



**making a difference
to the lives of people with
severe learning disabilities**

Reducing Restrictive Intervention of Children and Young People

Update of Case study results

February 2020

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ACKNOWLEDGEMENTS

We would like to express our deepest gratitude to every single family brave enough to trust us with their stories. We do not underestimate how difficult it is to speak out about the damaging, often catastrophic, consequences of the use of restrictive practices. Without the families' courage, input and willingness to share, we would not have been able to collect the evidence for this report. Our heartfelt thanks go to each and every one of you.

Thank you to the Sharland Foundation Developmental Disabilities ABA Research and Impact Network (SF-DDARIN) for researcher time.

Our thanks also go to the RRISC group (Reducing Restrictive Interventions and Safeguarding Children) which consists of the CBF, PABSS, Mencap, NASS, NSPCC, BILD, the Council for Disabled Children, MIND, Crisis Prevention Institute, Young Minds, Leigh Day and CRAE. We all have a shared aim - to ensure children with disabilities have their needs understood and met and are supported to thrive and develop.

SUMMARY

This report provides an update to the "[Reducing Restrictive Intervention of Children and Young People](#)" report jointly produced by the Challenging Behaviour Foundation (CBF) and Positive and Active Behaviour Support Scotland (PABSS) in January 2019. It contains a descriptive analysis of additional case study data from family carers on the use of restrictive interventions in schools, such as restraint and seclusion. This work was carried out due to significant concerns regarding the use of restrictive interventions on children and young people with disabilities, and the ongoing gap in knowledge and data collection on restrictive interventions taking place in schools.

Overall, case studies were completed by family carers for 720 children and young people across the UK who had experienced restrictive intervention. The children had a range of needs, covering developmental, educational, physical, and mental health needs, the most reported being autism (61%) and speech, language and communication needs (51%). Restrictive interventions most commonly started whilst the child was primary school age (5-11 years). Noteworthy, at school most children (87.6%) had experienced restraint and over half (60.7%) had experienced seclusion. Concerningly, most families (86.5%) reported that their child had been physically injured during a restrictive intervention.

These findings indicate several potential issues around restrictive interventions in schools for children with a range of developmental, educational, physical, and mental health needs, which need to be explored through more robust data. Key issues include that restrictive interventions: 1) can have serious negative impacts on children; 2) appear to be used in most of the school settings represented by participants on multiple occasions; 3) appear to be used for inappropriate reasons, rather than in extreme instances to protect the child from harming themselves or others 4) practices in some schools may not adhere to guidance and some unlawful, abusive practices are suggested; 5) parents are not always informed about restrictive interventions; 6) recording in schools may be infrequent and/or inadequate; 7) training may not always result in better practice; and 8) use of restrictive intervention in schools is likely to be widespread across the UK.

As a result of the findings from the case study data analysis, a number of recommendations are made including:

1. **Strengthen the law across the UK** to safeguard children from restrictive interventions and to prosecute those who use unlawful force against children
2. **Invest in early intervention, prevention and training** in order to support both families and staff to use evidence-based approaches to address challenging behaviour.
3. **Gather more evidence** about what is happening and strengthen safeguarding and accountability.
4. **Fund trauma support** for children and families who require support following restrictive interventions.

We hope this report can ensure greater attention and scrutiny and drive action to address the issues that the report has exposed.

INTRODUCTION

This report is an update to the "[Reducing Restrictive Intervention of Children and Young People](#)" report jointly produced by the Challenging Behaviour Foundation (CBF) and Positive and Active Behaviour Support Scotland (PABSS) in January 2019. This work was undertaken due to significant concerns about the use of restrictive interventions on children and young people with disabilities. Restrictive interventions are defined by the National Institute for Health and Care Excellence (NICE, 2015, page 17) as "*Interventions that may infringe a person's human rights and freedom of movement, including locking doors, preventing a person from entering certain areas of the living space, seclusion, manual and mechanical restraint, rapid tranquillisation and long-term sedation.*" For further information about the background to this work, see pages 7-9 in our previous report.

Since our first report was published in January 2019 there has been an increased focus on this issue, including: a Parliamentary debate in Westminster on 25th April 2019; attention from the media; a letter from the Children's Commissioners in Scotland, Northern Ireland and Wales to the United Nations (UN) Committee Against Torture (CAT); the Scottish Government response to The Scottish Children's Commissioner report "[No Safe Place](#)"; an evidence session in the Scottish Assembly on 7th November 2019 and the launch of a national campaign, 'In Safe Hands?' in Scotland; the Scottish Independent Care Review published in February 2020.

The CBF and PABSS have worked with families to establish a group called RRISC (Reducing Restrictive Interventions and Safeguarding Children). This is a group of families and national organisations who share the aim of reducing the use of restrictive intervention on children and young people.

The RRISC group has produced key messages which have been endorsed by the Challenging Behaviour Foundation (CBF), Positive and Active Behaviour Support Scotland (PABSS), the Council for Disabled Children (CDC), the National Association of Independent Schools and Non-Maintained Special Schools (NASS), Mencap, the British Institute of Learning Disabilities (BILD), Crisis Prevention Institute (CPI), Young Minds, the National Society for the Prevention of Cruelty to Children (NSPCC), MIND, Leigh Day and the Children's Rights Alliance for England (CRAE).

On 27th June 2019 the Department for Education published guidance on reducing restrictive intervention of children and young people "[Reducing the Need for Restraint and Restrictive Intervention](#)". Whilst the RRISC group welcomed this long-delayed guidance, it clearly does not go far enough on a number of levels, particularly as it does not apply to mainstream schools. The RRISC group wrote to the Children's Minister in October 2019 to call for stronger safeguards and guidance covering all settings.

Recently there has been increased scrutiny of the poor treatment of children and young people with learning disabilities and/or autism, including the use of restrictive interventions such as restraint and seclusion, in inpatient hospital settings. The Joint Committee on Human Rights published the findings of their inquiry "[The detention of children and young people with learning disabilities and/or autism](#)" and the Care Quality Commission (CQC) have published the [interim report](#) for their ongoing review of restraint, seclusion and segregation.

Although we welcome these reports, we remain concerned by the ongoing gap in knowledge and data collection on restrictive interventions taking place in schools, such as

restraint and seclusion, and lack of action to address the issues the reports have highlighted.

The RRISC group secured support from the Sharland Foundation Developmental Disabilities ABA Research and Impact Network (SF-DDARIN) to provide researcher time to analyse the case study data collected by PABSS from families to update the "[Reducing Restrictive Intervention of Children and Young People](#)" report. At a RRISC group meeting on 19th September 2019 we reviewed the emerging evidence set out in the present report and, in the absence of any statutory data collection or evidence-gathering to shed greater light on this issue, agreed that it must be made publicly available.

METHOD

The data presented in this report builds on the case study data collected by PABSS presented in the joint CBF and PABSS report “[Reducing Restrictive Intervention of Children and Young People](#)” from January 2019.

To collect case study data, PABSS invited family carers to anonymously share their child’s experiences of restrictive interventions in schools. Family carers completed a case study questionnaire by email or phone call. The case study questions covered:

- brief demographic information (e.g. the age of child, diagnosis, general location, i.e. local authority/council)
- the child’s experiences of restrictive interventions and the impact (e.g. the number of restraints or seclusions, reasons reported for the use of restrictive interventions, any injuries following restrictive interventions)
- follow-up after restrictive intervention (e.g. if a formal complaint was made, accountability)

For the list of case study questions, please see Appendix A, page 34.

All questions were voluntary so that family carers were in control of the information they provided for the case study. This was made explicit to family carers who expressed interest in taking part, as anonymity and privacy was crucial to protect the family carers and children.

Case studies were put together from the information family carers shared with PABSS between June 2017 and August 2019. Anonymous case study information was put into a spreadsheet by PABSS and shared with researchers at the University of Warwick who carried out a descriptive analysis to provide the data for this report.

FINDINGS

Putting it into perspective: Quotes from family carers

Two of the family carers who participated in the case studies provided quotes to further describe their child and family's experience of restrictive intervention in schools. These are included in this section to help to put the statistics from the case studies into perspective.

Case Study 'Annie'

Annie is 16 now. She is funny, loving and enthusiastic. She loves swimming, football, riding, going to concerts and spending time with her family. She is a daughter, older sister, younger sister, granddaughter, niece and friend.

Yet, as a result of her disabilities, Annie finds educational settings very challenging, she always has. She has Foetal Alcohol Spectrum Disorder and attachment difficulties.

After several school placements broke down due to schools recognizing they were unable to meet her needs she started at a specialist emotional mental health school (SEMH) with the promise of a therapeutic approach. A small school purportedly able to provide an individualised approach to her education. A school where it was claimed they used Positive Behaviour Support, a school with a therapy team on site.

Day four, according to school records was the first time they restrained Annie, for running up and down a corridor and kicking a door because she wanted to go home. The next day the same thing happened, this time she was 'taken' to a 'quiet room'.

Annie is never, ever restrained outside of education; there is no need if the right supports are in place, yet between Feb 2017 and Sept 2018 the school recorded 158 incidents which they considered to involve restraint. Many of these restraints spanned considerable time periods and involved multiple staff members.

The school would report that she had a wobbly day or had been held. We had no idea at the time what this meant in practice. When we got the incident reports, we realized she had often been held on the floor by 4/5/6 members of staff. Yet the school reported she was doing well, making progress. But she had started self-harming and making suicidal threats whilst at school.

Annie, having left the school, is now having trauma therapy and she is in a school with a very different approach. A school who truly use Positive Behaviour Support and have an unconditional positive regard for each child in their care. There are times when Annie's behaviour can still challenge those caring for her, times when she flips into fight/flight and resorts to old behaviours. But these times are becoming much less frequent and less extreme as staff seek to understand the "why" and seek to meet need rather than restrain and seclude.

Our whole family have been profoundly affected by what happened to Annie at school. And profoundly affected by the lack of accountability schools have, even when a child in their care has been left with post traumatic stress disorder (PTSD). We now want to do all we can to prevent this happening to other children who are by their very nature some of the most vulnerable in our society.

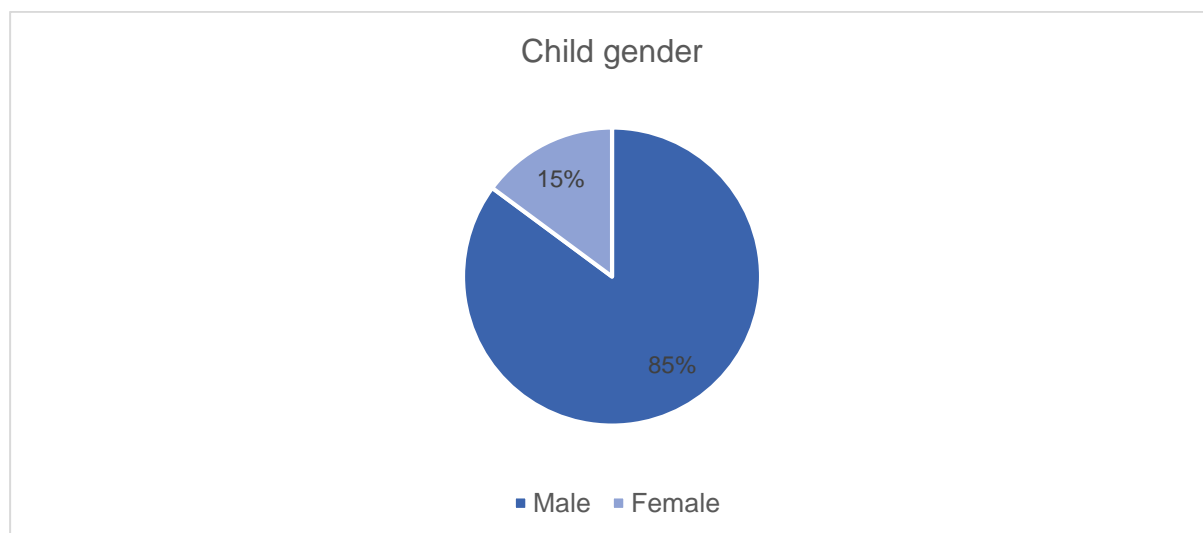
Who took part? – what we know about the children

Case study data were collected from parents of **720 children and young people** across the UK, who were reported to have experienced restrictive intervention, including restraint and/or seclusion.

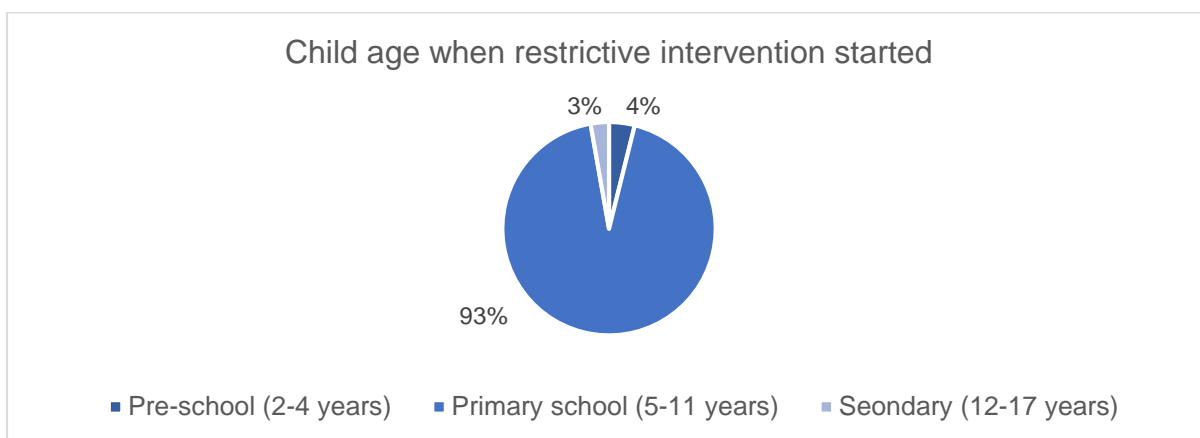
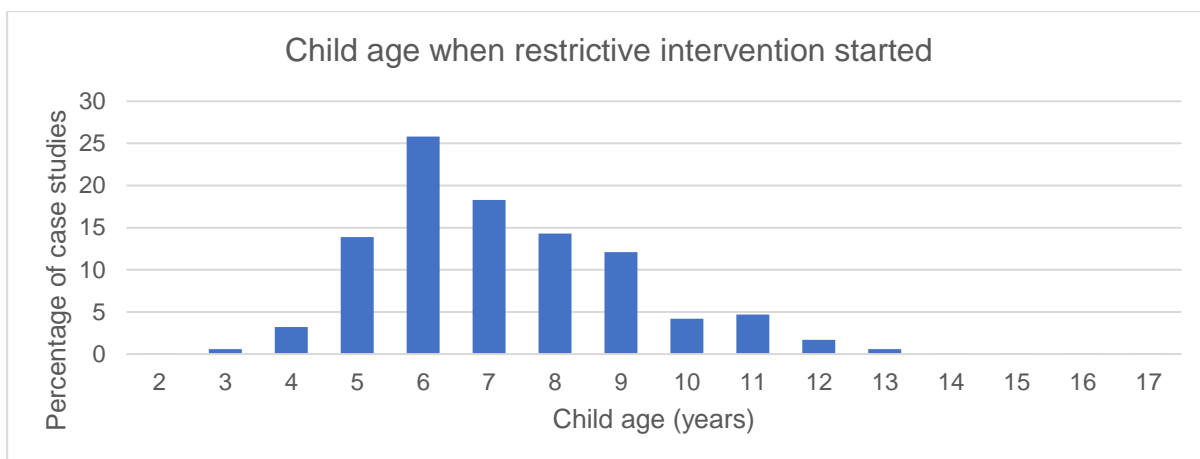
The case study data collected covered England, Scotland, Wales, Northern Ireland and Republic of Ireland. The geographical spread of the data included most of England, Wales and Scotland. There was less geographic spread in Northern Ireland. The figure below depicts areas the case studies covered¹.



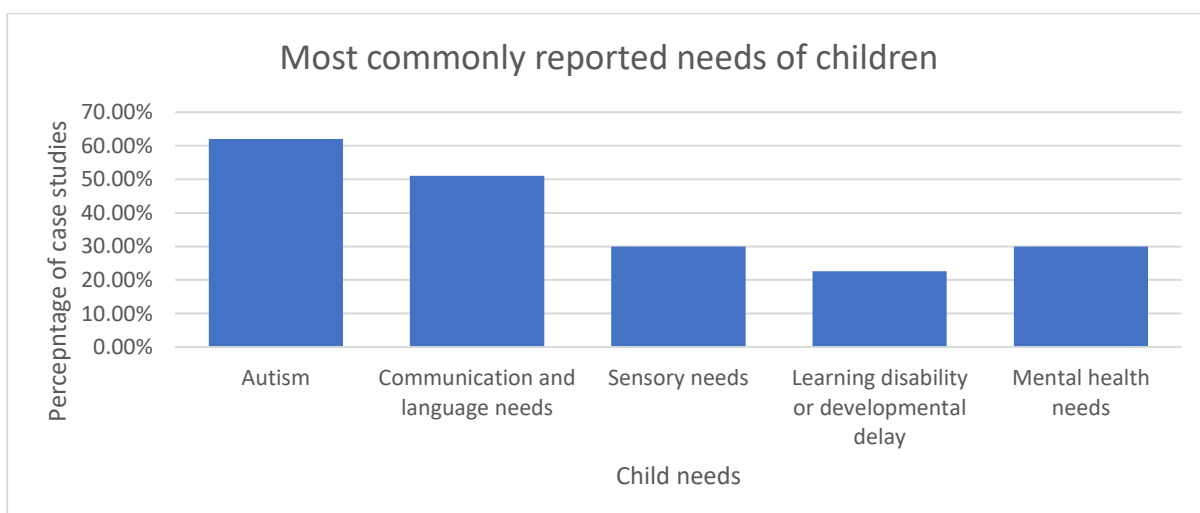
Most of the children were male (85%). The use of restrictive interventions was reported to have included children from the age of **2 to 17 years**. For most of the children, restrictive interventions started during primary school age (generally 5-11 years), but for other children restrictive interventions were reported to have started during pre-school age (2-4 years) or secondary school age (12+ years).



¹This figure is illustrative of the geographic spread of case study data collected as it does not include all of the location data available, due to limitations with the mapping tool used (<https://www.zeemaps.com/>).



The children and young people included in the case studies had a **range of needs**, covering **developmental, educational, physical, and mental health needs**, and many of the children were reported to have more than one need. The most commonly reported needs were autism (61%), speech, language and communication needs (including children who were non-verbal or mute) (51%), sensory needs (30%), mental health needs (including anxiety, attention deficit hyperactivity disorder, obsessive compulsive disorder, oppositional defiant disorder, trauma and attachment needs) (30%), and learning disabilities or developmental delays (including Down syndrome) (22.6%). The number of children with learning disabilities or developmental delays is likely to be higher, as it is often co-occurring with many of the needs identified.



Less commonly reported needs included pathological demand avoidance (6.7%), epilepsy (5%), cerebral palsy (3.8%), mobility needs (including children who used a wheelchair) (2.5%), dyspraxia (2.4%), asthma (1.8%), heart conditions (1.7%), hearing needs (including children who were deaf) (1.7%), dyslexia (1.5%) and “complex needs” (1.4%).

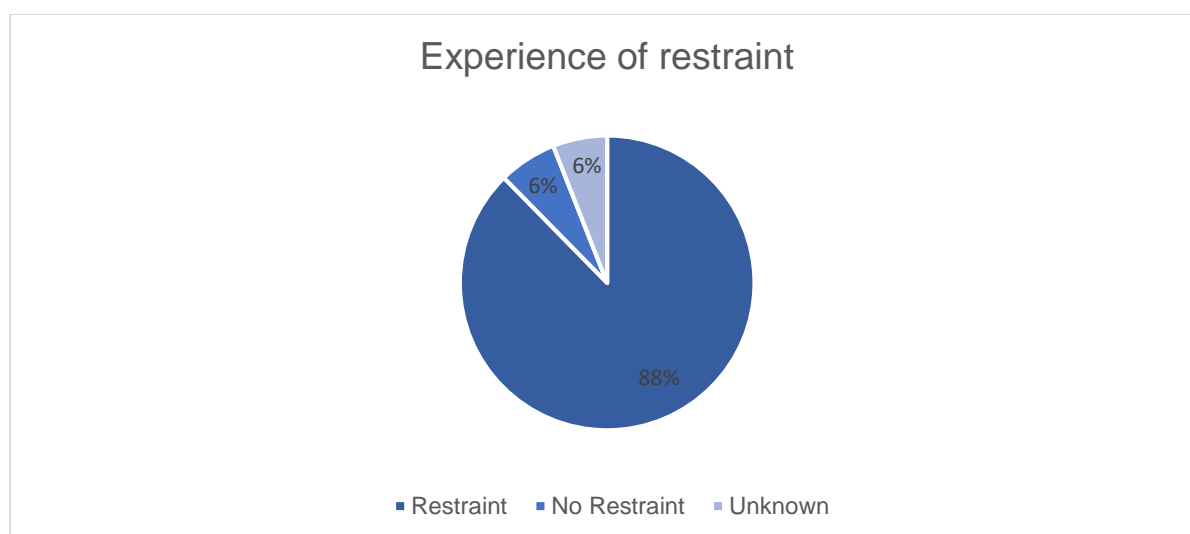
A range of other diagnoses and needs were only reported in a small number of case studies, such as visual impairment (including children who were blind), Tourette’s syndrome, tube feeding needs, and other physical and/or genetic needs (including brain injury, hydrocephalus, terminal illness, tuber scoliosis, hypermobility, low muscle tone, chromosomal disorder, Prader–Willi syndrome, Rett syndrome, Smith-Magenis syndrome, Edwards syndrome and long QT syndrome).

Experience of restraint – type and frequency

The case studies revealed that **the majority of children and young people had experienced restraint at least once at school**. Of the 720 case studies, 87.6% of the families reported that, to their knowledge, their child had been restrained at school at least once. Only 6.3% of families reported that, to their knowledge, their child had not been restrained. A further 5.9% were unsure if their child had been restrained in school.

Restraint was mostly physical, but also included mechanical and chemical restraints:

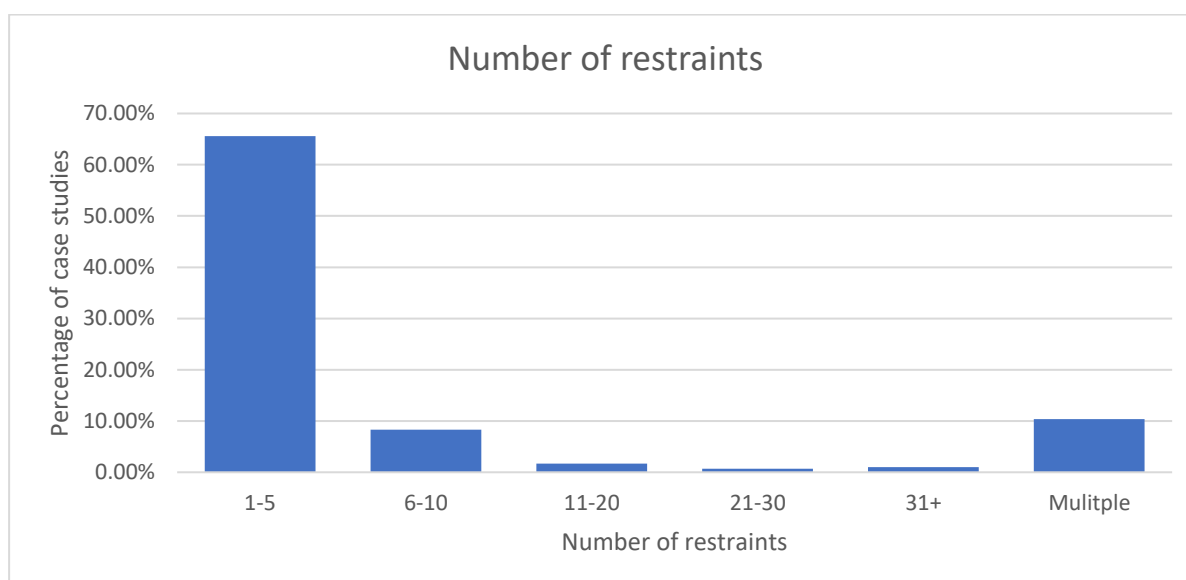
- **Physical restraint** refers to children being physically held and restrained by school staff
e.g. **“prone restraint” “face down restraint”**
- **Mechanical restraint** refers to children being strapped into Heathfield chairs, wheelchairs, wrist restraints, or hand cuffs, and/or being put in a spit hood
e.g. **“strapped in chair” “spit hood” “handcuffed” “wrist restraint”**
- **Chemical restraint** refers to when children were given medication to restrain them, including medication that was prescribed for another child
e.g. **“given meds not prescribed – went to hospital”**



When asked how often their child had been restrained in school, most families reported that (to their knowledge) their child had been restrained between 1 and 30 times (mean 3.08 restraints²) and 11.3% reported their child had been restrained “multiple times” (i.e. several times a day, every day of the school week).

In addition, seven families (0.97%) reported that their child had been restrained more than 30 times (e.g. 38, 53, 62, 63 and 80 times). Furthermore, several families reported they were not aware of the number of times their child had been restrained and some families had to make a Freedom of Information (FOI) or Subject Access Record (SAR) request to the school to get information. Through this route, one family carer reported their child had been restrained 350 times, and another reported their child had been restrained 300 times. This is highlighted in case study ‘Annie’ (page 7):

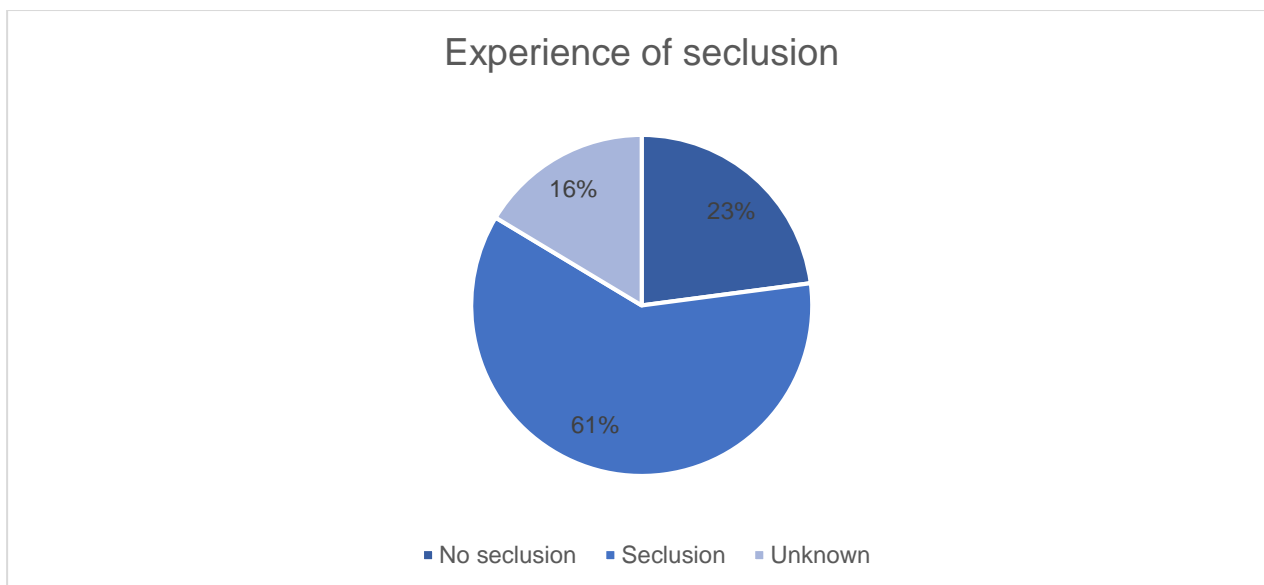
“between Feb 2017 and Sept 2018, the school recorded 158 incidents which they considered to involve restraint ... The school would report that she had a wobbly day or had been held. We had no idea at the time what this meant in practice. When we got the incident reports, we realised she had often been held on the floor by 4/5/6 members of staff”.



² The mean is calculated for values of 1-30 only

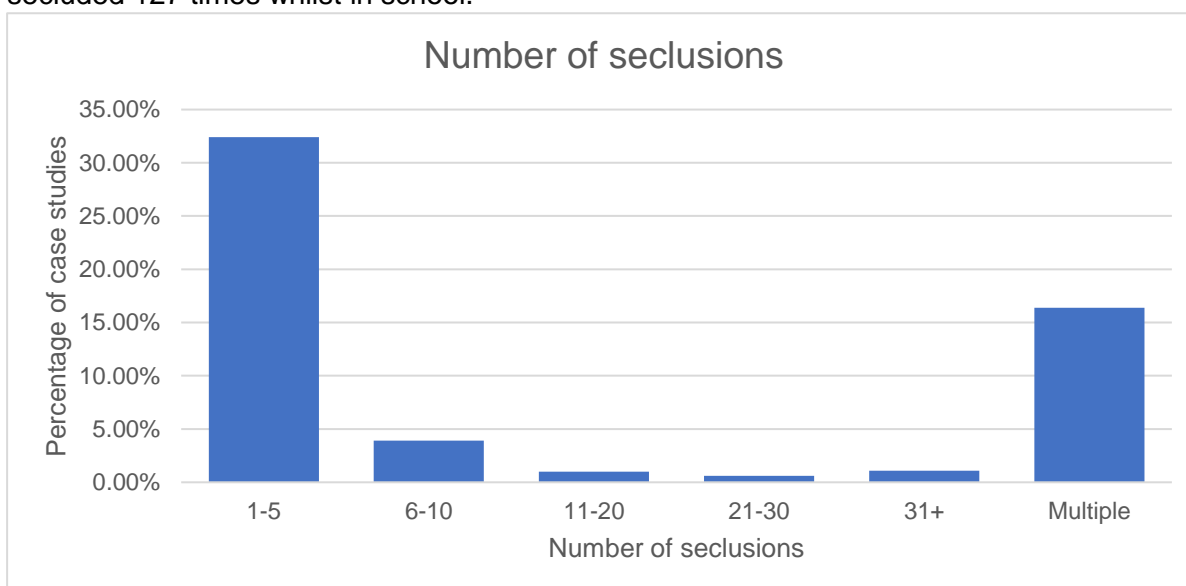
Experience of seclusion

Over half of the children and young people had experienced seclusion at least once whilst they were at school. Of the 720 case studies, 60.7% of the families reported that, to their knowledge, their child had been secluded at school at least once. Less than a quarter (22.9%) of families reported that, to their knowledge, their child had not been secluded at school. A further 16.4% were unsure if their child had been secluded in school.



When asked how often their child had been secluded in school, most families reported that (to their knowledge) their child had been secluded between 1 and 30 times (mean 3.37 seclusions³) and 16.4% reported their child had been secluded “multiple times” (i.e. several times a day, every day of the school week).

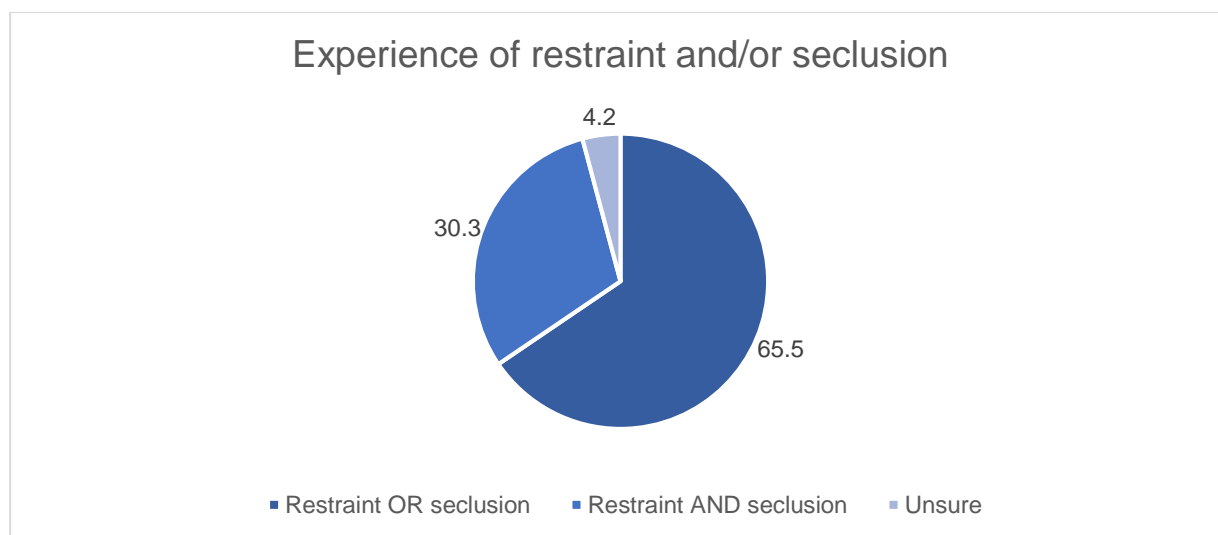
Eight families reported that their child had been secluded more than 30 times. Specific numbers of seclusions included 31, 37, 38, 47, 70, 75 and 84. Furthermore, following a FOI or SAR request from the family to the school, one family carer reported their child had been secluded 127 times whilst in school.



³ The mean is calculated for values of 1-30 only

Experience of both restraint and/or seclusion

More than one quarter of children and young people had experienced both restraint *and* seclusion whilst at school. Overall, 30.3% of the families reported that, to their knowledge, their child had been restrained *and* secluded, both at least once. In addition, more than half (65.5%) experienced restraint *or* seclusion at least once. A further 4.2% were unsure if their child had been restrained and/or secluded whilst at school.



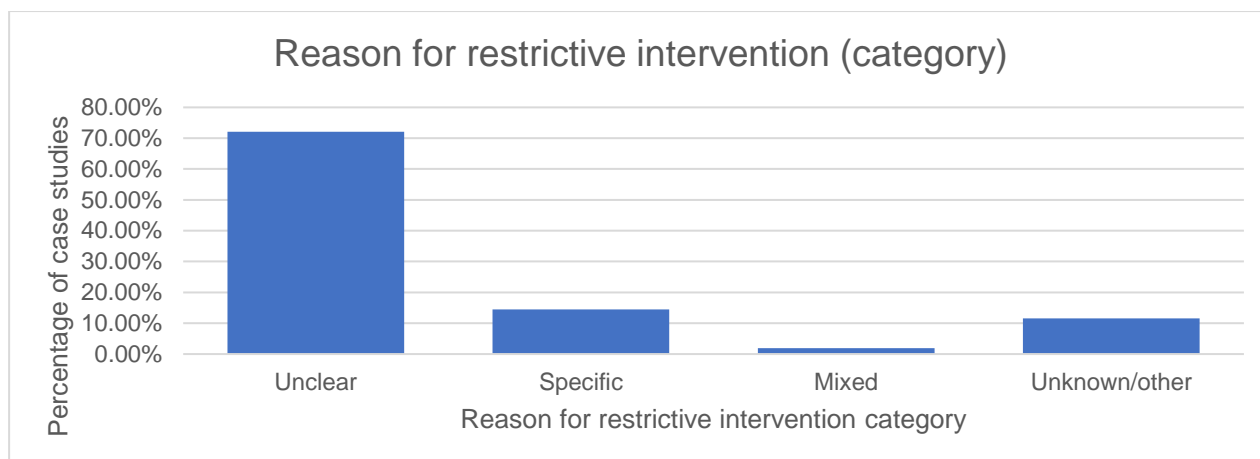
Reasons for the use of restrictive interventions

Families shared the reasons they were given for the use of restrictive interventions (i.e. restraint and/or seclusion) in school. Families reported they generally obtained this information from correspondence with the school (e.g. general contact, phone calls, daily diaries, meetings), though others obtained this information from school records or incident forms upon request.

The reported reasons for the use of restrictive intervention were coded into four categories:

1. **Unclear** – where reasons for restrictive intervention were vague and unclear (e.g. behaviour, sensory, refusing to comply)
2. **Specific** – specific reasons for restrictive intervention were given (e.g. running away, swearing, biting)
3. **Mixed** – both unclear and specific reasons were given in the same case study (e.g. swearing and non-compliance)
4. **Unknown/other** – reasons for restrictive intervention were unknown or undisclosed (e.g. reasons unknown, not specified or disclosed)

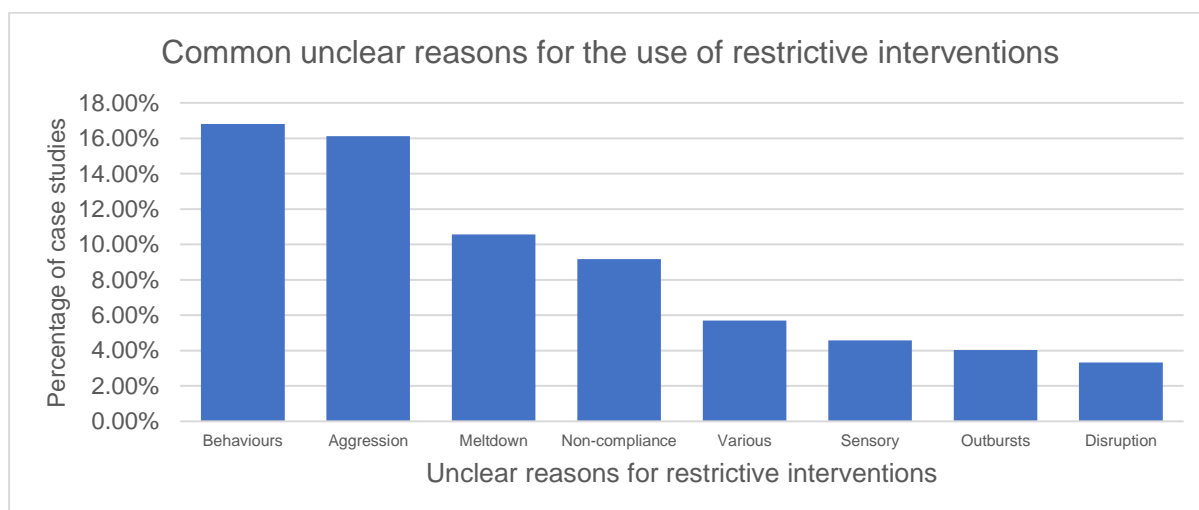
The majority of reasons reported were unclear (72.1%), with only 14.4% being given a specific reason and 1.9% being given both unclear and a specific reason together. A further 11.5% did not know the reason for the use of restrictive intervention.



Unclear reasons

The most frequent unclear and/or vague reasons given for restrictive interventions were behaviours (including “misbehaviour”, “naughty”, and “can’t behave”) (16.8%), aggression (including “violence”, “violent behaviour” and “violent tendencies”) (16.1%), meltdowns (10.6%), non-compliance (including “disobedience”, “defiance”, “refusal to comply”) (9.2%), various⁴ (5.7%), sensory (including “sensory overload” and “sensory behaviour”) (4.6%), outbursts (including “kicked off”, “uncontrollable” and “unmanageable”) (4.0%) and disruption (3.3%).

Less common unclear reasons reported for the use of restrictive intervention were “anxiety”, “upset”, “not coping”, “stubborn”, “self-harm”, “tantrum”, “acting out”, “cheek”, “disrespectful”, “disorder”, “enticed class”, “poor choices”, “scared teacher”, “preventative”, “easier”, “kept in chair”, “consequences”, “time out”, “into safe space”, “safety risk” and “duty of care”.



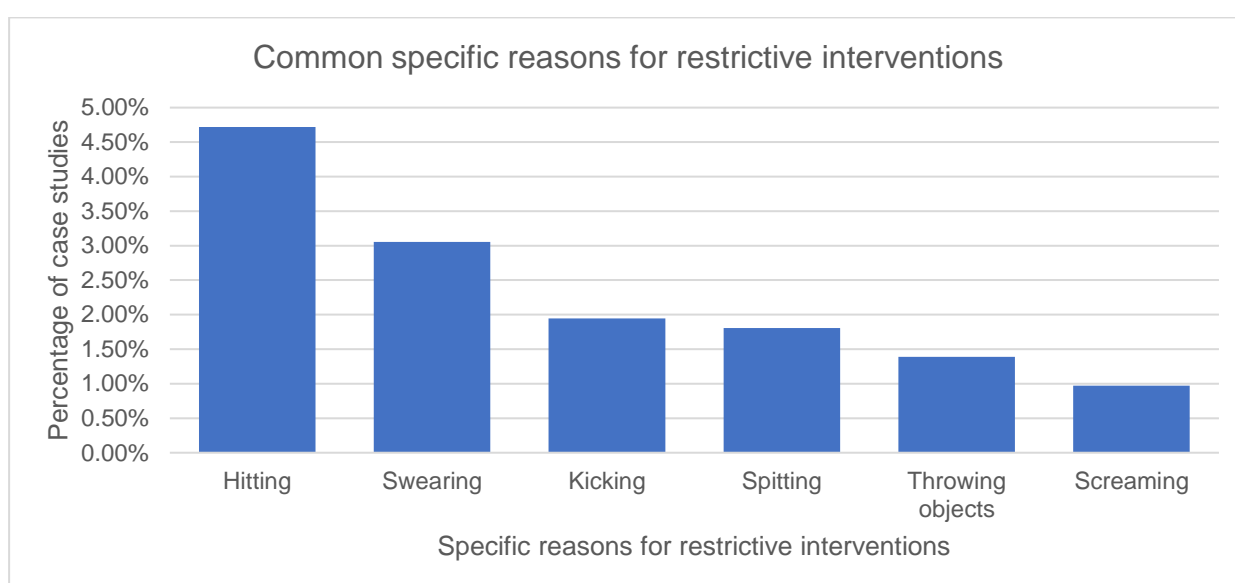
⁴ This category includes various unclear reasons not best described by the other categories listed.

Specific reasons

The most common specific reasons for the use of restrictive interventions were hitting (4.7%), swearing (including “bad language” and “verbal abuse”) (3.1%), kicking (1.9%), spitting (1.8%), throwing objects (1.4%) and screaming/shouting (1.0%).

Less common specific reasons for restrictive interventions were breaking objects, absconding (including “running away”), running (including “running in playground”), crying, overturning tables, biting, refusing to work or move, nipping, pushing, pulling hair, slapping, growling, banging desk, fidgeting, taking personal items (e.g. glasses), not listening, not sitting and having a seizure.

It is possible there may be overlaps between the categories of unclear and specific reasons, for example “behaviour” could refer to “spitting”, “shouting”, “hitting”, “refusing to work” or a different behaviour entirely.



Descriptions of situations where it is “reasonable” to use restrictive interventions (including restraint and seclusion), commonly cite **extreme and immediate instances to protect the child from harming themselves or others**.

A few of the reasons reported in the case studies *may* have met this description, as they indicate potential risk of harm to the child, young person, or others (e.g. “absconding”, “seizure”, “duty of care”, safety risk”, “self-harm”). However, **several reasons do not appear to indicate risk of harm to the child, young person or someone else**, suggesting these interventions are used when there is minimal risk of harm, such as low-level incidents or non-compliance (e.g. “swearing”, “cheek”, “disrespectful”, “preventative”, “crying”, “refused work”, “fidgeting”). One family carer stated their child was **“put in seclusion for screaming”**.

It is important to consider that, as the descriptions given of the reasons for the use of restrictive interventions were unclear, it is not possible to ascertain if the restrictive interventions were used in instances to protect the child from harming themselves or others.

Case Study 'Ben'

Ben, our son, is 12 years old and has complex needs which include a learning disability, autism, sensory processing disorder and psychological trauma. Ben was adopted by us when he was 3 with no diagnosis of disability.

He wasn't diagnosed until he was seven years old, up till then he was seen as a "naughty boy" and between the ages of 5-8 he was restrained 25 times in school. The impact of this upon Ben has been enormous. He has never attended one day of school full time. He has never been in classes but been segregated and secluded in rooms in schools when he was allowed to attend.

Ben's record of education is appalling. Currently Ben for the last year has sat in a community campus, which is part of a school, segregated and secluded with no daily contact with children. He desperately wants to belong and is a social little boy. The council responsible refuse to enrol him in any school saying they cannot meet his needs in his local school.

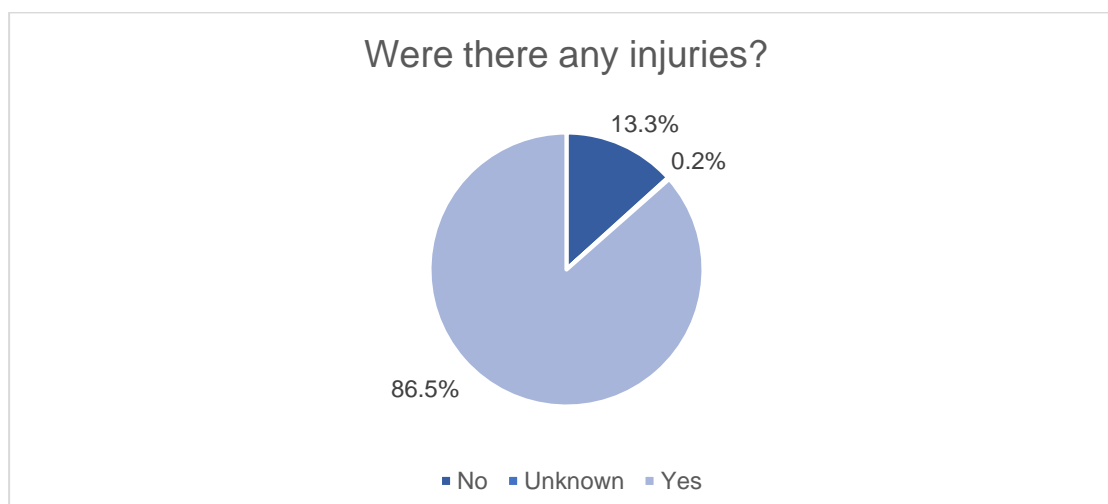
Our whole raison d'être has been trying to get Ben's rights upheld and his needs met.

Outside school, Ben is successful and attends mainstream youth club, mainstream judo and drama classes. Ben loves going to theatres and watching films. Education have failed Ben and continue to do so. We are currently involved in a legal battle to try and get Ben's needs met through the tribunal system.

Restraining and secluding Ben, locking him rooms at school, has done untold damage to Ben and nearly so nearly broken us as a family. Ben has so much to teach the world and contribute but to do that the system needs to change and start to hear the voices of children like Ben. Without substantial education and training of staff to understand behaviour and really listen to parents, sadly there will be many more Bens in the world.

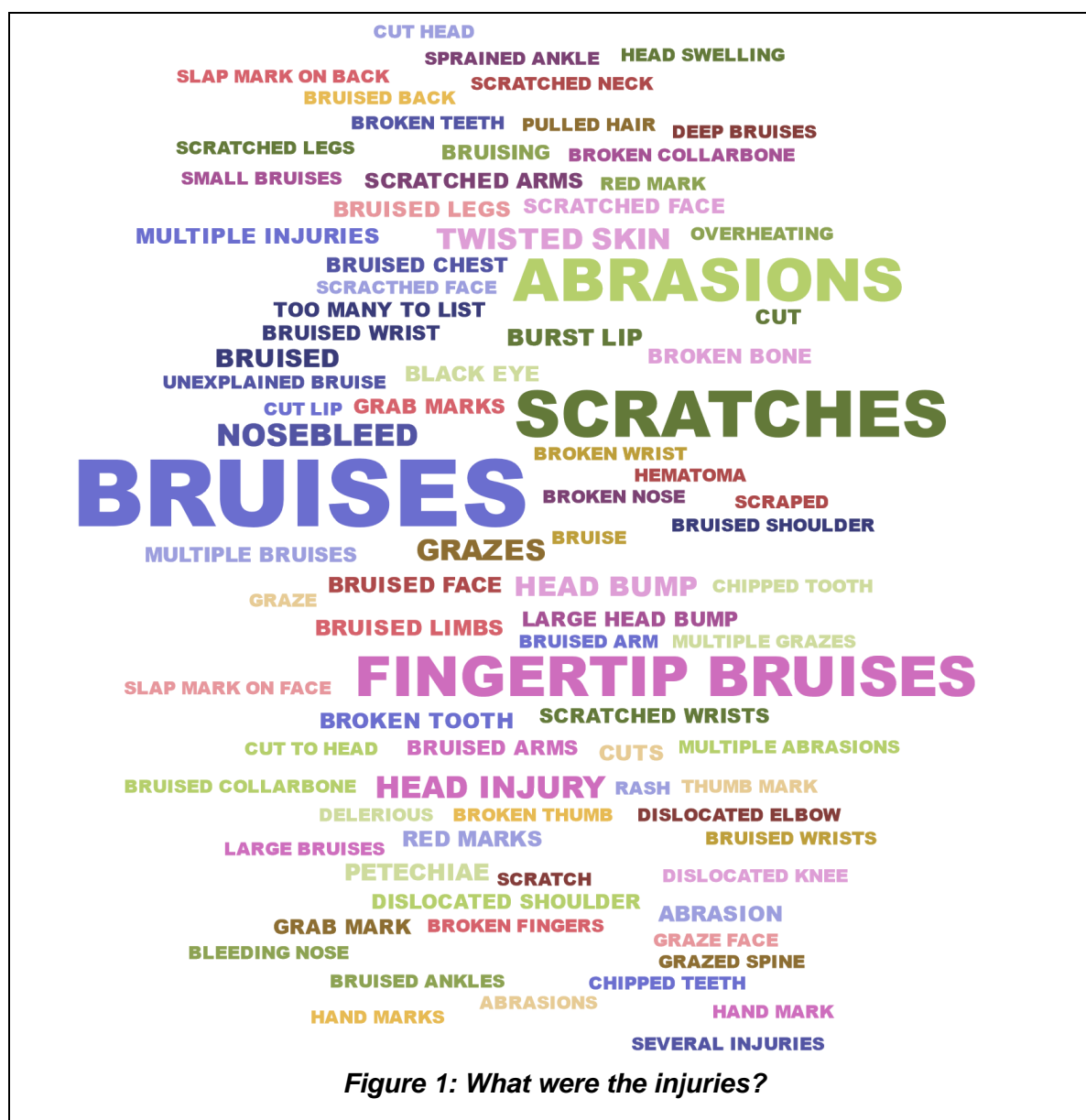
Impact of the use of restrictive interventions on children and young people

Most of the families (86.5%) reported that their child had been physically injured during restrictive interventions. Less than a quarter of families (13.3%) reported that their child had not been injured and 0.2% were unsure.



What were the injuries?

Families reported a range of injuries their child had sustained, with several reporting that their child had sustained more than one type of injury. See Figure 1 below for a visual representation of the injuries families reported.



The most commonly reported injuries were bruises (varied size and severity) (65.3%), fingertip bruises/dots (including finger, thumb, hand, grab and slap marks) (11.1%), abrasions (including scrapes and grazes) (8.8%), scratches (7.5%), head injuries (including swelling, bump and hematoma) (3.2%), cuts (2.6%), twisted skin (2.5%), hematoma or petechiae (i.e. bleeding under the skin) (1.3%), broken bones (including thumb, fingers, nose and collarbone) (1.0%), broken or chipped teeth (1.0%) and nosebleeds (1.0%).

A range of other injuries were reported in a small number of case studies, including red marks (0.8%), burst lip (0.8%), dislocated joint/bone (including elbow, shoulder and knee) (0.6%), black eye (0.4%), rash (0.3%), sprain (0.1%), over-heating (0.1%) and becoming delirious (0.1%).

In addition to the injuries listed, 2.2% families (16 families) reported their child had sustained multiple injuries without giving specific details of the injuries, such as **“too many injuries to count”**, 1.4% families did not specify the type of injury, such as **“multiple injuries to arms/legs”** **“hospitalised, injuries to limbs/back/head/torso”** and 0.4% families stated **“unknown”**.

Where were the injuries?

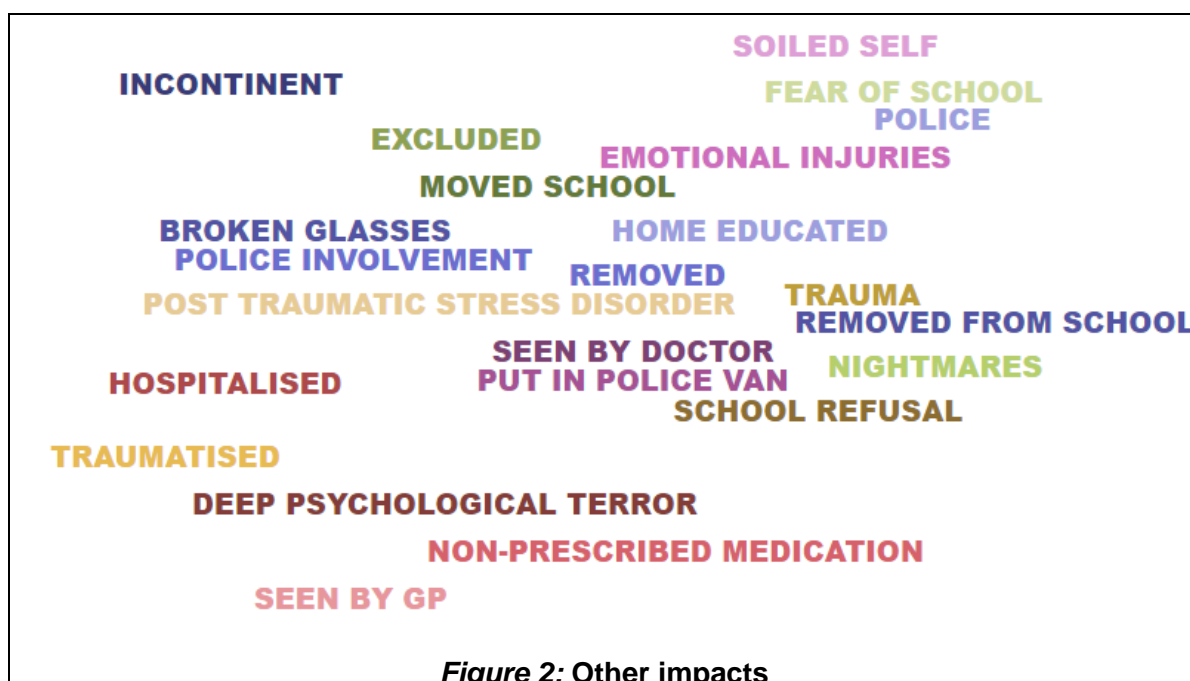
Injuries were most commonly on the child’s arms (including elbow and shoulder) (57.4%), legs (including thigh and knee) (30.0%), wrists (9.0%), face (including cheek and chin) (11.5%), back (6.8%), head (5.6%), chest/torso (2.9%), ankles (2.8%), neck or throat (2.1%), spine (1.7%), lips (1.5%), nose (1.4%), teeth (1.4%) and side (1.0%). Less frequently reported areas of injury were the child’s collarbone (0.8%), eyes (0.6%), hips (0.4%), feet or heels (0.3%), jaw (0.1%), ear (0.1%), hands (0.1%), thumbs (0.1%), fingers (0.1%) and toes (0.1%). A further 12.9% of families did not report the location of the injury, for example **“multiple abrasions”**, **“substantial bruises, seen by GP”** and **“various grazes and scratches”**.

Extract quotes from family carers regarding injuries:

“various bruises over a 2-month period”
“over 80 injuries in a year”
“too many to list ... bruises/scratches”
“always bruised on limbs after restraint”
“bruises on legs/torso – straps too tight”
“bruises to arms during time out
“bruises too many times to count”
“unexplained bruises”
“kept in chair, bruises on wrists and ankles”
“mobile but kept in chair/ strapped in – 131 days”

Other impacts of restrictive interventions

Other impacts of restrictive interventions reported by families included the child being removed from school (2.8%; 1.7% subsequently home-educated, 0.3% moved schools, 0.1% excluded), emotional injuries (including nightmares, fear of school, trauma, post-traumatic stress disorder and deep psychological terror) (1.7%), being hospitalised or given non-prescription medication (1.5%), needing to see a doctor (1.0%), incontinence (0.4%), police involvement (including the child being put in a police van) (0.4%) and the child’s glasses being broken (0.3%). See Figure 2 for a visual representation of the other impacts families reported.



Cause of injury

Although parents were not asked explicitly regarding the cause of injuries, several case studies provided details on the causes of injuries to children, which were significantly concerning. These included various types of restrictive practices, such as: being strapped into or kept in a chair (1.0%), spit hoods (1.0%), wrist and Velcro restraints (0.6%), being “removed”, secluded or isolated (0.4%), handcuffs (0.3%) and prone (i.e. face-down) restraints (0.3%). See Figure 3 for a visual representation of the causes of injuries families reported.

Several quotes raised significant concerns regarding the cause of injuries, such as:

“teacher slapped [child’s] face”

“broken thumb (teacher bent it back to punish)”

“painful rough handling”

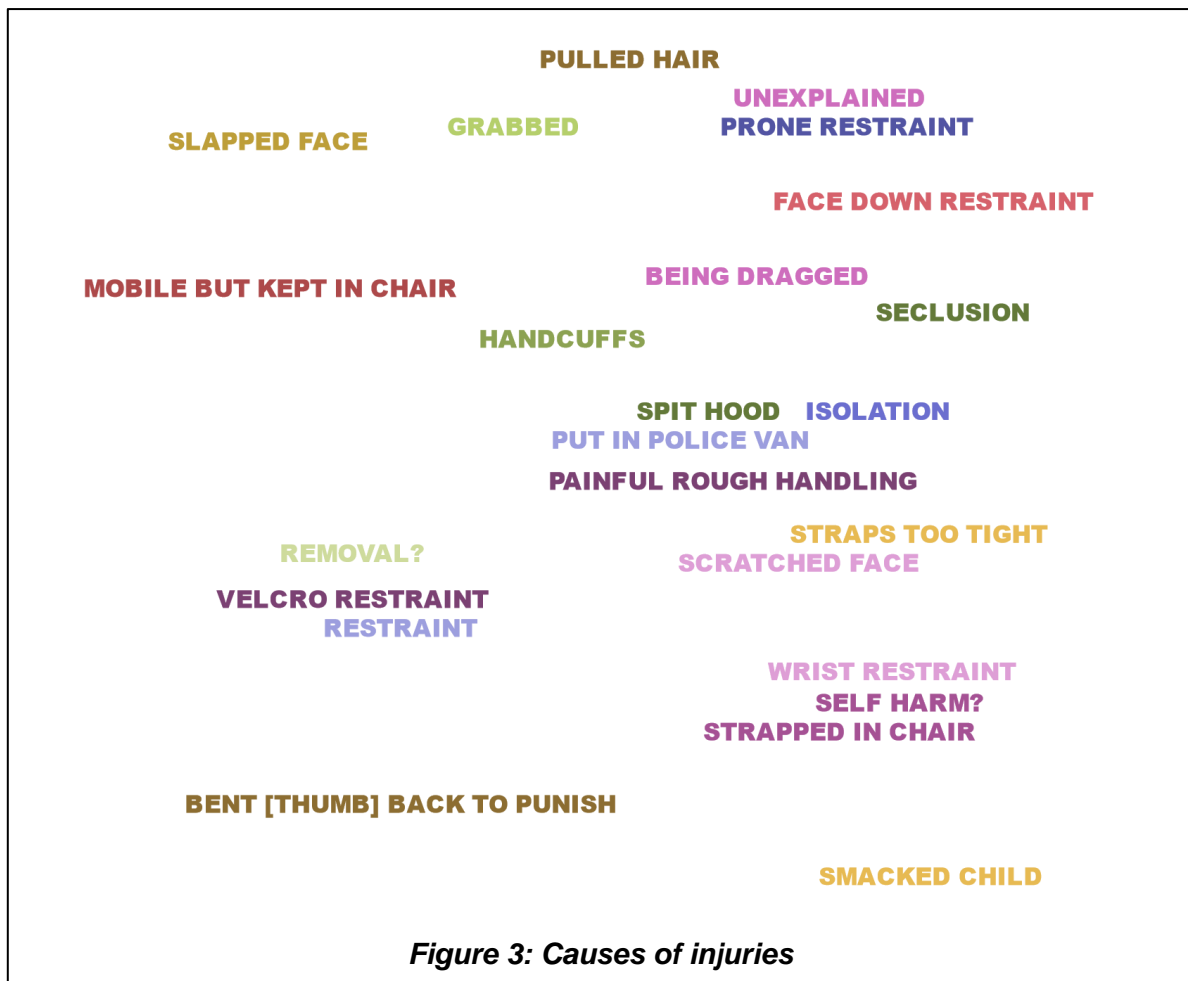
“small bruises to all limbs from removal”

“straps too tight”

“multiple abrasions from being dragged”

“teacher smacked child”

“pulled hair”

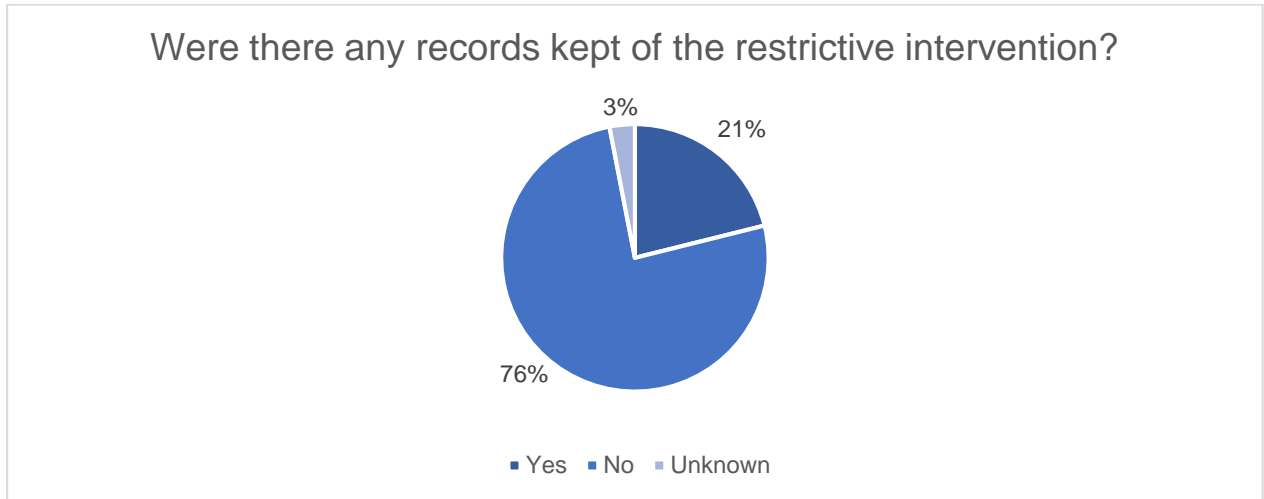


The **severity of the injuries reported by families is deeply concerning** and raises questions over the use of “*reasonable force to control or restrain pupils*” set out in the Department for Education’s guidance, whereby no more force should be used than is needed in the specific circumstance.

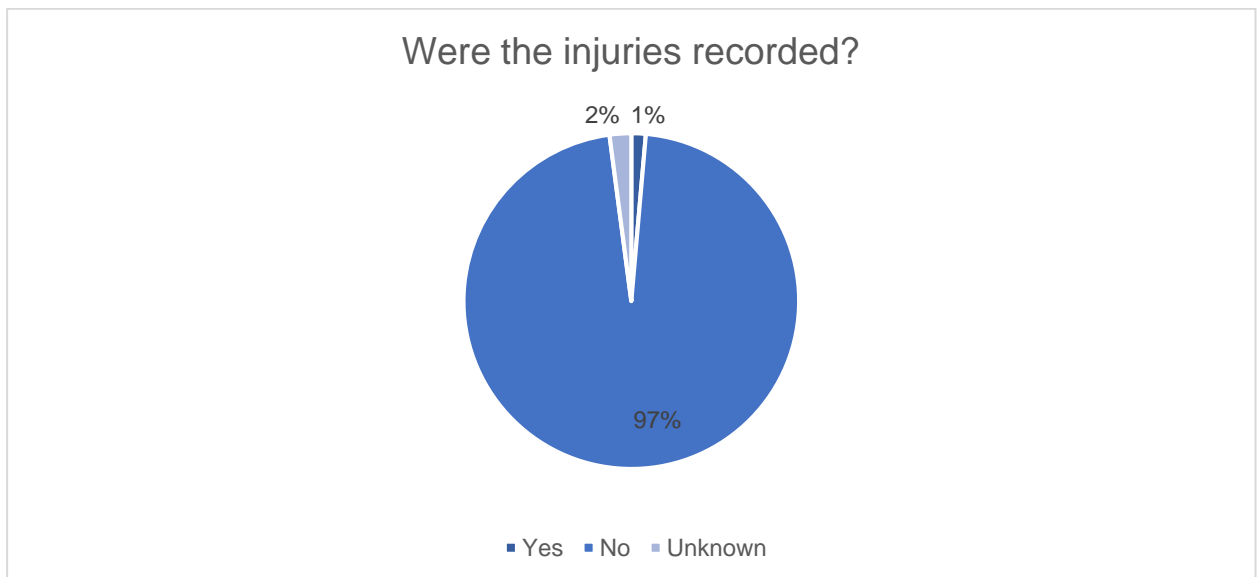
Some quotes also indicate **the use of force as a punishment for children, which is unlawful.**

Reporting and recording of restrictive interventions and injuries

Only 21.1% of families reported that, to their knowledge, records were kept on the use of restrictive interventions in school. Most (75.8%) reported that records were no kept.

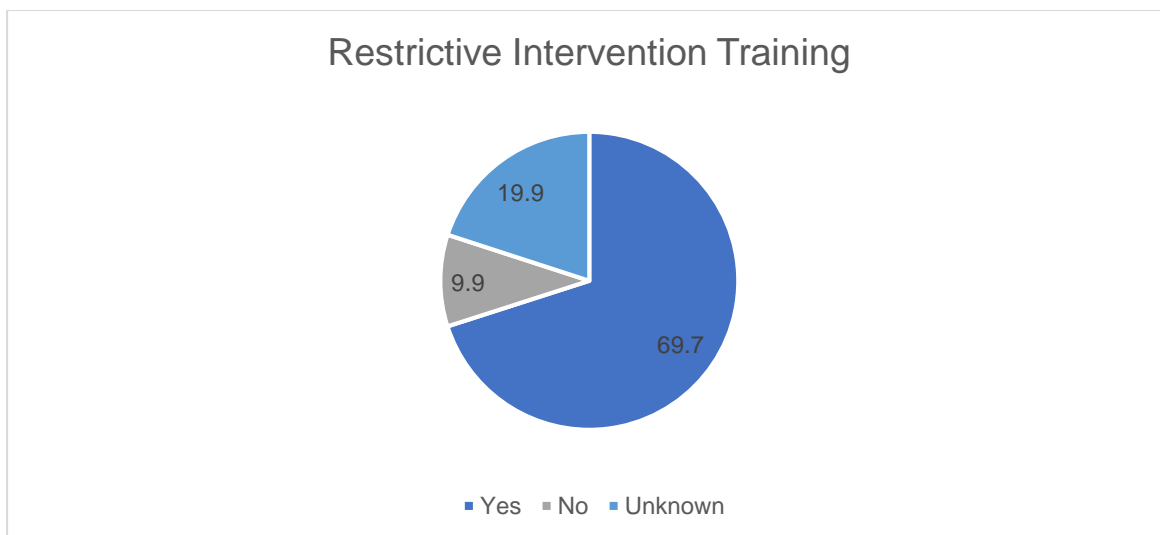


The majority of families (96.5%) reported that, to their knowledge, no records were kept on injuries following the use of restrictive interventions in school. Only 1.4% reported that records of injuries were kept and 2.1% did not know if injury records were kept or not.



Restrictive intervention training

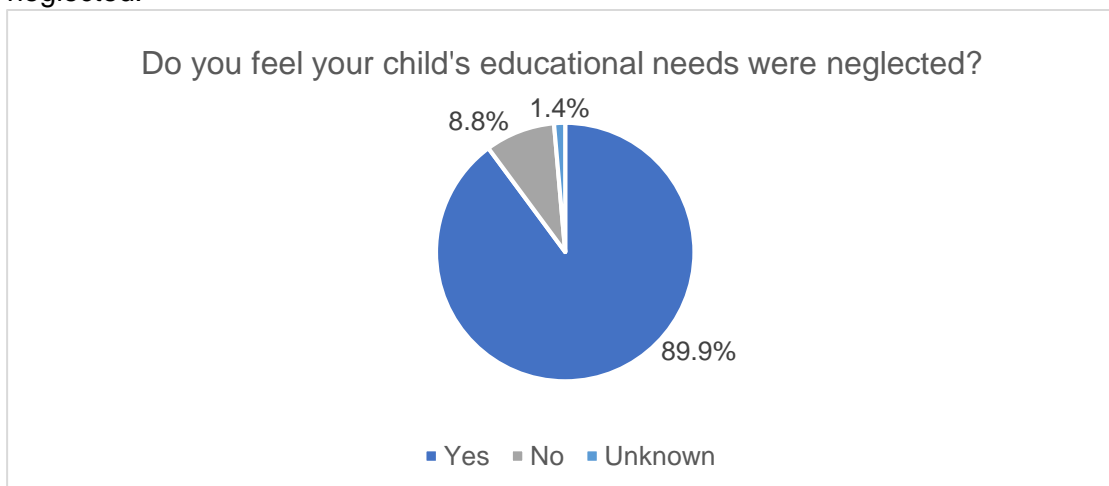
Most families (69.8%) reported that, to their knowledge, their child’s school had training in restrictive interventions, whilst 9.9% reported their child’s school did not have training in restrictive interventions (including “no policy” and “no legal requirement”). A further 19.9% of families did not know if their child’s school had restrictive intervention training or not.



Of the families who reported their child’s school had restrictive intervention training, a total of **23 training providers or courses were reported**. Families did name training providers which included some who would be regarded as reputable providers, training many school staff across the UK. We have not named these providers as the diversity of those represented suggests this is a systemic issue, requiring further scrutiny and attention, and this is an area where research is required. From the information we have it is not possible to deduce whether the training provided is inadequate (or indeed leading to greater numbers of restraints once staff receive training), or whether training is being misinterpreted or poorly applied.

Educational needs

An overwhelming majority of families (89.9%) felt that their child’s educational needs were neglected, whilst only 8.8% felt their child’s educational needs were not being neglected.



CONCLUSION

The case study findings indicate **a number of potential issues around the use of restrictive interventions in schools** for children and young people with a range of developmental, educational, physical, and mental health needs.

Before describing the issues that emerged from the case study findings, it is important to note that there are some limitations with the case study data presented in this report. Due to practical constraints, the case study data only included retrospective family carer report and was not collected as part of scientific research. Furthermore, the analysis conducted was purely descriptive, to highlight the overall findings from the case studies, as the researchers determined that more robust data is needed to run comparative analyses. Whilst these limitations inevitably affect the conclusions that can be drawn from the findings, the case studies clearly demonstrate that there are considerable issues with the use of restrictive interventions in schools, highlighted by the families of 720 children and young people across the UK, and **these issues need to be explored through more robust data collection.**

Issues

Issue 1: Restrictive interventions can have serious negative impacts on children

It is deeply concerning that the majority of families (86.5%) reported that their child had been physically injured during restrictive interventions. Bruises were the most commonly reported physical injury, however there were several other injuries were reported by a number of families, such as abrasions, scratches, head injuries, cuts, twisted skin, hematoma or petechiae, broken bones, broken or chipped teeth, and nosebleeds.

In addition to physical injuries, families reported emotional injuries including nightmares, fear of school, trauma, post-traumatic stress disorder and deep psychological terror. Furthermore, several children were removed from school.

These findings are reinforced by a recent report by the Centre for Mental Health "*Trauma, challenging behaviour and restrictive interventions in schools*" highlighting the way restrictive interventions can exacerbate distress and behavioural problems among children who have experienced trauma (Centre for Mental Health, 2020).

Although not covered in the case study questionnaire, this quote from a family carer shows the wider impact on the family

"Our whole family have been profoundly affected by what happened to Annie at school. And profoundly affected by the lack of accountability schools have, even when a child in their care has been left with PTSD".

Issue 2: Restrictive interventions appear to be used on multiple occasions in the schools represented by participants

An extremely high percentage of the case studies indicated that the child had experienced restraint (87.6%) or seclusion (60.7%) at least once whilst at school. Furthermore, more than one quarter (30.3%) of the case studies indicated the child had experienced both restraint and seclusion whilst at school.

Although considerable variation was reported in the reported frequency of restrictive interventions for each child, many families reported that their child had been subjected to restrictive interventions at school on multiple occasions. Following a Freedom of Information (FOI) or Subject Access Record (SAR), high frequencies of restraint and/or seclusion were reported for some children (e.g. one family reported their child had been

restrained 350 times, and another reported their child had been secluded 127 times). As families reported that prior to the FOI/SAR they were not aware of how frequent their child had been subjected to restrictive interventions, it is possible that the frequency of restrictive intervention use in schools might be higher than those reflected in the present case study data.

Issue 3: Restrictive interventions appear to be used for inappropriate reasons, rather than in extreme instances to protect the child from harming themselves or others

The reasons reported for the use of restrictive interventions were mostly unclear or vague and several did not appear to indicate they were used in extreme and immediate instances to protect the child from harming themselves or others. For example, several reasons appeared to describe events which had minimal risk of harm, such as low level incidents or non-compliance e.g. “refusing to work” “swearing” “spitting” “fidgeting” “not sitting” “upset” and “poor choices”. Guidance on the use restrictive interventions consistently maintain that the use of restrictive interventions for behaviours that challenge should only be used to reduce the risk of harm or maintain safety of child, young person and/or others, alongside proactive interventions to minimise behaviour that challenges (NICE, 2015).

As noted earlier, it is important to consider that, as the descriptions given of the reasons for the use of restrictive interventions were unclear, it is not possible to ascertain if restrictive interventions were used in extreme and immediate instances to protect the child from harming themselves or others. The wide range of reasons given for use of restrictive intervention, including unclear and unspecific reasons (72% of case studies), emphasise the urgent need for better quality reporting. The language used to describe the reasons for restrictive interventions can be misleading, for example “ran away” could highlight running away from staff in the school playground or absconding (i.e. running away from the school). Unclear reasons provided for the use of restrictive interventions could lead to potential categorical errors in the analysis.

Furthermore, several of the reasons provided describe an observable behaviour prior to the restrictive intervention, rather than an attempt to understand why the observable behaviour occurred. This understanding is vital to reduce future use of restrictive interventions. Guidelines published by NICE (2015) on the prevention and interventions for people with learning disabilities whose behaviour challenge highlight the importance of functional assessment of behaviours that challenge to gain an understanding of *why* behaviour occurs (for further details, please see page 27). Functional assessments are crucial to put proactive strategies (e.g. changing the environment or supports for the child, preventative strategies when ‘early warning signs’ are present) into place to reduce the likelihood of behaviours that challenge, thus reducing the reliance on restrictive interventions.

Issue 4: Restrictive intervention practices in schools may not adhere to guidance and some unlawful, abusive practices are suggested

In addition to the guidance on the use of restrictive interventions only to reduce the risk of harm or maintain safety of child, young person and/or others (see issue 3), other case study findings indicate restrictive intervention practices not adhering to guidance and in some cases being unlawful and abusive.

Guidance from the Department for Education (2013, p.4) states “*School staff should always try to avoid acting in a way that might cause injury, but in extreme cases it may not always be possible to avoid injuring the pupil.*” Considering the high incidence and the severity of injuries reported by families in the case studies, it is questionable if the guidance is being followed for children with special educational needs and disabilities.

Some case studies indicated the use of force as a punishment in schools, which is unlawful and abusive. For example, when describing injuries sustained, a family carer reported **“broken thumb (teacher bent it back to punish)”**. This is also suggested in some of the unclear reasons given for the use restrictive interventions, such as “misbehaviour” “naughty” and “can’t behave”. A family carer said, **“Our son has been seen as a “naughty boy” and between the ages of 5-8 he was restrained 25 times in school. Currently Ben for the last year has sat in a community campus, which is part of a school, segregated and secluded with no daily contact with children.”**

Guidance on “Reducing the need for Restraint and Restrictive Intervention” by the Department for Education (2019, p.41-42) states *“Mechanical restraint may be used to manage extreme aggressive behaviour directed towards others or to limit self-injurious behaviour of extremely high frequency and intensity... Any such devices should only be put in place by people with relevant training, qualifications, skill and experience.”* Spit hoods are one form of mechanical restraint reported by families in the case studies. This is extremely concerning as the use of spit hoods has been described as a human rights abuse by the Equality and Human Rights Commission, the Children’s Rights Alliance of England and Liberty. Other mechanical restraints reported include arm splints or being strapped into a chair. Chemical restraints, physical restraints and seclusion and segregation have all been reported in ways which raise questions about lawful and appropriate use. A family carer reported: **“Between Feb 2017 and Sept 2018 the school recorded 158 incidents which they considered to involve restraint. The school would report that she had a wobbly day or had been held. We had no idea at the time what this meant in practice. When we got the incident reports, we realized she had often been held on the floor by 4/5/6 members of staff”**

Our data suggests that restrictive interventions are being used too regularly with a lack of planning or a focus on children’s rights or evidence-based approaches to managing challenging behaviour. The 2019 guidance does not refer to all methods reported, including spit-hoods. Moreover, there is no detail about what “relevant training” consists of.

Issue 5: Parents are not always informed when restrictive interventions are used

Whilst a relatively small number some families reported in the case studies that they did not know if (or how often) their child had experienced restraint (5.6%) and/or seclusion (16.4%) at school, the data suggests that families are not being routinely informed when restrictive interventions have been used. Some families stated that they had only been informed that their child had been restrained and/or secluded after they directly asked someone at the school about injuries their child had returned home from school with.

Furthermore, the case studies with the highest reported numbers of restrictive interventions typically followed the family formally requesting to see their child’s records for the purposes of completing the case study (e.g. using a FOI/SAR). Several family carers reported that they were shocked by the frequency of restraint and/or seclusion. Prior to the FOI/SAR they were not aware of how often their child was subject to restrictive interventions at school.

Some families’ who requested to see their child’s records or submitted a FOI/SAR were refused, with the school or local authority stating the child had to request the information themselves. This lack of transparency regarding the use of restrictive interventions is concerning, especially considering over half of the children had communication needs (many do not communicate verbally), and other needs (developmental, educational, physical, mental health) that may impact their ability to request a FOI/SAR, let alone communicate their experience of restrictive interventions to their family or others.

It is possible that the case study data in this report may only be the “tip of the iceberg” – due to a potential under-reporting of restrictive interventions that families were not aware of.

Guidance by Ofsted (2018) on physical intervention and restrictions of liberty stipulates “Schools are not required to record and report incidents of the use of restraint. Similarly, informing parents is also good practice but not required.” Even when a “serious incident” is happening or a child is “at greater risk”, it is not obligatory for schools to inform parents. Ofsted guidance also states that schools can be asked by inspectors why parents have not been informed, but again it is not mandatory.

Similarly, under the Department for Education 2019 guidance on “Reducing the Need for Restraint and Restrictive Intervention” there is no requirement to notify families about the use of restraint, or to record or report it.

This means that the use and scale of restraint and other restrictive interventions in UK schools is currently unknown.

Issue 6: School records on restrictive interventions may be infrequent/inadequate

Similar to issue 5 above, the majority of parents reported that, to their knowledge, records are not kept of the use of restrictive interventions or on injuries the child sustained. However, it is possible the school keeps records on restrictive interventions and/or injuries that parents are not aware of.

Issue 7: The relationship between training and use of restrictive intervention is complex and our data raises concerns about the content of current training and accountability for its implementation

A high number of restrictive interventions and child injuries were identified where schools had received training, often from well known training providers in this field. This begs the questions what that training consisted of and how it was being implemented. Although the training providers cannot ensure that the guidelines of the training are implemented by staff in every setting, it should be their core responsibility to follow up and evaluate the effectiveness of their training, and some system is needed to accredit or quality assure training providers.

Issue 8: The issues highlighted in the use (and reporting of) restrictive interventions are widespread, rather than specific to certain areas or schools

There was a good geographical spread of the data across the UK, highlighting the breadth of the issue. As it does not appear to be limited to specific schools or geographical areas, this highlights the need for a widespread response to tackle these issues across all education provisions across the UK.

Evidence of what works

Over recent years a wealth of reports and guidance have set out the evidence about how best to support children with learning disabilities or autism whose behaviours challenge.

Challenging behaviours may include aggression, destruction, self-injury, and other behaviours (for example running away) which pose a risk to individuals and to those around them or which have a significant impact on everyday life.

Children with learning disabilities or autism may not have the social or communication skills to get their needs met, which is why the incidence of behaviours that challenge are higher in this group. Common reasons for challenging behaviour include pain or health reasons, to escape a difficult situation, anxiety, sensory reasons and simply to communicate an immediate need e.g. thirst, hunger, when no other method is available.

Functional assessments are recommended to ascertain the reasons for behaviours that challenge, so the need can be responded to, rather than the behaviour itself and proactive strategies put in place. Proactive strategies can reduce the use of restrictive interventions and the frequency of behaviours that challenge.

Functional assessments include clear descriptions of the behaviour, identifying events, times and situations that predict the behaviour, identifying reinforcers that maintain behaviours (i.e. the function or purpose the behaviour serves), and detailing the relationship between personal and environmental triggers, the behaviour and reinforcers. Functional assessments take into account a range of factors, for example the child's abilities and needs, the impact on quality of life, life history (e.g. experience of trauma), and the environment (e.g. how the child is engaged and choices are promoted, the range of activities available, how well structured the environment is) (for more details see NICE, 2015).

What works to reduce restraint and restrictive interventions?

There is a consensus among experts and across health and social care about the best way to support children with learning disabilities or autism whose behaviours challenge; this is reflected in numerous recent reports and guidance and is set out in NICE guidelines

2015 NICE Guideline NG11: "Challenging behaviour and learning disabilities: Prevention and Interventions for people with learning disabilities whose behaviour challenges" recommends family involvement, early intervention a functional assessment and development of a Behaviour Support Plan. It sets out interventions appropriate for children and young people.

2018 NICE Guideline NG93 "Learning disability and behaviour that challenges: service design and delivery" sets out in detail the local services that should be available to children and their families so that children are able to access a meaningful education and have a good quality of life.

It is not that no-one has identified a better way, but that the knowledge about what works is not being applied widely. Where evidence-based approaches are being used, schools have demonstrated dramatic reductions in the use of restrictive interventions.

Population based samples show an increased risk for behaviour problems in children with learning disabilities, by the time they are 3 years old. Children displaying challenging behaviours are at greater risk of social exclusion, institutionalisation, deprivation, physical

harm, abuse, misdiagnosis, exposure to ineffective interventions, and failure to access evidence-based interventions.

The Challenging Behaviour Foundation academic expert group recommends: early, evidence-based behavioural interventions; family support and early identification and rapid response using approaches such as Positive Behaviour Support (CBF, 2014). An example of the application of Positive Behaviour Support to an individual's life can be seen below:

Identifying Root Causes and Applying Positive Behaviour Support

Lucas is a nine-year-old boy with autism and a learning disability. It was getting difficult for Lucas to live at home as he was displaying a number of high-risk behaviours, including regularly running away. He was also displaying a lot of self-injury and some aggression. Lucas travelled to and from school via taxi and would often escape when leaving the taxi. A functional assessment showed that Lucas' life was very limited; the more he ran away the more he was restricted. Lucas had limited communication skills with which to express his needs. A Positive Behaviour Support Service assessment identified the function of Lucas' behaviour was to escape from the boredom and social isolation that the restrictions created. He simply wanted the ability to be outdoors and to run, which was very valuable to him but totally unavailable to him in his everyday life. Once this was understood and appropriate opportunities were introduced on a regular basis Lucas stopped running away altogether and his other behaviours have reduced. Lucas is now able to move freely around, and his functional communication skills and activity have increased.⁵

The National Association of Independent Schools and Non-Maintained Special Schools (NASS) asked member schools demonstrating good practice how they support young people, and 'what works' in terms of providing positive support. Some of the common themes are listed at Appendix B, page 36.

⁵ Case study retrieved from *Paving the Way: How to develop effective local services for children with learning disabilities whose behaviours challenge*, The Challenging Behaviour Foundation, 2015, page 11

RECOMMENDATIONS

Reports and expert groups over recent years have established that there is already a clear body of evidence about how best to support children with learning disabilities or autism whose behaviours challenge. The RRISC group is clear that there is no need for a new task force or report to reconsider the same issues – now is the time to take tangible action to stop harming children through the use of restrictive interventions.

Recommendation 1: Strengthen the law across the UK to safeguard children from restrictive interventions and to prosecute those who use unlawful force against children.

- Change the law to remove “the use of reasonable force to maintain good order and discipline”.

This change would be consistent with and go beyond the Children Wales Bill proposal to end the defence of reasonable punishment. The Education and Inspection Act 2006 currently allows the use of force for good order and discipline as opposed to adult health and social care legislation which only allows force if someone is “a risk to themselves or others”. This must be changed to make it compulsory to record any incident of restraint. The Apprenticeships, Skill and Learning Act 2009 amended the Education Act to make it compulsory to record any incident of restraint, subject to a commencement order which was never enacted. With the additional evidence available now, this needs to be rectified as soon as possible.

- There should be a new legal duty on Local Authorities and Clinical Commissioning Groups (CCGs) making it mandatory to notify families when their relative is subject to restraint or seclusion. This was recommended by the Joint Committee on Human Rights (JCHR) Inquiry about “The detention of young people with learning disabilities and/or autism” published in November 2019. We support that recommendation and await the Government response to it.
- Local Safeguarding Partnerships should monitor data collected by the Local Authority Designated Officer in order to detect and respond to identified issues.
- Statutory guidance is required about the use of restrictive intervention in all schools. Current guidance is non-statutory, which provides insufficient strength as a framework governing practice.
- The justice system must review the way it handles restrictive intervention cases. The current barriers in place (including not seeing children with learning disabilities as credible witnesses) which deny children, young people and their families access to justice must be addressed.

Recommendation 2: Invest in early intervention, prevention and training in order to support both families and staff to use evidence-based approaches to address challenging behaviour as set out in NICE guidance.

- Introduce evidence-based early intervention to support children with learning disabilities or autism whose behaviours challenge and their families across the UK; Early intervention should involve meeting needs and developing strategies which

teach children skills and improve their quality of life, making challenging behaviour less likely.

- Establish expert community PBS (or intensive support) teams to support both families and schools. This is recommended in NICE Guidance (2018) and would enable much needed expertise within the community to support children using evidence-based approaches.
- Invest in Positive Behaviour Support (PBS) training for the workforce, including school leaders and staff; Training should cover understanding of learning disability, autism, developmental needs and challenging behaviour as well as evidence-based approaches such as Positive Behavioural Support as recommended in NICE Guidance (2018). This training should be available to families as key partners. This approach would help the culture change needed to reduce interventions with staff at all levels, anticipating and preventing behaviours which can currently spiral into restrictive interventions.
- Initial teacher training must include training in understanding challenging behaviour displayed by children with learning disabilities and/or autism. Although Initial Teacher Training includes an increased coverage of SEND issues than previously, there is insufficient coverage of understanding challenging behaviour displayed by children with learning disabilities or autism. Addressing such behaviour under blanket behaviour policies could constitute discriminatory behaviour under the Equality Act 2010.
- Develop resources and materials in co-production with families, researchers and expert organisations to help Headteachers and school staff understand how to apply best practice. Many schools have successfully reduced restrictive interventions and can demonstrate how to apply evidenced based methods of support which safeguard children and uphold their human rights.
- Establish a framework to ensure quality assurance of and accountability for training for those working with children whose behaviours challenge in schools. This should build on existing training standards in Positive Behavioural Support, and a human rights perspective.

Recommendation 3: Gather more evidence about what is happening and strengthen safeguarding and accountability.

- Improve monitoring of restrictive intervention in schools and ensure reporting to families. This report highlights both the lack of clarity in reasons given by schools for using restrictive interventions and the high incidence of restrictive interventions reported by parents revealed by FOIs/ SARs. Monitoring needs to be consistent and include the reporting of incidents to families. It can also improve accountability and is important for providing justice to families when things go wrong.
- Invest in research in this area including robust data collection. Our findings provide only a small snapshot of what is happening in schools. Therefore, we call on the Government to fund further research in this area including the collection of robust data from families, schools, social workers and Local Authority Designated Officers. We need to properly understand what is happening in schools, as well as evidence

about training leading to improved practice and reductions in the use of restrictive interventions.

- Review safeguarding processes with regard to the use of restrictive practices to ensure they are used appropriately to safeguard children, including across Inspectorates (namely CQC, Care and Social Services Inspectorate Wales, Care Inspectorate Scotland, Healthcare Improvement Scotland, the Northern Ireland Regulation and Quality Improvement Authority, Ofsted, the Education and Training Inspectorate, Education Scotland and Estyn). This report suggests safeguarding approaches are currently insufficient when investigating restrictive interventions alleged to have taken place at school. As soon as a safeguarding referral is made families report that they are under suspicion, even where they have raised the alert due to injuries sustained while at school. Families report a fear of reprisal when reporting such incidents, leading to a fear that many incidents remain unreported. Inspectorates should review safeguarding and accountability arrangements within the current system in order to strengthen procedures.
- Accountability when children are harmed. A stronger accountability system is required which should include reporting and recording of restrictive interventions and action when children are harmed. Whenever there is any concern about harm to a child this should be discussed with managers and reported to the Local Authority Designated Officer in line with Working Together Guidance 2018.
- The current CQC review of restrictive practices and seclusion should be extended, with Ofsted, to include schools. CQC are conducting a review of seclusion and restraint which has been extended to cover children's health and social care settings, however, schools are excluded. The review should be extended, and Ofsted involved as a partner, so that schools become within scope.
- A rights-based approach and culture. We need to move to a rights-based approach, with a duty of candour so schools or other providers must explain exactly what happened when a restrictive intervention takes place. Learning from incidents can be used to avoid them in the future. It would be helpful to have a culture which enables questions to be asked and whistleblowing. Restrictive cultures are bad for staff as well as children.

Recommendation 4: Fund psychological and trauma support for children and families who require support following restrictive interventions.

- Invest in psychological therapeutic support for all children, young people and families who have experienced restrictive intervention, including evidence-based trauma support where it is needed. Fund and provide access to skilled support for those disabled children who have experienced traumatic restrictive interventions at school or in children's services settings, including effective support for their families. As this report shows, the impact can be very serious and there is currently no support

Restrictive intervention of children and young people is a hidden issue that must be exposed and addressed. Children should not be experiencing practices like these in settings that should be supporting, encouraging and enabling them to fulfil their potential.

We hope this report can be part of that exposure and drive action to address the issues.

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APPENDIX A

Case Study Information and Privacy Notice

Thank you for requesting to take part in my family case study project, please find the case study information form attached. Please complete the form the best you can.

If you have not already done so, I strongly recommend that you complete a subject access request (SAR)

Pupils attending any type of school have a right of access under the Data Protection Act 1998 to their own information. This is known as the right of subject access. When a child cannot act for themselves or the child gives permission, parents will be able to access this information on their behalf.

There are often records of incidents and/or recording of information that may or may not have been communicated to you regarding your child's education and time in school. If your child attends a maintained school, parents have an independent right of access to their child's educational record, under separate education regulations. More information can be found here <https://ico.org.uk/your-data-matters/schools/pupils-info/>

You may want to make sure you have your child's education records before you complete the form, however this is not a requirement to take part, it's simply a way of you being fully informed as a parent.

This privacy notice sets out how I use and protect the information that you give me. I am committed to ensuring that your privacy is protected.

What I collect

The only information I hold and collect is the information you have provided me with as per my family case study information form. I do not ask for any identifying details address, telephone number or contact details. The only information I require is what is on the form. If there is any information you do not wish to share, you are under no obligation to do so. The form is to be completed at your own discretion and you are in control of the information you provide.

If you do not wish to name your local authority/council area, then please simply state "Anon" on the form.

Once the form is sent back to me, I print out the form and delete your email from my computer. Please do not send me copies of care plans/letters/minutes from meetings or any photos that can identify you or your child with your form.

I do not collect or keep any kind of personal information other than the data you have given me as per the form, my case study is completely anonymous.

By sending back the family case study form, you agree to me using this data for my case study project. The purpose of my case study project is to inform and produce a report or paper with anonymised statistical data. This report or paper can then be shared to inform and improve practice and young people with learning disabilities and the issues around the use of restraint & seclusion.

The anonymised data will be processed and kept for as long as required by the purpose they have been collected for. Once the report or paper has been completed the forms will be shredded and destroyed.

Contact me

Questions, comments and requests regarding this privacy policy are welcomed and should be addressed to me by emailing calumsmummy@yahoo.com

Strictly Confidential: Beth Morrison Restraint/Seclusion case study group

COUNCIL:

BOY/GIRL:

AGE (When the restraint/seclusion started)

DIAGNOSIS (if any)

WHEN DID THE INCIDENTS HAPPEN?

ARE THEY STILL HAPPENING?

NUMBER OF RESTRAINTS:

NUMBER OF SECLUSIONS:

REASON FOR RESTRAINT:

REASON FOR SECLUSION:

DO YOU FEEL YOUR CHILD'S EDUCATION NEEDS WERE NEGLECTED?

WERE THERE ANY RECORDS KEPT?

WERE THERE ANY INJURIES (Y/N)

WERE THE INJURIES RECORDED? (Y/N)

TRAINING PROVIDER (IF KNOWN)

WERE THE POLICE CALLED?

DID YOU MAKE ANY FORMAL COMPLAINT?

ACCOUNTABILITY/COMPLAINT/OUTCOME DID YOU FEEL LISTENED TO?

WHAT WERE THE REASONS GIVEN FOR THE RESTRAINT?

WHAT WERE THE REASONS GIVEN FOR THE SECLUSION?

WHAT INJURIES WERE THERE (IF ANY) AND WHERE WERE THE INJURIES ON YOUR CHILDS BODY.

THANKYOU FOR TAKING PART.

BETH MORRISON calumsmummy@yahoo.com

APPENDIX B

NASS survey on what works to reduce restraint and restrictive interventions.

Some of the common themes were:

- building a whole-school culture of strong and respectful relationships with children and their families, rooted in recognising children's rights
- a personalised approach - making sure children have the right support to meet their needs, which reduces frustration, improves quality of life, and therefore reduces challenging behaviour
- understanding that behaviour is a way of communicating: understanding what's behind the behaviour, working on that with the child, and giving children as many positive ways to communicate as possible
- training all staff in de-escalation strategies (can include distraction, calm talking, giving choices and options, appropriate humour, negotiation)
- young people and families having as much control over their own support plans – and the wider decisions affecting the school – as possible
- environments that give children safe, calm spaces - and access to the outdoors - to give them chance to manage their feelings and 'reset'
- learning environments that help the young person engage e.g. small class sizes, high staff ratios
- specific therapies and interventions tailored to each young person's needs
- keeping rigorous data about any use of restrictive practice, and ensuring leaders use the data proactively to plan to reduce instances of restrictive interventions, both for individuals, and across any themes or pressure points that emerge from the data with wider significance for the school
- debriefing with the young person, their family, and everyone involved, to learn from any incident, support those involved, and with the aim of preventing the situation arising again
- early intervention - getting the right support early means children are more likely to find ways to communicate other than through their behaviour, and any challenging behaviours are less likely to become entrenched
- approaches that use positive behaviour support, a way of supporting people that encompasses many of the bullet point above