The Challenging Behaviour Foundation

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

A Statement on the Use of Restrictive Interventions

Children & young people with a learning disability in England, Northern Ireland, Scotland and Wales

March 2026

All Wales Forum Fforwm Cymru Gyfan

kindred for parents of children with complex needs

Learning Disability Wales Anabledd Dysgu Cymru

BASW England The professional association for social work and social workers

ARC Northern Ireland around since 1999

BASW Northern Ireland The professional association for social work and social workers

Learning Disability Professional Senate

FINI

LDE Learning Disability England

Speech and Language UK

ARC England

Kids Disabled children say we can

NWGSDC

CEREBRA Working wonders for children with brain conditions

Restraint Reduction Network

bild

SASW The professional association for social work and social workers

Disability Action

STOLEN LIVES

National Autistic Society

PABSS Positive & Active Behaviour Support Scotland

Llais Canolfaeithol Pobl ag Anabledduau Dysgu yng Nghymru Pobl yn Gyntaf Cymru Gyfan All Wales People First The National Voice of People with Learning Disabilities in Wales

mencap The voice of learning disability

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enable

Disabled Children's Partnership

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1. Summary

The aim of this statement is to share the evidence of harm caused by the misuse of restrictive practices across education, health and social care with a focus on children and young people with a learning disability.

Individuals with learning disabilities and/or autistic individuals, particularly children, are at an increased risk of being subjected to restrictive practice.

The rate of reported restrictive interventions in inpatient settings in 2021 was nearly 5 per adult, and 20 per child.[1] Protections and safeguards for children, particularly in education settings, are less than those for adults. This statement will focus on the use of restrictive practice and associated harm to children's physical and mental health.

Whilst guidance in each of the four nations within the UK differs, the use of restrictive practices and the clear evidence of harm caused is apparent in all.

Our call to action is for governments across the UK to recognise that the misuse of restrictive practices is a child protection issue and to implement rigorous safeguards to protect children from harm caused by the inappropriate use of restrictive practices.

The following specific action is required in relation to the use of seclusion and mechanical restraint:

- **Prohibit the use of seclusion.** Seclusion is outdated, inhumane and unsafe. There are effective ways to support children who display behaviours that challenge that do not rely on seclusion. The inappropriate use of seclusion can be an unlawful deprivation of liberty. A national programme is needed to oversee the safe elimination of seclusion in each UK nation.
- **Prohibit the use of mechanical restraints in education and care settings.** The use of specialist seating or other mechanical restraints with the aim to 'support' a child to remain stationary to engage in focused learning is inappropriate and infringes on their human rights.

Children with learning disabilities can be taught to sit down on a chair with time, patience and consistency. Mechanical restraint is not the least restrictive approach to achieving the aim of supporting a child to remain stationary to engage in focused learning. Mechanical restraints, such as car harnesses, may be required to ensure safe travel but should only be used if they are the least restrictive option and their use should be regularly reviewed to assess if they are still required.

For our complete list of recommendations, please see page 15

2. Introduction

The 'Restraint in Schools inquiry' by the Equality and Human Rights Commission (EHRC), 2021, defines restraint as *"an act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently"*.[2]

The EHRC 'Human rights framework for restraint' sets out good practice for using restraint, and the procedural safeguards that must be in place.[3] This framework reflects the requirements of Article 3, 8 and 14 of the European Convention on Human Rights, as incorporated into domestic law by the Human Rights Act 1998. This framework should therefore underpin any national legislation and guidance on restraint as part of Governments' legal duty to protect human rights.

The framework states that:

- Physical force to restrain may only be used as a last resort.[4]
- A child's best interests must be a primary consideration and given due weight in the decision to restrain.[5]
- Techniques intended to inflict pain as a means of control must not be used.[6]
- All persons using restraint must be adequately trained.[7]
- A person must be consulted and involved in a decision to restrain them, or to continue restraint for a prolonged period (where urgency permits).[8]
- Use of restraint should be recorded in proportionate detail, and any anticipated use of restraint must be planned and regularly reviewed.[9]
- Data should be collected and analysed by public bodies to identify if restraint is being used disproportionately.[10]

The framework states that it is never lawful to use:

- Restraint with intent to torture, humiliate, distress or degrade someone
- A method of restraining someone that is inherently inhuman or degrading, or which amounts to torture
- Physical force as a means of punishment, or
- Restraint that unnecessarily humiliates or otherwise subjects a person to serious ill-treatment or conditions that are inhuman or degrading.[11]

Specifically, the framework states that "Restraint is more likely to amount to inhuman and degrading treatment when it is used on groups who are at particular risk of harm or abuse, such as [….] ***children and disabled people***".[12]

Despite this, and despite varying government guidance in each nation (see Appendix A), reports of the use of harmful restrictive practice still persist across a range of health, education and social care services, including inpatient mental health, special needs schools for children with learning disabilities, pupil referral units, mainstream and residential schools and care homes.

There have been a multitude of high-profile media cases which have brought the issue of the misuse of restrictive practices in schools to the fore. These include Baston House School in 2019, Knockavoe school in 2019, the Hesley group in 2022, Five Acre Wood School in 2022, Derrymount school in 2023, Whitefield School in 2024, the Braybrook Centre in 2024, Life Wirral School in 2024 and Bridge school, in 2018 and 2024. A range of inappropriate restrictive practices were reported, including the use of physical restraints, such as holding young people face-down or against the floor, mechanical restraints, such as straps on special chairs adapted without an assessment of needs, and the use of spit hoods. Seclusion and isolation rooms were used for extended periods and for punishment rather than safety. Chemical restraint occurred through the use of unnecessary or excessive medication, and psychological control including threats, verbal humiliation and restricting access to basic human needs such as food, communication or family contact.

Studies suggest that children with learning disabilities from black, Asian and minority ethnic (BAME) communities may experience an excessive use of disciplinary procedures and practices of surveillance that result in negative consequences or seclusion.[13]

They can face enhanced difficulties navigating a complex education system that often overlooks the intersectionality of disability and race. The EHRC 'Restraint in schools inquiry' found that the least likely protected characteristic to be recorded was race, and evidence from other sectors with mandatory recording systems has highlighted disproportionate use of restraint on people from ethnic minorities.[14] Any practices going forward must therefore aim to be intersectional and inclusive of all experiences.

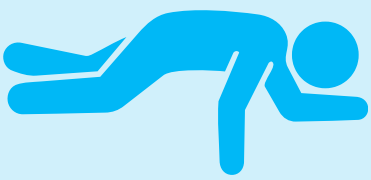
3. Harm caused by restrictive practices

A growing body of evidence has highlighted that restrictive practices are linked to distress, trauma and physical injury, causing significant and lasting harm. A co-produced study by the CBF and PABSS found that 86.5% of respondents reported physical injury to their child during restrictive intervention.[15] The misuse of restrictive interventions is associated with risks of extreme trauma and psychological damage and potential significant injuries or fatality.[16] They are therefore intrinsically unsafe.[17]

There is an urgent need to recognise that the misuse of restrictive practices is a child protection issue as it can cause significant physical and psychological harm. Government and services across the UK must take steps to implement procedural safeguards identified by the Equality and Human Rights Commission to protect children and young people with learning disability from harm caused by the inappropriate use of restrictive practices.

If restrictive practices are necessary due to the risk posed to a child or others, services should always seek to eliminate their use through the use of Positive Behaviour Support and restraint reduction plans which identify the causes of behaviours that challenge and implement proactive strategies, reasonable adjustments and reactive strategies which do not use force.

Physical restraint



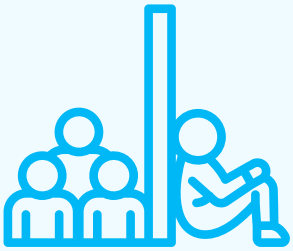
Physical restraint, particularly when holding children in positions which compromises respiration can be traumatic and risks fatal consequences. The positive and Safe programme, Department of Health and Social Care, states that *"face down, or prone, restraint can result in dangerous compression of the chest and airways and put the person being restrained at risk"*.[18]

The Department for Education and the Department of Health 'Reducing the Need for Restraint and Restrictive Intervention', 2019, strongly discourages prone restraint in all settings.[19] The Mental Health Units (Use of Force) Act 2018, statutory guidance for NHS organisations in England, states that there must be "no planned or intentional restraint of a person in a prone position on any surface, not just the floor".[20]

Whilst it is positive that guidance reflects the harm of prone restraint, there is still concern that there is little urgency to ensure that this guidance results in the elimination of the practice, and that other types of physical restraint that are equally dangerous are not recognised. A decade after the Positive and Safe programme, NHS figures show that prone restraint was used 5,427 times in 2023, and 3,732 times in the first 10 months of 2024 in mental health settings.[21]

Deaths and serious injury can occur from a variety of holds, including when children are held face-up (supine), whether the children are on floor or in bed, when children are held in seated positions, especially when in hyperflexion (bent forwards from the waist down), in kneeling positions and in standing positions. It should never be assumed that alternative restrictive holds instead of prone restraint are necessarily safe.[22] Any use of physical interventions must be tailored to meeting the immediate safety needs of an individual child and those around them, informed by a risk assessment of the physical and psychological needs of that child and carried out only by trained staff, regularly supervised and updated on the approved procedures which must be specified in writing in the child's support plan, which should be available for inspection.[23]

Seclusion



Seclusion is defined as supervised containment or isolation away from others in a room or area the child is prevented from leaving or feels like they can't leave.[24]

At present, seclusion is permitted in mental health inpatient services, complying with relevant legislation and guidance. In education settings, seclusion can occur without any monitoring from a trained child and adolescent clinician or specialist learning disability practitioner leading to long term psychological harm. However, even where the practice is not officially permitted, or recorded as such, it may still be being used.

A body of evidence has emerged highlighting that seclusion causes harm to children and young people. Seclusion can negatively affect mental health and cause consequences such as feelings of punishment and distress, development of PTSD symptoms and increasing the length of institutional admission.[25] Responding to people's expression of communication with aggression or threats of seclusion can undermine a sense of human belonging and agency for both the young people and the staff and will do more to damage the therapeutic relationship than approaching with openness and understanding.[26] Research shows experience of seclusion regularly leads to feelings of fear, anger and helplessness.[27] Staff actions are interpreted as neglectful and abusive.[28] A study in Ireland concluded that psychologists unanimously expressed the view that there was no therapeutic value to seclusion and was instead associated with a range of adverse outcomes.[29]

The 'Out of Sight – Who Cares?' report by the Care Quality Commission (CQC) found that, in hospital settings, providers understanding of what seclusion constituted was varied, and many children, young people and adults subject to seclusion did not have access to therapeutic and meaningful activities. What was described in care plans as 'therapeutic activities' were, in practice, found to be merely observations of the patient.[30] In community services, not all services recognised or recorded that they were using seclusion. Personal stories in the inquiry suggest that, in many cases, seclusion was used as an alternative to taking the time to deliver person-centred care. Long-term effects noticed included deterioration of physical health, decreased mobility, loss of social skills and psychological wellbeing.[31]

The Mental Health Act code of practice for England states: *"Seclusion can be a traumatic experience for any individual but can have particularly adverse implications for the emotional development of a child or young person. This should be taken into consideration in any decision to seclude a child or young person. Careful assessment of the potential effects of any seclusion by a trained child and adolescent clinician is required, especially for those children and adolescents with histories of trauma and abuse, where other strategies to de-escalate behaviours may be more appropriate than the use of seclusion".*[32]

An Oversight panel led by Baroness Hollins, which focused on people with learning disabilities and/or autistic people who are detained in mental health and specialist learning disability hospitals recommended in 2023 that the use of seclusion with children and young people under the age of 18 should be ended with immediate effect. She also recommended that seclusion was renamed solitary confinement.

When seclusion is used in an emergency to prevent a reasonably anticipated serious outcome then much like any other form of restrictive practice, it should only be used if it is the least restrictive intervention available. The UN General Assembly resolution 46/119 states that *"Physical restraint or involuntary seclusion of a patient shall [...] be employed [...] only when it is the only means available to prevent immediate or imminent harm to the patient or others".*[33]

Furthermore, any permitted incident of seclusion must only take place where a functional assessment, a child-centred support plan and appropriate staff training and supervision are in place. A comprehensive record of every incident, including supervision records and post-incident reviews must be made. Seclusion should only ever be used as a temporary intervention in emergencies to manage severe risks which cannot otherwise be managed with an adequate degree of safety and should never extend longer than absolutely necessary.

In literature and across services, there are a wide range of euphemisms used to describe the practice of seclusion, including 'calming rooms', 'safe spaces' and 'quiet rooms'. This creates confusion surrounding the practice and muddies the water between when a child chooses to take themselves to a welcoming space to regulate themselves and when a child is required by staff to enter a room, often by force, and denied the opportunity to leave thereby depriving them of their liberty.

De-escalation rooms can be a positive experience when they are child-centred with suitable furnishing and equipment, and a child or young person is free to choose to remain or leave the space. Teaching children ways to self-soothe and self-regulate is a positive therapeutic intervention and should be encouraged. Children will likely need staff support and encouragement to use these spaces.

However, there is a clear distinction between the positive encouragement of, and the use of, de-escalation rooms, and forcing a child to remain in a space which they cannot freely leave.

Ofsted states that restrictions that amount to seclusion can also include the use of high bed sides or high door handles which prevent a child from leaving without staff support.[34] Another common example is the use of "safe spaces" which are locked from the outside and therefore constitute seclusion as the child is confined to an area and free exit is prevented.

We recognise that there may be exceptional circumstances in which some methods of seclusion may be required to prevent serious harm. These 'exceptional circumstances' should only include rare instances such as an imminent threat to life; for example, a child or young person in possession of a knife or gun who is threatening others whilst school staff await the support of the police. These instances of 'exceptional circumstances' should be clearly defined in legislation and guidance to prevent other unnecessary instances of harmful seclusion being described as such.

Mechanical restraint

In the CQC review of restrictive practices, 'Out of Sight', in community settings, staff reported that mechanical restraint was mainly used to help people travel safely. However, they found many examples where mechanical restraint, such as farm splints or harnesses, were not being monitored by the service, commissioners or professionals from the community teams.[35]

In Northern Ireland, the Western Health and Social Care Trust was found to have not appropriately overseen the use of specialist chairs on an autistic child and did so without a proper assessment of the child's needs, resulting in these being used as a means of restraint.[36]

Originally used for feeding, the parent found that her child was regularly belted and strapped into the chair and that a wheeled base was fitted rather than allowing the child to walk.

At Five Acre Wood special school, it was found that staff were routinely strapping 2 autistic siblings into chairs despite their parents' objections,

and the school telling them it was a 'one-off'.[37] During an investigation, the school admitted that the use of straps amounted to mechanical restraint and should have been agreed with the parents and put into a care plan, and that less restrictive options were not considered.

The use of mechanical restraints, such as specialist seating with straps, to restrain ambulant children with learning disabilities is inappropriate and infringes their human rights. Its use carries substantial risks that can undermine patient wellbeing, such as the risk of a range of physical injuries as well as distress, trauma and anxiety.[38]

A study found that the use of mechanical restraint was associated with an increased risk of somatic harmful outcomes (physical negative health outcomes).[39] The study references increased relative risk within 30 days of conditions such as blood clots, pneumonia and physical injuries.[40] NICE guidance on 'managing violence and aggression in children and young people' states mechanical restraint should not be used on children.[41]
Mechanical restraint can amount to a deprivation of liberty in a similar way to seclusion. The following 'acid test' sets out the following criteria for determining whether a person is deprived of their liberty:

1. The individual is under continuous supervision or control.
2. They are not free to leave.[42]

If these criteria are met, then authority must be sought which complies with Article 5(1) of the European Convention on Human Rights (ECHR).[43] Without the proper authority, any restriction amounting to a deprivation of liberty would be considered a breach of Article 5 and would be considered unlawful.

All instances of mechanical restraint should be reported and recorded. The EHRC 'Restraint in schools' inquiry found that 11% of schools using mechanical restraint did not record these incidents.[44]

Mechanical restraint e.g. safety harnesses may be required to enable children and young people to travel safely. They should only be used if they are the least restrictive option and, when approved by clinical professionals for the health and safety of the child. They should only be used when the child is travelling, and their use should be regularly reviewed.

Over-medication

People with a learning disability are thought to be 16 times more likely to be prescribed an antipsychotic than the general population.[45] NHS England, 2018, estimated that 35,000 adults with a learning disability, autism or both are being prescribed an antipsychotic, antidepressant or both without appropriate clinical justification.[46]

A CQC report found that medicines were used as chemical restraint in all inpatient services except one that they visited. They found that staff did not always have appropriate guidance, including lacking detail on when a medicine was needed and the correct dosage, and the outcome and effectiveness of medicines was not always recorded. One person describes their experience of being "forcibly drugged" which "took over every aspect of [her] very being."[47]

The then Co-Director of the learning disabilities team in Public Health England stated that "psychiatric drugs are often given to people with learning disabilities to try and manage challenging behaviour. These drugs have important side effects, but the evidence that they are effective is limited."[48]

Research suggests that those with learning disabilities are particularly at high risk of side effects, suggesting that they are more sensitive to psychotropic medication than those without a learning disability. These side effects can then have a significant negative impact on quality of life. Side effects can include sedation, weight gain and increased diabetic risk, among others.[49] NHS England state that "long-term use can lead to significant weight gain, organ failure and, in some cases, death."[50]

4. Alternative approaches to behaviours that challenge: Positive Behavioural Support, Trauma Informed and Attachment Based Practice

Central to the diagnosis of a learning disability is significant developmental delay. This typically includes delays in cognitive development, communication and emotional and behavioural regulation.[51] Children with a learning disability are more likely to be dependent for longer on the presence of key adults to co-regulate their emotions and behaviours and, in the absence of these connections and relationships, may readily become and stay dysregulated.[52]

Without substantial person-centred adaptions, it is likely that those with a learning disability may at points find sensory environments and expectations overwhelming, and this distress can place themselves or others at risk.[53] The starting point for support planning must always be "are we meeting the basic needs of the child concerned?".[54]

Trauma-informed practice, attachment-based practice and Positive Behavioural Support (PBS) are informed by the idea that all behaviour communicates an unmet need that adult caregivers must identify in order to support the individual effectively.[55] They focus on understanding the basic, underlying need that is being communicated through the use of behaviour which may be perceived as challenging, and to consider the range of environmental and contextual factors that can influence behaviour. Rather than seeking to control, prevent or punish these behaviours, these alternative approaches seek to understand and focus on prevention through connections, relationships, developing co- and self- regulation, skill-building and environmental modifications rather than restrictive practices.

Positive Behavioural Support

Positive Behavioural Support (PBS) is an evidence-based, multicomponent framework which combines functional assessment, person-centred planning, teaching new skills and environmental change to reduce behaviours that challenge.[56]

It is a widely recommended approach to support children and young people with learning disabilities who display behaviours that severely challenge, including NICE guidance. A central component of PBS is to "understand that behaviour that challenges often indicates an unmet need".[57] By taking an attachment based, person-centred, collaborative and trauma-informed approach when complemented by PBS, this allows effective support to be put in place and quality of life enhanced.[58]

Research evidence suggests that PBS in special education settings can result in significant reductions in behaviours that challenge.[35] Studies have shown that PBS significantly improves behaviour, quality of life and occupational outcomes for individuals with a learning disability.[59] It has also been shown to have a positive effect on individual personal development and self-determination.[60] Growing evidence shows that attachment-aware and trauma-informed approaches in schools increase engagement, reduce the use of sanctions and have stronger associated learning outcomes.[61] It has been reported to have a positive impact on both children and staff wellbeing.[62]

Attachment-based and Trauma-informed approaches

Children with learning disabilities are at increased risk of exposure to events such as restraint and seclusion associated with trauma and more likely to develop traumatic reactions. They are also less likely to have their trauma recognised.

Trauma-informed approaches are based on the view that behaviours which can be seen as challenging may be shaped or influenced by past or ongoing trauma and so seek to recognise the prevalence and understand the ongoing effect of trauma on cognitions, emotion, behaviour and relationships.[63] By recognising trauma-related signs and adapting responses, the aim is to avoid re-traumatisation and prioritise physical and relational safety and support de-escalation.[64]

Trauma-informed approaches seek to increase practitioners' awareness of the negative impacts trauma can have on individuals and their ability to feel safe or develop trusting relationships.[65]

Practically, organisations should prioritise the physical, psychological and emotional safety of service users and staff, embedding a culture of transparency on decisions about an individual's care and supporting service users to share in personal decision making, choice and goal setting.[66]

Attachment-based approaches aim to move away from more traditional 'punishment-reward' systems of behaviour management approaches towards a more relational and inclusive approach.[67] These approaches view behaviour as a communication of an emotional need, and that this should be responded to accordingly.

NICE guidelines specifically recommends that services should aim to promote person-centred care and support, maximise people's choice and control and help people to have a good quality of life.[68] It is recommended that staff who work in services in which restrictive interventions may be used should be trained in psychosocial methods to avoid and minimise the use of restrictive interventions.[69]

5. Our Policy Recommendations

The best interests of the child must be the primary consideration when responding to behaviours that challenge. A shift is required to recognise the harm caused to children and young people through the inappropriate use of restrictive practices and ensure that the least restrictive approach is always followed. This will require increased support for families, paid carers and staff.

Aside from the harm caused, research has shown that use of physical interventions can actually escalate behaviours that challenge and undermine therapeutic relationships.[70] Cumulative stressors in the workplace caused by overwork, stress or poor training has been regarded by patients as a major contributory factor to continued challenging behaviour.[71] Similarly, various reports by staff suggest that, in part, restrictive interventions are increasingly used out of a response to various systemic issues, such as a lack of adequate training, staffing levels, work pressure and poor staff wellbeing, and a missing systematic policy to involve parents and carers in care decisions. Statutory guidance for NHS organisations in England recognises this harm, stating that "the use of force can have serious and sometimes fatal consequences."[72]

Despite small changes in guidance, CQC's 'Restraint, segregation and seclusion review: Progress report (March 2022)' found that the recommendation 'people see a reduction in the use of restrictive interventions' was not achieved.[73]

To successfully move away from the over-reliance and misuse of restrictive practices on children and young people with learning disabilities the following action is required by government and services:

- Substantial targeted investment in early intervention and prevention to support parents and professionals to enable children with learning disabilities to thrive.[74]
- National training standards for children and young people's services across the four nations of the UK to ensure consistent support across service providers, and to ensure that staff have the knowledge and skills and regular access to reflective practice supervision needed to positively support children with learning disabilities who display behaviours that challenge. Staff should be trained in alternative methods, to minimise the use of restraint and in how to safely use restrictive practices as needed in exceptional circumstances.
- Recording and reporting procedures to be established in services for children and young people across the four nations of the UK to 'enable the lawfulness of the restraint to be assessed' and enable safeguarding of children and young people
- Implement funded programs to end the misuse of seclusion/solitary confinement of children and young people with learning disabilities. This practice is outdated, inhumane and unsafe. There are effective ways to support children who display behaviours that challenge that do not rely on seclusion. The inappropriate use of seclusion can be an unlawful deprivation of liberty.
- End the use of specialist seating with straps to restrain ambulant children with learning disabilities in schools and nurseries. This is inappropriate and infringes on children and young people's human rights. Mechanical restraint is not the least restrictive approach to achieving the aim of supporting a child to remain stationary to engage in focused learning.
- Repeal legislation which gives staff the power to use force to "maintain good order and discipline" in schools. It is inappropriate to use force to maintain good order and discipline. There are less restrictive ways of achieving this aim which do not harm children and young people. Restrictive practices should only be used as a last resort for the protection of children and young people or others.

- Stronger safeguarding for children and young people including:
  - National child protection guidance in all four UK nations to recognise organisational abuse and closed /corrupted cultures. Organisational abuse includes neglect and poor professional practice as a result of the structure, policies, processes and practices in an organisation. CQC defines a closed culture as "a poor culture that can lead to harm, including human rights breaches such as abuse".
  - Data from schools on the use of restraint and restrictive practices shared with local safeguarding partnerships to provide local oversight from an external agency from a safeguarding perspective.
  - Inspectorates across the UK to monitor national and service-level restraint data as part of inspections in all settings.
  - Training for social workers in restrictive practices to enable better identification of the harmful use of restrictive practices and enable suitable safeguarding responses informed by evidence-based practice.
  - Provide training for the police to enable them to better identify cases involving the misuse of restrictive interventions, including restraint and seclusion.

6. Conclusion

Children with disabilities are at significantly higher risk than their peers of being injured due to the use of restraint and seclusion and the risks associated.[75]

The Council for Children with Behaviour Disorders have argued that *"Repeated use of physical restraints for any one student or across different students should be viewed as the failure of educational programming and the likelihood that […] interventions for the students are inadequate and should be modified"*.[76]

Restrictive practices clearly carry substantial risks of harm and often indicate systemic failures within care and education settings. As illustrated, the use of restrictive interventions not only perpetuates physical harm, but can also lead to psychological harm, breakdowns in therapeutic interventions and mistrust, not only between the young people and staff but also between family and carers. These injuries undermine human rights principles by restricting autonomy and dignity.

Reducing restraint is not only a matter of safeguarding physical safety but

also a commitment to upholding human rights and promoting positive, person-centred approaches that foster well-being, inclusion, and respect.
There is evidence to suggest that a Positive Behavioural Support approach not only leads to a significant decrease in the use of restrictive practice, but also improves quality of life, communication and relationships for individuals with learning disabilities and autism. It is vital that Government's undertake statutory legislation and work with families, people with learning disabilities and charities to produce effective, person-centred policy.

7. Appendix A– national policy context

Scotland

Parents and campaigners led by Kate Sanger and Beth Morrison have been campaigning for "Callum's law" to introduce legal duties to record and report restraint and statutory guidance for the use of restrictive practices. The Children (Scotland) Act 1995 establishes the welfare of the child as paramount, however, there is currently no single statutory document which directly regulates restraint or seclusion in schools.

Most current guidance is non-statutory and encourages the reduction of use of restrictive practices, but without legal standing to require compliance. The Scottish Commission for Learning Disability (SCLD) developed a national Positive Behavioural Support Community of Practice following the publication of the Scottish Government's 'Coming Home' report in 2018.[77] This advocates a person-centred, evidence-based and whole-system approach and offers less restrictive alternatives to physical restraint and psychotropic medication. 'Rights, Risks and Limits to Freedom' 2013 also provides non-statutory guidance for professionals on how to minimise the use of restrictive practices in care settings.[78]

Similarly, the Scottish consultation 'Included, Engaged and Involved: Part 3' 2022, now under development after reviewing responses, has showed a need for more accountability and oversight of restrictive practices and the need for national guidance.[79]

The Education (Additional Support for Learning) (Scotland) Act 2004, which is statutory, mandates involvement of the parent/carer and child in their support planning and creates an obligation to prevent escalation through appropriate support, however it does not explicitly reference restrictive practice.[80]

Daniel Johnson MSP's Restraint and Seclusion in Schools (Scotland) Bill has been debated in Scottish Parliament.[81] If enacted this would require Scottish Ministers to issue statutory guidance on the use of restraint and seclusion in schools, including statutory standards for training, monitoring and oversight and a requirement to record and report instances of use of restrictive practice.

Wales

Various Welsh guidance aims to raise awareness of restrictive practices, including 'Positive approaches: Reducing restrictive practices in social care', 2021.[82] This provides practical examples of positive and proactive approaches and ways of working that support safe practice and can reduce the need for restrictive practices. The 'Reducing restrictive practices framework', 2022, outlines that restrictive interventions should only be used as a last resort.[83] However, these documents are non-statutory and therefore there are no statutory duties to comply.

Statutory guidance can currently be found in the Social Services and Well-Being (Wales) Act 2014 which emphasises the importance that restrictive practices are minimised, proportionate and used only as a last resort.[84] Similarly, statutory guidance 'Keeping Learners Safe' references the non-statutory 'Reducing restrictive practices framework' but does not otherwise provide a robust statutory foundation or detailed requirements for the safe use, monitoring and oversight of restrictive practice.[85]

Northern Ireland

Parents and campaigners led by Deidre Shakespeare have been campaigning for 'Harry's Law' for a number of years, which would mandate reporting of incidents of isolation or restraint.

The Department for Education launched a public consultation in 2023 on the draft 'Statutory guidance on the reduction and management of restrictive practices in Educational Settings'.[86] This aims to clarify 'restrictive and supportive practices' and reduce and minimise the use of restrictive practices. The draft guidance establishes that restrictive practices should only be used when it is necessary and proportionate to do so, to prevent harm.

A Task and Finish group was established in 2025. In March 2025, the Royal College of Nursing resigned from the taskforce expressing serious concerns over the current direction of the Department for Education's approach.[87] Since then, a number of other organisations have also pulled out.[88]

Key statutory legislation in Northern Ireland is the Education (Northern Ireland) Order 1998.[89] NI Government have also previously committed to repealing Article 4. 1 (c) of the Education (Northern Ireland) Order 1998. In this article, *"A member of staff […] may use […] such force as is reasonable"*

to prevent a pupil *"engaging in any behaviour prejudicial to the maintenance of good order and discipline."* The Minister, Paul Givan, has recently stated that he wants to further consider the position around this repeal.

England

Parents and campaigners, including Elly Chapple, founder of Can Do Ella, have been campaigning for a human rights approach to restrictive interventions in England, including a ban on seclusion and the development of mandatory training standards.

The statutory Education and Inspections Act 2006, Section 93, gives staff power to use 'reasonable force' to use force and maintain good order and discipline.[90]

Non-statutory guidance 'Positive Guidance where Children can Flourish' states that schools can adopt policies to place disruptive pupils in isolation rooms, although it emphasises this must be lawful, reasonable and proportionate whilst considering the best interests of the child.

The Department for Education's revised guidance 'Restrictive interventions, including use of reasonable force, in schools: Guidance for schools in England', replacing the 2013 version, is due to come into force April 2026.[91] This will introduce a statutory duty to record and report all incidents of uses of force, including seclusion. It applies to all schools in England. It also states that all staff who are likely to need to use restrictive interventions should be adequately trained in its safe and lawful use, and in preventative strategies, although no statutory minimum training standards have been developed to go alongside this.

The Department for Education and Department of Health "Reducing the need for restraint and restrictive interventions" 2019 guidance is non-statutory guidance which applies to all children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties in health and social care services and special education settings.[92]

8. Appendix B– Signatories

The following organisations support 'A Statement on the Use of Restrictive Interventions: Children and Young People with a Learning Disability in England, Northern Ireland, Scotland and Wales':

Kate Young, Director - **All Wales Forum**

Joe Powell Chief, Executive Officer - **All Wales People First**

Samantha Leanord, England Director - **Association for Real Change**

Leslie-Anne Newton, Director - **Association for Real Change NI**

Andrew Reece, Strategic Lead for Wales & England - **BASW England**

Jane Shears, National Director for - **BASW NI**

Ben Higgins, CEO - **Bild**

Jess Camburn-Rahmani, CEO - **Cerebra**

Catherine Thornton, Chief Officer - **Conwy Connect for Learning Disabilities (CC4LD)**

Nuala Toman, Head of Accessibility - **Disability Action**

Stephen Kingdom, DCP Campaigns Manager - **Disabled Children's Partnership**

Theresa Shearer FRSE, CEO - **Enable**

Caroline M Kelly, Network Coordinator - **Families Involved NI (FINI)**

Adrian Roper, Cadeirydd/Chairperson - **Good Life Alliance**

Katie Ghose, CEO - **Kids**

Elaine Davis, CEO - **Kindred**

Viki Baker and Ashok Roy, Co-Chairs - **Learning Disability Professional Senate**

Sam Williams, Policy and Communications Manager - **Learning Disability Wales**

Dan Scorer Head of Policy, Public Affairs, Advice & Casework - **Mencap**

Wayne Crocker, Director - **Mencap Cymru**

Karen Gilgunn, Head of External Affairs - **Mencap NI**

Mel Merritt, Assistant Director of Policy, Research and Strategy - **National Autistic Society**

Appendix B– Signatories

The following organisations support 'A Statement on the Use of Restrictive Interventions: Children and Young People with a Learning Disability in England, Northern Ireland, Scotland and Wales':

Sarah Goff and Sarah Martin-Denham, Co-Chairs - **National Working Group on Safeguarding Disabled Children**

Jack Marshall BEM, Kate Chate and Tim Kielty, Elected Member Representative Body Co-Chairs - **Learning Disability England**

Beth Morrison, Founder - **PABSS**

Sarah Leitch, Director of Development - **Restraint Reduction Network (RRN)**

Jane Shears, National Director - **SASW**

Jane Harris, Chief Executive - **Speech and Language UK**

Dawn Cavanagh - **Stolen Lives**

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