



Welsh Government
Consultation Document

Reducing Restrictive Practices Framework

A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings.

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

Reducing Restrictive Practices Framework

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This framework is applicable across childcare, education, health and social care sectors, therefore some generic terms are used throughout the policy.

Organisations: When we refer to **organisations** this includes schools, social care providers and health care providers, foster care agencies and registered childcare settings.

Person centred: When we use the term **person centred** this also means child centred for children.

Person or people: When we use the terms **person** or **people** this includes all children (up to the age of 18 years) and adults (age of 18 years or over).

Restrictive practices:

'Restrictive practices are a wide range of activities that stop individuals from doing things that they want to do or encourages them to do things that they don't want to do. They can be very obvious or very subtle.' (Care Council for Wales, 2016)

This term covers a wider range of activities that restrict people, including restraint.

Restraint:

'An act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently' (Welsh Government, 2016a)

It includes:

- physical restraint
- chemical restraint
- environmental restraint
- mechanical restraint
- seclusion or enforced isolation
- long term segregation
- coercion

Personal Plan: In this framework the term 'personal plan' includes a care and support plan, care and treatment plan, plan for a child in a childcare setting and/or individual education plan.¹

Practitioners: When we refer to practitioners we mean all people who are paid to work with people in childcare, education, social care and health settings, including agency or sessional workers. For the purposes of this framework the term practitioners also includes foster carers, adult placement carers and registered child minders but **not** unpaid carers.

¹Individual education plans can be provided as part of current arrangements under the [Special Educational Needs Code of Practice for Wales](#). These arrangements will be replaced as part of the [phased implementation of individual development plans](#) under the Additional Learning Needs and Education Tribunal (Wales) Act 2018. This Framework is intended to inform practice in relation to individual education plans where they exist under current arrangements and individual development plans under new arrangements as they are implemented.

Introduction

1. This framework is intended to promote measures and practice that will lead to the reduction of restrictive practices. The framework also seeks to ensure that where restrictive practices are used this is informed by person centred planning, within the context of the service setting and in a way which safeguards the individual, those whom they interact with, and those who provide services to them.

2. In order to achieve the aims of this framework, organisations should have a threefold focus:

- Preventing the necessity for restrictive practice through the development of reduction strategies and through the promotion of a human rights approach, for example, positive behaviour support (PBS).
- Working with individuals towards reducing the level of response where a potential need for restrictive practice is identified as part of the person centred planning and practice process.
- Where situations requiring restrictive practice are identified as unavoidable, ensuring that there is prior planning and training to ensure safety for all concerned.

Purpose of framework

3. The Welsh Government considers that the guidance it issues on restrictive practices should ensure that those who work with children and adults in childcare, health, education and social care settings share a common framework of principles and expectations informed by an approach that actively promotes human rights.
4. The Welsh Government is clear that the use of restrictive practices and restraint should be within the context of the [European Convention on Human Rights](#) and in line with the principles described in the *Human Rights Framework on Restraint* produced by the [Equality and Human Rights Commission](#).
5. The approach set out in this framework seeks to promote the rights and principles set out in the [United Nations Convention on the Rights of the Child](#) (UNCRC); [United Nations Principles for Older Persons](#) and the [United Nations Convention on the Rights of Persons with Disabilities](#).
6. The framework is intended to inform commissioners of services and service providers, who should refer to the framework when drafting policies and procedures, reviewing current arrangements and arranging or commissioning training. The framework does **not** advise on individual actions required in specific circumstances or specific service settings, nor does it recommend specific methods of restraint.

7. This Framework is non-statutory however it sets out the Welsh Government's expectations for policy and practice in reducing restrictive practices across childcare, education, health and social care settings as part of a person centred approach. As such the Inspectorates: Estyn; Health Inspectorate Wales and Care Inspectorate Wales will consider compliance with the approach set out in the Framework when they carry out inspections.
8. This framework replaces the Framework for Restrictive Physical Intervention Policy and Practice, Welsh Assembly Government (2005).

Relevant Legislation and policy

- Additional Learning Needs and Education Tribunal (Wales) Act 2018 (as requirements come into force)
 - Equality Act 2010
 - Mental Capacity Act 2005
 - *Mental Health Act 1983: Code of Practice for Wales* (Welsh Government, 2016)
 - Mental Health Units (Use of Force) Act 2018
 - Social Services and Well-being (Wales) Act 2014
 - Part 4 Code of Practice (Meeting Needs), Social Services and Well-being (Wales) Act 2014
 - Special Needs Educational Needs Code of Practice for Wales 2004
 - Additional Learning Needs Code (as requirements come into force)
 - The Public Sector Equality Duty, Equality Act 2010 (EA 2010) s149
 - Working Together to Safeguard People Volume 1: Introduction and Overview (Welsh Government, 2016b)
 - Working Together to Safeguard People Volume 5: Handling Individual Cases to Protect Children at Risk (Welsh Government, 2018b)
 - Working Together to Safeguard People Volume 6: Handling Individual Cases to Protect Adults at Risk (Welsh Government, 2018c)
 - The Child Minding and Day Care (Wales) (as amended) Regulations 2010
 - Safe and Effective Intervention - Use of Reasonable Force and Searching for Weapons (Welsh Government Guidance, 2013)
 - The Learning Disability – Improving Lives Programme (Welsh Government, 2018a).
 - Together for Mental Health (Welsh Government, 2012)
 - National Minimum Standards for Regulated Childcare for children up to the age of 12 years (April 2016)
9. This is not an exhaustive list and settings should ensure they are up to date with the statutory requirements placed on them through legislation and guidance.
 10. Welsh Government legislation and policy seeks to promote a rights based approach to practice with children and adults. This means involving people in decisions about the support and services they receive and the outcomes they want to achieve. It also means planning to meet needs in a person centred way that promotes wellbeing and the opportunities for individuals to realise their rights.

11. One of the implications of this for practice is the need to plan with, and for, people so that measures are in place to prevent and reduce the use of restraint and other restrictive practices.

The human rights framework for the reduction of restrictive practices

12. Human rights are the basic rights and freedoms that belong to every person in the world. They are based on core principles such as dignity, fairness, equality, respect and autonomy. Human rights are relevant to day-to-day life. They protect the freedom of people to control their own life, to take part effectively in decisions made by public authorities which impact upon their rights, and to receive fair and equal services from public authorities.
13. The use of all restrictive practices including restraint should be in line with the principles described in the *Human Rights Framework for Restraint* produced by the [Equality and Human Rights Commission](#) (EHRC, 2019).
14. The EHRC Framework defines restraint as:

‘An act carried out with the purpose of restricting an individual’s movement, liberty and/or freedom to act independently.’ (EHRC, 2019)
15. The term restraint can apply to a number of different acts (for example, physical restraint, chemical restraint, mechanical restraint, seclusion, social restraint, psychological restraint, and long term segregation (see glossary for definitions)). Restraint does not necessarily require the use of force, it can also include acts of interference, for example moving someone’s walking frame out of reach.
16. Any act of restraint has a potential to interfere with a person’s fundamental human rights and everyone has an obligation to respect human rights. All acts of restraint must be **lawful, proportionate** and the **least restrictive option** available.
17. The best way to avoid restrictive practices including restraint is to work preventatively and meet needs before crisis arises. However, there may be rare occasions when it is unavoidable. Any anticipated use of restrictive practices must be planned and regularly reviewed (EHRC, 2019). Section 5 sets out how to use restrictive practices including restraint lawfully and the circumstances in which it can be used. **It is never lawful to use restraint to humiliate, degrade or punish people.**
18. Human rights are for everyone equally. It may be that in some circumstances some individuals are more ‘at risk’ of fundamental violation of their human rights because of their experience of trauma or discrimination. For people to enjoy their rights, these need to be accessible. This means that some individuals need to be treated differently to enjoy the same rights as others.
19. People who have past trauma, who experience communication barriers, or who have other differences, may find certain restrictive practices particularly distressing and may find some situations particularly challenging and harmful. These characteristics – sometimes understood as ‘vulnerabilities’ – should be taken into account when understanding how best to protect such individuals’ human rights.

20. Organisations should:

- have a clear policy in place for all workers that helps them to understand their duties under human rights and legal frameworks;
- set out in such a policy the organisational commitment to reducing the use of any restrictive practices;
- ensure that all workers are aware of the policy and understand its intended impact on their practice.

21. Restrictive practices and restraint should only be used within the appropriate legal frameworks, and each agency should ensure that they are aware of and operating within the parameters of legislation and guidance relevant to them, to the people they support and those for whom they provide services.

Positive behaviour support

22. Working towards the reduction of restrictive practices involves adopting alternative preventative approaches; one key approach is positive behaviour support (PBS). PBS has developed over the past 25 years and is an evidence based multi-component framework for supporting people who have behaviours that challenge, or who may be at risk of developing these. Its primary focus is to improve quality of life through an understanding of the reasons why an individual may use their behaviour to communicate and get their needs met; and then to use this understanding to build better support, to support positive outcomes, and to improve the services that individuals receive.
23. PBS is regarded as best practice. It has been defined and described in a variety of studies over the years, and can be summarised as having four main components (MacDonald et al, forthcoming):
- *PBS is focused on improving quality of life.* The most important goal of PBS is to improve the quality of life; this is a non-contingent and non-negotiable commitment, regardless of diagnosis, setting or behaviour. The aim is to make life better for the individual so they have less need to use behaviours that challenge.
 - *PBS is based on specific values.* PBS is person centred and only uses interventions which respect the dignity of the individual and support the reduction of restrictive practices. There is a commitment to the co-production of PBS guidelines, taking account of the perspectives of the people whose plans they are and those involved in their care and families. Punishment approaches are never used in PBS.
 - *PBS uses tools to understand what the individual's behaviour means.* This includes the use of assessment tools to find out the meaning for the individual and PBS guidelines to ensure people's needs are understood and met in safer ways. Families are often a rich source of information in providing an understanding about the communication needs and meaning of their child's behaviour. PBS supports the use of a data based approach to practice and this is helpful in terms of restrictive practice reduction.
 - *PBS is a system-wide approach.* PBS is most effective and successful when it is implemented across a whole service or organisation, rather than just for an individual. It is also multi-component and will often involve adapting the individual's whole environment to meet their needs better as well as making sure they are able to develop new skills and have more opportunities. Active support is an important part of PBS as it enables individuals to have more engagement and choice in their daily lives.

More information and links to resources about PBS, including competence frameworks, workforce development frameworks and training standards, can be found on the website of the [PBS Alliance](http://www.bild.org.uk/about-bild/aboutbild/pbsalliance/) (see <http://www.bild.org.uk/about-bild/aboutbild/pbsalliance/>).

24. Anyone at risk of restrictive practices because of behaviours that challenge should have a person centred assessment which will aim to find out the purpose of the behaviour.
25. Anyone at risk of restrictive practices should have PBS guidelines in place (or other equivalent person centred positive approach). This should contain a range of proactive strategies, designed to improve the individual's life so that they have access to the type of support that they need; and also reactive strategies, designed to deal with behaviours that challenge when they occur, including minimising risk.
26. PBS guidelines should have an emphasis on proactive strategies, rather than reactive strategies, and all strategies should be linked to an understanding of the message contained in the behaviour.
27. Proactive strategies should include environmental changes, to make the environment more suitable for the individual, and teaching new skills or behaviours, so that behaviours that challenge become less likely.
28. Reactive strategies should include person-specific alternatives to the use of restrictions, for example, distraction, de-escalation, active listening, strategic capitulation, withdrawal etc.
29. All workers supporting individuals who are at risk of having behaviour that challenges and being subjected to restrictive practices should be trained appropriately. This training should be comprehensive, competence based, designed to impart knowledge and enhance skills, and should contain an element of practice based coaching and learning. It should be at an appropriate level for the worker's role. Support from more experienced practitioners to apply the learning in practice should always be combined with any classroom-based training.
30. A practice leadership approach should be adopted to support the implementation of PBS, with an emphasis on directly supporting workers, by clarifying aims and expectations, coaching, mentoring, role-modelling and providing feedback to reinforce appropriate performance.
31. Implementation of PBS guidelines should be monitored and reviewed in order to ensure that they are being carried out as intended.
32. PBS guidelines should be regularly reviewed in order to ensure that they are still fit for purpose and address the individual's current circumstances and behaviour. These reviews should be on at least a six-monthly basis, but should be sooner if there are indications that an earlier review would be helpful (for example, increased incidents or behaviour that challenges, poor quality of life, poor implementation fidelity, high levels of staff turnover, concern from key stakeholders).
33. Foster carers and adult placement carers should also have access to appropriate training and support. It is beneficial for both groups if carers are involved in training alongside service providers.

Chapter 3

Principles for practice supporting the reduction of restrictive practices

34. Evidence from research and practice suggests a number of key areas for action within organisations wishing to reduce their use of restrictive practices (Colton, 2004, 2010; Huckshorn, 2005; Allen, 2011; NASMHPD, 2008). These essential components include:

- leadership; recording and data collection;
- workforce development; stakeholder involvement;
- post incident support and review; and specific restraint reduction strategies.

These key components are often found to be missing or corrupted in restrictive and abusive cultures.

35. Organisations should review their current progress in each area and use this to inform their organisational restrictive practice reduction strategies. There are a number of user friendly tools available that can help to support this exercise (see for example [Restraint Reduction Network, 2019](#)).

36. The cultural change from crisis management to prevention and reduction focused practice that improves wellbeing is about winning hearts as much as minds. It needs planning and constant attention. Of course, most practitioners wish to avoid crisis by working preventatively, but when services and practitioners are under stress the default culture can become more restrictive (Paterson, 2014). Restrictive practices can quickly become embedded and accepted as the way that things are generally done. As individuals' lives become more restricted they are more likely to provide challenges to services and a vicious circle is created. Organisations should reflect on culture and practice and should seek to embed preventative strategies and person centred practices in order to create virtuous circles that can withstand challenging times.

Leadership

37. The reduction of restrictive practices can only be properly implemented and maintained through a whole organisational approach. Messages about reduction should be clear throughout all organisational systems and policies, governance guidelines, and workforce development programmes. Leadership is described as a critical factor (Allen 2011; Colton 2004, 2010; [Huckshorn, 2005](#)) to support this. Leadership is needed at organisation, service and direct practice level.

38. The senior leaders of organisations should articulate their commitment and the actions in place to reduce restrictive practices. There should be an organisational restrictive practice reduction strategy that is regularly reviewed and the outcomes from the review should be shared. Successful reduction at any level in the organisation should be celebrated. Reduction goals should be explicit in mission statements and policies, which should include clear definitions of all restrictive practices.

39. Senior leaders should have knowledge of the range and extent of restrictive practices that are used within the organisation. There should be a system for collecting this

information across the whole setting and organisation. Senior leaders should be confident that all members of the workforce recognise the range of restrictive practices in use.

40. Service managers should ensure that there are regular audits and reviews of restrictions within their services.
41. There should be a named organisational lead for restrictive practice reduction who has oversight and governance of reducing restrictive practice. In addition there should be restrictive practice reduction champions or practice leaders within individual services whose role is to share and role model good practice. These roles should have clearly defined tasks, responsibilities and reporting lines.
42. Service managers should ensure that the monitoring and review of individual personal plans includes consideration of planned restrictive practices and reduction guidelines.
43. Organisations have a duty of care towards practitioners and should recognise that workplace stress can have an adverse impact on the quality of practice. Appropriate measures to support the wellbeing of the workforce should be in place.
44. Organisations must ensure that practitioners understand their safeguarding responsibilities and are familiar with the organisation's safeguarding policy and procedures. Safeguarding issues must be reported to social services or the police in line with requirements set out in the Wales Safeguarding Procedures and relevant guidance:
 - Working Together to Safeguard People Volume 1: Introduction and Overview (Welsh Government, 2016b);
 - Working Together to Safeguard People Volume 5: Handling Individual Cases to Protect Children at Risk (Welsh Government, 2018b)
 - Working Together to Safeguard People Volume 6: Handling Individual Cases to Protect Adults at Risk (Welsh Government, 2018c)
45. Where there is any indication that restrictive practices are being used inappropriately this should be reported as a safeguarding concern. Organisations should ensure that practitioners are made aware of the organisation's whistleblowing policy.
46. Organisations should ensure that individuals and their families receive information about their right to make a complaint and the relevant process for making a complaint. They should also receive clear information on how to report a safeguarding concern.

Recording and data collection

47. Good data collection practice is an essential element in any reduction plan and supports transparency. Monitoring current practice is dependent on robust but user-friendly recording systems that support good analysis. Data collected about restrictive practices can be used for identifying baselines, setting goals for reduction, monitoring equality issues, and flagging concerns and successes at organisational, service and individual levels. For more information on types of data that can be collected to support reduction see [Bowring \(2015\)](#) and [Royal College of Psychiatrists \(2018\)](#).

48. Recognising and recording restrictive practices should be part of ongoing workforce development activities. Regular competence checking should support this and extra training should be provided where a need is identified. Particular attention should be paid to the language that is used to describe individuals and incidents; it should be objective, accurate and respectful.
49. Data on the use of restrictive practices should be reviewed and analysed regularly to monitor trends. There should be clear organisational and service timetables for review of restrictive practices data, and these should include development of any remedial actions. An example of a minimum requirement for information that should be recorded when a restraint has been used is set out in Appendix 2. Organisations should collect this data for all services and should have this information publicly available. They should be able to show how they are using the data to inform reduction strategies.
50. Any data collected should have a clear purpose, i.e. to enhance an individual's quality of life, and not just be collected for the sake of it. Consent should be sought if personal information is recorded as part of data collection activities in line with GDPR requirements.
51. If families are asked to collect data to support a plan for the individual, a family-centred system should be developed together with them. There should be a clear process for any identification of extra support if needed after data is collected and analysed.
52. Any injuries sustained as a result of the use of restraints or other restrictive practices should be recorded and reported as a safeguarding issue inline with the safeguarding policy and procedures of the setting or organisation.

Workforce development

53. All practitioners and carers should have value based training and ongoing support in developing skills to work within a preventative framework. Examples of preventative frameworks include PBS (see section 3), recovery based approaches, restorative justice, Safewards, PACE etc., as relevant to different sectors and organisations.

The content of training should involve:

- understanding of the meaning of behaviours that are described as challenging;
- understanding of trauma;
- human rights and how they relate to the use of restrictive practices
- person centred practices;
- proactive interventions that improve wellbeing and prevent behaviours that challenge;
- examining attitudes and attributions to behaviours that are described as challenging.

The training content should refer to the organisation's whistleblowing policy so people understand how to respond if they believe someone's rights are being infringed.

54. Training outcomes are more easily embedded into practice if practice leaders work alongside and coach less experienced colleagues.
55. It is often the case that more resources are allocated to training workers to use physical restraint than training in preventative methods of working. Learning to physically restrain can be one of the first things new workers are trained in and assessed as competent to do. A cultural change is needed here, as training priorities send strong messages to practitioners about behaviours that are expected in the organisation. The organisational goals for reduction need to be explicit from the start of the induction process. Practitioners should feel confident and knowledgeable so they can identify and question unnecessary restrictive practices. It is more likely that they will feel confident to do this in an open supportive culture, where skilled practice leaders have a good influence on team values and practice.
56. Training content should include contributions from people with lived experience of having restraint or other restrictive practices used on them. It is important that practitioners who apply restraint have an understanding of the personal and often traumatic impact it can have.
57. There should be ongoing team and individual development activities which explore practitioners' understanding of restrictive practices and reduction strategies, and review the use of restrictive practices on a regular basis. Updates on the organisational reduction strategy and mission should be a regular part of team meetings.
58. Managers should be watchful for signs of restrictive cultures developing. They should facilitate regular discussion about restrictive practices and create a non-blaming environment where practice can be discussed and questioned.
59. All practitioners (including bank and agency workers) who will be expected to use restraint should have accredited competence-based training. Practitioners should receive training in prevention approaches and de-escalation before they receive training in the use of restraint. Practitioners should not receive blanket training in the use of restraint – any training should be based on a training needs analysis and individual person centred support needs. The need for training in any restraint should be regularly reviewed with the training provider.
60. The training should also cover the trauma that can be experienced both by people who are restrained and those who carry out the restraint. Any training should also include perspectives from people who have lived experience of being restrained.

Person centred practice, action and involvement

61. Organisations should promote person centred practices and individual rights. Institutionalised cultures where blanket rules are applied are likely to support unnecessary use of restrictive practices and punishment approaches. The values of the organisation should promote the recognition of individual needs and acknowledge the power imbalance between those who need support and those who provide it. Person-centred planning means involving the individual who a Plan relates to in a

meaningful way in discussions and decisions about what should be included in the Plan.

62. Person centred care refers to a process that is people focused, promotes independence and autonomy, provides choice and control and is based on a collaborative team philosophy. It takes into account people's needs and views and builds relationships with family members. The delivery of person centred care requires both safe and effective care and should result in a good experience for people. Individuals and their families must be able to participate fully in the process of determining and meeting their identified care and support needs through a process that is accessible to them. What is important to a person includes the things that really matter to them, that give pleasure and meaning, and provides quality of life.
63. Everyone involved in the individual's life should be familiar with and understand the guidelines set out for the child or adult for whom the plan has been developed. The planning process should ensure that everyone involved in the individual's life is clear about guidelines contained in any plan for an individual. Children and adults should be assured a consistent response to behaviour support and the use of restrictive practices regardless of the setting – whether they are in a full-time residence, a place where they live sometimes or a setting where they receive childcare, education, health or social care.
64. Consent should always be sought about the inclusion of any restrictive practice in a plan; even if an individual is detained it would be important to include their wishes in any plan (for example through advanced directives).
65. Children, adults and families should also be asked to contribute to policy development and service design. The ideal should be to co-produce all elements of support with the involvement of key stakeholders. Special efforts should be made to engage with people of all ages for whom communication and language differences may be barriers, including those for whom verbal communication is not the primary method of communication. Alternative communication techniques and use of technology should be considered where this may be helpful.
66. Families should be involved and given accurate up-to-date information. They should be supported to recognise restrictive practices in services and have user friendly processes for questioning or challenging the use of these. This could involve shared training or the provision of very clear information to families about what constitutes a restrictive practice and how concerns can be raised.
67. In line with a child rights approach, organisations should ensure that children are given access to information to enable them to understand their rights in relation to the use of restrictive practices.
68. The Social Services and Well-being (Wales) Act 2014 provides children and young people with the entitlement to an active offer of advocacy from a statutory Independent Professional Advocate (IPA). This entitlement applies when they become looked after or become the subject of child protection enquiries leading to an Initial Child Protection Conference. The 'active offer' is made directly to the child by the Advocacy Service. An 'active offer' is a sharing of information about the statutory rights and entitlement of a child, in particular circumstances, to access support from an

Independent Professional Advocacy Service. Information should be shared with them that includes an explanation about the role of Independent Professional Advocacy, what it can and cannot do, how it operates based on their wishes and feelings, its independence and how it works solely for the child/young person. This should also include its policy on confidentiality and significant harm – this explains the statutory right of children and young people to be supported to express their views, wishes and feelings as well as their right to make a representation or complaint.

69. The Social Services and Well-being (Wales) Act 2014 requires Local Authorities to arrange for the provision of an independent professional advocate when a person can only overcome the barrier(s) to participate fully in the assessment, care and support planning, review and safeguarding processes with assistance from an appropriate individual, but there is no appropriate individual available.
70. In addition Welsh Government has funded Age Cymru to deliver the Golden Thread Project working with Commissioners and Providers of advocacy to develop a National Framework for Commissioning Independent Professional Advocacy for Adults in Wales.
71. The Mental Health Act as it applies in Wales makes statutory provision for all adults and children who are receiving inpatient mental health care (whether detained under the Act or not) or are subject to a Guardianship Order or a Community Treatment Order to be eligible for the support of an Independent Mental Health Advocate (IMHA). Whilst a child, young person or an adult has the right to refuse the support of an IMHA and to elect to use the support of a different independent advocate, they must be provided with information about the availability of the relevant and commissioned statutory independent advocacy. The Mental Health (Independent Mental Health Advocates) (Wales) Regulations, 2011 sets out the relevant regulations.
72. People with lived experience should be involved in all aspects of service design, policy development and training. However, this should be done mindfully and care should be taken to ensure support is available for people who may be traumatised by talking about their experiences. People with lived experience should be fairly reimbursed for their time.

Post incident review and support

73. People with lived experience clearly tell us that the use of restraints and other restrictive practices can trigger traumatic memories for them (Hollins, 2019) and care should be taken to find out what support they need after an incident that has involved a restrictive practice.
74. It is equally likely that employees who work in challenging services will find some aspects of their work very stressful (Thompson and Rose, 2011; Baker, 2017) and will experience restrictive practices such as restraint as traumatic. An individualised approach is needed in both cases as both personal and organisational factors will influence the level of distress that people experience.
75. The provision of the right post incident support is likely to have a positive influence on restrictive practice reduction initiatives through its role in the repair of trusting relationships and re-establishment of feelings of safety. However, it needs to be

implemented well and alongside other strategies as part of a whole organisational approach to reduction. There is a small but emerging evidence base that indicates that care should be taken with the range of post incident practices that are often grouped under the umbrella term debriefing.

76. Best practice and review of the limited evidence base suggest there are two main components of post incident practice, each with a distinct purpose:

1. *Post incident support*: attention to physical and emotional wellbeing of the individuals involved.
2. *Post incident review*: to learn from the incident and reflect on practice.

Post incident review requirements for those involved in incidents where physical restraints are used are outlined in [NICE Guidance NG10](#) and [QS154](#) (NICE, 2015, 2017).

77. This framework recommends that personalised emotional support is provided both immediately, and in the longer term, if needed, both to workers and to adults and children who have been subject to restrictive practices. Post incident support should be available after any incident where restrictive practice such as restraint has been used and after any incident that may have had an impact on the individuals involved. It should also be available to those who have witnessed the incident. The support should include assessment and treatment of any medical needs and provision of immediate emotional support.

78. Organisations should have a person centred policy for providing both immediate and longer term support after any use of restrictive practices. The policy should indicate future options for accessing longer term support or counselling if needed. This may include individual and/or group supervision/debriefing and individual psychological therapy delivered by trained professionals. The policy should make clear the confidential nature of anything discussed in an emotional support session and how this supports other policies like safeguarding and whistleblowing.

79. Post incident learning reviews should be clearly separated from immediate post incident support. They should be conducted in a blame-free manner by experienced and trained senior staff members. They should contribute to organisational learning. Any post incident learning reviews in which adults and children who have been subject to restrictive practices are involved should be part of a person centred therapeutic support plan, and should be led by the needs of the person

Specific reduction strategies

80. Organisations and services should adopt evidence based preventative strategies and interventions that support the reduction of restrictive practices. Some of these will be setting or sector specific. Interventions should be primarily concerned with improving a person's quality of life and wellbeing. They often consist of various components of good practice drawn from different areas such as sensory assessment, communication, active support, risk management, improving physical health, trauma informed support, recovery models and safe wards in mental health etc. PBS provides a well developed framework that can be used to combine these in person centred ways.

Personal plans

81. Where an individual is at risk of any restrictive practice being used on them behaviour support guidelines should be included in their personal plan. These behaviour support guidelines should be continually under review and should be adapted as the needs of the individual develop or change.

82. If behaviour support guidelines contain a restrictive practice the personal plan should also include guidelines for reduction of future use of the restrictive practice. These reduction guidelines should be regularly monitored and reviewed and should be transferred from service to service, as part of the individual's personal plan.

Principles for the use of restrictive practices

83. The Welsh Government is clear that the focus of policy and practice should be on the reduction of restrictive practices as part of person-centred planning. However, organisations should ensure that where restrictive practices are used this is within a framework that supports human rights.
84. Organisations should have a policy that outlines conditions for the use of restrictive practices in any of their services. This policy should be agreed by the board or senior management team. It should cover physical restraint, seclusion, chemical restraint and mechanical restraint.
85. This policy should:
- reference human rights and legal frameworks described within this document;
 - ensure that definitions of restrictive practices are easily available and embedded through; workforce development mechanisms, organisational messages and policy;
 - have clear protocols and governance guidelines for the use of restrictive practices, and for monitoring of people during and after use, including the requirements for medical checks;
 - be easy to understand and apply, and should be communicated to all practitioners; paid carers; people being supported and the families and external agencies that the organisation works alongside ;
 - make clear that it is never acceptable to use coercion and other forms of social and psychological restraint;
 - contain guidance about risk assessments which must be undertaken before using any restrictive practice. The risks to the individual should be considered, and any restrictive practice which increases the risk to the individual should not be used. The individual's environment should be risk assessed to ensure that there is nothing within it that would cause risk during the use of restrictive practices;
 - provide clear guidance for recording information following the use of any restraint in relation to what is to be recorded when, by whom, and the purpose of the recording (see [Royal College of Psychiatrists, 2018](#) for more guidance);
 - make clear that any use of a restrictive practice should be recorded even if its use is prescribed in a personal plan;
 - outline the process for the collection of this data from all their services. It should be available to external organisations on request;
 - provide guidance for seeking consent for use of restrictive practices.
86. Organisations that use seclusion must have a policy with very clear guidance for workers about its use. There should be a clear definition of seclusion that all workers understand and its use must be carefully monitored. Sometimes practices that are referred to as time out, chill out or isolation, including the use of sensory tents, meet the definition of seclusion if the child or adult is put in a room and not able to leave of their own free will.
87. There will be occasions within all settings when individuals need to access areas away from noise or other people. It is important that quieter areas are provided and that

people can access them of their own free will when needed and return from them when they choose. These areas should not be very confined or locked spaces but pleasant, quieter areas of a building, or an outdoor space.

88. Seclusion should not be used in any social care settings; it can be extremely traumatic and it is not recommended that children should be secluded in any setting.
89. Welsh Government exclusion guidance for education settings recommends the use of internal exclusion as an alternative to formal exclusion, since supervision of the work being undertaken by the learner during this period can be appropriately reviewed and supported. This supports the right of all children and young people to receive an education, a right that may not always be fulfilled during formal fixed-term exclusion. (<https://gov.wales/sites/default/files/publications/2018-03/exclusion-from-schools-and-pupil-referral-units.pdf>)
90. Isolating learners in education settings through the use of seclusion, where a child is forced to spend time alone against their will, is not supported by the Welsh Government. However, it is recognised that seclusion may happen in exceptional and emergency situations. This could include, for example, where the safety of a child or children would be compromised if seclusion were not used. The Welsh Government issued 'Safe and Effective Intervention: use of reasonable force and searching for weapons' in March 2013. The document provides guidance on the use of quiet or isolation rooms. (<https://gov.wales/sites/default/files/publications/2018-03/safe-and-effective-intervention-use-of-reasonable-force-and-searching-for-weapons.pdf>)
91. Face-down restraint (referred to as prone restraint) carries an elevated risk and should not be used or considered for use except in exceptional circumstances as part of an agreed protocol, and as a person centred approach where it is the preferred response of the individual themselves. The use of face-down restraint should be signed off at senior board level. Any use of face-down restraint should be carried out with the presence of one additional worker (not involved in the restraint) to monitor the individual's health and wellbeing. Any unplanned use should trigger an immediate review. Where face-down restraint is used, organisations should have a policy on its use
92. Mechanical restraints should only be used in exceptional circumstances and only when prescribed by and under the direction of an appropriately qualified professional. Workers should be trained in their use, and all use should be recorded, including duration.
93. Any intended use of restrictive practices as a response to a behaviour that challenges should be in the individual's behaviour support guidelines in their individual plan and should be reviewed regularly. Any use of a restrictive practice that is not in the individual's personal plan should trigger an immediate review. There should be guidelines in the individual's personal plan of how the use of the restrictive practices will be reduced in the future.
94. Restraints should only ever be used within the principles of least restrictive and last resort. That is the least restrictive method with the least amount of force (proportional

to the risk) for the minimum amount of time. They should only be used if absolutely necessary (if there is a genuine belief that significant harm is likely to occur to the individual or others if it is not used, and if other less restrictive methods have been tried and have failed). Restraints that cause pain intentionally should **never** be used.

95. Restrictive practices must be part of an overall person centred approach and should be tailored specifically to the individual for whom it is being used, in particular for individuals who are at greater risk due to age, frailty, health problems, trauma history or other risk factors. It should be clear within the behaviour support guidelines why that intervention is most appropriate for them. Restrictive practices should be used within the context of an overall therapeutic relationship and never used as punishment. Guidance should be sought from a medical practitioner to ensure there are no health reasons that would elevate the risk of using certain restraints. Children and people are at particular risk physically and psychologically and the principles for upholding children's rights detailed in Section 2 of this document should be followed.
96. Decisions about the use of restrictive practices should take into account any cultural or religious factors for individuals.
97. Safeguarding policy should be followed and appropriate actions should be taken inline with the Wales Safeguarding Procedures to ensure that individuals are safe and protected from abuse.
98. Restrictive practices should never be used to compensate for staff shortages or other resource difficulties.
99. Following any occurrences of restrictive practices being used, the relevant people/bodies should be informed, in line with the personal plan. Family members should be informed unless the personal plan indicates otherwise.

Glossary

Adverse childhood experiences (ACEs): [Adverse Childhood Experiences \(ACEs\)](#) are traumatic experiences that occur before the age of 18 and are remembered throughout adulthood. These experiences range from suffering verbal, mental, sexual and physical abuse, to being raised in a household where domestic violence, alcohol abuse, parental separation or drug abuse is present. Good practice assessment and intervention regarding ACEs would be included in a PBS framework.

Behaviours that challenge: These are sometimes referred to as challenging behaviour, or as behaviours of concern, or stressed and distressed behaviours.

Co-production: This refers to a way of working whereby people and practitioners work together as equal partners to design, plan and deliver care and support (Welsh Government, 2013a).

Duty of care: At times, a care provider may have a duty of care to use a restraint, in order to ensure the safety of supported individuals or others. Where people are at a high risk of causing injury to themselves and/or others, restraint may be required to manage risks and keep the person safe.

Organisation: Examples of organisations include education settings, social care providers and health care providers, NHS trusts, private hospitals, foster care agencies and registered childcare settings.

PBS: Positive behaviour support.

PBS guidelines: These are sometimes referred to as PBS plans, behaviour support plans or behaviour intervention plans.

People with lived experience: People with a lived experience of receiving services and experience of having restraint applied to them. The term can also apply to families and carers.

Personal plan: In the context of this guidance, the term 'personal plan' is used to refer to any of the following:

- Care and Support Plan under Part 4 of the Social Services and Well-being (Wales) Act 2014;
- Part 6 (looked after child) Care and Support Plan under the Social Services and Well-being (Wales) Act 2014. (This becomes subsumed within a Pathway Plan when the young person turns 16.)
- Individual treatment plan under the mental health legislation
- Individual education plan under the Special Educational Needs Code of Practice for Wales (under current arrangements at the point of publication of this Framework).
- Individual development plan under the Additional Learning Needs and Education Tribunal (Wales) Act 2018 (under future arrangements as the requirements of the Additional Learning Needs and Education Tribunal (Wales) Act 2018 come into force).

An individual may have more than one of these plans, depending on their needs and circumstances, and generally these will be integrated into one holistic plan which sets out the individual's need for care and support and/or treatment. These plans will be based on assessments of individual needs and will incorporate the personal wishes and aspirations of the individual. Within the personal plan, there will be guidelines on specific areas, for example, reduction of restrictive practice guidelines, positive behaviour support guidelines.

Person centred practice: This is about working in a person centred way and is a strengths based approach which involves:

- getting to know an individual
- respecting and valuing their histories and backgrounds, and understanding:
 - their likes and dislikes
 - their skills and abilities
 - their preferred communication style and support structures
- understanding the impact of their environment upon them and using this to identify ways to support people consistently in every aspect of the care that they receive
- involving them and people important to them in co-producing their own support

This term includes children and adults but may be described as child centred practice where applied to a child.

Positive behaviour support (PBS): This is a person centred, evidence based, framework for supporting people who have, or who may be at risk of developing, behaviours of concern. Its primary focus is to improve the person's wellbeing and quality of life, through the use of behavioural assessment and proactive prevention strategies. PBS is recommended in NICE guidance and is in full accord with Welsh social care policy. The PBS framework has many similarities with other good practice and trauma informed approaches e.g. awareness of ACEs.

Post incident review: A review that consists of two separate components:

1. *Post incident support.* This is the support that is immediately offered to an individual who has been involved in an incident. It should include assessment and treatment of any medical needs and provision of immediate emotional support.
2. *Post incident reflection and learning review.* This is a non-blaming review where the factors that led to the restraint being used are examined and actions are agreed that support the prevention of future incidents or the minimisation of impact and less restrictive response in the future.

(Restraint Reduction Network, 2019)

Practice leadership: This is the development of good support for workers, through: coaching; providing feedback and modelling good practice; reviewing the quality of support in regular one to one supervision; and reviewing how well the team is enabling people to engage in meaningful activity and relationships (Mansell and Beadle-Brown, 2012, p108).

Proactive strategies: These are central to PBS and primarily aim to promote wellbeing, enhance quality of life and meet a person's unique needs, thereby reducing behaviours that challenge. They are therefore sometimes referred to as primary prevention or early intervention. There are a wide range of primary prevention strategies within the PBS framework that can be adapted and implemented in person centred ways. Proactive primary prevention of behaviours that challenge is an essential element of successful reduction of restrictive practice.

Reactive strategies: These are strategies used when a challenging behaviour is being presented. They have the primary aim of bringing the incident to an end in a timely and safe manner, with due regard to the individual's rights and dignity. They could be restrictive or non-restrictive. Examples of non-restrictive reactive strategies include de-escalation, diversion, distraction or strategic capitulation. Examples of restrictive, reactive strategies include restraints such as physical restraint.

Reasonable adjustments for workers with disabilities or health conditions: Employers must make reasonable adjustments to make sure workers with disabilities, or physical or mental health conditions, are not substantially disadvantaged when doing their jobs.

Recovery based approaches: The recovery model is a holistic person centred approach to mental health care based on the premise that it is possible to recover from a mental health condition and that the most effective recovery is patient directed.

Restorative justice: Restorative justice brings those harmed by crime or conflict and those responsible for the harm into communication, enabling everyone affected by a particular incident to play a part in repairing the harm and finding a positive way forward. This is part of a wider field called restorative practice. Restorative practice can be used anywhere to prevent conflict, build relationships and repair harm by enabling people to communicate effectively and positively. Restorative practice is increasingly being used in schools, children's services, workplaces, hospitals, communities and the criminal justice system.

Restraint: Restraint may also be called restrictive interventions in some sectors. Restraint is: *an act carried out with the purpose of restricting an individual's movement, liberty and/or freedom to act independently* (Welsh Government, 2016a).

Restraints includes the following:

Chemical restraint

This sometimes refers to the use of medication to manage an individual's behavior. This can include either medication administered via intra-muscular injection, or given orally. It includes medication routinely prescribed, or used 'as required'. Chemical restraint could also be in the form of covert administration of medication when used outside of the requirements of the Mental Capacity Act 2005 and relevant NICE Guidance.

Clinical holding

This is the use of physical restraint to allow for essential clinical assessment and treatment to take place. It involves 'immobilisation, which may be by splinting, or by using limited force. It may be a method of helping children (and adults), with their permission, to manage a painful procedure quickly or effectively' (RCN, 2010). It should be recorded as a restraint.

Environmental restraint

This refers to the use of physical barriers to restrict freedom of movement, such as locked doors, either to restrict someone in an area, e.g. their bedroom, or to prevent them accessing an area, e.g. the kitchen.

Long-term segregation

Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the person to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a person should not be allowed to mix freely with other patients on the ward or unit on a long term basis.

Mechanical restraint

This refers to the use of equipment which restricts freedom of movement, for example, arm splints, some types of harness, and restraint chairs.

Physical restraint

This refers to the use of direct physical force to restrict freedom of movement.

Prone restraint

Prone restraint is a face-down, floor based, physical restraint which is very restrictive and presents increased risk for the individual. It has been shown to be associated with high rates of injury and, in certain circumstances, death, due to positional asphyxia.

Seclusion

This is a particular type of environmental restriction whereby a person's freedom is restricted by confining them to a specific space, e.g. their bedroom, or to a specially designated seclusion room. It does not necessitate the locking of doors for it to be regarded as seclusion. A worker holding the door from outside has the same effect. Seclusion should not be confused with 'time out', which is a punishment based behavioural technique. Diversion to a low-stimulus environment (e.g. a quiet room) in the event of a person being over-stimulated or distressed would not be regarded as seclusion, provided the person is not confined there against their will and is free to leave at any point.

Unplanned interventions

It is recognised that unplanned restraints may occur in emergency situations, for example, if risk behaviour occurs that was previously unforeseen. Any unplanned use of restraint should be the subject of an investigation within 24 hours of its use.

Restraint reduction guidelines: Assessment, planning and review measures aimed at reducing the number of times that restraint techniques are used within defined settings, or in relation to a specific individual (Restraint Reduction Network, 2019).

Restrictive practices: Restrictive practices include restraint (see above), but also include a wider range of activities which restrict people. Restrictive practices are a wide range of activities that stop individuals from doing things that they want to do or encourage them to do things that they don't want to do. They can be very obvious or very subtle (Care Council for Wales, 2016).

Restrictive practices include the following:

Blanket rules

These are rules that are applied across a service or setting, irrespective of individuals' needs, preferences or rights, e.g. everyone having to go to bed at the same time, or all doors being locked.

Observations

This refers to staff observations of an individual which may be required in order to maintain safety, depending on an individual's history and particular behaviours of concern. This may be an invasion of the individual's dignity and privacy and therefore is regarded as a restrictive practice.

Restricted access to items

This refers to locking away or otherwise restricting access to items that the person wishes to access. This may be for safety reasons, for example, the control of hazardous substances, such as household cleaning products or items that someone may use to harm themselves. Restricted access may also be legally imposed by the criminal justice system, for example, to have access to the internet limited.

Restriction by default or interference

This is restricting someone in a more subtle way, e.g. removing someone's walking aid so that they cannot mobilise independently, or placing furniture in such a way that someone is unable to leave a room.

Social coercion

This refers to other people in positions of power, e.g. workers, forcing supported individuals to do something against their will, or stopping them from doing something that they want to do, by the use of threats, implied threats, or other social pressures (e.g. taunting, mocking or humiliating).

Technological restrictions

This is the use of technology, such as electronic systems, tracking devices or CCTV, to monitor a person's movements. Although these may not in themselves restrict a person, they involve monitoring a person's movements, and therefore they are within the scope of this policy.

Safewards: This is a model for reducing conflict and containment used mainly in hospital settings for people with mental health problems. It has some similarities with PBS and trauma-informed care (see <http://www.safewards.net/model>).

Significant life events: These include important changes in an individual's life, both positive and negative. For individuals with some conditions these may be changes and disruptions to their routines; for others these may be the onset of a deteriorating condition such as sensory loss or dementia; for others these may be a sudden change to their lives such as stroke, accidents, loss and bereavement); and for others it may be a crisis affecting them (Welsh Government, 2013a).

Strategic capitulation: Giving the person what is wanted or is being demanded through the behaviour used to bring a crisis to safe resolution or to prevent a crisis from occurring.

Training needs analysis (TNA): The first step in the training process, designed to identify performance gaps that can be remedied by training. It consists of surveillance, investigation and data analysis (Restraint Reduction Network, 2019).

Trauma informed care: An organisational structure and treatment framework that involves understanding, recognising and responding to the effects of all types of trauma. It aims to improve the psychological and emotional wellbeing of people accessing services (Restraint Reduction Network, 2019).

Appendix 1

Key legislation and guidance

The Public Sector Equality Duty, Equality Act 2010 (EA 2010) s149

Certain public authorities are subject to specific duties under the Equality Act 2010. The Public Sector Equality Duty (PSED), was created under the Equality Act which came into force on 5 April 2011. The PSED replaced the race, disability and gender equality duties. It applies in England, Scotland and in Wales. The general equality duty is set out in section 149 of the [Equality Act 2010](#).

Section 153 of the Act enables the Welsh Ministers to impose specific duties on certain Welsh public bodies through secondary legislation. For Welsh and cross-border Welsh public bodies, specific duties have been finalised by the Welsh Assembly government and came into force on 6 April 2011.

[The Equality Act 2010 \(Statutory Duties\) \(Wales\) Regulations 2011](#)

Those public authorities subject to the general equality duty must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not

There is evidence that some individuals who share a protected characteristic under the Equality Act 2010 are more likely to be restrained than others who do not share that characteristic (for example, individuals from black and ethnic minority groups). When this is the case in a service, the provider should understand why individuals with that characteristic are more likely to be restrained than others and should consider what steps they can take to eliminate any disparities. Providers who are delivering a public function (whether or not they are a private entity) are subject to the public sector equality duty (Equality Act 2010 s149) and must have due regard to the disproportionate use of restraint on a group that is protected under the Equality Act 2010.

For guidance on which public authorities are subject to the specific duties, please see:

- Guides to the PSED in Wales, available at: <https://www.equalityhumanrights.com/en/advice-and-guidance/guides-psed-wales>
- Review of the PSED in Wales, available at: https://www.equalityhumanrights.com/sites/default/files/review_of_psed_in_wales_full_report_english_nov2014.pdf

Reasonable Adjustments

Under the [Equality Act 2010](#) public sector organisations have to make changes in their approach or provision to ensure that services are accessible to disabled people as well as everybody else. Reasonable adjustments can mean alterations to buildings by providing lifts, wide doors, ramps and tactile signage, but may also mean changes to policies, procedures and staff training to ensure that services work equally well for people with learning disabilities.

For example, people with learning disabilities may require :

- clear, simple and possibly repeated explanations of what's happening and of treatments
- help with appointments
- help with managing issues of consent in line with the [Mental Capacity Act](#).

Public sector organisations shouldn't simply wait and respond to difficulties as they emerge: the duty on them is 'anticipatory', meaning they have to think out what's likely to be needed in advance.

The Social Services and Well-being (Wales) Act 2014

Any persons exercising functions under the Social Services and Well-being (Wales) Act 2014, in relation to a child who needs care and support and child carers who need support, **must** have due regard to Part 1 of the United Nations Convention on the Rights of the Child adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 ("the Convention"). (available at <https://ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>)

Any persons exercising functions under the Social Services and Well-being (Wales) Act 2014, in relation to adults who need care and support and adult carers who need support, **must** have due regard to the United Nations Principles for Older Persons as adopted by the General Assembly of the United Nations on 16 December 1991 (available at <https://www.ohchr.org/en/professionalinterest/pages/olderpersons.aspx>).

In addition to those UN conventions and principles set out in the Social Services and Well-being (Wales) Act 2014, when exercising social services functions in relation to disabled people who need care and support and disabled carers who need support, local authorities **must** have due regard to the United Nations Convention on the Rights of Persons with Disabilities (available at: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>).

The Education Act 1996 and the Special Educational Needs (SEN) Code of Practice for Wales

The SEN Code of Practice for Wales provides advice to local authorities, maintained schools, early years settings and others on carrying out their statutory duties under the Education Act 1996 to identify, assess and make provision for children's SEN. The SEN Code of Practice includes advice on individual education plans and on:

- working in partnership with parents
- pupil participation

- working in partnership with other agencies

<https://gov.wales/sites/default/files/publications/2018-03/special-educational-needs-code-of-practice-for-wales.pdf>

The Additional Learning Needs and Education Tribunal (Wales) Act 2018

When implemented, this Act will include a duty to involve and support children, their parents and young people. This means having regard to:

- the views, wishes and feelings of the child and the child's parents or the young person
- the importance of them participating as fully as possible in decisions
- the provision of the information and support needed to enable participation in decisions made under the Act

The Additional Learning Needs and Education Tribunal (Wales) Act 2018 also requires that local authorities and NHS bodies must have due regard to the United Nations Convention on the Rights of Persons with Disabilities under this part of that Act.

Current arrangements for SEN under the Education Act 1996 and the SEN Code of Practice for Wales (as described above) will be replaced over time through the phased implementation of provisions introduced through the Additional Learning Needs and Education Tribunal (Wales) Act 2018 and the Additional Learning Needs Code.

Supporting children's rights

[The Right Way: A Children's Rights Approach](#) (Children's Commissioner for Wales, 2017) and the [UNCRC](#), and in particular :

- *Article 19: You have the right to be protected from all forms of violence, abuse, neglect and bad treatment by the people who look after you*
- *Article 36: Governments must protect children from all other forms of bad treatment*
- *Article 37: You have the right not to be punished in a cruel or hurtful way*

Under the UNCRC, children's rights are given special human rights protection, recognising that children are in the process of emotional and physical development; as such, they face particular challenges and will have different needs than adults.

Alongside the EHRC Framework, a number of relevant principles should be taken into account in settings where children are supported:

- Children should be given meaningful opportunities to influence decisions about their lives and give consent where they are able to
- Organisations should be accountable to children for decisions that affect their lives. Children's rights are entitlements, they are not optional, and organisations should develop policies that reflect this
- Children's rights should be at the centre of planning and delivery of support within children's organisations. Specifically, within an education setting, all children have a right to an education and therefore any restrictions which interfere with learning should not be used

- Weighty justification should be given to any restraint of children and young people. The impact of restraint on children's development, both physically and emotionally, cannot be underestimated
- Best interests and children's rights should be carefully balanced with the use of restrictive practices. Circumstances where normal parental restrictions might be in place are generally lawful, for example holding the hand of a five year old near a busy road

[*A Children's Rights Approach*](#) describes how organisations can implement a principled and practical framework for working with children, grounded in the UNCRC, helping public bodies to integrate children's rights into every aspect of decision making, policy and practice.

Information about the UNCRC and the Children's Rights Scheme published by the Welsh Government can be accessed at: <https://gweddill.gov.wales/topics/people-and-communities/people/children-and-young-people/rights/?lang=en>

Local authorities and NHS bodies must also have due regard to the UNCRC (see <http://www.legislation.gov.uk/anaw/2018/2/part/2/chapter/1/crossheading/participation-United-nations-conventions-and-access-to-information/>).

Supporting rights for people living with dementia

In 2014, the Older People's Commissioner for Wales published a report following her review of care homes, 'A Place to Call Home'. There were a number of required actions set for the Welsh Government, public bodies and service providers including the promotion of a rights based approach for supporting individuals living in care home settings, and the development of a 'national, standardised values and evidence based dementia training programme' that would ensure that older people were not continued to be misunderstood and labelled as 'challenging' or 'difficult' (see http://www.olderpeoplewales.com/en/reviews/residential_care_review.aspx).

In 2016, Social Care Wales published 'Good Work: A Dementia Learning and Development Framework for Wales'. This promotes values and rights based approaches to support individuals living with dementia, including the importance of understanding behaviour 'using appropriate person-centred techniques in the care and support of people with dementia who behave in ways that might be perceived as challenging' (see https://socialcare.wales/cms_assets/file-uploads/Good-Work-Dementia-Learning-And-Development-Framework.pdf).

In 2018 Social Care Wales also launched an information hub with a range of resources aimed at supporting the sector in understanding the role they play in the support and care for people with dementia (see <https://socialcare.wales/service-improvement/people-with-dementia>).

The Learning Disability – Improving Lives Programme

This programme emerged from the challenge in the Welsh Government's strategy, 'Prosperity for All', to look at the services that are provided to ensure they support everyone to live a healthy, prosperous and rewarding life. A review was undertaken to better

understand whether people with a learning disability have what they need to lead successful lives. The review findings suggest that education (mainstream or specialist schools) should embrace evidence based interventions such as positive behaviour support (PBS) consistently to reduce restraint and avoidable medication (see <https://gov.wales/docs/dhss/publications/learning-disability-improving-lives-programme.pdf>)

Together for Mental Health

This is the Welsh Government's 10 year strategy to improve mental health and wellbeing. Published in October 2012, following significant engagement and formal consultation with key partner agencies, stakeholders, service users and carers, it is a cross-government strategy and covers all ages. It encompasses a range of actions, from those designed to improve the mental wellbeing of all residents in Wales, to those required to support people with a severe and enduring mental illness. (See <https://gov.wales/docs/dhss/publications/161010deliveryen.pdf> for more details.)

The strategy consists of five chapters and is underpinned by 18 high level outcomes including:

- People feel in more control as partners in decision making about their treatment and how it is delivered
- Service user experience is improved, with safety, protection and dignity ensured and embedded in sustainable services

Delivering the actions set out in the plan will make a positive contribution to the Welsh Government's equality objectives through a commitment to identify and meet the needs of *all* groups in relation to mental health. The plan also considers the articles contained within the [UNCRC](#) (United Nations, 1989).

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