Restraint and care plans in the Court of Protection: Positive Behaviour Support plans for people with learning disabilities

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Introduction

1. The Court of Protection is frequently asked to approve care plans for people with learning disabilities whose behaviours challenge. A significant number of people in this position may also be autistic. In addition to care plans produced pursuant to the Care Act 2014 or other statutory requirements, where "challenging behaviour"[1] has been identified, there will usually be a behaviour management plan too - often wrongly called a Positive Behaviour Support (PBS) plan - in place. Many services will say that they have a PBS plan but often such plans are simply reactive behavioural management plans (focused on how to respond/ react to individuals when engaging in challenging behaviour), rather than a more comprehensive PBS plan. A PBS plan should cover both proactive aspects of support (that endeavour to reduce the need for behaviour that challenges in the first place) and more reactive aspects of care and support that are implemented when challenging behaviour occurs. Despite recognition that prone restraint should not be used, and that any restraint should be a last resort, these plans are often approved in the CoP, even where they include prone restraint. Part of the reason for this may be that the witnesses (including independent experts) say that this form or level of intervention is necessary. This can then leave the Court with limited options in terms of approving or rejecting the plans – if every health professional involved says that the plan is necessary and proportionate, it can be difficult for a lay party to challenge the plan and for the judge to depart from the consensus professional view.

2. It is known that such restrictive practices may, in fact, not be required notwithstanding the professional consensus - it is not unusual for a person to move to a different setting, with a different care provider, and for there to be a significant reduction in the level of restraint required. In some cases in the authors' experience, a change in setting and provider has meant that physical restraint which has been part of a person's care plan for many years can be entirely eliminated. This suggests that care plans that include restraint require extremely careful scrutiny, and that there needs to be a more robust approach to challenging professional opinion, particularly where sufficient attempts have not been made to reduce or eliminate restraint. It may be that the use of restraint is not, in fact, a last resort; instead appropriate assessment, intervention and support have not been effectively implemented.

3. This note has been complied by Dr Theresa Joyce and Victoria Butler-Cole QC, with the aim of providing some background information to legal practitioners and advocates on appropriate approaches to supporting people whose behaviours challenge; and also to suggest areas they might wish to consider when reviewing care plans and

[1] See the next section for discussion of "challenging behaviour."

putting questions to witnesses, including experts. We hope this will enable lawyers to put the Court in a position to form a view as to whether a PBS plan is informed by the evidence base and reflects good practice, and also whether the restrictive physical interventions being used are both necessary and proportionate.

4. We are aware that there are a range of views about the use of PBS plans, and the use of restrictive physical interventions. Our starting point is that the use of PBS plans is supported by policy and guidance, but what should always be challenged is the inclusion of restraint within any such plan. We consider that the use of restrictive physical interventions for people with learning disabilities and/or autism both **should** be eliminated and **can** in many circumstances be eliminated even within the constraints within which the Court of Protection is invited to operate. This note aims to give legal practitioners and advocates tools to challenge plans which include restraint. We have tried to include information that will assist in challenging the typical plans seen in England and Wales, but we acknowledge that there are wider questions, which are not within the scope of this document.

5. The note addresses the following:
- What is challenging behaviour?
- What is Positive Behaviour Support and what should plans include?
- 15 potential questions to ask about PBS plans
- Appendix 1 (policy and practice guidance extracts)
- Appendix 2 (Flowchart of PBS plan components)

What is challenging behaviour?

6. "Challenging behaviour" became the accepted term for what used to be known as problem behaviour, or behaviour problems in the l1990's. There remains disagreement about whether 'challenging behaviour' is the right term, and there is now a shift to using the term 'behaviours that challenge' to indicate that the behaviour is a challenge to those supporting the person. The issue of terminology is outside the scope of this paper, which seeks to provide assistance to advocates working within the current framework.[2]

7. Challenging behaviour has been defined as follows:

> '*Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities.'*[3]

[2] Both terms are used in this note.

[3] Source: Emerson, E (1995), cited in Emerson, E (2001, 2nd edition): Challenging Behaviour: Analysis and intervention in people with learning disabilities. Cambridge University Press

'*Behaviour can be described as challenging when it is of such an intensity, frequency, or duration as to threaten the quality of life and/or the physical safety of the individual or others and it is likely to lead to responses that are restrictive, aversive or result in exclusion.'* [4]

8. The change from 'problem behaviour' to 'challenging behaviour' was intended to signal a move away from seeing the problem as residing in the person, but instead in the way they are supported or 'treated' by those around them – as a product of the interaction between the person and an aspect of their social environment. It recognised that it is not just the case that the person has learned how to behave in a challenging way because it brings them a reward (which was frequently considered to be the case, for example by obtaining attention from staff or carers). It instead conceptualised challenging behaviour as having a communicative function – the person is not able to just tell someone what they want or need because they do not have a functional method of communicating their needs. This may be due to difficulties with verbal communication, and challenging behaviour is a more effective way (sometimes the only way) of getting their needs met.

9. Challenging behaviour can also be due to the person living in an environment where staff are not sufficiently skilled to meet their needs. The person becomes distressed because those supporting them are unable to understand what they need and respond appropriately to them. The distress is itself a form of communication. For example, a person might want someone to come and spend some time with them. They do not have the words or skills to obtain this by asking. In their increasing distress, they might throw a chair. Those caring for them immediately respond by coming over to the person, talking to them and trying to find out why the person threw the chair. The person learns that throwing the chair results in the social attention that they want. They might therefore repeat the behaviour the next time they want someone to spend time with them. They learn that throwing a chair gets their needs met. The behaviour is therefore functional in the context the individual finds themselves.

10. Those supporting a learning disabled or autistic person should therefore ask the question "what function does the challenging behaviour serve for the person?" If you can work out what function the behaviour serves (i.e. what need the behaviour meets) then you can help the person and those who are supporting them to learn a more appropriate way of getting that need met.

11. There are four main types of function, as follows:

    Sensory: The person engages in behaviours that make them feel better by creating an internal reaction. For example, they might rock, flick their fingers or other behaviours that stimulate their senses and can result in the person feeling e.g. more calm. The function is to impact on their own internal state.

[4] Source: Royal College of Psychiatrists, British Psychological Society, Royal College of Speech and Language Therapists, (2007), Challenging behaviour – a unified approach

Access to items or activities: The person needs access to food, drink etc. They might learn that, for example, shouting at someone results in them being offered a drink 'to calm them down'. Or they might want to engage in an activity, and learn that the activity is offered to them if their behaviour becomes challenging as a response by those caring for them; with the aim of diverting or distracting them from engaging in the behaviour.

Social interaction: The person needs some social contact. As described above, they might learn that tipping over a chair results in someone coming over to them and talking to them about what they are doing. Or they might spend long periods of time in their room alone, and challenging behaviour results in someone coming to see them.

Escape: The person is finding a situation or some form of sensory stimulation too difficult. For example, they might be being taught how to do a task and they don't understand the instructions. They bang their head on the table, and the demands to do the task stop. Or there is too much noise and challenging behaviour results in them being removed from the environment and placed in a quieter one. (They may not always respond to demands by seeking to escape – it depends on circumstances when the level of demand is too high for them to cope with at that point in time.)

Autistic people, in particular, can have significant difficulties with sensory processing and can find too much sensory input to be very distressing. For example, a person might be placed in an environment where there is too much noise, light, where there are smells that they cannot process. The noise, light, smells etc may seem fine to people who are not autistic, but the effort to make sense of sensory input can result in severe distress and challenging behaviour. Sensory assessment allows for information to be gained regarding which senses the person has more difficulty in processing, which can then lead to adaptations to the environment and activities that support their needs in this area. For example, a cupboard door that is brightly coloured, with stainless steel handles might result in visual overload for an individual. Changing the colours, reducing the range of colours, and removing the handles could make the environment much less distressing. An individual might also seek out sensory input, which can also impact on their behaviour.

12. Service providers need to remember that every person is different and therefore each situation is different, which means that assessment and design of interventions must be done individually for each person, with any specific behaviour potentially serving more than one function, or multiple behaviours serving the same function.

What is Positive Behaviour Support and what should PBS plans include?

13. Positive behaviour support (PBS) is '*a person centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviours that challenge. It is a blend of person-centred values and behavioural science and uses evidence to inform decision-making. Behaviour that challenges usually happens for a reason and may be the person's only way of communicating an unmet need. PBS practitioners aim to understand the reason for the behaviour so as to better meet people's needs, enhance their quality of life and reduce the likelihood that the behaviour will happen*.' [5]

14. A good PBS or care plan, would be built upon a detailed assessment of the functions of the person's challenging behaviour. This would be done by careful observation and recording of what happens around the time that the person becomes challenging. This is often referred to as 'ABC' recording. (ABC means "Antecedent, Behaviour, Consequence"). The observation and records should be able to say what was happening immediately before the behaviour began (A) (e.g. what the person was doing, who was there, what they were doing, what was said – often referred to as setting events and triggers); what the person actually did (B) (threw chair, hit someone etc.) and what happened immediately afterwards (C), and including when the behaviour stopped (the person was moved somewhere quiet, the person was given something to do etc). It would also look for antecedents in terms of those times and circumstances when it seemed the behaviour might be more likely to occur (e.g. if the person was tired, hungry, upset etc.). It would also be built upon good consultation with those who know the person well – including importantly their family.

15. The plan would then include methods of enabling the person to have their needs met proactively by using, for example, more appropriate communication methods. These methods might include both teaching the person ways of communicating their needs, and training staff to ensure that people have their needs met before the need to engage in challenging behaviour arises (for example, ensuring the person gets regular social interaction if that is what they need, or ensuring they have consistent and regular access to food and drink if that is the need they are trying to communicate.) It would also include how staff might know what signs to look for that would suggest that the person was becoming distressed, as this would allow them to intervene before the behaviour escalated. The plan would need to be reviewed to assess whether the hypotheses about the functions of the behaviours are borne out in practice. Sometimes implementation of the plan is the issue, in which case staff training and support would need to be addressed.

16. The consequences of getting the plan wrong could mean an increase in challenging behaviour. If staff or carers believe that the person behaves as they do because they want attention and decide to walk away in an attempt to stop rewarding it, then they

[5] Centre for the Advancement of PBS, PBS key messages, January 2017 and quoted in: Brief Guide: Positive behaviour support for people with behaviours that challenge. Care Quality Commission 2017

risk inadvertently rewarding those behaviours if the function is actually for the person to escape the demands being placed upon them. The person learns that shouting, hitting (or whatever the behaviour is) results in the demand being withdrawn by the staff walking away.

17. A good PBS plan with the elements set out below should enable a good understanding of what the behaviour in question means for that individual. It should also address how the service/carers are trying to improve the person's quality of life, and develop their skills. The formats and headings may vary somewhat, but the content should address the issues outlined below.

    a. **Assessment**
        i. good information about the person's life and the people and things that are important to them.
        ii. clear statement of the person's needs and how they relate to the person's behaviours
        iii. A clear description of behaviour(s) that is/are challenging
        iv. detailed functional assessment and analysis (including communication and sensory assessment) which ties directly into the plan
        v. formulation of how the person's history (including physical and mental health, and any past trauma or abuse) and current support interact with these needs.

    b. **Information about the person, so they are not viewed solely in the context of challenging behaviour**
        i. A description of how to support the person to have a good quality of life
        ii. goals and aspirations for the person's life

    c. **Communication**
        i. Clear strategies to teach the person how to communicate their needs

    d. **Teaching skills**
        i. Ways to identify and teach new skills (general and related to the functions of the behaviours)

    e. **Environmental management**
        i. Ways to arrange the environment to minimise the risk of challenging behaviour occurring – for example, managing noise, keeping to routines etc.

    f. **Preventive and reactive strategies**

i. Clear description of early warning signs, reasons for the behaviour and situations or things that make it more likely to occur (including environmental factors)
ii. what to do to minimise the risk of escalation
iii. information on how to adapt support when the person shows early signs of distress/challenging behaviour (preventative strategies)
iv. Clear guidance on what to do if the behaviour occurs (reactive strategies)

g. **Post-incident support**
   i. Clear guidance on what to do to support the person after the behaviour occurs
   ii. A review of what happened and why and if there is any learning to prevent re-occurrence – and if any changes are needed to the PBS plan

h. Staff training and support
   i. Details of the training that staff need to have in respect of the plan
   ii. Details of debriefing after incidents

i. Monitoring and review
   i. Clear statements on monitoring and review of the plan: who will do it and how often it will happen
   ii. what will happen if it is found that the plan is not being properly implemented; there is no decline in challenging behaviour; or no decline in the use of restrictive interventions.

18. If any of these components are missing, the plan should explain why that is.

19. If the current placement is unable to deliver the components of a good plan, or unable to deliver the environment that would support it, then consideration would need to be given to either how to make such adaptations or finding a more appropriate placement. For example, if noise from other residents in a placement is something which leads to behaviour that results in the use of restraint or seclusion, then it may well be necessary to find a home for the person which they do not share with other people.

20. There must be ongoing monitoring of data around behaviour, so that interventions can be developed and adapted as they are implemented. Review may need to be very frequent if there are serious incidents or there is very frequent use of restrictive practices (for example monthly reviews where any amount of physical restraint is being used). It is useful if the service can present a rationale for the length of time between reviews (that relates to the person's specific needs).

21. Extracts from policy and good practice guidance relevant to PBS plans is set out in the appendix to this document. It is important that service providers and professionals are able to describe and discuss the extent to which the available guidance has been followed, and reasons for not following it – if that is the case.

22. The use of restraint in the absence of good practice as outlined above should be challenged, as in such circumstances restraint cannot be considered to have been employed as a last resort if more positive strategies have not been developed and implemented.

Proactive strategies

23. Proactive strategies should make up the majority of the PBS plan. They should be based on people's goals and agreed by them and those who are important to them. They should include teaching new skills, teaching effective communication, adapting the environment to make it less stressful, developing routines that the person understands and ensuring that staff manage those routines in a consistent way, revise activities etc. If the environment and the staff are organised in a way that understands the person's needs and behaviours, then challenging behaviour is less likely to occur.

Preventive and reactive strategies

24. Preventive and reactive strategies are designed to keep the person (and those around them), calm if they are becoming distressed and also safe if they are becoming more anxious and distressed and challenging behaviour is likely to occur. They consist of actions such as trying to distract and divert the person, giving them what they want, talking calmly to them, leaving the room. The aim is to de-escalate the behaviour.

25. It is unfortunately not unusual for documents labelled as PBS and care plans to focus on how to support/manage the person when they are already either starting to show signs that they are becoming distressed, or have begun to behave in a challenging way, rather than focusing on proactive strategies to avoid the challenging behaviour arising in the first place.

26. Whilst PBS plans allow for the use of restrictive interventions (including restraint and seclusion) this is on the basis that the other preventive and reactive management strategies have failed to de-escalate the behaviour, and is justified on the basis that it is the last resort. Experts supporting the use of restraint should be able to describe what has been tried, what they are doing about situations where proactive support has not worked and the justification for restraint as the last resort, in line with the level of risk the behaviour poses to the individual and/or others. They should also be able to explain how the plan is achieving the goal of eliminating restraint.

27. There may be situations where restraint, or other restrictive interventions, have been in place for some time, and they are accepted – without challenge – as a necessary or inevitable part of the care plan. It should not be assumed that restraint is the only option for managing the behaviour in this scenario, and it is likely that a new assessment and care plan should be considered. This should not be precluded because

strategies have 'already been tried and they didn't work'. It is possible that a) the previous strategies were not based on assessment and formulation as outlined above; b) the person's needs have changed and a new assessment might address them more appropriately or c) the staff team has changed and is adopting previous plans without a full understanding of them or training in how to deliver individually based support for the person.

Staff training

28. When considering the appropriateness of PBS/care plans it is important to examine the nature and content of the training that staff who are implementing the PBS plan have received, given that good support is likely to be linked to a combination of factors with staff training being central. The training should include consideration of the specific needs of the particular person receiving support (as determined by the assessment outlined above). Many providers 'buy in' training from external providers, which typically can include how to use methods of restraint. It may be helpful to examine the actual content of this training and its relationship to the person's identified needs. There are also standards for those providing training in the use of restrictive interventions.[6]

29. It is common for staff to be trained in what is described as PBS. This can cover a range of training, but is often a reference to participation in a single 2 to 5 day course. Many courses spend time teaching physical interventions, including holding, breakaway and physically guiding the person which can leave staff with the impression that PBS is about how to carry out restrictive practices, rather than how to avoid them. It is unlikely that a course of this length will do much more than introduce staff to the principles of PBS. There is some evidence to suggest that implementing PBS for an individual cannot be learned effectively in this way, or within this timeframe. [7]

30. Staff working with individuals whose behaviour is so challenging that they are subjected to restraint, should also be trained in how to work with that specific individual, and staff should have a good understanding of that person and the rationale for the support strategies that are used. These should take account of functions of behaviour, communication, sensory needs etc. This would typically require support from a psychologist, a qualified behaviour analyst or the organisation's own in-house specialist behaviour team (the organisation should be able to describe the qualifications of any in-house team). Physical restraint should not be taking place without regular and frequent oversight from a psychologist, behaviour analyst or similar.

[6] Restraint Reduction Network (RRN) Training Standards First edition James Ridley Sarah Leitch BILD 2020

[7] Hassiotis A, Poppe M, Strydom A, Vickerstaff V, Hall IS, Crabtree J, et al. Clinical outcomes of staff training in positive behaviour support to reduce challenging behaviour in adults with intellectual disability: cluster randomised controlled trial. The British Journal of Psychiatry. Cambridge University Press; 2018; 212(3):161–8. https://doi.org/10.1192/bjp.2017.34 PMID: 29436314

31. There should also be clear mechanisms for on-going staff support and supervision – providing care can be stressful for staff, and their reactions to challenging behaviour can be impacted if support for them is not in place. Managers need to have good skills (and/or access to good advice and support) in order to deliver effective support.

32. It is necessary to look at staffing levels and the use of agency staff when considering the quality of care and need for restrictive interventions, to see whether there is a correlation between aspects of staffing and the frequency or nature of restrictive interventions that are being deployed. Changes in staffing levels, the introduction of new staff, frequent changes in staff, unpredictability of staffing arrangements, and a lack of adequately trained staff (with particular reference to the person's specific needs) can all contribute to the level or frequency of the use of restrictive intervention. Sufficient numbers of staff is important, but it is more important that all staff know what they are doing and are skilled in meeting the person's individual needs. Services sometimes respond to situations of challenging behaviour by increasing staffing levels and 1:1/2:1/3:1 staffing becomes the norm. This does not necessarily produce the intended outcome – skills can be more important than numbers. If there is extensive use of agency staff, and staffing itself may be contributing to the use of restrictive interventions, then more detailed plans for training agency staff may be required.

Use of restraint as a last resort

33. This indicates that restraint is only used when all other support strategies to reduce an individual's distress have been tried and failed. This is usually taken to mean that proactive, preventive and non-restrictive reactive management strategies have been tried and failed. It is important to confirm what proactive strategies are in place, how they are being implemented, whether staff know how to deliver them, how they are being monitored for effectiveness. Without these steps being in place, it is not reasonable to state that restraint has been used as a last resort either generally, or on a specific occasion.

Circumstances when physical restraint is used

34. Staff may report, for example, that the person becomes challenging when engaging in community activities, that they have to use restraint to get them back in their car and therefore they are not going to engage in those activities. This can result in a more restricted life and potentially more challenging behaviour, especially if the activity has been identified as a preferred one for the person.

35. If access to these activities is to continue, then the plan should use utilise the information from the functional (and other) assessments that have been carried out and arrange to undertake the community activity at a time when the known triggers are less likely to occur. For example, if noise or crowds are a problem, go at a quieter time for a shorter period. This can also help if the person finds waiting difficult. If the person is scared of dogs, then avoid parks at times when there are likely to be more around, and have a plan in place for if one is seen in the distance. Staff should also be aware of the person's 'mood' prior to going out – if they are already somewhat

aroused or distressed then environmental triggers might be more powerful, and result in challenging behaviour, and an alternative activity might need to be undertaken. If there are problems with adhering to plans and routines, for example because of unreliable access to transport, or insufficient 1:1 staff hours, these triggers should be addressed.

36. Ultimately, it may be that different activities need to be identified which do not result in the use of restrictive interventions, If this is not done, P can be subject to a vicious cycle of challenging behaviour > restricted opportunities > diminished quality of life > increase in challenging behaviour.

15 questions to ask about PBS plans

1. **What assessments have been undertaken to understand the functions of the person's behaviours?** This should have included assessment of:
    a) the functions of behaviours: what function does the behaviour serve for the person? Is challenging behaviour their way of communicating that they want something (e.g. attention, food, drink, something to do) or are trying to escape from something (e.g. a difficult task, too much noise, too many people? The assessment requires good record keeping and data analysis of incidents (ABC charts etc) and should be undertaken by a psychologist, clinical nurse specialist or other professional trained in behaviour analysis
    b) a communication assessment: showing how the person communicates, their level of understanding (which is often less than attributed to them), how best to communicate with the person and what forms of augmentative or alternative communication should be in place. This could include signing, use of symbols or pictures and technological systems. A speech and language therapist should undertake this.
    c) a sensory assessment if the person is autistic: an occupational therapist can assess whether the person is hyper or hypo sensitive to sensory stimuli (for example, the person may be very sensitive to certain sounds or to bright lights and could become very distressed if exposed to them.) The person might also need specific types of sensory activity or stimulation to self-regulate.
    d) skills assessment: what can the person currently do, and what new skills could they learn, in a range of areas (including personal care, cooking, money etc). A nurse or an OT would often undertake (or supervise) this type of assessment
    e) assessment of preferred objects/activities – it is helpful to understand what the person likes doing – this can be used to build a daily/weekly program for them. This can be undertaken by support staff, and external support from an MDT might be helpful.
    f) goals/aspirations of the person, including by consultation with the key people in their lives.
    g) health assessment: underlying health conditions can contribute to challenging behaviour – if the person is in pain, or feeling unwell, and is unable to

communicate this, then their distress can result in challenging behaviour. This should be undertaken by a nurse and possibly the GP.

h) assessment of any mental health issues and consequent medication, and their potential impact on the person's behaviour.

The views and experience of family members should be part of the above assessments. The assessments should be integrated into an overall PBS plan, and not presented just as individual assessments.

2. What do you understand to be the functions of P's behaviours?

Relevant professionals and carers should be able to describe functions relating to behaviours, and how to meet the person's needs in a way that does not require them to behave in a challenging way.

3. How does the PBS/care plan for the person address the need to develop more appropriate methods of communicating?

There are a range of possible supports. This often includes 'now and next' boards, Makaton, Picture exchange communication system (PECS), a visual timetable, a communication passport, tablet-based methods etc. These should be based on good assessment of what/how the person understands and how they are supported to use communication methods. This should usually be following assessment and advice from a speech and language therapist. Staff should be trained in the communication methods that the person uses. As noted above, inability to communicate needs is linked to challenging behaviour.

4. Has this information been put together into a coherent plan that can be used by those supporting P?

The team supporting the person should be able to describe how the various assessments have been put together to form a coherent plan, and also how it is being implemented.

5. What monitoring mechanisms are in place to see if the plan is working (and how far apart are the reviews?)

If there are reviews only every 6 to 12 months, then they are unlikely to be delivering appropriate detailed monitoring and adjustment of the plan. They may only be happening as part of a regular review of the person's care, which is not sufficient. If restraint/seclusion are being used, then there should be frequent and regular monitoring of behaviour and review of interventions. If a PBS plan that utilises restraint regularly and frequently is in place, it could be reasonable to expect at least monthly review to support good practice. If restraint is not reducing, and/or challenging behaviour is not reducing then the care plan should be reviewed by those with expertise in these methods (probably an MDT or a competent inhouse behaviour team). If none of these are available/involved there will be a question for the court as to what efforts have been made to access them.

If there is no change in the rate of occurrence of behaviour and consequent restraint/seclusion, then consideration should be given to whether the staff team are trained and supported in delivering individually-based support to the person. It may also be that the environment is not appropriate and cannot be adapted to meet the person's needs, in which case it may be necessary to find a placement for the person where these environmental issues can be considered as part of the commissioning process.

6. **Can you describe the steps taken to ensure other, less restrictive options than restraint have been utilised?**

For example, what is known about the sort of environment that the person needs and what has been done to ensure that it is in place?

7. **What proactive strategies are in place?**

Elements described above, including improving quality of life, teaching new skills, adapting the environment, supporting the person's communication etc. The strategies should be developed on the basis of the assessment and formulation work that should be available for the court to consider.

8. **What reactive strategies are in place?**

Elements described above, including removing/changing triggers, de-escalation, prompting the person to use skills that help them cope, listening, diversion to preferred activities etc – again using the assessment and formulation work described above

9. **How often is restraint used?**

Providers and commissioners of care should be able to produce good quality data. Managers should be reviewing the information and the organisation should also be aware of the frequency of use of restraint/seclusion in order to effectively implement a restraint reduction strategy.

10. **What are the plans to reduce restrictive practices?**

This should include effective monitoring of the current care plan and its implementation, as well as organisational oversight and plans to reduce restraint

11. **What specific training have the staff team had?**

Training needs to include understanding of challenging behaviour, and should also address what the challenging behaviour means for the individual who is engaging in it. There should be discussion of proactive strategies and how they will be delivered, as well as reactive strategies. Training needs to be specific to the person, not just generic training, or training about the practical aspects of restrictive physical interventions.[8]

12. **When was it?**

It can occur as part of induction. If there is a yearly 'refresher' – what does it consist of and how does it relate specifically to the person's needs and behaviours?

[8] The PBS Academy has produced guidance and standards for PBS training: http://pbsacademy.org.uk/pbs-standards/

13. Have all staff received it?

It is not always the case that all staff have received training. This makes it even more difficult to have consistent and safe responses, as well as make it more difficult for staff to understand the meaning of the behaviour for the person.

14. Has there been individual feedback with support staff?

There should be clear guidance on debriefing after the use of restraint/seclusion, and also discussion of why the incident happened and what (if anything) could have been done differently to reduce the likelihood of future occurrences. Managers may find that some staff are more likely than others to undertake restraint, and this should be noted and the reasons for it needs to be examined.

15. How are agency staff supported to know the behaviour/care plan?

A long care plan is unlikely to be read and absorbed. Many services have a 'grab sheet' which outlines (typically on one side of A4) the main methods of supporting the person – including when they might be becoming distressed and how to respond. As noted above, if there is extensive use of agency staff, and staffing itself may be contributing to the use of restrictive interventions, then more detailed plans for training agency staff may be required.

Care plans often follow a pre-determined structure, and behaviour is usually a category within them. The court should be able to have access to the documentation that lies behind the thinking and conclusions in any care plan that addresses behaviour.

CONCLUSION

37. The use of restrictive physical interventions for people with learning disabilities and/or autism should be eliminated, but the Court of Protection is often asked to approve plans which permit such interventions. This note aims to give legal practitioners and advocates tools to challenge such plans. The authors welcome comments which can be sent to vb@39essex.com.

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APPENDIX 1 – policy and practice guidance extracts

NICE Guidance on Challenging Behaviour (NG 11). This guidance outlines good practice in care planning, including:

1.6 Behaviour support plan

1.6.1Develop a written behaviour support plan for children, young people and adults with a learning disability and behaviour that challenges that is based on a shared understanding about the function of the behaviour. This should:

- identify proactive strategies designed to improve the person's quality of life and remove the conditions likely to promote behaviour that challenges, including:
    - changing the environment (for example, reducing noise, increasing predictability)
    - promoting active engagement through structured and personalised daily activities, including adjusting the school curriculum for children and young people
- identify adaptations to a person's environment and routine, and strategies to help them develop an alternative behaviour to achieve the function of the behaviour that challenges by developing a new skill (for example, improved communication, emotional regulation or social interaction)
- identify preventive strategies to calm the person when they begin to show early signs of distress, including:
    - individual relaxation techniques
    - distraction and diversion onto activities they find enjoyable and rewarding
- identify reactive strategies to manage any behaviours that are not preventable (see section 1.9), including how family members, carers or staff should respond if a person's agitation escalates and there is a significant risk of harm to them or others
- incorporate risk management and take into account the effect of the behaviour support plan on the level of risk
- be compatible with the abilities and resources of the person's family members, carers or staff, including managing risk, and can be implemented within these resources
- be supported by data that measure the accurate implementation of the plan
- be monitored using the continuous collection of objective outcome data
- be reviewed frequently (fortnightly for the first 2 months and monthly thereafter), particularly if behaviour that challenges or use of restrictive interventions increases, or quality of life decreases **1.3 Identifying the correct interventions and monitoring their use**
- 1.3.1When discussing and deciding on interventions with autistic adults, consider:
- their experience of, and response to, previous interventions
- the nature and severity of their autism
- the extent of any associated functional impairment arising from the autism, a learning disability or a mental or physical disorder
- the presence of any social or personal factors that may have a role in the development or maintenance of any identified problem(s)
- the presence, nature, severity and duration of any coexisting disorders
- the identification of predisposing and possible precipitating factors that could lead to crises if not addressed.

- identify any training for family members, carers or staff to improve their understanding of behaviour that challenges shown by people with a learning disability
- identify those responsible for delivering the plan and the designated person responsible for coordinating it.

NICE guidance on Autism spectrum disorder in adults: diagnosis and management
1.3.2When discussing and deciding on care and interventions with autistic adults, take into account the:

- increased propensity for elevated anxiety about decision-making in autistic people
- greater risk of altered sensitivity and unpredictable responses to medication
- environment, for example whether it is suitably adapted for autistic people, in particular those with hyper- and/or hypo-sensory sensitivities (see recommendation 1.1.8)
- presence and nature of hyper- and/or hypo-sensory sensitivities and how these might impact on the delivery of the intervention
- importance of predictability, clarity, structure and routine for autistic people
- nature of support needed to access interventions.

1.3.3When discussing and deciding on interventions with autistic adults, provide information about:

- the nature, content and duration of any proposed intervention
- the acceptability and tolerability of any proposed intervention
- possible interactions with any current interventions and possible side effects
- the implications for the continuing provision of any current interventions.

1.3.4When deciding on options for pharmacological interventions for behaviour that challenges or coexisting mental disorders in autistic adults:

- be aware of the potential for greater sensitivity to side effects and idiosyncratic responses in autistic people **and**
- consider starting with a low dose.
- 1.3.5For any intervention used in autistic adults, there should be a regular review of:
- the benefits of the intervention, where feasible using a formal rating of the target behaviour(s)
- any adverse events
- specific monitoring requirements of pharmacological interventions as highlighted by the summary of product characteristics
- adherence to the intervention.

CQC guidance on PBS:
All providers must take account of the Department of Health's guidance.
This states that services that support people whose needs and histories mean they are likely present with behaviours that challenge should use 'recovery-based approaches and delivery of care in accordance with the principles of positive behavioural support'. This applies to all services that work with people with learning disabilities or autism who present with behaviour that challenges, as well as services for people who are elderly and confused who may become agitated.

Providers should also act in line with NICE Guideline 103 and adopt this framework to anticipate and reduce violence and aggression and the use of restrictive interventions.

CQC's position for the purpose of its inspections is that:

- Staff should have made a recent assessment of the person's behaviour and created a behaviour support plan (or equivalent) and those making assessments should be adequately trained and supervised.
- Assessments should be individualised and holistic, and include a functional assessment of behaviour.
- Staff should be trained to avoid or minimise restrictive interventions, and in de-escalation techniques.
- The behaviour support plan (or equivalent) should state in detail all the interventions to change behaviour pro-actively and to manage behaviour reactively. • The behaviour support plan (or equivalent) should include effective monitoring of behaviour and use the data gathered to aid its continued development.
- Providers should have a transparent policy on the use of restrictive interventions, with an overarching restrictive intervention reduction programme.
- Where there are any incidents of physical restraint, the multidisciplinary team should conduct an immediate post-incident debrief, monitor and respond to ongoing risks, and contribute to internal and external reviews

APPENDIX 2: PBS FLOWCHART

From 'Positive Behaviour Support. An information Pack for Family Carers' PBS Academy and Challenging Behaviour Foundation (2019) p 50