√	√	√	√	√	√	√
Health/Human	√	√	√	√	√	√	√	√	√	√	√
Timings (minutes)	90										15

KEY
Green √ = Foundation Safety Interventions included
Red x = Skills not included
Yellow√ = Advanced Skills included

Table 2: Holding

Name & Sequence / Market	Seated			Standing			Team Interventions 2 staff)	Transitions (2 staff)	Children Holds			3rd Person		Advanced Team Interventions (3 staff)	Transitions (3 staff)	Standing to floor transitions (Slips, Trips and Falls)		Standing to floor transitions (Slips, Trips and Falls)	
	Low	Med	High	Low	Med	High			Seated (chair)	Seated (floor)	Standing	Seated	Standing			Standing to Seated	Standing to Supine	Standing to Kneeling	Standing to Supported Prone
Education	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Health/Human	√	√	√	√	√	√	√	√	x	x	x	√	√	√	√	√	√	√	√
Timings (minutes)	150											30		20	15	35	35	35	35

CPI SI Advanced and Advanced Emergency programmes are designed for organisations that support individuals who are more likely to demonstrate more complex or extreme risk behaviours. It provides

effective tools and decision making skills to help staff manage higher risk situations, offering a wider array of verbal and physical intervention options. Both programmes are Bild ACT certified as meeting the RRN standards for training curricula and provide Continuing Education Credits (CEC) and Continuing Professional Development (CPD) Credits.

The Outcomes First Group have set a clear procedure for organisations to follow in times where an organisation feels there is a justified need for Advanced and Emergency Disengagements and/or Holding Skills. This procedure requires the organisation to make an application to the Reducing Restrictive Practices (RRP) Board by completing an Request for Advanced or Emergency CPI training Form. The board will process the application and if necessary commission CPI on behalf of the requesting organisation to complete a Validation Visit. CPI will compile a report, the report is then presented to the Board for final approval of an advanced and emergency programme being delivered to that organisation. The requesting organisation will be responsible for the commissioning costs of the Validation Visit. In times of approval the Board will hand the organisation over to Learning and Talent who will liaise directly with CPI to arrange for the agreed Certified Instructors (CI) to attend an advanced and emergency programme. As part of this procedure organisations are required to reapply to the Board on an annual basis before the approved CI's are reaccredited

Safety Intervention – Advanced and Emergency ™

CPI

KEY | Blue √ = Skills included

Table 1: Disengagement

Name & Sequence / Market	Strike	Wrist	Clothes	Hair	Neck	Body	Bite	Interventions (fights)			Neck (high risk)	Emergency Responses											
								Low	Mediu m	High		Thumb		Dorsal Hand		Torso		Sternum		Mandibular		Columellar	
												Escape	Rescue	Escape	Rescue	Escape	Rescue	Escape	Rescue	Escape	Rescue	Escape	Rescue
Education	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Health/Human	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Timings (minutes)	90										15	115											

Table 2: Holding

Name & Sequence / Market	Seated			Standing			Team Interventions (2 staff)	Transitions (2 staff)	Children Holds			3rd Person		Advanced Team Interventions 3 staff)	Transitions (3 staff)	Standing to floor transitions (Slips, Trips and Falls)		Standing to floor transitions (Slips, Trips and Falls)		Emergency Team Interventions (3 staff)	Emergency Floor Holding		Rapid Tranquilisation	Seclusion		
	Low	Med	High	Low	Med	High			Seated (chair)	Seated (floor)	Standing	Seated	Standing			Standing to Seated	Standing to Supine	Standing to Kneeling	Standing to Prone		Supine	Supported Prone		Entry	Search/removal of unsafe items	Exit
Education	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Health/ Human	√	√	√	√	√	√	√	√	×	×	×	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Timings (minutes)	150											30		20	15	35	35	35	35	40	50	50	30	30	30	30

The group understands that staff within an organisation may find themselves in a circumstance where they must intervene, in an unplanned manner, in times of an emergency and before the organisation has been able to make an application to the Board. The Board have produced the below policy to support organisations:

8.0 SECTION 3 – EMERGENCY FLOOR HOLDS

The Outcomes First Group (OFG) are members of the Restraint Reduction Network and continue to be committed in reducing the use of restrictive practices and restraint.
The group do not, in general, permit the use of emergency floor holds but understand that there may be an exception event when a child, young person or adult presents extreme risk behaviour to self or other, resulting in emergency floor holds being necessary as a temporary/short term risk management strategy to ensure safety.

Purpose

- To ensure the safety and well- being of children, young people or adults who may be subject to floor holds.
- To ensure the safety of any staff involved in emergency floor holds.
- To ensure monitoring, oversight and accountability of any floor holds applied.

Procedure and Reporting

If a child, young person or adult is placed in a school or home with knowledge that emergency floor holds may be required an application must be made to the Reducing Restrictive Practices (RRP) Board for approval to ensure there are sufficiently trained and certified members of staff. The approval of such techniques must then be included in the approved services Restraint Policy.

A risk / behaviour management plan for the child, young person or adult must be completed detailing the exact circumstances in which emergency floor holds may be required, any medical conditions of the person, the technique(s) to be used, and the arrangements for medical attention, debrief of all involved and informing after any incident.

The risk / behaviour management plan must specify all risks associated with emergency floor holds and how those risks will be mitigated.

The risk / behaviour management plan and risk assessment must be agreed and signed by all key stakeholder.

The risk / behaviour management plan must be signed off by the services Regional Director or Regional Manager.

In times where emergency floor holds are actioned as part of the risk / behaviour management plan the organisations Regional Director or Regional Manager is to be notified via email immediately after the incident.

The groups view is if a child, young person or adult takes themselves to the ground during a restraint they should be released, unless evidence can be provided that maintaining the hold is necessary due to safety reasons e.g. an emergency where there is a risk of extreme harm and an alternative course of action is considered a greater risk. In times where reasonable force has been applied resulting in the use of a restraint on the floor a senior within the organisation must be verbally informed immediately and the exception event must be recorded before the staff involved depart. The Regional Director or Regional Manager must be notified immediately via email. The Regional Director or Regional Manager is responsible for the monitoring of these exception events and when they feel it is necessary make an application for a visit using the RRP Supportive Visit Application Form.

Records of any emergency floor holds must include:

- Being recorded as Reasonable Force unless the advanced and emergency programme has been approved and delivered.
- The exact circumstances of the hold – justification/reasoning.
- Detail of the emergency floor holds used.
- Why an alternative hold could not be implemented.
- The methods applied to monitor and observe the risks of restraint, not just the head and breathing but warning signs which indicate psychological and physiological/anatomical harm.
- The training received by the staff involved in the hold.
- Full and detailed de-briefs for all people involved including how emergency floor holds can be avoided in the future.

- Details of medical follow-ups.
- Senior manager and Regional Director or Regional Manager sign off.

All records of emergency floor holds must be sent to the Regional Director or Regional Manager for review. Following an emergency floor hold the risk / behaviour management plan must be reviewed to include any lessons learnt from the debriefing process.

9.0 SECTION 4 – COLLABORATION OF PERSON CENTERED TRAUMA INFORMED CARE

Within OFG, we have a Trauma Informed Practice Strategy to inform the services we support. Trauma is subjective, and can be a result of early adverse childhood experiences (such as emotional abuse, physical abuse, domestic violence) and intergenerational trauma. We also consider trauma more widely, such as bullying and not fitting in often experienced by individuals who are neurodivergent. The majority of those within OFG may have also experienced education trauma, e.g. school breakdowns, experience of restraints. Working with trauma can be incredibly rewarding as well as challenging, and colleagues within OFG can experience the impact of this, e.g. burnout, secondary trauma.

The earlier in life trauma happens, the more profound the impact on a child's development. People who have experienced trauma in early childhood (sometimes called Adverse Childhood Experiences or ACEs) often struggle to self-regulate and seem to always be in a state of high alert to protect themselves from r harmful experiences (The Complex Trauma Model, Cooke et al). This is their automatic, learned response and not signs of pathology, rather, **they are survival strategies that have helped them cope** with what has been experienced. Some of the signs of trauma we might see are:

- Mood instability
- Self-harm.
- Eating needs.
- Mis-understanding and being drawn to risk which can lead to further victimisation.
- Flashbacks, nightmares and hyper-vigilance.
- A sense of terror
- Auditory hallucinations
- Difficulty with problem solving and managing impulses.
- Physical aggression.

Trauma-informed care focuses on 'what happened to the person' instead of 'what's wrong with the person' and helps staff understand how the person's behaviour developed, how this impacts on the person now and how to help the person develop new coping strategies. When taking a trauma- informed approach, it is important for staff to reflect on their own behaviour and responses to individuals (what CPI calls the Integrated Experience) by being aware of how their approach may adversely impact on the person. This approach to 'going beyond the behaviour' is also consistent with our Person-Centred Behaviour Policy and our Neurodivergent Affirming Behaviour Policy.

- **Triggers -**staff approaches, the environment or situation may trigger self-protection responses e.g. sights, sounds, smells, tone of voice and touches may remind the person of their trauma.
- **Flashbacks -** situations may trigger recurring memories, feelings and thoughts associated with the trauma.
- **Traumatic stress -** brings the past to the present and can trigger a response of intense fear, horror and helplessness in which extreme stress overwhelms one's capacity to cope.

OFG's Trauma Informed Practice Strategy supports staff reflective practice and increasing our own awareness and mitigating this through well-being approaches. We work on understanding the impact of trauma and also how we support it. We standardize practice through Connect, Co-Regulate and Co-Reflect. Connect supports building relationships in an attachment and trauma informed way, Co-Regulate helps recognize and develop ways to manage, and Co-Reflect supports individuals to learn safe ways of living to their full potential.

10.0 SECTION 5 – A HUMAN RIGHTS APPROACH TO REDUCING RESTRICTIVE PRACTICES & RESTRAINT GROUP ADVICE ON HUMAN RIGHTS

It is important that organisations do everything they can to eliminate restrictive practices and ensure that when restrictive practices are necessary, they are 'exception events' used to manage risk behaviour. When restrictive practices are used, the aim should be to maximise safety and minimise harm.
Historically, restrictive practices in all settings have been misused so taking a human rights approach can help organisations ensure abuse is avoided. The organisation should provide staff, individuals and families with clear information regarding when restrictive practices may be used as well as specify which restrictive practices are considered acceptable. Organisations must ensure that staff, individuals and families know that restrictive practices should never be used as a punishment, and never be used to force compliance with rules. The British Institute of Human Rights (2013) published a framework to help staff think about how human rights can underpin professional practice.

The PANEL principles help staff consider how best to support people who present behaviours that challenge.

Key Principle	What This Means	What This Looks Like
Participation	Enabling participation of all key people and stakeholders	Consulting with and involving people in their care and support
Accountability	Ensuring clear accountability, identifying who has legal duties and practical responsibility for a human rights-based approach	Outlining responsibilities under the Mental Health Act and Mental Capacity Act, measuring quality of life outcomes against agreed standards
Non- Discrimination	Avoiding discrimination, paying attention to groups who are vulnerable to rights violations	Using person-centred approaches that do not discriminate, making sure staff are sensitive to culture and diversity

Empowerment	Empowering staff and people who use services with knowledge and skills to realise rights	Raising awareness through education and resources, explaining how human rights are affected by restrictive practices
Law	Complying with relevant legislation including human rights obligations, particularly the Human Rights Act	Identifying human rights implications of supporting people who challenge; considering fairness, respect, equality, dignity and autonomy

In addition to the human rights approach outlined CPI can provide the group's organisations with resources co-produced by people with a lived experience to reinforce the underpinning values of a person-centred, trauma-informed approach.

The CPI **Keep Me Safe, Treat Me With Respect** booklet and poster help explain the appropriate use of restrictive physical interventions (RPI) taught within CPI programmes. Designed for individuals and families. The Keep Me Safe booklet explains why and when a restrictive physical intervention (RPI) may be used, when it should not be used and gives people help and advice on what to do if they feel any restrictive practice has been used unnecessarily. The Outcomes First Group advocate and promote organisations to use these resources and have them on display where possible.

The **Watching Brief** is a human rights-based practice guide for using non-instructed advocacy, co-produced by CPI, ASIST Advocacy Services and people with a lived experience. The Watching Brief helps people implement non-directed advocacy using eight domains to ordinary living which represent aspects of life that any reasonable person would wish to consider if they were able to express their views.

Corrupted Cultures

Where restrictive practices are misused and abused, it is common to find that such practice develops within an organisation or staff team over time. Often, it is difficult to identify who, why, when and where abusive practices started, but the misuse and abuse of restrictive practices typically occurs in a 'corrupted culture'. Many people think that a corrupted culture develops because of the building services are in, so modernising buildings and changing where services are delivered is often seen as the way to prevent abusive practice. However, despite the closure of long stay hospitals, a greater focus on care in the community, integrated education, and personalised budgets, abusive practices continue to occur.

A corrupted culture is a working environment where staff adopt unethical, unprofessional and illegal action to gain benefit or to minimise harm. It develops as a result of the social values and culture within an organisation. This can be at an organisation-wide level, a team level or even individual staff level. Corrupted cultures are typically insidious, developing slowly with practice gradually becoming more and more abusive, often without the people within the organisation noticing until it becomes too late. Services that offer person-centred, trauma-informed support are less likely to develop corrupted cultures as their services and support are based on human rights and co- production. Organisations that recruit for values, train for values, coach and supervise for values and undertake performance management and disciplinary action for values are rarely corrupted.

Corrupted cultures have common characteristics and follow a similar path. This means that organisations, staff and families can look for the signs and act to identify each step so that corrective actions can be taken. Some common features include inequality and stigmatisation, isolation and a lack of external and internal review, inexperienced workforce with low levels of knowledge and skill, poor working practices and values, poor leadership and management. A corrupted culture prioritises the needs of the workforce over the needs of users and families who access the service and authorises coercive and restrictive practices as a means

of control. The Outcomes First Group have implemented an internal review system to combat against corrupted cultures and promote organisations to use the six steps below to examine and consider where each organisation is on this journey to corruption.

CPI's Five steps to a corrupted Culture

Step 1: Us and Them
At the start of the journey to corruption, organisations and their staff find ways to depersonalise, stigmatise and de-value the people they are there to support. Emphasis is placed on difference, and similarities are dismissed. Behaviour is negatively labelled 'deviant,' and a level of threat is reinforced to dehumanise people.

Step 2: Control
Once a difference is created ('Us and Them'), rules establish an imbalance of power. Those with power('Us') enforce the rules. Those without power ('them') follow the rules so that rules are used to create a culture of control. Basic human rights are denied, instead creating a range of 'privileges' which have to be earned and which can be taken away.

Step 3: Do Harm
Use degrading and dehumanising language and practices in ways that those with control ('Us') would not accept. Emphasise risk as the justification for the degrading and dehumanising practices and find creative ways to manage and contain people with coercion and restrictive practices. Justify excessive restriction and approaches which may breach people's human rights on the basis that it's the only way to manage 'Them'.

Step 4: Apathy
Stand by and watch it happen because the organisational whistle blowing procedures are ineffective. Accept the fact that you are a lone voice, and no one will listen to your concerns. Become tolerant of abusive practices and find excuses to justify them. Normalise practice (e.g., 'it's the only way'; 'we have no choice'; 'you don't know how difficult these people are'; 'we support those people no one else can work with').

Step 5: Contain
Develop more ways to restrict, segregate and isolate people from their friends, families and from their wider community and society. Deny people their cultural and social heritage and strip people of their individual identities by ascribing non-human characteristics (e.g.,'she behaves like an animal; he has the strength of ten men'). Develop 'specialised services and support' that only certain staff can work in. Induct new staff to the 'culture' and remove those staff who don't conform or who challenge practice.

The Outcomes First Group have established a robust structure (see section 6) which incorporates the above as an assessment to identify, monitor and regulate organisations, ensuring that all align to the group wide ethos, values and culture.

11.0 SECTION 6 – THE OFG BOARD APPROVED MODEL TO MONITOR & REGULATE THE USE OF RESTRICTIVE PRACTICES & RESTRAINT

All organisations within the Outcomes First Group must ensure there are consistent, efficient and effective records maintained to remain compliant with the completion of all post procedure actions that OFG expect when a restrictive practice and/or restraint has been used. The nominated Reducing Restrictive Practices Lead will support the organisations leadership team to ensure compliance is maintained.

Each organisations leadership team will ensure that a policy has been written and is kept up to date and includes the statement above and the groups Reducing Restrictive Practices and Restraint Plan below.

Reducing Restrictive Practices and Restraint Plan

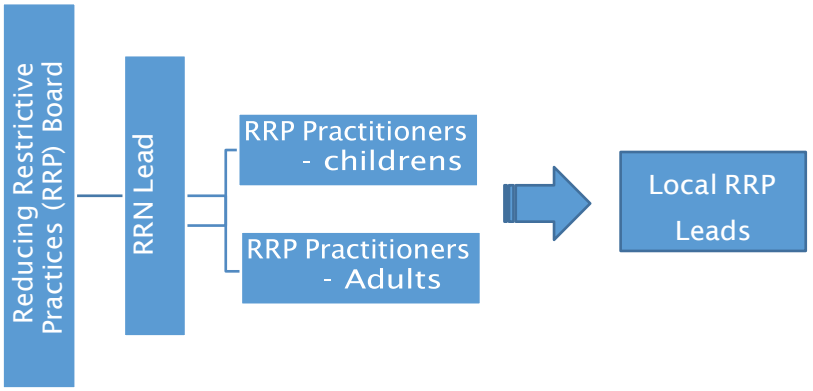
Objectives

To support a group wide reduction in the use of restraint and restrictive practices and ensure effective and efficient reporting/recording, monitoring and regulation to support preventative practices for the future.

To ensure adherence to the Restraint Reduction Network (RRN) Training Standards in line with the Group's memberships and affiliation with BILD ACT providers.

Group Approach

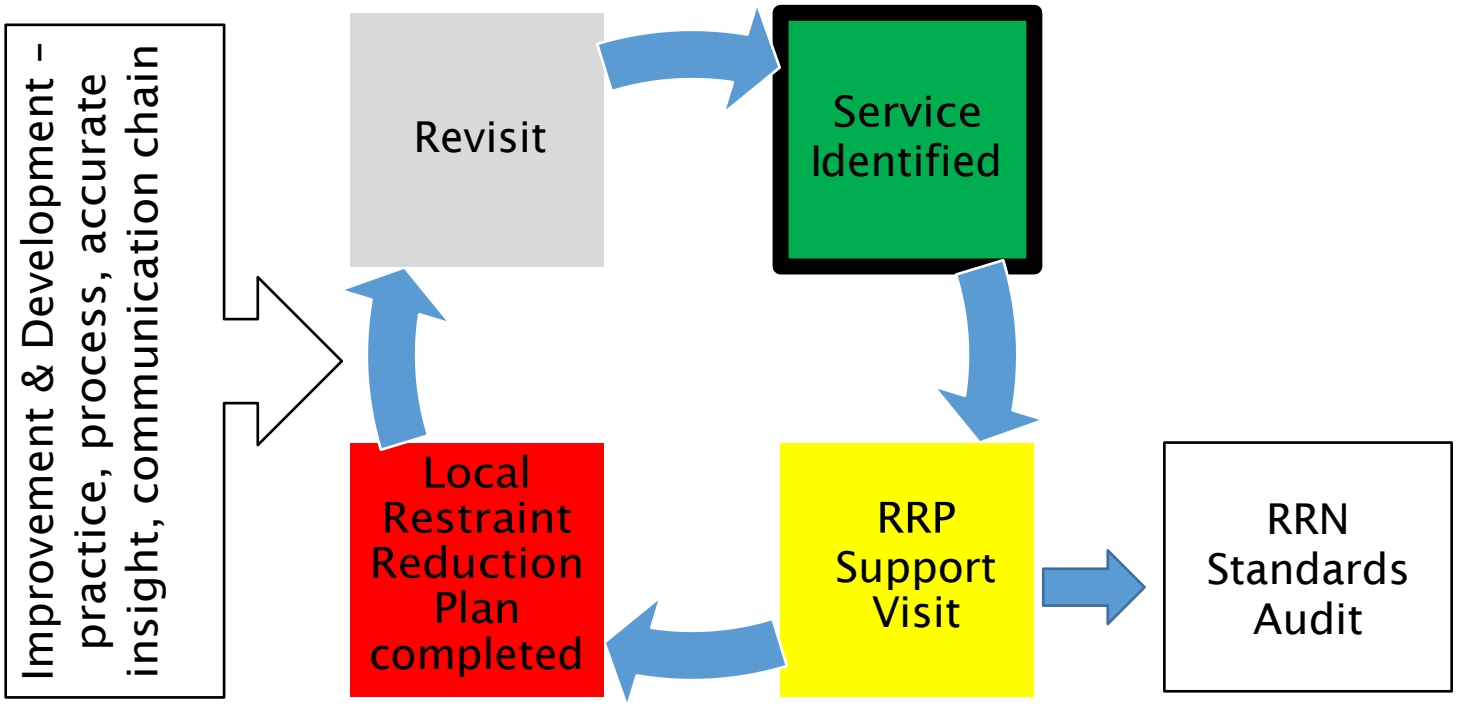
- The Groups Reducing Restrictive Practices (RRP) Board will manage the objectives, the Groups Restraint Reduction Network Pledge Action Plan, central terms of reference and the coordination of Reducing Restrictive Practices (RRP) Support Visits across fostering, education and care as determined by core system data, internal and external inspections/visits and Improvement Board agenda.
- A governance data rating of organisations (green, yellow, red) on the use of restraint and restrictive practices and service compliance will be adopted and quarterly reports compiled, the data will be presented to the RRP Board and can activate a Reducing Restrictive Practices (RRP) Support Visit and completion of an Improvement Plan monitored by the allocated Reducing Restrictive Practices (RRP) Practitioner and Local RRP Lead. In times of further concern a higher-level visit will involve the completion of the Groups RRN Standards Audit Tool. The findings from the audit will form the foundations of a live monitoring tool for an Improvement Board involving the organisations leadership team, Regional Director or Regional Manager, National Care Manager, and Clinical Lead.
- In times where a concern or complaint has been raised as part of whistleblowing and/or a safeguarding concern in relation to the use of restraint the Board are to be directly informed on rrpboard@ofgl.co.uk so the above process will be followed.
- Identified regional RRP Practitioners will conduct scheduled RRP Support Visits in liaison with service RRP Leads.



- Support visit reports of identified priority organisations will be circulated to the leadership team, Regional Director or Regional Manager, National Care Manager (if required) and the Board.

- Organisations will be assessed against the RRN Training Standards criteria and the Six Core Strategies to prepare for and contribute to whole Group periodic RRN compliancy inspection.

The Support Visit Process



12.0 SECTION 6 – REQUESTING A REDUCING RESTRICTIVE PRACTICES SUPPORT VISIT

As part of good practice and to support organisational improvement and development an organisation can request a visit using the RRP Supportive Visit Application Form . Once submitted a practitioner will be assigned to complete a support visit. The practitioner will audit the use of restrictive practices and restraint and to ensure compliance to the Restraint Reduction Network (RRN) Training Standards and the Six Core Strategies. The compiled report will provide the organisation with an improvement plan, to which they will be measured against throughout the reviewing process.

13.0 SECTION 7 – DEFINITIONS OF COERCION AND RESTRICTIVE PRACTICES

Coercion

Coercion involves a range of interventions which aim to bring about cooperation from an individual who is unwilling or unable to accept care and support, in other words persuading someone to do something they do not want to do. Whilst coercive interventions are aimed at helping people make choices in their

best interests, there are ethical concerns about coercion since the typical interventions range from informal persuasion, inducements, or pressure to explicit compulsory methods and acts of force such as detention under the Mental Health Act and restrictive practices including forced medication (rapid tranquilisation), physical

restraint, seclusion and external body searches.

It is important to remember that there is a subjective psychological element linked to the relationship between the individual and the care professionals. The person being coerced may feel they lack influence and control, choice, and freedom, and they may have a feeling of depersonalisation.

Restrictive Practices

A restrictive practice (or restraint) can generally be described as any approach used to restrict a person's liberty of movement, whether the person objects to such restriction or not. Considered only as a possible response to risk behaviour at the third level of the *Crisis Development Model*SM, restrictive practices are categorised as 'Tertiary' or 'Crisis/ Reactive' Interventions. The Equality and Human Rights Commission (2019) provide a much wider definition which states:

'"Restraint" is an act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently. This may or may not involve the use of force. Restraint does not require the use of physical force, or resistance by the person being restrained, and may include indirect acts of interference, for example removing someone's walkingframe to prevent them moving around'.

Restrictive practices or restraint can be much more than the use of force. The Restraint Reduction Network Training Standards (2019) divide restrictive practices into four distinct categories that may be used to manage risk behaviours.

Category A - Physical Restraint

Physical Restraint is defined by the Department of Health (2014) as *'any direct physical contact where the intention of the person intervening is to prevent, restrict, or subdue movement of the body, or part of the body of another person'.* Physical restraint can also be called manual restraint, physical intervention and restrictive physical intervention (RPI).

Clinical Holding is physical restraint used solely for the delivery of safe care and treatment to a person who lacks capacity to consent for such treatment. The British Society for Disability and Oral Health (2009) define clinical holding as *'the use of physical holds to assist or support an individual to receive clinical care and treatment'.*

The Royal College of Nursing (2010) provide further clarification by including the use of clinical holds as *'a suitable method of helping children and adults, with their permission, to manage a painful procedure quickly or effectively'.*

Category B - Environmental Restraint

Seclusion is a specific method of environmental restraint typically used in acute and secure mental health settings and is defined as *'the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving'* (Mental Health Act 1983 Code of Practice, 2015).

The Equality and Human Rights Commission's Human Rights Framework for Restraint (2019) recognises that seclusion is enforced isolation by *'locking a door or using a door the person cannot open themselves, or otherwise preventing them from leaving an area'.*

Enforced isolation is also a method of environmental restraint which goes beyond formal seclusion and is sometimes described by other terms such as **Enhanced Care, Segregation, Separation, Time Out** or **Solitary Confinement**.

Long-Term Segregation is a specific form of enforced isolation involving *'a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determine that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis'*(Mental Health Act 1983 Code of Practice, 2015).

The Outcomes First Group do not permit the use of seclusion as a planned intervention within children organisations. In times that an organisation, from all divisions, have used seclusion as part of an emergency intervention they are to inform the Regional Director or Regional Manager. When seclusion is perceived as a necessary disciplinary penalty as set out in Behaviour and Discipline in Schools Advice for Head Teachers and School Staff section 42 (DfE January 2016) the organisation is required to make an application for board approval.

In relation to the groups adult division any organisation currently using, or requiring the use of seclusion must make an application for board approval.

Category C - Chemical Restraint

Although the use of antipsychotics and sedatives may constitute chemical restraint, especially for individuals who lack capacity to consent, **Rapid Tranquilisation** is a specific emergency form of chemical restraint and refers to *'the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduce agitation and aggression. This may provide an important opportunity for a thorough psychiatric examination to take place'* (Mental Health Act 1983 Code of Practice, 2015).

Category D - Mechanical Restraint

Mechanical restraint involves *'the use of a device (e.g. belt or cuff) to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control'* (Care Quality Commission, 2015a).

Although the use of belts or cuffs is typically associated with the police and prison service, some acute mental health and forensic settings permit mechanical restraint to contain extreme violence and/or when certain individuals are admitted or transferred to and from hospital to minimise the risk of absconding.

In some settings, especially children and adults with severe intellectual disabilities, mechanical restraints (splints) may be used to minimise the impact of injury from self-harm. A range of equipment designed for another purpose may be used as mechanical restraint, so it is not uncommon to find furniture and other equipment being used to restrict a person's liberty. This includes beanbags, bedrails, harnesses, belts, confusing door handles, keypads or other electrically operated entry and exit systems. These methods of restriction often go unnoticed, unreported and unrecorded by staff as these approaches are viewed as taking safety precautions rather than restrictive practices.

All CPI programmes that include restrictive physical interventions contain a unit covering decision making, an assessment of risk and the legal, professional and ethical issues related to restrictive practices. This unit enables staff to make reasonable and proportionate decisions about the use of any physical intervention for the management of risk behaviour so that you can provide a sound justification for such actions if challenged by others. When deciding to use (or not to use) a restrictive intervention, your decisions and actions are judged, typically retrospectively, by many people including:

- The individual subject to restriction and their families.
- Colleagues, managers, and employer.
- Professional bodies.
- Regulators.
- Commissioners.
- Courts.

It is important that your decisions and subsequent actions not only reflect the key themes of decision making outlined in CPI training, but also reflect the legal and professional expectations for your field of work as there may be specific requirements, guidelines or legislation that relate to your setting or user group. Ensuring your decisions and actions reflect the current legal and professional expectations and obligations helps ensure your decisions are viewed as last resort, least restrictive, reasonable and proportionate in the circumstances, as well as justified and defendable.

14.0 SECTION 7 – GROUP ADVICE ON DUTY OF CARE

Duty of Care

A Duty of Care is the legal obligation imposed on an individual requiring them to adhere to a standard of reasonable conduct while performing any act that could reasonably foresee harm to others. It is the first element that must be established to proceed with any case of negligence and takes account of harm that may arise from the action taken as well as harm arising from a failure to act. Duty of Care can be viewed as a social contract between individuals and the implicit responsibilities individuals have towards others.

A three-part test establishes if a Duty of Care exists:

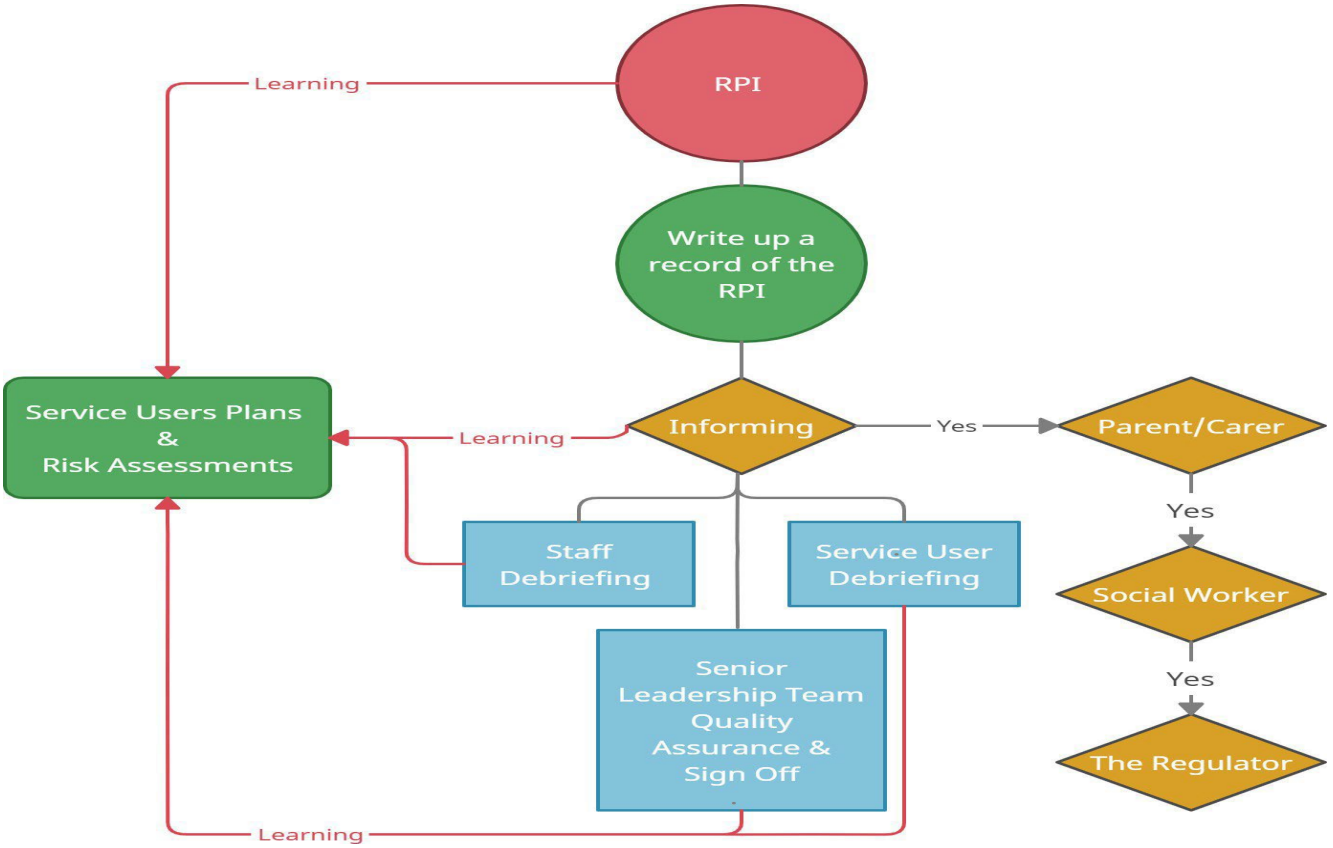
- Harm must be a reasonably foreseeable result of the individual's action (or lack of action).
- A relationship must exist where there is a clear expectation to uphold a Duty of Care.
- It must be fair, just and reasonable to impose such a duty.

As professionals, you have a clearly defined Duty of Care. You have a responsibility under this duty to ensure any action or failure to act in relation to risk behaviour does not cause any reasonably foreseeable harm. In so doing, you must consider the risk of harm associated with the action you take and compare this to the risk of taking no such action so that the outcome results in no harm or the least amount of harm reasonably foreseeable in the circumstances.

15.0 SECTION 8 – OFG EXPECTATIONS ON DEVRIEFING AND POST INCIDENT ACTIONS

In line with CPI fourth stage, the Outcomes First Group have set a high expectation for all organisations to complete and record post incident actions.

The below model has been fully integrated into management information systems (MIS) used across the group. It is each organisations responsibility for this to be complied with. The group expect that each time a restraint or restrictive practice has been used in line with the group's definition, the following procedure is to be adhered to.



16.0 SECTION 9 – OFG DEFINITION, LAW AND PROFESSIONAL ISSUES RELAED TO THE USE OF RESTRICTIVE PRACTICES AND RESTRAINT

The Outcomes First Group define actions that constitute to restrictive practices and restraint as set out in Reducing the Need for Restraint and Restrictive Practices (2019) section 1.10.

- Physical restraint: a restrictive intervention involving direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.
- Restricting a child or young person's independent actions, including removing auxiliary aids such as a walking stick or coercion, including threats involving use of restraint to curtail a child or young person's independent actions.
- Chemical restraint: the use of medication which is prescribed and administered (whether orally or by injection) by health professionals for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.
- Mechanical restraint: the enforced use of mechanical aids such as beanbags, belts, cuffs and restraints forcibly to control a child or young person's individual's movement.
- Withdrawal: removing a child or young person involuntarily from a situation which causes anxiety or distress to themselves and/or others and taking them to a safer place where they have a better

chance of composing themselves. We also refer to this concept below as Imposed Withdrawal.

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

There is a wide range of legislation, guidance and standards which influence how restrictive practice can be used and legally justified. Below is a summaryof the main reference materials which relate to legal and professional practice. Organisations within the Outcomes First Group are responsible for ensuring that localised policy incorporates sector relevant legislation as presented below. It is the responsibility of professionals working in education, health or social care settings, to ensure they are familiar with the expectations and standards of conduct that influence practice and ensuring decisions and actions reflect the expectations of the organisation in accordance with these professional and legal requirements.

1. The Restraint Reduction Network (RRN) Training Standards, 2019

The RRN Training Standards provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings. They ensure that training is directly related and proportionate to the needs of specific populations. The standards outline the importance of delivering evidence-based accredited training which provides knowledge and skills that go far beyond the application of physical restraint or other restrictive interventions.

The standards are mandatory for all training with a restrictive intervention component delivered to NHS commissioned services for people with mental health conditions, learning disabilities, autistic people and people living with dementia in England. They can also be applied to:

- The wider education, health and social care sectors.
- Children and adult services.
- The UK and internationally.

2. Human Rights

United Nations Convention of the Rights of the Child, 1989; Human Rights Act, 1998; United Nations Convention of Rights of Persons with Disabilities, 2006; Equality Act, 2010

Human rights are the basic rights and freedoms that belong to every person in society from birth to death and apply regardless of where you are from, what you believe or how you choose to live your life. Your human rights can never be taken away, but they can be restricted in the interests of society.

Human Rights Act 1998: Articles 2, 3, 8 and 14

The Human Rights Act creates legal obligations for the protection of rights for all those living within a democratic society. The Act applies to all public authorities and shapes the legal duties of staff to respect and protect everyone's human rights, especially in relation to the use of lawful restraint.

Article 2 reinforces our legal Duty of Care and requires *'all reasonable steps to be taken to protect a*

person's right to life' including stopping an intervention if it is likely to result in harm and/or intervening to protect a person from themselves or others where a failure to act could result in harm.

Article 3 prohibits *'torture, and inhuman and degrading treatment or punishment'* which may include different types of assault on human dignity and physical integrity as well as acts of unjustified suffering. Although under Article 3 actions which inflict a sufficient severity of pain may be considered torture, especially if undertaken *deliberately*, the use of any restrictive intervention must not cause harm (arising from either intended, negligent actions or failures to protect) amounting to degrading or ill- treatment. When deciding if any intervention is a breach of Article 3, the Court will consider the severity and intensity of suffering inflicted on an individual based on anassessment of factors including the:

- Duration of the action
- Physical and psychological impact/effects
- Sex, age, gender and health of the person
- Manner and execution of the intervention

Article 8 requires staff to involve the person in decisions about their care and treatment and to ensure that the use of any restrictive practice is the least restrictive option based on the prevailing risks.

Article 14 protects the right against discrimination and means that restrictive practices must not be undertaken on the grounds of race, ethnicity, age, gender or other status or protected characteristic.

3. Legislation relating to children and young people

Child Care Act (Ireland) 1991; Protection of Children Act, 1999; Protection of Children (Scotland) Act, 2003; The Children Act, 2004; Children (Emergency Protection Orders) Act (Northern Ireland), 2007; The Children and YoungPerson Act, 2008; Working Together to Safeguard Children, 2015; Children First Act (Ireland), 2015

A range of legislation provides the legal basis for how social services and other agencies deal with issues relating to children. This legislation has been introduced so that all individuals looking after children, in the home, workplace, school or other setting, are aware of how children should be looked after and legally protected.

Whilst different legislation may give greater or lesser focus on the use of restrictive practice, there is a universal expectation that the use of any force should be a last resort, reasonable and proportionate to the circumstances. The overall aim is to protect the child or young person from harm. This range of legislation aims to make sure the care children and young people receive is well supported, of high quality and tailored to their needs whilst also improving their educational experience and achievements.

The Protection of Children and Vulnerable Adults Order (Northern Ireland), 2004; The Safeguarding Vulnerable Groups Act 2006; Protection of Vulnerable Groups (Scotland) Act, 2007

Legislation and guidance to safeguard vulnerable groups (children and adults) implements more stringent ways to carry out checks on those individuals who wish to work with children, the elderly or people who are classed as being in positions of vulnerability. This legislation gives employees powers, in conjunction with those bodies who oversee the checking of potential new employees, to help confirm the safety and reliability of those individuals who wish to work with those who fall under the auspice of vulnerable groups.

Education and Inspections Act, 2006; Best Practice Guidelines in the Use of Restraint (Child Care:

Residential Units) (Ireland), 2006; The Use of Reasonable Force Guidelines, 2013; Behaviour and Discipline in Schools, 2013; Safe and Effective Intervention – Use of Reasonable Force and Searching for Weapons (Wales), 2013;
Reducing the Need for Restraint and Restrictive Intervention, 2019

Advice for schools is intended to clarify the use of force to help school staff feel more confident about using this power when they feel it is necessary, and to make clear the responsibilities of head teachers and governing bodies in respect of this power.

Within current guidance, 'reasonable force' covers the broad range of actions that involve a degree of physical contact with pupils to control or restrain. This can range from guiding a pupil to safety by the arm through to more extreme circumstances such as breaking up a fight or where a student needs to be restrained to prevent violence or injury.

'Reasonable in the circumstances' relates to the specific event in which force is used and means using no more force than is needed based on the risks presented. 'Restraint' means to hold back physically or to bring a pupil under control and is typically used in more extreme circumstances. In accordance with guidance for schools, reasonable force cannot be used as a punishment.

Guidelines also provide advice to head teachers and school staff on developing a school behaviour policy. By law, the head teacher must set out measures in the behaviour policy which aim to:

- Promote good behaviour, self-discipline and respect.
- Prevent bullying.
- Ensure that pupils complete assigned work.
- Regulate the conduct of pupils.

The Reducing the Need for Restraint and Restrictive Intervention (2019) guidance reflects previous guidance for England and Wales and states: *'Restrictive intervention should only be used when absolutely necessary, in accordance with the law and clear ethical values and principles which respect the rights and dignity of children and young people, and in proportion to the risks involved. It can never be a long-term solution, and we are particularly concerned about long-term or institutionalised uses of restrictive interventions.'*

This guidance is advisory and applies to the following settings and services:

- Local authorities, Clinical Commissioning Groups and NHS commissioned health services.
- Maintained and non-maintained special schools, special academies, special free schools, special post-16 institutions and independent educational institutions.
- Children's homes (including secure children'shomes) and residential holiday schemes for disabled children.
- Local authority and independent fostering service providers.

Child Protection

Child Protection is the protection of children from violence, exploitation, abuse and neglect and is enshrined in Article 19 of the United Nations Convention on the Rights of the Child. Child protection systems are the means by which any organisation, or individual, is charged with the safety of children under their care. Organisations are obliged by law to inform the authorities of any suspicions they have in relation to the welfare and safety of any individual to which the organisation educates or cares for. If an individual/organisation suspects sexual abuse, physical or emotional cruelty, maltreatment or instances of risk

(which can include the use of restraint), they should follow set procedures to inform the correct authorities so that a thorough and proper investigation can take place.

Child protection guidelines are designed to ensure that where such a suspicion of potential harm is raised, it is acted upon in good time and with the full cooperation of all the relevant bodies. This ensures that all agencies involved in any such investigation are fully conversant with each individual case and are also able to act in the best interests of any child or vulnerable person that may need help.

4. Legislation relating to adults

Adults with Incapacity (Scotland) Act, 2000; Mental Capacity Act, 2005; Deprivation of Liberty Safeguards, 2007; Adult Support and Protection (Scotland) Act, 2007; Mental Capacity Act (Deprivation of Liberty Amendments), 2009; Assisted Decision-Making (Capacity) (Ireland) Act, 2015; Mental Capacity Act (Northern Ireland), 2016; Liberty Protection Safeguards, 2019

Legislation related to capacity is designed to protect vulnerable people over the age of 16 around decision making based on the presupposition that every adult,whatever their disability, has the right to make their own decisions wherever possible. Where a decision is too big or complicated for a person to make, even with appropriate information and support, then mental capacity legislation requires people supporting someone without capacity to make a 'best interests' decision for them.

The Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS), which apply only in England and Wales, are an amendment to the Mental Capacity Act 2005 to ensure that people who cannot consent to their care arrangements are protected if those arrangements deprive them of their liberty. Under the Mental Capacity Act, liberty safeguards allow restraint and restrictions that amount to a deprivation of liberty to be used in hospitals and care homes only in circumstances where such restrictions are in a person's best interests. As such, to deprive a person of their liberty, care homes and hospitals must request standard authorisation from alocal authority.

Mental Health Act, 1983; Mental Health (Scotland)Act, 1984; The Mental Health (Northern Ireland) Order, 1986; Mental Health Act (Ireland), 2001; Mental Health (Care and Treatment) (Scotland) Act, 2003 Code of Practice Vol 1, 2 and 3; Mental Health Act (1983) Code of Practice, 2008; Mental Health Act Code of Practice for Wales, 2016

Mental health legislation covers the reception, care and treatment of mentally disordered persons. The Mental Health Act Code of Practice aims to provide stronger protection for individuals and clarify roles, rights and responsibilities. This includes:

- Involving the person and, where appropriate, their families and carers in discussions about the persons care at every stage.
- Providing personalised care.
- Minimising the use of inappropriate blanket restrictions and restrictive interventions including medication, physical (manual) restraint and seclusion.

5. Other related guidance

Framework for Restrictive Physical Intervention Policy and Practice. Welsh Assembly Government, 2005; Positive and Proactive Care, 2014; Positive and

Proactive Workforce, 2014; Guidance for Designated Centres: Restraint Procedures, 2014

A range of guidance provides a framework for staff and service providers towards changing the culture and practice to ensure people who receive health and social care do so in a safe manner which promotes independence and recovery. These various documents recognise the importance of a therapeutic environment emphasising primary and secondary preventive approaches to eliminate or minimise the use of restrictive practices.

Violence and Aggression: Short-Term Management in Mental Health, Health and Community Settings (NG10), 2015

This guidance for healthcare covers the short-term management of violence and aggression in adults, young people and children. It aims to safeguard both staff and people who use services by helping prevent violent situations and providing guidance to manage them safely when they occur. Regarding the use of restrictive interventions, section 1.4 emphasises the importance of staff training and offers guidelines on the use of manual (physical), mechanical, chemical and environmental restrictions.

Care Act, 2014; Health and Social Care Act, 2008(Regulated Activities) Regulations, 2014; Social Services and Well-Being (Wales) Act, 2014

The Care Act and related legislation sets out the statutory responsibilities for integrating care and support. It places specific responsibilities on local authorities for safeguarding so that people at risk are protected from abuse. Abuse includes the misuse and abuse of restrictive practices, coercive interventions which may lead to physical, psychological or sexual abuse, as well as neglect and acts of omission. Importantly, this legislation is designed to prevent 'organisational abuse' including poor care practices and ill- treatment.

(a) Regulation 12: Safe Care and Treatment

The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe. There are inherent risks in carrying out care and treatment, especially when restrictive practices are used, so under this regulation, it is not considered to be unsafe if providers can demonstrate that they have taken all reasonable steps to ensure the health and safety of people using their services.

(b) Regulation 13: Safeguarding Service Users From Abuse and Improper Treatment

This regulation safeguards people who use services from suffering any form of abuse or improper treatment while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005. Providers must have a zero- tolerance approach to abuse, unlawful discrimination and restraint and must have robust procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the service, including visitors.

(c) Regulation 20: Duty of Candour

This regulation intends to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support and providing truthful information and an apology.

College of Policing Memorandum of Understanding: The Police Use of

Restraint in Mental Health & Learning Disability Settings, 2017

The memorandum sets out a national position about when police can be asked to attend incidents which occur in mental health settings, for what reasons and what can be expected of them when they do attend especially in relation to the use of restrictive practices. Circumstances which may prompt police involvement include situations with an immediate risk to life or limb, immediate risk of serious harm, hostage taking, the use of a weapon or serious damage to property.

17.0 REFERENCES AND FURTHER INFORMATION SOURCES

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