**Herefordshire Children’s Services**

***Isolation, Seclusion, Restriction and Restraint Policy***

1. **INTRODUCTION**
   1. The majority of children and young people who become looked after by Herefordshire Children and Families Services are in care because they have experienced poor parenting, neglect and abuse. Their pre-care experiences can mean that these children are more vulnerable, have complex needs and may present challenging behaviours. Their experiences can leave the children in a state of ‘blocked trust’ towards their care givers.
   2. These children may also have experienced many changes in caregivers and find it hard to trust adults. They may believe that their caregivers aren’t safe and can’t always be turned to for comfort and help. They may develop insecure and disorganised attachments and try to control the relationship and the environment often to stop those caring for them from becoming emotionally close to them.
2. **SCOPE OF THIS POLICY**
   1. This policy applies to any child who is looked after by Herefordshire Council who resides in a foster placement (irrespective of if this is internal or IFA) or residential placement; and any child who attends as 38 week per year residential special school setting.
3. **LEGAL CONTEXT**
   1. The use of all forms of physical intervention and physical contact are governed by criminal and civil law. The unwarranted or inappropriate use or threatened use (for example, by raising a hand, or threatening to use a physical intervention) of force may constitute a criminal offence. In addition the application of physical restraint may infringe the human rights of a child or young person and so the use of restrictive physical interventions must be consistent with the Human Rights Act 1998 and the United Nations Convention on the Rights of the Child (ratified by the UK in December 1991). However, in certain circumstances the use of a Restrictive Physical Intervention can be justified:

* In school and education settings Section 93 of the Education and Inspections Act 2006 enables school staff to use such reasonable force necessary to:
* prevent or stop the committing of any offence by a pupil;
* prevent or stop personal injury to, or damage to the property of any person (including the pupil themselves) by a pupil; or
* prevent or stop a pupil prejudicing the maintenance good order and discipline.
* Social care residential settings i.e. Children’s homes, are governed by the Children’s Homes (England) Regulations 2015 which cover:
  + behaviour management and discipline (regulation 19);
  + use of restraint (regulation 20);
  + employment of suitably trained and qualified staff (regulation 32(3)(b)); and
  + behaviour policies including monitoring, reporting and recording (regulation 35).

Regulation 20 of the Children's Homes (England) Regulations 2015 states restraint in relation to a child must be necessary and proportionate and only permitted for the purpose of preventing the following:

* injury to any person (including the child);
* serious damage to the property of any person (including the child); or
* a child who is accommodated in a secure children's home from absconding from the home.
* Regulation 13 of the Fostering Services (England) Regulations 2011 concerning behaviour management and children missing from foster carer’s home states:
* “13(1) The Fostering Service provider shall prepare and implement a written policy on acceptable measures of control, restraint and discipline of children placed with foster parents.
* 13 (2) The Fostering Service provider shall take all reasonable steps to ensure that:
* no form of corporal punishment is used on any child placed with a foster carer;
* no child placed with foster carer is subject to any measure of control, restraint or discipline which is excessive or unreasonable; and
* Physical restraint is used on a child only where it is necessary to prevent likely injury to the child or persons or likely serious damage to property.”
  1. Fostering service providers are governed by the Fostering Services (England) Regulations 2011 (the Regulations). The Regulations are complimented by the [National Minimum Standards in Fostering Services](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/192705/NMS_Fostering_Services.pdf) (the NMS) and together these form the basis of the regulatory framework under the Care Standards Act 2000. They emphasise the importance of the provision of advice and training to foster carers. NMS 3 sets out how fostering services should support foster carers to manage appropriately and de-escalate challenging behaviour, including the provision of specialist training where necessary. All fostering service providers are expected to follow the NMS.

1. **USING PHYSICAL INTERVENTION**
   1. While physical intervention is never desirable, it might sometimes be necessary and compatible with the actions of a ‘good parent’. Physical Intervention (Restraint) should only be used when absolutely necessary, in accordance with the law and clear ethical values and principles which respect the rights and dignity of children and young people, and in proportion to the risks involved. It can never be a long-term solution.
   2. Such decisions are often finely balanced. When considering a physical intervention, the carer will need to make a dynamic risk assessment that considers:

* the risk or potential risk identified, and the extent to which the outcome is imminent;
* the range of opportunities available to minimise or negate that risk;
* the risks inherent in intervening, and the risks inherent in not intervening.
  1. Any decision about physical intervention must be proportionate, and must use only the amount of force necessary to achieve the desired outcome, and for the shortest period of time possible (*Davidson et al, 2005; ADCS, 2009; Department for Education, 2014; Department of Health, 2014; Ministry of Justice et al, 2015; NICE, 2015*).
  2. In any situation, the least restrictive intervention available should be used, based on the specific needs of an individual and others whose actions may impact upon them. This means that, wherever possible, attempts should be made to use physical presence before any physical contact, and to use non-restrictive contact before moving to restraint. The appropriateness of the physical intervention must always be related to the age, maturity, understanding and capacity of the individual.
  3. **Early Identification** of children who have experienced childhood trauma that has resulted in them developing an insecure or disorganised attachment is important to ensure they experience those caring for them doing the best they can to understand them.
  4. The **Strengths and Difficulties Questionnaire (SDQ)** is a brief emotional and behavioural screening questionnaire for children and young people. The tool can capture the perspective of the children and young people, their parents, caregivers, teachers and Social Workers. The first Strengths and Difficulties Questionnaire for a child should be completed as a component of the Initial Child Looked After Health Assessment.
  5. All children over the age of 2 years, who are looked after by Herefordshire Children and Families Services should have a Strengths and Difficulties Questionnaire completed every 6 months; this should be available for consideration at the child’s Annual Health Assessment and at each Child Looked After Review.
  6. This means all those involved in the child’s care (Social Workers, foster carers, residential workers and other key professionals) need to work together to develop consistent and effective ways for the child to understand, make sense of and manage their emotions, thoughts and behaviour. In doing so children can be supported to believe that the adults really will keep on trying until things get better for all of them.
  7. All those involved in the care of the child should work positively and confidently with them and find the least intrusive way possible to support, empower and keep children safe. The foundation of good practice in working with children should be:
* building relationships of trust and understanding;
* understanding triggers and finding solutions;
* if incidents do occur, defusing the situation and/or distracting the child wherever possible;
* clear recording of all incidents of challenging behaviour by the foster carer, placement, fostering agency, school and child’s Social Worker; especially where a child or young person has experienced any of the following:
* Isolation
* Seclusion
* Restriction
* Deprivation of Liberty (irrespective of whether a DoLS Order is in place)
* keeping parents informed;
* keeping appropriate agencies;
* notification to the Local Authority Designated Officer (LADO) in those cases where there are issues about professional practice and/or professional conduct.
  1. For children and young people who display challenging behaviours that persist over time consideration should be given to whether a referral should be made to:
* GP
* Play Therapy
* SEEDS Project – where behaviours are observed in both home and school settings; or within the community
* Suitable specialist advice – where consideration is being given to either a step-up or step-down to/from residential provision
* CAMHS
* Specialist Assessment, for example Occupational Therapy, Sensory Assessment, Education, Health and Care Assessment (SEND), Mental Capacity Assessment/DoLS
* Foster Carers Clinic – for children placed with local Authority Carers within Herefordshire
  1. If a child or young person has been assessed as requiring a therapeutic foster placement or residential placement; a Supporting Positive Behaviour Plan should be developed. This should be monitored by the IRO within the Child Looked After Review. Equally, where a child struggles to manage their behaviour in a mainstream foster placement consideration should be given to developing a Supporting Positive Behaviour Plan.

1. **ISOLATION, SECLUSION, RESTRICTION AND PHYSICAL INTERVENTION (RESTRAINT)**
   1. ***Isolation*** *– “where a child or young person is not allowed to mix freely with others”*; this may in some instances apply to a young person who is placed within an adolescent psychiatric unit or secure accommodation. The term isolation, is often interchangeable with ‘seclusion’ and these practices are regulated (see 5.7 below).
   2. **Delegated Authority:** Given the seriousness of isolation, and the impact of such measures on the young person’s emotional well-being a Supporting Positive Behaviour Plan should be developed by the multi-agency team involved in the child’s care. This should clearly specify under what circumstances the use of isolation may apply and it is essential that this is signed off by:

* Head of Service
* Senior Managers of the provision and the attending Psychiatrist (in the case of a child placed in an Adolescent Psychiatric Unit); or Psychiatrist/Clinical Psychologist in residential/residential school settings
* Independent Reviewing Officer (IRO).
  1. The isolation of a child or young person residing with foster carers or in a residential setting (other than those identified at 3.1) without supervision is not acceptable practice.
  2. In the event concerns are expressed that a child or young person has been placed in isolation, irrespective of the length of time isolation was used; this should be reported immediately to the Local Authority Designated Officer; and where appropriate the Manager of the Contracts Team. The Head of Service should be informed immediately where a decision has been made to report a concern to the Local Authority Designated Officer.
  3. The use of isolation within a foster placement or residential setting would raise concerns of:
* Poor professional practice; and/or
* Professional Misconduct
  1. The Head of Service and LADO should determine whether a Position of Trust Meeting should be convened in accordance with the Herefordshire Safeguarding Partnership and West Midlands Regional Safeguarding Procedures (see Tri-X).
  2. ***Seclusion*** – is the *“the supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving.”* *Department of Health, Para 87 P and P 2014*
  3. Any use of seclusion is likely to contravene Article 5 of the Human Rights Act: The right to liberty and security and its use in any setting should be questioned. Seclusion should not be used as either a treatment or a punishment.
  4. The Mental Health Act Code of Practice (2015) acknowledges the particular risks attached to seclusion:

*“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.”*

* 1. If a person is isolated and prevented from leaving a room of their own free will then this meets the accepted criteria for seclusion, even if it is called by a different name. This would also apply for any equipment such as a ‘Safe Space Tent’ which prohibits a child from leaving the equipment without the assistance of an adult.
  2. Common euphemisms or alternative terms may be: time out, isolation, chill out, or single separation. There could be a number of methods that prevent someone from leaving a room including a perceived or real threat. It is for good reasons that the use of the seclusion in care and health settings for children and adults in England is strictly regulated.
  3. Seclusion should be used in emergencies only for those who are being detained under the Mental Health Act 1983 or subject to a Deprivation of Liberty authorisation, or Court of Protection order under the Mental Capacity Act 2005. There is clearly defined process with a hierarchy for authorisation, where and how the restriction is monitored.
  4. Outside of these specific circumstances seclusion should not be used.
  5. The use of seclusion within a foster placement or residential setting would raise concerns of:
* Poor professional practice; and/or
* Professional Misconduct
  1. In the event concerns are expressed that a child or young person has been placed in seclusion, this should be reported immediately to the Local Authority Designated Officer. The Head of Service should be informed immediately where a decision has been made to report a concern to the Local Authority Designated Officer.

The Head of Service and the Local Authority Designated Officer will determine whether a Position of Trust Meeting should be convened in accordance with the Herefordshire Safeguarding Partnership and West Midlands Regional Safeguarding Procedures (see Tri-X).

* 1. **Delegated Authority**: Given the seriousness of seclusion, and the impact of such measures on a child’s emotional well-being (even where this is supervised) a Supporting Positive Behaviour Plan should be developed by the multi-agency team involved in the child’s care for any child or young person detained under the Mental Health Act 1983 or subject to a Deprivation of Liberty authorisation, or Court of Protection order under the Mental Capacity Act 2005. This should clearly specify under what circumstances the use of seclusion may apply and it is essential that this is signed off by:
* Head of Service
* Senior Managers of the provision and the attending Psychiatrist (in the case of a child placed in an Adolescent Psychiatric Unit) or Psychiatrist/Clinical Psychologist in residential/residential school settings
* Independent Reviewing Officer (IRO).
  1. ***Restrictive Intervention* –** Restrictive intervention should only be used when absolutely necessary, in accordance with the law and clear ethical values and principles which respect the rights and dignity of children and young people, and in proportion to the risks involved. The terms restrictive intervention and restraint are often used interchangeably; however for the purposes of this policy restriction is defined as:

*“Planned or reactive acts that restrict an individual’s movement, liberty and/or freedom to act independently and using force or restricting liberty of movement (or threatening to do so).”*

* 1. Restrictive intervention can take many forms and these are described below.
  2. ‘**Consequences**’ - Restriction can result following a child’s behaviour and might be considered to be a ‘consequence’ of this. Consequences should only be chosen after efforts have been made to understand the behaviours and communicate with the child this understanding and offering to unconditionally accept. Consequences will be logical, linked to the behaviour and developmentally appropriate. When a child is able to be, they can be involved in decisions about the consequences. This will aid the carer helping to regulate the feelings of shame of the child so they can feel remorse and at the same time make amends.
  3. Children who experience difficulty in communicating will require specialist support from a professional who is able to communicate and understand them; in order to ensure they understand what has happened, and more importantly why it happened. This is to enable the child to develop the skills to self-regulate their emotions and behaviours when they find themselves in a difficult or stressful situation.
  4. **Placement Plan -** At the point where a child is first placed with foster carers, residential placement or residential special school agreement should be reached as to the type of consequences (restrictive practices). These may include:
* The curtailment of leisure activities, additional house chores, loss of privileges, use of increased supervision.
* Grounding, particularly if a young person has returned late or not at the agreed time.
* The appropriation of pocket money or savings to repair damage or for the replacement of loss. Restitution may be in full, in part or merely token but children and young people must not be deprived of more than two thirds of their total spending money for the week.
* The confiscation, temporarily or permanently, of any article or substance belonging to a child if that same article, material or substance be considered potentially dangerous or injurious to property or persons.
* The use of a safe space for a child, should be considered within the context of ‘seclusion’. Where it is believed that a child requires a ‘safe space’ in which to calm themselves when distressed or dysregulated; HIPPS should be consulted (where the child resides in Herefordshire); and consideration should be given to developing a Supporting Positive Behaviour Plan to ensure those involved in the child’s care have the knowledge and skills necessary to deflect or de-escalate a situation safely. For those children residing outside of Herefordshire a specialist assessment should be undertaken by a suitably trained professional (e.g. Occupational Therapist, Psychiatrist, Clinical Psychologist etc.).
  1. The following consequences may not be imposed upon children (they are Non- Approved):
* Any form of corporal punishment such as any intentional application of force as punishment, including tapping, slapping, pushing, punching, pulling, grabbing or rough handling and throwing missiles. This does not prevent a person using necessary physical intervention. (See 5. 25 below)
* Any consequence relating to the consumption or deprivation of food or drink. It is well established that the enjoyment of eating and drinking is fundamental to a child’s healthy physical and emotional development. Meal times should be well-managed, orderly, social occasions in the life of a child and it would be quite inappropriate for a child to be refused meals or food, or routinely be excluded from communal meals. (If a child is able to manage communal meals successfully). Deprivation of food and drink should be taken to include the denial of access to the amounts and range of foods and drink normally available to children in the home to maintain their health and happiness, but would not include instances where specific food or drinks have to be withheld from a child on medical advice.
* Equally, it would be inappropriate to force a child to eat foods, which he disliked. It would be right, however, to encourage a child to try a wide range of foods. Medical advice must be sought if children consistently refuse to eat, over eat or appear to have eating disorders such as bulimia or anorexia nervosa. Meals are provided at reasonable set mealtimes and food is available to children when they miss a set meal.
* Any restriction on a child's contact with his or her parents, relatives or friends, visits to the child by his or her parents, relatives or friends, a child's communications with any of the persons listed as ‘persons with whom the child can have contact’, or his or her access to any telephone helpline providing counselling or advice for children. This does not prevent contact or communication being restricted in exceptional circumstances, where it is necessary to do so to protect the child or others.
* ‘Time Out’ – Time out is a punishment based behaviour modification technique; and is a form of restriction. It uses the theory that if you remove something positive from someone when they display an unwanted behaviour, they will learn over time to change that behaviour. It should only be used in very special circumstances under the direction of an appropriately qualified professional where a best interests and consent have been carefully considered alongside a functional assessment of the behaviour.
  1. The use of non-approved restrictive practices within a foster placement or residential setting would raise concerns of:
* Poor professional practice; and/or
* Professional Misconduct
  1. In the event concerns are expressed that a child or young person has been placed in seclusion, this should be reported immediately to the Local Authority Designated Officer. The Head of Service should be informed immediately where a decision has been made to report a concern to the Local Authority Designated Officer. The Head of Service and the Local Authority Designated Officer will determine whether a Position of Trust Meeting should be convened in accordance with the Herefordshire Safeguarding Partnership and West Midlands Regional Safeguarding Procedures (see Tri-X).
  2. ***Physical Intervention/Restraint*** *– “physical restraint refers to the use of direct physical force to overpower and prevent or significantly restrict the movement of a child or young person against their will. Restraint must only ever be used for the purposes of preventing harm to the person being restrained, harm to other people, or to prevent significant damage to property. It might be used in an unpredicted emergency or as part of an agreed plan with a particular child or young person”.*
  3. Where a child is placed within a residential placement or residential special school setting; there is an expectation that all staff have received appropriate training provided by the setting in regards to the use of Physical Intervention or Restraint.
  4. It is important to understand that babies and toddlers will be restrained by their caregivers in the course of normal family life. The most obvious example is using a car seat or booster chair to prevent injury to the child. On other occasions, a good parent will simply hold a small child securely for the purposes of keeping them safe. So restraint in the context of this Policy does not include this normal age-appropriate parenting with babies and toddlers.
  5. Every child and young person has a right to be treated with respect and dignity, and deserves to have their needs recognised and be given the right support. Some children and young people with learning disabilities, autistic spectrum conditions or mental health difficulties may react to distressing or confusing situations by displaying behaviours which may be harmful to themselves and others and are at heightened risk of restrictive intervention to minimise the impact of their behaviour, on them and on other people.
  6. Children and young people, their families and carers have said that restraint and restrictive intervention are traumatising. These children and young people also recognise that there may be times when these approaches may need to be used for their protection and to keep them, and others, safe. We know that use of restraint and restrictive intervention can have long-term consequences on the health and wellbeing of children and young people, and that it can have a negative impact on staff who carry out such intervention.
  7. Using positive behaviour support and other alternatives which can de-escalate challenging behaviour, and tackle the reasons for it at source, should be the preferred approach.

1. **SUPPORTING POSITIVE BEHAVIOUR PLANS (RISK MANAGEMENT PLANS)**
   1. Where children’s presenting behavioural needs are complex or where behaviours give rise to serious concern, such as violence, drug or substance misuse, self-harming, or bullying. Some children’s behaviour can also put staff and carers at risk and consideration needs to be given how both staff and carers can manage children’s behaviour that does not place the child, caregivers other children at risk of harm. In such situations a Supporting Positive Behaviour Plan (Risk Management Plan) should be developed; which should be needs led and informed by assessment. In some instances, this may require a specialist assessment to be undertaken by a Clinical Psychologist, Occupational Therapist, Educational Psychologist or CAMHS.
   2. Where it is recognised that a particular child or young person will or may routinely need a level of physical intervention or restraint, then it is important that careful consideration is given as to whether this child can safely be cared for in the context of a foster home. Again, the range of factors discussed above will need to be considered.
   3. In some cases, behaviour necessitating restraint will be linked to a child’s disability, and in these situations (and others) it is essential that the foster carer is encouraged to make full use of any strategies or techniques that have been developed in school or by other professional services. Every effort must be made to minimise and reduce the behaviour that leads to the need for physical restraint.
   4. Where the need for restraint remains, despite these efforts, this should be formally agreed as a behavioural management plan in the context of a placement agreement meeting or in a similarly formal setting. The record of that meeting should set out the child or young person’s views and how these were taken into account, the birth family’s views and how these were taken into account, the foster carer’s views, and those of other professionals involved in the child’s care. The plan should address a number of factors:

* the efforts that will routinely be taken to avoid the need for restraint;
* the likely behaviours that will lead to restraint, where known (for example for a disabled child some forms of behaviour, such as head banging serves as a form of sensory feedback; as does ‘cutting’ for non-disabled children who self-harm):
* the type of restraint that will be employed and who will be involved in this (considering the role of the foster carer’s support network where appropriate);
* arrangements to ensure that the foster carer is fully trained in relation to restraining children and/or this particular child;
* preparation of the child or young person, and any other foster children who are living in the home;
* arrangements for recording following a restraint and who will be notified;
* arrangements for debriefing the child and foster carer following each incident of restraint;
* arrangements for supporting the child or young person, including with advocacy services, where appropriate;
* arrangements for monitoring patterns of restraint and reviewing the behavioural plan.
  1. **Delegated Authority:** Given the seriousness of restraint, where it is considered that the use of restraint should be included within the child’s Supporting Positive Behaviour Plan (Risk Management Plan) it is essential that this is signed off by:
* Head of Service
* senior managers in the fostering service or Registered Manager and/or Regional Manager (residential placement); and by the
* Independent Reviewing Officer (IRO).

1. **POST-RESTRAINT ACTIVITY**
   1. Following a one-off unpredicted incident of restraint, or a more predictable restraint that has been authorised in the context of a Supporting Positive Behaviour Plan (Risk Management Plan), a number of actions should follow:

* consideration should be given as to whether medical assessment or treatment is required, or whether this should be offered to a child or young person. This should be discussed with the child’s allocated Social Worker or EDT (out of hours) as soon after the incident as possible;
* the foster carer, or residential placement should carefully and accurately record the incident, including the series of events leading up to the restraint, the restraint itself, and the resolution or ending;
* for those children in foster care, the carer should notify their supervising social worker/fostering service of what happened, in line with locally agreed procedure, and have the opportunity to be debriefed;
* for those children in residential care, the Registered Manager should be informed; in line with locally agreed procedure; and the residential staff involved in the incident should have the opportunity to be debriefed;
* the child should be given the opportunity to be debriefed by their Social Worker; a suitably skilled professional when communicating with a child with communication difficulties; or a responsible adult who was not involved in the incident, in line with locally agreed procedure;
* depending on the locally agreed policy and the requirements of the child’s Supporting Positive Behaviour Plan, the child should be given a copy of the foster carer’s record and invited to add their views;
* the child should be offered an advocate and reminded of their entitlement to make use of the complaints procedure;
* the child should be offered the opportunity to speak with their Independent Reviewing Officer.

1. **DEPRIVATION OF LIBERTY** 
   1. There may be circumstances where a child or young person require restrictions to ensure their safety and the safety of others in their community. Where this applies, irrespective of the age of the child consideration should be given to obtaining legal advice; to establish whether the proposed restriction is ‘reasonable’; or whether it requires authorisation by the Court.

**RELEVANT GUIDANCE:**

* Non- statutory, advisory guidance published by the DfE: [Reducing the need for restraint and restrictive intervention (June 2019](https://www.gov.uk/government/publications/reducing-the-need-for-restraint-and-restrictive-intervention))
* Statutory guidance published by DfE: [Children’s homes regulations, including quality standards: guide (March 2015)](https://www.gov.uk/government/publications/childrens-homes-regulations-including-quality-standards-guide)

**National Institute for Health and Care Excellent guidance:**

* [Learning disabilities and behaviour that challenges: service design and delivery (March 2018)](https://www.nice.org.uk/guidance/ng93)
* [Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (May 2015](https://www.nice.org.uk/guidance/ng11)
* [Looked-after children and young people (updated 2015)](https://www.nice.org.uk/guidance/ph28)
* [Autism spectrum disorder in under 19s: support and management (August 2013)](https://www.nice.org.uk/guidance/cg170)