Restraint Reduction and the use of Restrictive Practice in Schools Procedure

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Contents

Scope

This procedure applies to all National Autistic Society schools that provide support for children, young people and adults.

Purpose

This procedure outlines the National Autistic Society's approach to the use of restrictive practices within schools that support children, young people, and adults where the organisation holds a duty of care.

Its aims are:

- To provide clear guidance to staff on which forms of restrictive practices are permissible, and under what circumstances they may be considered.
- To identify and prohibit unacceptable forms of restrictive practices, with clear rationale for their exclusion.
- To ensure the use of restrictive practices is minimised, and that where necessary, reduction plans and proactive strategies are in place to support this goal.

The rights and dignity of children, young people, and adults using National Autistic Society Schools must be upheld at all times, including during episodes of physical distress or dysregulation.

Any use of restrictive practice must:

- Be implemented solely to ensure safety.
- Support recovery from distress and dysregulation.
- Promote the development of effective coping strategies and practical life skills.
- Be part of a broader strategy aimed at reducing the need for intervention over time.

This procedure must be read in conjunction with: SO-0040 – Restraint Reduction and the use of Restrictive Practice in Schools Policy and SO-0030 – Supporting Behaviour in Schools Policy.

Commitment to Restraint Reduction

The National Autistic Society education directorate has pledged to the Restraint Reduction Network (RRN) to focus on reducing restrictive practices across its schools. This commitment includes adherence to the Six Core Strategies promoted by the RRN, which provide a systemic framework for cultural change:

Leadership – Strong leadership at both organisational and practice levels.

Data Collection and Analysis – Evidence-based decision-making and progress monitoring.

Workforce Development – Training focused on preventative, not reactive, methods.

Use of Prevention Tools and Strategies – Including trauma-informed approaches and Positive Behaviour Support.

Involvement of People with Lived Experience – Ensuring their voices inform reduction strategies.

Post-Incident Support and Debriefing – Emotional support and reflective learning opportunities for all involved.

Introduction

A broad range of proactive approaches and strategies should be employed to reduce the likelihood of distress escalating into incidents that may result in harm. These include, but are not limited to:

- Designing and maintaining learning environments that are responsive to the individual needs of children, young people, and adults.
- Implementing de-escalation techniques and distraction strategies to support emotional regulation.
- Developing personalised communication plans and sensory profiles to enhance understanding and reduce distress.
- Applying low arousal approaches at all times.
- Other elements of support (see Supporting Behaviour in Schools Policy – SO-0030).

Despite these preventative measures, there may be rare occasions where, as a last resort, a strategy involving restrictive practice is necessary. In such cases, restrictive practices must be used solely to maintain the safety and welfare of the children, young people, adults we support, our staff, and the wider community.

All staff will be trained in approved techniques. Any unplanned intervention that falls outside of a person's Individual Behaviour Support Plan (IBSP) will be subject to review and investigation. This ensures that the action taken was proportionate to the risk, applicable to the situation, and that support strategies are developed to prevent recurrence.

Restrictive interventions must only be considered when all other alternatives have been exhausted and there is an immediate need to prevent harm. In such cases, any intervention must be:

- **Lawful** – compliant with relevant legislation and regulatory frameworks.
- **Justified** – based on a clear and documented rationale linked to the individual's assessed needs.
- **Proportionate** – the level of restriction must match the level of risk presented.
- **Least Restrictive** – the intervention must have the minimum impact necessary on the individual's rights, freedom, and dignity.

All restrictive practices must be subject to regular review and oversight to ensure they remain appropriate and necessary.

To meet the criteria, all preventative options must first be exhausted. (See Related document: Non-restrictive and restrictive intervention practice.)

Staff should remain conscious of Social Validity and how the intervention may appear to observers not involved in the situation and how they would wish themselves, their family members, or friends to be treated in similar circumstances.

Planning, Assessment, and Prevention

All children, young people and adults educated in National Autistic Society schools will have an Individual Behaviour Support Plan (IBSP). This plan provides detailed, person-centred information about the pupil.

Individual behaviour support plans must adopt a person-centred approach, providing detailed information about the child, young person or adult behavioural presentation. This includes hypotheses regarding the function of specific signs of distress, identification of contributing environmental and personal factors, antecedents, and known triggers.

Wherever possible, the plan should be developed collaboratively with the child, young person or adult and/or their family or carers to ensure it reflects their lived experience and preferences.

The plan must clearly describe the proactive, secondary preventative, and reactive strategies to be implemented by those supporting the child, young person, or adult. These strategies aim to enhance the person's quality of life and minimise the risk of harm to themselves or others, in line with Restraint Reduction Network (RRN) Key Strategies 3 and 4.

Where necessary and in the best interests of the child, young person or adult, reactive strategies may include the use of restrictive practices. These must always represent the least restrictive option.

Medical Needs

Particular care should be taken with any physical practice involving the children, young people, or adults who have or maybe at risk of vulnerable joints and/or underlying health problems such as swallowing difficulties, obesity, or cardiac issues. These factors significantly increase the risk of harm during physical interventions.

When assessing the needs of any children, young people and adults that require the use of a restrictive practice as part of their support plan, it is essential that advice is sought from the relevant medical professionals around the use of such practices for the individual when underlying medical conditions are diagnosed and/or apparent

When considering the use of new restrictive practices, reasons could be:

- Following unplanned response.
- Change in health/medical need.

- Change in environment.
- Change in circumstance.
- Change in presentation.

The following processes should be applied and followed:

- Underlying medical issues identified at the assessment stage.
- Advice sought as part of any proposed offer of placement around the use of Restrictive Practice and the how this may influence any potential regression, relapses or risks to the children, young people, or adults.
- A risk management plan should be developed that includes input and guidance from the relevant professionals, the Director of Education and the National Lead in Low Arousal and Behaviour Management.
- Any unmanaged or uncontrolled risks in the risk management plan escalated through the Risk Escalation framework.
- Comprehensive post incident analysis ensuring any potential effects from the use of such practices have been monitored, recorded, and reported to the relevant professionals.
- Where a child, young person or adult is currently accessing our schools with underlying medical issues and does not have a plan in place, this must be organised internally, and the relevant professionals contacted in order to implement the strategies and documentation to support policy expectation.
- Awareness of the significant harm that may be caused to a child, young person or adult due who may be at risk due to their physical development.

If a restrictive practice is used with someone who has underlying health issues, medical attention must be sought immediately (RRN Key Strategy 5).

Mental Capacity

The Mental Capacity Act 2005 applies to pupils over the age of 16. The Mental Capacity Act does not prevent restrictive practice, but it offers an additional framework and assessment to ensure that vulnerable adults have their freedoms protected.

The Mental Capacity Act should be considered in the planning and assessment stage and should guide IBSP plans for post-16 pupils.

As stated above, IBSP plans should be developed with the pupil. All pupils should be assumed to have capacity to consent to their IBSP and any restrictions. Pupils should be able to understand and agree to their IBSP plan and any restrictions. However, where a pupil's capacity to make this agreement is doubted, an assessment of mental capacity should be undertaken.

Under the Mental Capacity Act, a person is assumed to have capacity unless there is evidence that they are not able:

- to understand the information relevant to the decision
- to retain (keep in mind) that information
- to use or weigh that information as part of the process of making the decision, or
- to communicate their decision (whether by talking, using sign language or any other means).

Mental capacity assessments are issue specific, meaning that someone may not have capacity in relation to a particular issue but may have capacity in relation to a different issue.

Where a pupil over 16 has been assessed to not have capacity in relation to their behavioural support, the plan must be agreed as in their best interest and least restrictive option by the relevant people involved in their care (RRN Key Strategy 5). All documentation must be reviewed on an annual basis and be kept in the individual's support folder.

Physical Restrictions

All behaviour support plans, including any restrictive practices, must be reviewed annually as a minimum and stored securely within the child, young person, or adults support documentation.

Restrictive practices may take various forms and do not always involve direct physical intervention. All staff must be aware of the definition, implications and potential impact of such practices and ensure their use is justified, documented, and monitored appropriately.

Restrictive practices may be included as part of a reactive strategy only when they are in the **best interests of the individual** and the **least restrictive option available** to safely manage the situation.

All incidents need to be recorded on CPOMS to ensure consistency, transparency, and accountability.

Physical Restraint

Physical restraint refers to the use of direct physical contact by one or more individuals to compel a person to do something against their will, or to prevent them from doing something they wish to do.

Staff employed by the National Autistic Society will receive appropriate training in Studio 3 'Managing Signs of Distress' techniques, where necessary, to ensure the safety of the children, young people, and adults they support, as well as their own safety and that of the public.

The National Autistic Society maintains a strict policy prohibiting the use any unacceptable and dangerous interventions under any circumstances.

All physical interventions must be used only as a last resort, in line with the principles of least restriction and in the best interest of the individual.

Chemical Restraint

Chemical restraint refers to the use of prescribed medication with the primary purpose of influencing or controlling an individual's behaviour. This may include the administration of pro re nata (PRN) medication, such as sedation or rapid tranquilisation, where medication is used to prevent an individual from engaging in a behaviour they wish to perform, or to compel them to engage in a behaviour they would otherwise resist.

The use of any PRN medication must be governed by a clearly defined, individualised protocol developed by the prescribing medical professional in collaboration with a multi-agency team. This ensures that the intervention is clinically justified, person-centred, and aligned with safeguarding principles.

Any pupil requiring a PRN (pro re nata) prescription for behavioural or emotional wellbeing needs within the school environment must be discussed with the Director of Education prior to inclusion in their care plan. This ensures appropriate oversight, safeguarding, and alignment with educational and clinical responsibilities.

For further guidance, refer to the related document: Non-restrictive and restrictive intervention practice.

Environmental Restraint

Environmental restraint refers to the intentional use of the physical environment to restrict an individual's access to specific areas, objects, or activities, with the aim of influencing or controlling their behaviour. This form of restrictive practice involves modifying or limiting the environment to manage a person's movements or actions.

The National Autistic Society does not advocate the use of environmental restraint, recognising that such practices can undermine autonomy, dignity, and wellbeing.

All staff must be aware of the ethical and legal implications of environmental restraint and ensure that environments are designed to support independence, safety, and positive behavioural outcomes.

Mechanical Restraint

Mechanical restraint involves the use of materials or equipment to restrict or prevent an individual's movement. Examples include devices such as arm splints or belts. This form of restraint is considered a restrictive practice when it is used to engage a person in an activity they do not wish to do or prevent them from engaging in an activity they wish to pursue.

Surveillance

Surveillance involves the monitoring of individuals, environments, or property through observation or technology. This may include staff physically observing a person, as well as the use of devices such as cameras, microphones, or GPS trackers. When surveillance is

used to monitor individuals in a way that limits their privacy, autonomy, or freedom of movement, it may be considered a restrictive practice. Its application must be clearly justified, proportionate to the identified risk. Surveillance should be reviewed regularly by a multidisciplinary team to ensure it remains ethical, lawful, and in the best interests of the person being supported.

Cultural Restraint

Cultural restraint refers to the use of cultural norms or expectations to control or influence an individual's behaviour, particularly when it results in limiting their autonomy or expression. This may involve preventing a person from expressing their cultural identity or preferred ways of being, restricting participation in activities that are meaningful to their values, ethnicity, or culture, or causing them to feel ashamed, inferior, or humiliated due to perceived differences. Such practices are considered restrictive and can have a significant negative impact on a person's wellbeing, dignity, and sense of self. All staff must be aware of the risks associated with cultural restraint and ensure that support is respectful, inclusive, and culturally affirming.

Psychological Restraint – Coercion

Psychological restraint refers to the use of communication strategies that exert psychological pressure on an individual, compelling them to engage in actions they do not wish to take or preventing them from doing things they value. This form of coercion can undermine autonomy and emotional wellbeing and must be recognised as a restrictive practice.

Blanket Rules

Blanket restrictions are rules or policies applied broadly to groups of individuals without consideration of personal circumstances or individual risk assessments. These may include limitations on access to specific places, personal belongings, or meaningful activities. When used without justification, blanket restrictions can significantly impact a person's liberty and rights.

Restrictive practices can be categorised as planned or unplanned practices.

Planned Restrictive Practice

Planned restrictive practices refer to pre-arranged interventions that are clearly documented within an individual's behaviour support plan. These interventions are informed by comprehensive risk assessments, RAMPs, Restraint Reduction Plans, Training Needs Analysis (TNA), therapeutic input and clinical judgement. All planned interventions must be in the individual's best interests, represent the least restrictive option available, and be used for the shortest duration necessary to ensure safety and wellbeing.

Only techniques sanctioned by Studio 3 may be used, and staff must be fully trained in their application, with training tailored to the specific needs of the children, young people, or adults they support. The use of any planned restrictive practice must be reported within 24

hours of the intervention taking place, in line with organisational reporting protocols and safeguarding requirements.

Unplanned Restrictive practices

Unplanned restrictive practices refer to interventions that occur in response to unforeseen or emergency situations, where immediate action is required to prevent serious harm to the child, young person, adult, or others. These interventions are not pre-arranged and may arise unexpectedly, such as physically intervening to prevent someone from running into traffic.

Unplanned responses must still be lawful, justified, carried out in the individual's best interests. Any unplanned restrictive practice must be the least restrictive approach possible and for the minimum time necessary to ensure safety. The use of any unplanned restrictive practice must be reported within 24 hours of the intervention, in accordance with organisational procedures and safeguarding requirements

Wherever possible, an unplanned response should still be a studio 3 sanctioned and trained technique. However, in an emergency if this was not practicable, but an intervention is still urgently needed to prevent harm to self-and/or others, staff must follow the legal principles laid out at the start of the 'Restraint Reduction and the use of Restrictive Practice in Schools' Policy.

Where unplanned or unintentional incidents of restrictive practices occur, they should always be recorded, opportunity given to debrief, followed by a reflective session/incident analysis to ensure learning and continuous safety improvements take place (RRN Key Strategy 6).

If monitoring shows that an unplanned restrictive practice is required on more than one occasion in a 4-week period, the Individual Behaviour Support Plan, RAMP and risk assessments should be amended to include any planned restrictive practices, along with proactive measures to reduce the need for such interventions over time (RRN Key Strategy 6).

Unacceptable and dangerous interventions

There are a number of interventions that are either unacceptable, dangerous, and often both:

- Pain compliance techniques.
- Supine restraint (face-up/back on floor/other surface).
- Prone (face-down/chest on floor/other surface).
- Any restraint involving joint locking.
- Any restraint that compromises or restricts the airway.
- Any restraint that involves forcing the head forward onto the chest area.

The above interventions should be avoided even in emergency situations.

Seclusion and Segregation

Seclusion refers to the supervised containment or isolation of a child, young person, or adult in a room from which they are **prevented from leaving**.
Seclusion normally takes place as a direct response to manage an incident or episode.

In line with the Restraint Reduction Network and the Department of Education guidance, the organisation does not permit the use of involuntary seclusion. This position reflects our commitment to safeguarding, inclusive practice, and the minimisation of restrictive interventions.

We recognise that **involuntary** seclusion is not a lawful response to distressed behaviour and is incompatible with our values of dignity, safety, and person-centred support. Our approach is aligned with the Department for Education's guidance on behaviour and exclusions, and we actively promote preventative and de-escalation strategies to support all learners.

If a person is involuntary confined for a short time, they are still likely to be harmed by the experience and may have psychological impact and immediate aversive reactions for example, isolation panic. Isolation panic includes experiences of rage, loss of control, breakdowns in wellbeing, psychological regression and increases in self-harm. Self-harm is more likely to occur in confinement and in the immediate period after confinement.

Seclusion may be described or implemented using a variety of terms or practices. While terminology may vary, the core principles governing the use of seclusion remain applicable in all instances. Examples may include, but are not limited to:

- Time out
- Segregation
- Safe space
- Chill-out room
- De-escalation room
- Quiet room
- Calming room
- Garden time or locked garden
- Solitary time
- Staff withdrawal (eg staff behind locked doors)

It is important to recognise that even when seclusion is described indirectly or framed as part of a supportive strategy, the same ethical, legal, and procedural standards apply.

Seclusion must never be used:

- As a punishment or threat.
- As part of a behaviour management programme.
- Due to staff shortages.

- Where there is a risk of suicide or self-harm.
- For staff convenience or comfort.

Restraint and seclusion can cause trauma, distress, and undermine the dignity of children, young people and adults. These practices should only ever be used as a last resort, in response to an immediate risk of harm, and never as punishment, for staff convenience, or due to staffing shortages.

The Department for Education's 2025 draft guidance introduces a statutory duty for schools to record and report all significant incidents involving the use of force to parents or carers from September 2025.

Seclusion as an Unplanned Restrictive Practice

If seclusion is used as an unplanned response to an extreme situation, monitoring throughout the period (until the present/immediate danger has passed) must be undertaken in line with the guidance above and as soon as is practicable, within 24 hours, the Director of Education and Children's Services and the Nominated Individual must be notified of the incident.

Segregation

Segregation refers to the practice of caring for a child, young person, or adult in isolation from others, without regular opportunities for social interaction. It is typically a deliberate decision and may still be considered segregation even if limited interaction with staff or peers is permitted particularly if the isolation extends beyond two school days.

Segregation is usually an active decision to care for somebody separately.

If the isolation has been in place for 2 school days or more, it should still be considered segregation even if the person is allowed periods of interaction with staff and or peers.

The reasons for the use of segregation are as follows:

- When an individual is displaying high levels of distress or behaviours of concern that impact the wellbeing of themselves or others.
- Children, young people and adults' personal hygiene or health is having an impact on others physical or emotional well-being.
- To safeguard an individual from harm, including bullying, sensory overload, or emotional distress.

Any segregation must be evidence-based and in the children, young people and adults' best interests. Should staff require further information on this, they can contact the Director or Assistant Director of Education.

Planned Withdrawal

Where there is 'Staff Withdrawal' as part of the children, young people and adults' Behaviour Support guidelines and/or Restrictive Practice Plan, it needs to be agreed as part of a transdisciplinary process and form part of the person's Risk Management and Restraint Reduction plan.

Staff Withdrawal (Non-Seclusion/Non-Restrictive Practice)

There may be occasions where staff temporarily withdraw from a space to support a child, young person, or adult in regulating their emotions, maintaining privacy, or in response to a direct request from the individual. This approach is only appropriate when:

- Doors remain unlocked, ensuring the individual has the freedom to leave or request staff engagement at any time.
- It is clearly outlined in the individual's proactive support or therapeutic plan and led by the preferences of the individual wherever possible.
- Robust monitoring protocols are in place to ensure the strategy is used appropriately and safely.
- Staff are fully trained in the use of this intervention, including when and how to implement it, and how to record and report its use.

This strategy must never be used as a form of seclusion or control, and must always uphold the individual's rights, dignity, and autonomy.

Staff Withdrawal (Seclusion)

If staff withdrawal results in a child, young person, or adult being left alone in a room with a locked door, this constitutes seclusion. Such practice is considered a restrictive intervention and must only be used in exceptional circumstances where there is a clear, imminent, and immediate risk to safety.

Use of seclusion in this context must:

- Be agreed through a multi- or trans-disciplinary process.
- Be based on actual risk and present/current/evidenced risks.
- Be clearly documented in the individual's Behaviour Support Plan and Restrictive Practice Plan.
- Be part of a wider Risk Management and Restraint Reduction Plan.
- Include robust monitoring and documentation protocols.
- Ensure the individual is safe and supported throughout, in line with their risk assessment and safeguarding plan.
- Staff should be fully trained in the use of this intervention, including when and how with clear procedures for implementation, recording, and reporting.

If a staff withdrawal seclusion takes place as an unplanned restrictive practice, this must be reported within 24 hours to the Director of Education, and the Nominated Individual.

Responding to Distressed Behaviour and Use of Restrictive Practices (Aligned with RRN Key Strategies)

1. Staff must respond to distressed behaviour in a calm, proportionate, and considered manner, prioritising the safety and wellbeing of pupils, colleagues, and themselves. This reflects RRN Key Strategy 1, which promotes a preventative, trauma-informed approach to behaviour.

2. All staff must be trained in techniques tailored to the individuals they support, based on thorough training needs assessments and embedded within Behaviour Support Plans, Risk Assessments, RAMP's and Restraint Reduction Plans. This aligns with RRN Key Strategy 3, ensuring staff are equipped to respond safely and ethically.

3. Risk must be regularly assessed and managed through updated plans to safeguard individuals, others, and property, in line with RRN Key Strategy 3 and the commitment to safe, preventative practice.

4. Restrictive practices must be proportionate, reasonable, and never used as punishment. They must be person-centred, documented, and regularly reviewed, reflecting RRN Key Strategy 2, which focuses on reducing the use of restrictive interventions and promoting ethical practice.

5. Individuals should be involved in decisions about restrictive practices wherever possible, with input from families, advocates, and support networks. Communication must be accessible and respectful, in accordance with RRN Key Strategy 5, which promotes transparency, inclusion, and respect for rights and dignity.

6. Restrictive practices must never cause pain, pressure on joints, or compromise the airway, in line with RRN Key Strategy 2 and the protection of human rights.

7. Staff should consult with colleagues, prioritising those with the closest relationship and understanding of the individual, even over seniority. This collaborative approach supports RRN Key Strategy 4, which encourages shared decision-making and professional accountability.

8. Restrictive practices should only be used when no safer alternatives are available, reinforcing RRN Key Strategy 1 and the emphasis on prevention and de-escalation.

9. Only Studio 3-approved techniques should be used, and only by trained staff, unless in emergencies or where bespoke plans indicate otherwise. This is consistent with RRN Key Strategy 3, ensuring safe and appropriate use of interventions.

10. Bespoke practices must be agreed by a multidisciplinary team and signed off by Studio 3, the National Lead in Low Arousal and Behaviour Management, and the Director of Education. Local trainers cannot approve or teach bespoke methods, maintaining fidelity to RRN Key Strategy 3 and governance standards.

11. All Temporary/Agency staff must first complete the 3-day Managing Signs of Distress training before being trained in bespoke techniques, ensuring competency in line with RRN Key Strategy 3.

12. Only Studio 3 or the National Lead in Low Arousal and Behaviour Management may approve and train internal trainers in bespoke practices, which must be documented and used only for specified individuals, maintaining consistency with RRN Key Strategy 3.

13. Restrictive practices should be used for the shortest time necessary, with environmental adjustments made to reduce intervention time, it may be necessary, depending on which is the least restrictive, to move other people to a safer environment to reduce the intervention time. This supports RRN Key Strategy 2 and the principle of least restriction.

14. Staff must follow behaviour support guidelines detailing all strategies and interventions, including restrictive practices, in line with RRN Key Strategy 4, which promotes clarity and consistency in practice.

15. Careful consideration must be given to the use of restrictive practices when supporting an individual who is engaging in self-injurious behaviour (SIB) or deliberate self-harm. A comprehensive risk assessment and a clearly agreed technique should guide the support strategy. If all other approaches have been attempted and proven ineffective, agreed and approved Studio 3 restrictive practices should be used as a last resort, unless it's decided a physical intervention will increase the risk of harm. This approach aligns with RRN Key Strategy 1 and emphasises the importance of trauma-informed, preventative practices.

16. After any restrictive practice, an independent person must check the individual for injuries, ensuring accountability and safeguarding in line with RRN Key Strategy 4.

Debriefing (RRN Key Strategy 6)

Debriefing refers to the opportunity provided to children, young people, adults, and staff following an incident to discuss the emotional impact it has had on them. It is a supportive process that enables individuals to express their feelings freely and openly, and to be assisted in processing and recovering from the experience.

Post-incident debriefing is recognised as an approved and effective practice (Department of Health, 2014). It supports emotional recovery, promotes learning from crisis situations, and contributes to the reduction of future restrictive practices. High-quality debriefing helps to

repair, build and maintain trusting relationships, fostering a sense of safety and emotional security. It also enhances self-awareness and communication, leading to improved outcomes for individuals, families, and staff.

- Debriefing sessions must remain confidential unless safeguarding concerns are disclosed. They are not to be used to influence changes to behaviour support guidelines, nor should they serve as a forum for analysing or reflecting on staff practice. Separate processes such as Reflective Supervision or Incident Analysis are designed for that purpose and should only be undertaken after the debriefing has been offered or completed.
- While participation in a debrief is optional, it is strongly recommended for the children, young people, and staff. Everyone has the right to decline a debrief following an incident.
- No narrative or detailed content from the debrief should be recorded; however, the offer and the acceptance or refusal of the session must be logged appropriately.
- Where a debriefing session has taken place, it must be recorded as part of the incident documentation, for example within CPOMS.
- Debriefing must be offered to any child, young person or adult who has been subject to restraint, in accordance with their individual behaviour support guidelines.
- Debriefing should be offered as soon as reasonably possible following the incident.
- Reasonable adjustments must be made to ensure accessibility. For example, where an individual has difficulty processing verbal information, visual supports should be provided. Effective communication is the foundation of safe care, and making reasonable adjustments is essential to reducing distress and minimising the use of restrictive practices.
- Debrief guidance NAS Debrief Guidance - 2023 V2.0
- https://restraintreductionnetwork.org/wp-content/uploads/2022/06/Post-Incident-Debriefing-Guidance-for-staff-working-with-autistic-people-or-people-with-learning-disabilities.pdf

Training (RRN Key Strategy 1-5)

For Tiered Framework see the policy part of this document and the 'Managing Signs of Distress Framework'

All training that includes physical interventions and restrictive practices must be assessed and tailored to meet the specific needs of both the school and the individuals being supported. In line with the Restraint Reduction Network Training Standards, training must be proportionate to the needs of the population and setting, and reflect the unique characteristics, vulnerabilities and communication styles of the children, young people and adults involved.

Training should not focus solely on technical competence but must promote a person-centred, therapeutic approach that protects human rights, prioritises prevention and de-escalation, and supports a positive culture of care. A thorough training needs analysis should be conducted to ensure that the content, delivery, and outcomes of the training are relevant, ethical, and effective. Training must be delivered by competent trainers who can evidence knowledge and skills that extend beyond the application of physical restraint, and who are committed to reducing reliance on restrictive practices.

This approach is consistent with the RRN's national benchmark for ethical training in education settings, and supports the development of safe, reflective, and rights-based practice.

This guidance must be followed:

- All physical skills training must be based on a thorough assessment of both the school's context and the individual needs of the children, young people and adults being supported. Training must be proportionate, relevant, and tailored to the specific risks and support requirements identified within the setting.
- Where there is a need for staff to be trained in any form of physical intervention or restrictive practice, a Risk Management Plan, Training Needs Analysis, and where appropriate, a Restraint Reduction Plan must be completed. Following this assessment, a formal Training Request Form should be issued by the principal, relevant Behaviour Support or Therapy team.
- The training proposal must be updated annually or when there are any significant changes throughout the school year.

All staff

In accordance with Restraint Reduction Network Training Standards (Key Standard 1.2.1), all staff must receive preventative training before undertaking any training in restrictive interventions. Preventative training should focus on understanding behaviour, de-escalation strategies, trauma-informed approaches, and the promotion of positive relationships.

This process ensures that training is ethical, evidence-based, and aligned with national standards for reducing reliance on restrictive practices, while safeguarding the rights and wellbeing of both staff and the individuals they support.

As part of their induction into the organisation, all staff are required to complete a minimum of six hours of additional training, as outlined in RRN Key Strategy 1. This training supports staff in working positively and proactively with children, young people, and adults, and in understanding individual needs, this is a minimum requirement for all staff.

- Each member of staff is expected to complete the full training framework appropriate to the Tier of the school in which they work. Best practice recommends completing the full course every three years, or sooner if there is a significant change in school context or role.

- Refresher training attendance every 12 months is mandatory. The refreshers will cover components of the full three-day course and will be recorded on the training proposal. Trainers will be notified via a formal Training Request Form.
- All staff must be well-versed in the Studio 3 Low Arousal Approach. This includes an understanding of the Low Arousal principles, self-awareness and environmental awareness. The Low Arousal Approach underpins our commitment to reducing restrictive practices and promoting safe, respectful, and person-centred care.
- All staff working in **Tier 1 schools** are required to complete Managing Signs of Distress - Day 1 Theory as a minimum training standard. To ensure understanding and retention of the theoretical content, staff must complete a 20-question multiple-choice questionnaire following the training session.
- Staff working in **Tier 2 schools** must complete a minimum of Managing Signs of Distress - Day 1 Theory and Day 2 Physical Skills Training, which is tailored to the individual and school context. In addition, all Tier 2 staff are required to attend mandatory annual refresher training, which includes the theory component and any physical skills identified through a training needs assessment.

  Where a need for restrictive practice is identified through a Training Needs Analysis, staff must also complete Day 3 training focused on safe and ethical restrictive interventions. This tiered approach ensures that training is proportionate, relevant, and aligned with the Restraint Reduction Network (RRN) Training Standards, supporting safe, person-centred practice across all settings.
- All staff working in **Tier 3 schools** are required to complete the full Managing Signs of Distress training programme, which includes:
  Day 1: Theory
  Day 2: Physical Skills
  Day 3: Physical Skills - Restrictive Practices

  All training undertaken must be needs-assessed to ensure it is proportionate, relevant, and aligned with the children, young people, adults needs and environmental risks present in the school setting. Staff must also attend mandatory annual refresher training, which includes the theory component and any physical skills identified through ongoing assessment.
  This structured approach ensures that staff are equipped with the knowledge and skills required to support the children, young people, and adults safely and ethically, in line with the Restraint Reduction Network (RRN) Training Standards and the organisation's commitment to reducing restrictive practices.

- Staff working in **Tier 4 schools** are required to complete the full Managing Signs of Distress 3-Day training programme.

  In addition to the core training, any Tier 4 sanctioned techniques must be monitored and delivered in line with the specific needs of the children, young people, adults, the supporting team, and the organisation's Restraint Reduction Pledge. Staff must attend

an additional workshop focused on the safe and ethical application of the specific Tier 4 strategy being implemented.

All training must be needs-assessed to ensure it is proportionate, relevant, and aligned with the risks and support requirements of the setting. Mandatory annual refresher training is required for all Tier 4 staff, covering the theory component and any physical skills identified through ongoing assessment.

This approach ensures that staff are equipped to deliver safe, person-centred support in complex environments, in full compliance with the RRN Training Standards and the organisation's commitment to reducing restrictive practices.

Recording, reporting, and monitoring (RRN Key Strategy 6)

- All incident reporting should be in-line with the Incident Management Policy and Procedure.
- Any incident involving the use of restrictive practice must be recorded on CPOMS within 24 hours.
- Any use of environmental changes to restrict movement, administration of PRN medication to manage signs of distress, and the use of mechanical restraint must be recorded using the designated restrictive practice forms within 24 hours. Refer to Related documents: *Non-restrictive and restrictive intervention practice* and *How to complete the restrictive practice form*.
- All incidents involving a restrictive practice must be documented on a Restrictive Physical Intervention (RPI) form and/or CPOMS record. These records are retained by the school and monitored by the Senior Leadership Team, who are responsible for reviewing and signing off each report.
- If any child, young person, adult or staff sustains an injury as a result of the restrictive practice, an accident report must be completed in addition to the incident documentation and reported to the Health and Safety Lead, the Director of Education, Safeguarding Team, and the National Lead in Low Arousal and Behaviour Management.
- The Health and Safety Lead, the Director of Education, Safeguarding Team, and the National Lead in Low Arousal and Behaviour Management will advise on when incidents must also be formally reported in writing to external agencies such as Ofsted, Social Care, or the Local Authority. Required information is detailed in Related Document: Information to be recorded for each use of a restrictive physical intervention.
- All completed incident records must be reviewed and signed off by the appropriate senior staff member, in line with the school's internal protocol.

- Individual Behaviour Support Plans must include clear strategies aimed at reducing reliance on restrictive practices over time. These plans should reflect a proactive, person-centred approach.
- Following any incident involving restrictive practice, the support team must review the restrictive practice prescribed for the child, young person or adult.
- Formal reviews of all plans must take place at least annually, and more frequently if required. These reviews should be conducted alongside relevant risk assessments and RAMPs.
- After any use of restrictive practice, the individual Behaviour Support Plan and associated risk assessments must be reviewed and updated as necessary to reflect learning and ensure continued safety and appropriateness of support.

This policy is grounded in a human rights-based approach, as outlined by the Equality and Human Rights Commission.

Related Documents

- Information to be recorded for each use of a restrictive physical intervention
- Non-restrictive and restrictive intervention practice
- Restrictive practice form
- How to complete the restrictive practice form
- Procedure for admission
- Unplanned response reporting
- Managing signs of distress framework
- Incident analysis form
- Studio 3 verification sheet
- Protocol for unplanned restrictive practices
- Training request referral form
- Restrictive practice risk management plan (blank)
- Incident management policy (QS-0001)
- Complaints and compliments management policy – schools (QS-0010)
- Schools safeguarding children and young people (child protection) policy (SO-0189)