NAS Use of Restrictive Practice in NAS Schools and Services (Policy) SO-0039

Version Number	V7.0
Date of Issue	20 August 2003
Latest Revision	20 June 2023
Date of next Review	June 2024
Distribution	All employees
Owner	Directors of Adult Services / Education & CYP Services
Policy Lead(s)	National Lead for Behaviour Management and Low Arousal, Head of PBS, Clinical Leads and Safeguarding Lead
Consultation	CIMM
Department	All Services
Ratified by Committee	*Pending*

TABLE OF CONTENTS

Scope

This policy applies to all National Autistic Society services that provide support for children, young people and adults where the National Autistic Society has a duty of care.

Purpose

The purpose of this policy document is:

To state the National Autistic Society's philosophy towards the use of and reduction in restrictive practice(s) within the relevant legal and regulatory framework.

The rights and dignity of people who use National Autistic Society services, even when behaving in a physically challenging way, must always be borne in mind. Any restrictive practice must be used with a view to keeping them and others safe, with the aim of allowing the individual not only to recover from significant dysregulation and distress, but also to acquire alternative adaptive behaviours and functional skills that, over time, decrease the level of intervention needed.

NOTE - Procedure for admission to a school or service where an individual is dependent on seclusion or restraint to manage his or her behaviour must be read in conjunction with this Policy (Related Document - SO-0039-005-0723).

All staff are required to adhere to the principles and values set out in the NAS Ethical Framework and endeavour to embed them in their daily working ethos and routines.

Introduction

Autistic individuals sometimes behave in ways that others can find challenging and which, on some occasions, may be dangerous; potentially resulting in harm to the person displaying the behaviour, peers, staff or the public. Such behaviours may initially appear to be unpredictable and can be frightening for all concerned including the person displaying the behaviour.

Across the United Kingdom, the primary duty of the National Autistic Society as a care and education provider is to ensure the people we support are safe from harm. The fundamental but complex need to balance the right to freedom, dignity and respect, with ensuring safety from harm is at the heart of this policy and guidance (The Restraint Reduction Network (RRN) Key Strategy 1).

Legal context

British Institute of Learning Disabilities (BILD) define a restrictive practice as:

'The implementation of any practice or practices that restrict an individual's movement, liberty and freedom to act independently without coercion or consequence. Restrictive

practices are highly coercive actions that are deliberately enacted to prevent a person from pursuing a particular course of action" - BILD Code of practice 4th edition.

Regarding physical intervention, the crux of common law (both criminal and civil) is that;

- Any threat of non-consensual touching is an assault
- Any actual touching is battery
- Any wrongful hindrance to mobility is false imprisonment

The law recognises that there are situations where some restrictive practice is necessary as an act of care. For example, if someone has a learning disability, mental illness or related disorder, that puts someone at risk, carers may have a legal duty to restrain the person in his or her own interests. Where someone takes on a caring role, he or she owes a 'duty of care' to the person. This means that the carer must do what is reasonable to protect the person from reasonably foreseeable harm. If someone's actions could put other people at risk, staff have a duty of care to respond positively, which might include as a last resort restraining the person to prevent harm.

To ensure that we follow best practice when managing signs of stress and physically challenging behaviour, we follow and adhere to the guidance within the BILD codes of Practice and the RRN guidance, the guidelines include trainer and trainee codes of practice and the 6 key strategies to the reduction of the use of restraint.

The 6 Key strategies for restraint reduction

These are;

Strategy One: Leadership. The organisation develops a mission, philosophy and guiding values which promote non-coercion and the avoidance of restraint. Executive leaders commit to developing a restraint reduction plan which is implemented and measured for continuous improvement.

Strategy Two: Performance Measurement. The organisation takes a 'systems' approach and identifies performance measures which determine the effectiveness of its restraint reduction plan and which measure key outcomes for customers.

Strategy Three: Learning and Development. The organisation develops its staff with the knowledge and skills to understand and prevent crisis behaviour. Training is provided which gives staff the key competencies and supports the view that restraint is used as a last resort to manage risk behaviour associated with aggression, violence and acute behavioural disturbance.

Strategy Four: Providing Personalised Support. The organisation uses restraint reduction tools which inform staff and shape personalised care and support to customers.

Strategy Five: Communication and Customer Focus. The organisation fully involves customers in a variety of roles within the service, identifies the needs of customers and uses these to inform service provision and development.

Strategy Six: Continuous Improvement. The principle of post-incident support and learning is embedded into organisational culture.

For the National Autistic Societies Services in Scotland Only - refer to best practice from the Mental Welfare Commission for Scotland, Rights and Limits to Freedom and Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People.

Anyone using restraint must make sure they comply with the law. Inappropriate or excessive restraint is a violation of human rights and could be an assault and result in criminal proceedings.

There is no specific piece of legislation dealing with 'restraint', setting out what is lawful in a care setting and what is not.

The law relating to the use of restraint is largely the common law. This is law which has developed over the years as cases come before the courts. Certain powers to restrain may be available under the Adults with Incapacity (Scotland) Act 2000 and implied under the Mental Health (Care and Treatment) (Scotland) Act 2003. There are also regulations under the Regulation of Care (Scotland) Act 2001 concerning the use of restraint by care providers. See also Safeguarding Board Act (Northern Ireland) 2011 and Mental Capacity Act (Northern Ireland) 2016.

Restraint exercised without legal authority may be a criminal offence. In these circumstances the individual carrying out the restraint may face prosecution as well as disciplinary action. Any physical act which causes injury, affront or harm to the victim could constitute an assault if there is no lawful justification for its use. The common law recognises that someone may use force or restraint if there is reason to believe another person is about to cause him or her harm. No more than the minimum necessary force can be used. If the person acts in bad faith or uses more force than is reasonably necessary, his or her action is outside the law. No client is to be restrained other than in exceptional circumstances. Staff should use restraint only if this is the only practicable means of securing the welfare of the client or of other clients.

A restrictive practice is only justified in law if there is the presence of a clear, imminent and immediate danger. The term 'clear, imminent and immediate danger of harm, when all other non-physical interventions have been tried and failed we must always be clear about the difference between immediate danger of harm and an assumed / predicted outcome. In this context last resort refers to everything that has been tried and failed. It does not justify action taken to prevent a possible danger unless incident data clearly shows that a given behaviour or cue quickly results in escalation to a dangerous level, in which case a planned intervention may be justified in the short term, whilst further more positive and proactive strategies are developed (See British Institute of Learning Disabilities Code of Practice).

As well as the presence of a clear, imminent and immediate danger staff must also be able to demonstrate that all other available less restrictive options have been tried and failed before the use of a restrictive practice. Immediate and imminent risk of harm to themselves or others, **last resort** and when everything else has been tried and failed. The Managing Signs of Stress framework and training offers guidance and a series of non-restrictive and non-aversive techniques to avoid/reduce the use of restrictive practices. There is an expectation that alternatives to a restrictive practice would increase with staff training, experience and knowledge of the individual (RRN Key Strategy 4).

If you can find no alternative to using a restrictive practice then you should use it. (Examples of Non-Restrictive Practice see Related Document - SO-0039-002-0623)

Duty of Care – National Autistic Society staff have a duty of care towards the people supported, which requires the organization to take reasonable care to avoid doing something or failing to do something which results in harm to another person. There are situations where some action must be taken and it is a matter of choosing the course of action that would result in the least harm.

Best Interest – The principle of best interest applies. A member of staff must demonstrate that in the presence of a clear and immediate danger they have considered all available alternatives, acted in the best interest of the person in their charge, have considered that not acting could result in greater harm, and does not use unreasonable or excessive force, then the action can be defended in law.

Reasonable & Proportionate – Any force used must be 'reasonable and proportionate', reasonable in that it is the minimum force required to prevent injury and proportionate in that it is not excessive given the seriousness and likely harmful consequences of the person's behaviour. As with all issues to do with caring for, developing and teaching the children, young people and adults we support, decisions need to be made on the best available knowledge at the time.

Duty of Candour – The National Autistic Society has a Duty of Candour to ensure that we are open and transparent with the people using our services, whether or not something has gone wrong.

A useful concept to bear in mind when carrying out any restrictive practice is that of Social Validity. During any restrictive practice we should be conscious both of how our intervention may look to others not involved in the interaction and how we would like ourselves, family members or friends to be interacted with in similar circumstances.

Restrictive Physical Interventions

All those supported by the National Autistic Society who require any form of behavioural intervention will have a Positive Behaviour Support Plan / Positive Individual Support Plan that provides detailed information relating to all aspects of a person's behaviour and how to support them.

Restrictive practices can be categorised as planned or unplanned practices: (see RPI Procedure for further details – SO-0039-001-0623.

Medical attention should be sought if a Restrictive Practice has been used to support someone with underlying health issues (RRN Key Strategy 5).

Seclusion

Seclusion and segregation are recognised terms in mental health inpatient environments and are defined in the Mental Health Act code of practice. The review seeks to identify to what extent similar practices are used in adult social care environments.

Seclusion: Seclusion refers to the supervised confinement and isolation of a person, away from other people who use services, in an area from which the person is prevented from

leaving, where it is of immediate necessity for the containment of severe behavioural disturbance which is likely to cause harm to others.

The reason for seclusion might be because the person is highly dysregulated, overly-aroused, agitated, overactive, aggressive, is making serious threats or gestures towards others, or is being destructive to their surroundings, when other therapeutic interventions have failed to safely contain the behaviour. **Staff should not use seclusion as a default action when an individual presents as being dysregulated.**

The Human Rights Act (1998) sets out important principles regarding protection from abuse by state organisations or people working for these institutions (including the National Autistic Society). It is an offence to lock an individual in a room without recourse to the law (even if they are not aware that they are locked in) except in an emergency.

The right to liberty and personal freedom is enshrined in Article 5 of the Human Rights Act (1998) and is protected by the criminal and civil law. For these reasons the use of seclusion outside the Mental Health Act or Mental Health (Care and Treatment) (Scotland) Act 2003 or Mental Capacity Act (Northern Ireland) 2016 should only be considered in exceptional circumstances and should always be proportional to the risk presented by the child or person supported.

In a community setting, any form of environmental restriction imposed on individuals should be legally authorised. Therefore, if it is foreseen that it may be necessary to use a form of environmental restriction such as seclusion beyond dealing with an initial emergency in a community setting, an application should be made for a DoLS under the Mental Capacity Act 2005 or an application for welfare guardianship under the Adults with Incapacity (Scotland) Act 2000 or Mental Capacity Act (Northern Ireland) 2016 should be considered.

Under the Children Act 1989 any practice or measure, such as 'time out' or seclusion, which prevents a child from leaving a room or building of his/her own free will, may be deemed a restriction of liberty. Under this Act, restriction of liberty of children is only permissible in very specific circumstances, for example when the child is placed in secure accommodation approved by the Secretary of State or where a court order is in operation. Advice for staff working in children homes is that seclusion should not be used - if it is used as an unplanned response to prevent harm in an emergency, there should be an immediate review and risk assessment and the production of a plan that considers the use of proactive strategies and less restrictive options.

For National Autistic Society Services in Scotland Only - refer to best practice from the Mental Welfare Commission for Scotland, Rights and Limits to Freedom and Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People.

Anyone using restraint must make sure they comply with the law. Inappropriate or excessive restraint is a violation of human rights and could be an assault and result in criminal proceedings.

There is no specific piece of legislation dealing with 'restraint', setting out what is lawful in a care setting and what is not.

The law relating to the use of restraint is largely the common law. This is law which has developed over the years as cases come before the courts. Certain powers to restrain may be available under the Adults with Incapacity (Scotland) Act 2000 and implied under the Mental Health (Care and Treatment) (Scotland) Act 2003. There are also regulations under the Regulation of Care (Scotland) Act 2001 concerning the use of restraint by care providers.

Restraint exercised without legal authority may be a criminal offence. In these circumstances the individual carrying out the restraint may face prosecution as well as disciplinary action. Any physical act which causes injury, affront or harm to the victim could constitute an assault if there is no lawful justification for its use. The common law recognises that someone may use force or restraint if there is reason to believe another person is about to cause him or her harm. No more than the minimum necessary force can be used. If the person acts in bad faith or uses more force than is reasonably necessary, his or her action is outside the law. No client is to be restrained other than in exceptional circumstances. Staff should use restraint only if this is the only practicable means of securing the welfare of the client or of other clients.

Training (RRN Key Strategy 1-5)

All training which includes the use of Physical Interventions and Restrictive Practices should be assessed by Service and Individual needs. The process will be managed through the use of a Tiered Service/School approach and Individual Risk Management Planning and Training needs assessments. (RRN Key Strategy 3, 4 & 5).

Any agreed plan around the training of staff in the use of Restrictive Practices, should include a completed Restraint Reduction Plan as part of the overall plan, and should be monitored in line with our internal monitoring and reviewing processes to ensure the justified and necessary use of the restriction, and promote the reduction where proactive management plans are in place and working for the individual (RRN Key Strategy 6).

Training must be provided to the highest individual tier needed within the service / school that the staff member is working in, this is to ensure that the use of restrictive practices are minimised, and clear reduction plan(s) and strategies exist for those where restrictive practice is necessary.

Tiered Framework

Tier One

Tier 1 focuses on services and schools (classes) and individual people where we see no, to minimal episodes of behaviours that challenge / Signs of Stress from the people we support, and are considered to be low risk.

These services include:

- Outreach
- Supported living Services
- University/College Support

- Social Enterprises
- Inclusive of Admin Staff and Volunteers

Tier Two

Tier 2 focuses on services and schools (classes) and individual people where we see minimal, to medium levels of behavioural presentation (Higher frequency, higher level of severity), and would require staff members to be well versed in the use of breakaway techniques, and understand the importance of being aware of yourself, your environment and the potential risks of supporting people that access these services and schools.

These services include:

- Some supported living services (Lone working)
- Day Service Resources
- Schools, Classes and all support staff
- Some Residential Services

Tier Three

Tier 3 focuses on services and schools (classes) and individual people where we see high levels of behaviours that challenge and high levels in the use of restrictive practices and unplanned restrictive practices (High Frequency, High Severity, High risk, Increased Duration). Such environments and individuals require staff members to be trained and highly skilled in the use of the physical skills taught in the 3 Day Managing Signs of Stress training framework (days 2 and 3), and again, understanding the importance of being aware of yourself, your environment and the potential risks of supporting people that access these services and schools.

These services include:

- Schools
- Residential Services
- Day Service Resources
- Some single occupancy Supported Living Services
- Bank Staff and Regular use Agency Staff should be trained to the tier they are working in

Tier Four

Tier 4 - service/school trained staff members will hold specific/bespoke methods around the use of restraint that fall outside of the generic Managing Signs of Stress training.

These techniques will be agreed at a multidisciplinary level and sanctioned by Studio III training LTD/ Positive Behaviour Management.

Responsibilities

Trustees

- Trustees review of policy on the use of Restrictive Practices.
- Trustees will monitor the reduction in use of Restrictive Practices on a quarterly basis.

Director - Adult Services / Education & Children's Services

- Monitoring of implementation of this policy.
- Monitor the use of Restrictive Practices on a regular basis.
- Ensuring the allocation of internal and external resources (including clinical and counselling) to address the needs of individuals we support and staff with regard to the implications of serious challenging behaviour.

Principals, Area Managers and National Autistic Society Service Managers

- Enforcing the implementation of this policy in their school or adult service
- Maintaining a comprehensive recording and reporting process relating to the use of restrictive practices
- Ensuring relevant staff undergo training in the use of restrictive practice, with regular refreshers; currently provided by Studio III / PBM
- Supporting care teams in developing risk assessments and behaviour support and care plans with regard to restrictive practices – with particular reference to calling for external or internal expert opinion as required.
- Ensuring plans are shared with parents/advocates, purchasers and other interested agencies, and where appropriate with the child or adult concerned, recognising the importance of consent in terms of the fundamental issues of respect and dignity.
- Regular monitoring of such plans.

All Staff

- Working always in the best interests of the child or adult.
- Taking part in training provided in the use of restrictive practices and applying the principles and strategies taught.
- Satisfying themselves that they are clear on what they may and may not do in terms of restrictive practices, seeking clarification as necessary.
- Using Support & Supervision sessions to confirm their understanding of this policy and to seek further explanation or personal development as necessary.
- Following the recording and reporting procedures.
- Contributing to the development of behaviour support or care plans, and good practice.

Complaints

Adults, parents, guardians, carers or children and young people have the right to offer comments and refer to the local complaints procedure (or Complaints Resolution (services) Policy QS-0009/ Complaints Resolution in Schools QS-0010) in the case of any disagreement in the use of restrictive practices.

Alternatively contact can be made with the appropriate external regulator: Care Quality Commission (England) / Care Inspectorate Wales / the Care Inspectorate, Scotland / Regulation and Quality Improvement Agency (Northern Ireland) / Ofsted – details can be found on the internet.

Whistleblowing

Employees of the National Autistic Society have a duty to voice any concerns over care practice. Please refer to the Policy on Whistleblowing (HR-0002) for further information.

References

Restraint Reduction Network – https://restraintreductionnetwork.org
KCSiE
Adult Support and Protection (Scotland) Act 2007
Positive and Proactive Care: reducing the need for restrictive interventions (2014)
Code of Practice for the use and reduction of restrictive practices. 3rd edition (2010) BILD
Care Standards Act 2000
Carers Guide to Physical Interventions and the Law (2005) Christina Lyon and Alexandra Pimor, BILD, ISBN 1-904082-815
Children (Scotland) Act 1995
Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People. The Scottish Institute for Residential Child Care 2013
Children's Act 1989
Children's Homes Regulations (2001) – amendment (2011)
Use of Reasonable Force - Department for Education - www.education.gov.uk
Guidance on the Use of Restrictive practices for Pupils with Severe Behavioural Difficulties - Department for Education – www.education.gov.uk
Easy Guide to Physical Interventions for people with Learning Disabilities, their Carers and Supporters (2002) BILD, ISBN 1-902519- 973
Education and Inspection Act 2006
Welsh Assembly - Framework for Restrictive practice Policy and Practice - March 2005
Good practice in Physical Interventions (2006) Ed Sharon Paley and John Brook, BILD, ISBN 1-904082-742
Human Rights Act 1998
Mental Capacity Act 2005.
Mental Health act 1983 Code of Practice (2015 Revision) The Stationery Office London – www.tsoshop.co.uk
Mental Capacity Act 2005, s20
Deprivation of Liberty Safeguards (DoLS) 2009
Liberty Protection Safeguards (Date TBC)

Adults with Incapacity (Scotland) Act 2000
Mental Health Care and Treatment (Scotland) Act 2003
The Children (Northern Ireland) Order 1995
Safeguarding Board Act (Northern Ireland) 2011
Mental Capacity Act (Northern Ireland) 2016
Mental Welfare Commission for Scotland, Rights and Limits to Freedom - www.mwcscot.org.uk
Positive and Proactive care: reducing the need for restrictive interventions (April 2014) Department of Health
Rights, Risks and Limits to Freedom – Mental Welfare Commission
Murphy, G. & Wilson, B. (1985) Self-injurious Behaviour. British Institute of Learning Disabilities, Kidderminster. – www.BILD.org.uk
Education and Inspections Act 2006 (Part 7, Discipline, Behaviour and Exclusion). www.legislation.gov.uk
Regulation of Care (Scotland) Act 2001. www.scotland.gov.uk/publications
The Care Act 2014

Related Documents

SO-0039-001-0623	Information to be recorded for each use of a Restrictive practices
SO-0039-002-0623	Non-Restrictive & Restrictive Intervention Practice
SO-0039-003-0623	Restrictive Practice Form
SO-0039-004-0623	How to complete Restrictive Practice Form
SO-0039-005-0723	Procedure for Admission to a School or Service where an individual is dependent on seclusion or restraint to manage his or her behaviour
SO-0039-006-0623	Unplanned Response Reporting
SO-0039-007-0623	Managing Signs of Stress Framework
SO-0039-008-0623	Incident Analysis Form
SO-0039-009-0623	Studio 3 Verification Sheet
SO-0039-010-0723	Protocol for Unplanned Restrictive Practices
SO-0039-011-1120	Training Request / Referral Form
SO-0039-012-0623	Restrictive Practice Management and Restraint Reduction Plan
QAF2	Incident Management Policy & Procedure
HR-0002	Whistleblowing Policy
SO-0029	Behaviour Support in Schools & Adult Services

QS-0009	Complaint Resolution (Adult Services) Policy
QS-0010	Complaint Resolution (Schools & CYP Services) Policy
NAS Website	NAS Ethical Framework