



Therapeutic Thinking

Principles of Restraint Reduction and Elimination



September 2023



Therapeutic Thinking in Hertfordshire is owned by Hertfordshire county Council.

Training and practice within schools is the responsibility of the head teacher and governors. Within other services it is the responsibility of the employer and management



Introductions - online

Please join us with cameras on (where comfortable) for the intro.

Once we are sharing the PowerPoint, please turn off mics.

Cameras are optional. Please join with your cameras for activities and closing thoughts.

Please return from breaks in good time.

Where possible we will maintain confidentiality but, where obliged under safeguarding frameworks, it may be necessary to pass on concerns.

PLEASE use the chat. Add comments, questions, stories, asides, requests, feedback etc. The facilitator will interject where appropriate or bank comments and questions for the breaks and the end session.



Introduction - Live

- Mobile phones
- Toilets and fire drills
- Refreshments and breaks
- Signing-in and acknowledgement
- Safeguarding responsibilities

Where possible we will maintain confidentiality but, where obliged under safeguarding frameworks, it may be necessary to pass on concerns.

Joining the commitment to therapeutic management of behaviour

Hertfordshire

ESSET (Essex)

TADSS (Dorset)

Cambridgeshire

Peterborough

West Berkshire

Central Bedfordshire

Reading

East Sussex

West Sussex

Wokingham

Ealing

Meridian Trust

Southend SEN Trust

Local context slides

Therapeutic Thinking Ltd. works in collaboration with local authorities and multi-academy trusts

Slides marked local context slide are created by the commissioning organisation

All other slides are created by Therapeutic Thinking Ltd. and shared with all engaged stakeholders

Outcomes after 2 years

- 235 tutors trained
- Restraint reduction and elimination had been prioritised.
- RPI (restrictive physical Intervention) reduced by an average of 89%
- Spread of RPI reduced by an average 60%
- Controversial prone and supine restraints were eliminated
- Reported reduction in injuries to staff and children
- Reported reduction in number of exclusions
- Reported increase in children's emotional literacy
- Reported increase in staff confidence

Outcomes after 7 years

- 980 Tutors trained (over 12,000 staff trained)
- A county-wide, multi agency approach
- Financially cost neutral element of the local authority generating investment capital for continued development.
- Sustained 90% reduction in restraint and restrictive physical intervention throughout special education.
- Only 2 children requiring restrictive physical intervention plans and training, from 280 mainstream schools who submitted data.

Shift of focus in 2017

- A shift within mainstream schools from parachute training to creating in school capacity
- A strong focus on developing equity rather than equality
- Use of therapeutic thinking to reduce:
 - number of permanent exclusions
 - number of fixed term exclusions (now suspensions)
 - number of exclusion days
 - number of reduced timetables



Responsibility for health and safety

- Participants should remain focussed and professional throughout, including keeping the noise level down, following instructions and responding immediately to the lead
- Participants must be encouraged to communicate any known risk to the people they are working with
- Participants should monitor their own wellbeing and opt out if there are any signs of emotional or physical harm and speak with the lead before continuing



Responsibility for health and safety

- Everybody should participate in a way that means others are protected from harm
- Nobody should make sudden unannounced movements
- Nobody should resist against a technique unless specifically asked to do so by the lead
- Anybody aware of a health and safety risk should immediately inform the lead



Professional conduct

- Training in physical techniques will, by its nature, take people outside of their normal comfort zone and involve a degree of touch and close contact unusual in a professional arena
- Staff should not use this as an opportunity for humour that could in any way be considered prejudicial or inappropriate in terms of a professional environment
- Everybody should participate in a way that means others are protected from harm



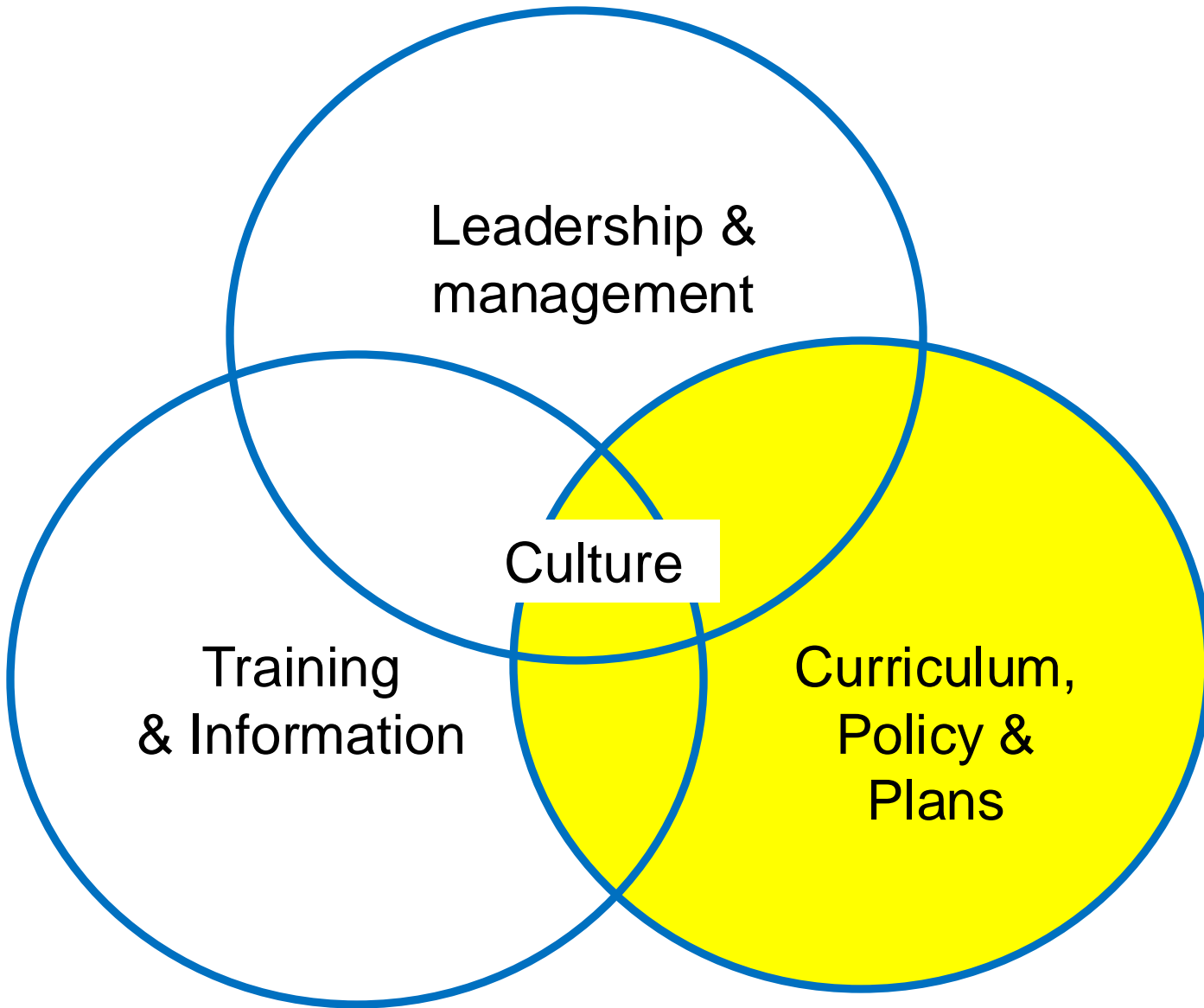
Professional conduct

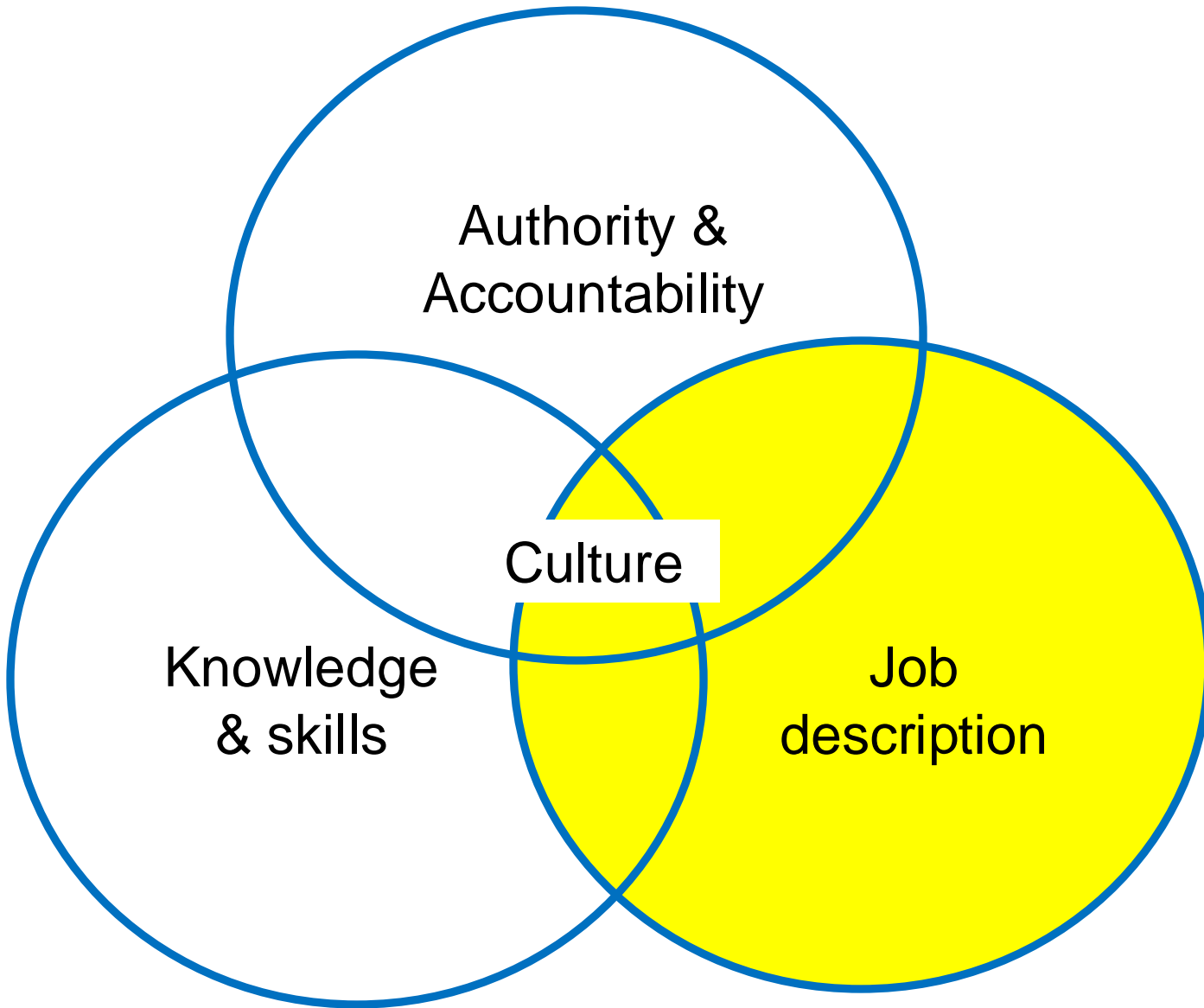
- Staff should seek permission before touching
- Staff should release any hold immediately if asked
- Staff should practise with groupings that maximise emotional wellbeing; some may choose to remain in a gender-specific group or with their own class group
- The lead may suggest groupings based on physical size or other factors, but nobody should feel pressurised to join a specific group



Programme

Details will be added to reflect the timings and content of the session







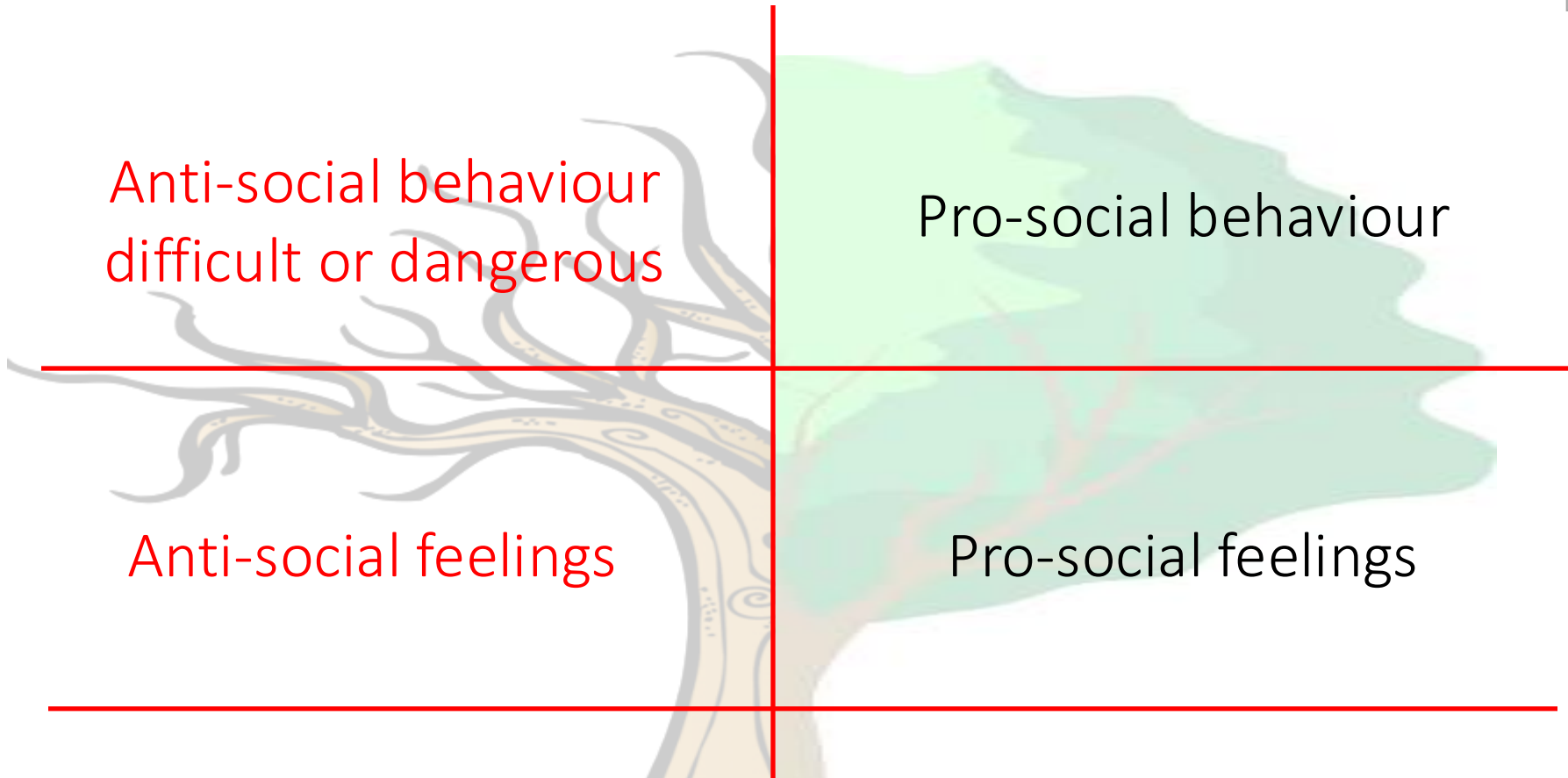
Therapeutic thinking

An approach to behaviour that prioritises the
pro-social feelings of everyone
within the dynamic



Therapeutic tree activity

- Allocate groups to consider the therapeutic impact of restraint on different elements of the dynamic
- Groups can be allocated:
 - The CYP being restrained
 - The CYP audience (separating into those who internalise and those who externalise)
 - Staff restraining
 - Staff audience (those who can not or will not restrain)
 - Visitors
 - Parents (CYP restrained, CYP never restrained)



The use of restrictive physical intervention (RPI) restraint



Therapeutic tree activity

- Ask delegates to complete their tree for their specific element of the dynamic
- Look at the therapeutic impact of restraint, not only the CYP being restrained but on other members of the dynamic
- Where there are pro-social feelings, explore if these would be more likely without restraint. The audience might feel safe that a dangerous behaviour is stopped but they would feel safer if the dangerous behaviour had not occurred and the restraint had not been necessary
- Look for worrying feelings such as CYP being excited because of what they are seeing



Department
for Education

Call for evidence

Use of reasonable force and restrictive practices in schools

Launch date 16 February 2023

Respond by 11 May 2023

Introduction

- The Government is committed to ensuring all schools are calm, safe, and supportive environments where pupils and staff can work in safety and are respected.
- The Schools White Paper sets out plans to make sure every child can reach their full
- potential by receiving the right support at the right time. This includes pupils who are vulnerable and have special educational needs and disabilities (SEND).

Continued..

- In line with these aims, the Department for Education has commenced an ambitious programme of work to provide clarity and support for school leaders and staff.
- This includes publishing the recently updated guidance documents, 'Behaviour in Schools', 'Suspension and Permanent Exclusion', and 'Searching, Screening and Confiscation'.
- These documents are practical tools to help schools create calm, safe and supportive environments.

What is the purpose of this call for evidence?

- Section 93 of the Education and Inspections Act 2006 provides all school staff, including non-teaching staff, with the power to use reasonable force to prevent pupils from hurting themselves or others, from damaging property or causing disorder. When it is safe, lawful and absolutely necessary, the Government supports school staff to use reasonable force, including restraint, as an intervention.
- The Government recognises that the misuse of reasonable force or restrictive practices can have a significant and long-lasting effect on the pupils, staff members and parents involved, as well as the wider classroom, which can potentially hinder the creation of a calm, safe and supportive school environment.

- The Government is therefore committed to minimising the use of reasonable force, including restraint and other restrictive practices in all schools in England, including special schools and alternative provision.
- This work programme will include updating the ‘Use of reasonable force’ guidance, 2013, to provide school staff with advice on how to minimise the use of restraint and in instances where it is absolutely necessary and lawful to use reasonable force or restrictive practices, to do so as safely as possible.

This call for evidence will focus on:

- how pupils are impacted by the use of reasonable force, restraint and restrictive practices, including those with SEND.
- how school leaders and school staff minimise the need to use force, restraint or other restrictive practices whilst ensuring that the environment feels safe for all pupils and staff.
- how school leaders and school staff ensure that when force, restraint or other restrictive practices are used, they are used safely and effectively.

- how schools record incidents of use of force, restraint or other restrictive practices, and how they use and report this data.
- how school leaders support pupils, their parents and staff who have been involved in or affected by an incident of reasonable force, restraint or other restrictive practice.
- how, in relation to such matters, schools meet their duties under the Human Rights Act 1998, Equality Act 2010 and Children and Families Act 2014.

1

What are your or your child's experiences of incidents of reasonable force including . restraint or restrictive practices in school?

Please provide any lessons learned from these experiences.

Not applicable

Open text (state your response below

3

The current 'Use of reasonable force' guidance, 2013, states that head teachers need to take their own decisions about staff training and head teachers should consider whether members of staff require any additional training to enable them to carry out their responsibilities.

Do you think national training standards on the use of reasonable force, restraint or other restrictive practices should be developed or adopted?

Yes

No

Don't know

6

The Department for Education has committed to a programme of work to minimise instances of the use of reasonable force, restraint and other restrictive practices in all schools through preventative measures.

The updated 'Use of Reasonable Force' guidance will provide school staff with a range of safe and effective approaches when dealing with extremely challenging situations, including preventing a situation from escalating further than it needs to. What do you think are the most effective methods of de-escalation? If applicable to your experience, please refer to de-escalation approaches used to support children with SEND.

Open text (state your response below)

7

How can schools practically ensure they meet their legal duties towards pupils with SEND or in relation to other protected characteristics when assessing the need to use reasonable force, restraint or other restrictive practices and the impact of its use?

Open text (state your response below)



Audit of Need



Audited Need for Therapeutic Thinking responses to RPI

Name:	DOB:	Age:
Sex / gender:	Cultural heritage:	Diagnosis (if known):
Accurately describe the behaviour for which RPI, restraint or a personal safety responses are being considered. Please include frequency (how often the behaviour is observed) and severity (the harm recorded as a result of the behaviour)		
How well equipped is the school/setting to manage this inclusion (position in circles)? Summary of the risks posed to self and others by the behaviour of concern.		
Is the Therapeutic Tree updated?		
Experiences affecting the child		
Feelings affecting the child		
Physical characteristics (height, weight, physical differences)		



Additional risk factors (medical or emotional diagnosis or needs, substance misuse etc.)
Any known developmental issues
Communication differences (visual or hearing impairment, adaptive communication, any known sensory processing issues)
Is the therapeutic plan updated?
Context or triggers (high risk times, places, people activities)
De-escalation options to use (unusual strategies that are effective)
De-escalation options to avoid (common strategies that have proved ineffective)
Principle of 'last resort' why may de-escalation be ineffective (triggers are hidden, difficulty in communicating)



Staff matching (who is best to de-escalate, who is safest for involvement with RPI)

Training needs (does anybody require additional training in de-escalation, RPI, Communication)

JUSTIFICATION (what harm will be prevented at what level)

Environmental Risk Assessment (necessary changes chairs etc, limited access)

Student Shape (standing, seated on chairs, seated on the floor)

Adult shape (standing, kneeling, seated in chairs)

Destination technique (elbow tuck lone worker, elbow tuck figure 4, etc.)

Transitions (describe the messy bits, taking hold, letting go etc.)



What makes it safe? (reminders of detail)

What makes it effective? (reminders of detail)

Social validity (how will it feel for the child, how will it look to others)

How has the person (or their advocate) been consulted with and contributed to this assessment?

Protective consequences (limits to freedom to CONTROL risk of harm)

Educational consequences (how are we going to TEACH internal discipline)

Unresolved risk factors (issues for management)

8

What, if any, support should be provided to pupils, parents and school staff involved after an incident of force, restraint or other restrictive practice? This may include witnesses of an incident.

Open text (state your response below)

9

The current 'Use of reasonable force' guidance, 2013, says that "schools should consider how best to record incidents of reasonable force." In what circumstances, if any, do you think schools should record the use of force or restraint? Please give details in the box below.

- Every instance of physical contact
- Physical restraint rather than redirection such as guiding
- Every instance where an injury is caused
- It should not be recorded
- Don't know

- **9a**
- What details about such incidents should be recorded? Select all that apply:
- Type of incident
- What happened prior to the incident including any triggers for the incident
- Why it was used
- Who was involved
- Whether the pupil has SEN and which protected characteristics they have
- Lesson/location
- Time/date including how long incident lasted
- It should not be recorded



Restrictive Intervention Record Form

Student Name:

Location of Incident:

D.O.B:

Time and Date of Incident:

Reporting Member of Staff:

Justification for physical intervention (tick all that apply):

To prevent harm to self	<input type="checkbox"/>
To prevent harm to other children	<input type="checkbox"/>
To prevent harm to adults	<input type="checkbox"/>
To prevent damage to property	<input type="checkbox"/>
To prevent loss of learning (see plan)	<input type="checkbox"/>

Predicted harm prevented by physical intervention with predicted levels (see Individual Plan)
 e.g. bruising to peers, lacerations, destruction of computer, 20 mins of geography lost for 15 child or young person's etc.)

Incident Form/Book Complete Y/N

Medical Treatment / Injuries Y/N

Damage to Property Y/N

Name(s) of additional staff witness:	Name(s) of additional student witness:





Unresolved Harm/ Details of damage to property (costs and details of harm to property and people including medical intervention:

Triggers:
Additional factors:

Management:	Comments:	
How was the incident resolved?		
What were the Consequences? Protective and Educational		
Has student reparation/ de-brief taken place?	Y/N	
Has staff de-brief taken place?	Y/N	
Has the Risk Management plan been reviewed or updated?	Y/N	
Was there Police involvement?	Y/N	
Has there been Internal Exclusion / Suspension / PEX?	Y/N	





Primary de-escalation techniques used
(please state order in which they were used)

Verbal advice and support		Offering services of other staff	
Calm talking		Informing of consequences	
Distraction		Taking non-threatening body position	
Reassurance		De-escalation script	
Humour		Clear instruction / warning	
Negotiation		Withdrawal from activity	
Offering choices and options		Diversion	

Number	Description of how technique was employed
1	
2	
3	
4	
5	

Restraint techniques including sequence of techniques, time and staff involved:

Time	Technique	Shape	Staff name

Duration of restraint: _____ **Duration of incident:** _____





Is there any physical mark or harm caused by the use of restraint?	Y/N	Details:
Has the student indicated that this was caused by the use of physical intervention?	Y/N	Actions: <ul style="list-style-type: none"> • •

Incident reporting and monitoring	
Incident reported to: Head Teacher by:	
Parents / Carer informed by:	@
Student wellbeing verified by:	@
Staff wellbeing verified by:	@
Incident form completed by:	@

Verification of account of incident:		
Staff name	Staff signature	Date

Reporting staff name: _____ Signature: _____

Incident form coordinator check signature: _____ Date: _____

10

To whom do you think schools should report the data they collect on incidents involving use of reasonable force, restraint or other restrictive practices? Select all that apply:

- Head teachers/senior leadership
- Parents
- Governors and/or trustees
- Department for Education
- Local authority for any child
- Local authority for child with an EHCP or a social worker
- Other (specify in open text box below)

13

How does your school follow up with the people involved in an incident of reasonable

force, restraint or other restrictive practice, including the pupil, staff, parents and other pupils who are witnesses?

- There is no follow up
- Don't know
- Open text (state your response below)

13a

If 'no follow up' selected:

What, if any, are the barriers preventing schools from following up with parents, pupils and school staff?

- Open text (state your response below)

Activity

1. What support and follow is provided to pupils, after an incident restraint or other restrictive practice?
2. What support and follow up is provided to parents, after an incident restraint or other restrictive practice?
3. What support is provided to staff, after an incident restraint or other restrictive practice?
4. What support is provided to witnesses, after an incident restraint or other restrictive practice?
5. Have we identified any gaps?

14

In the 'Behaviour in schools' guidance, 2022, schools are encouraged to have strong and effective systems for data capture, including all components of the behaviour culture which should be monitored and objectively analysed regularly by skilled staff.

Additional expectations or requirements over data capture apply in certain settings, such as special schools.

What, if any, are the challenges involved in recording data on the use of reasonable force, restraint or other restrictive practices?

Open text (state your response below)

Additional questions for parents

The Government has committed to make the recording and reporting of incidents of use of reasonable force to parents a legal duty by bringing section 93A of the Education and Inspections Act 2006 11 into force when parliamentary time allows.

Questions 18 and 19 focus on how school policies are currently communicated to parents.

18

The current 'Use of reasonable force' guidance, 2013, says that every school is required to "have a behaviour policy and to make this policy known to staff, parents and pupils.

The governing body should notify the head teacher that it expects the school behaviour policy to include the power to use reasonable force

“Schools do not require parental consent to use force on a student but schools should take steps to ensure that staff, pupils and parents are clear about when force might be used.”

How well do you feel your child's school communicates school policies with you?

- Very well
- Fairly well
- Neither well nor poorly
- Fairly poorly
- Very poorly

19

How confident are you in your child's school's behaviour policy and use of reasonable force?

- Very confident
- Fairly confident
- Neither confident nor unconfident
- Not very confident
- Not at all confident

Training Needs Analysis

Therapeutic Thinking
Principles of RPI, Reduction and Elimination
Training Needs Analysis

This training needs analysis (TNA) helps us to identify what support your organisation requires in relation to restraint and will assist us in developing the curriculum for your training. The answers you provide will not affect your eligibility to participate in the course.

1. What is the name of your setting?

2. What is your setting type and age range of the children or young people who attend?

3. How many children/young people are there on roll?

4. Do you currently support any children or young people who have restraint as part of a planned response?

Yes

No

5. If yes to Q4, how many children/young people currently have restraint as part of a planned response?

6. If yes to Q4, please list which restraint techniques you are currently using within your organisation:

7. Are each child or young person's needs audited to create individual responses?

Yes

No

8. What analysis and planning supports the audited needs of your children/young people?

9. What mechanisms do you use to ensure people with lived experience of restrictive physical interventions are involved in the review and development of practice?

10. Does every child or young person who has restraint as part of a planned response have evidence of restraint reduction over the past 12 months?

Yes

No

11. Does your organisation have a named person responsible for restraint reduction?

Yes

No

12. How many staff do you intend to train in Principles of RPI (restraint, restrictive interventions, personal safety) once your tutors have completed the course?

13. What are their roles?

14. Have you delivered Therapeutic Thinking training to staff within the past 12 months?

Yes

No

15. Does your organisation have the following policies in place?

Safeguarding	YES <input type="checkbox"/>	NO <input type="checkbox"/>
'Whistleblowing' (raising a concern)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
The use of restrictive interventions and/or other restrictive practices	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Behaviour Policy	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Stakeholder involvement (how the organisation includes the views of people it provides services to, those with lived experience, and/or families or advocates)	YES <input type="checkbox"/>	NO <input type="checkbox"/>

16. Please provide a description of the behaviours you currently see in your setting that require restraint:

Authorisation by person with responsibility for restraint reduction (i.e. headteacher, service manager or named member of staff with responsibility in the organisation).

By signing below you are stating that you have read this document and agree with the information it contains.

Name: _____

Role in school / organisation: _____

Signature: _____

Date: _____



Therapeutic thinking

An approach to behaviour that prioritises the prosocial feelings of everyone within the dynamic



Behaviour

- Traditional responses to behaviour work on a deficit model, mainly concerned with how we respond to anti-social behaviours. This approach is often reflected in recording, where logs of children's anti-social behaviour are recorded but evidence of strengths that could be developed remain absent.
- With a therapeutic approach the priority is to focus on strengths rather than deficits to plan how we build empathy and resilience.
- If behaviour is everything someone says or does, it is important to monitor and record the pro-social behaviours, as well as planning our responses to anti-social behaviour, in order to promote and evidence progress.



Agreed definitions

Different professionals and different specialities at times use different language to describe the same principle or concept.

To ensure consistent communication it is important that we unite and use the same language with the same definitions.



Behaviour definitions

- Anything a person says or does, everything we see or hear
- Everything from the most prosocial to the most antisocial.
- Behaviour takes on additional relevance when we consider how it impact on self and others.



Pro-social definitions – strengths-based model

- Behaviour which is positive, helpful, and intended to promote social acceptance
- Behaviour characterised by a concern for the rights, feelings and welfare of others
- Behaviour which benefits other people or society
- Creates helpful feelings in self and others.



Anti-social definitions – deficit model

- Behaviour that causes harm to an individual, the community or to the environment
- Behaviour that is likely to cause injury, harassment, alarm or distress.
- Behaviour that violates the rights of others.
- Creates unhelpful feelings in self and others.



Difficult behaviour

- Behaviour that is antisocial, but not dangerous.

Dangerous behaviour

- Behaviour which will imminently result in injury to self or others, damage to property or behaviour that would be considered criminal if the person was the age of criminal responsibility, such as racist abuse.

It is important to be able to differentiate between behaviour that is difficult or dangerous and those which are simply inconvenient.



Unsocial Behaviour

- Not seeking to associate with others but not to the detriment of self or others.
- Not choosing to behave sociably in the company of others, but not to the detriment of self or others
- Not doing as instructed or dictated, but not to the detriment of self or others



Challenging behaviour

Some definitions of challenging behaviour fail to recognise that it is the adult who is challenged by the behaviour rather than the child who is challenging.

Different adults when faced with the same behaviour would debate the use of the term challenging. The following definition recognises challenging behaviour as communication of unmet need.

Challenging Behaviour is how we talk about a range of behaviour which some people with severe learning disabilities may display when their needs are not being met.

The Challenging Behaviour Foundation



Dynamic

- A group brought together by choice or circumstance.
- Everyone who is affected by an individual or institution.

To study dynamic:

- we analyse the behaviour of people when they are grouped with others.
- we analyse the relationships people have with each other and consider how these relationships could change.



Therapeutic thinking principles of RPI





Audit of need

- Complex personal safety responses should not be taught where elbow control or fix and stabilise would be sufficient
- The least restrictive and intrusive techniques, that will meet the need as audited, should be the only techniques taught
- All principles of restraint reduction and elimination (Step Up) training is based on audited need



Principles of restraint reduction and elimination (Step Up) planning

- Planning involves use of the graduated response and the embedded analysis and planning tools
- It is likely where RPI is considered, all available tools will have been used and we will have a full therapeutic plan (risk reduction plan)
- An electronic version of the toolkit is available



Individual analysis and planning





Graduated response

Where, despite using a therapeutic approach, areas of concern are unresolved the graduated response can provide a framework for individual personalised planning.

This approach should maximise resources, finding quick simple solutions where the need to differentiate is easily evidenced, and providing in-depth analysis where the needs are more complex.

Using assess plan do review and all available multiple agency input we should be able to evidence that all available adaptations have been considered before resorting to requests for suspension, exclusion or change of placement.



Graduated response

<p>Universal Behaviour Curriculum</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Teach pro-social behaviour. <input type="checkbox"/> Include within pupil induction. <input type="checkbox"/> Establish routines. <input type="checkbox"/> Staff role-model expectations. <input type="checkbox"/> Create positive relationships. <input type="checkbox"/> Use positive phrasing to communicate expectations.
<p>Targeted Behaviour Policy</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Predict and prevent anti-social behaviour, progress to pro-social behaviour - a plan for the majority. <input type="checkbox"/> Check if the identified behaviour is covered in policy. <input type="checkbox"/> Follow the policy. <input type="checkbox"/> Record the impact of policy on pupil's behaviour. <input type="checkbox"/> Analyse the dynamic using the inclusion circles. <input type="checkbox"/> If an individual plan, additional to or different from policy, is needed, move on to Early Prognosis.
<p>Targeted Plus Early Prognosis</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Describe the behaviour factually and unemotionally. <input type="checkbox"/> Gather appropriate and authentic pupil voice. <input type="checkbox"/> Gather information from relevant parties, including multi-agency colleagues, in respect of: <ul style="list-style-type: none"> <input type="checkbox"/> Function of behaviour <input type="checkbox"/> Health and wellbeing <input type="checkbox"/> Context <input type="checkbox"/> Cultural expectations <input type="checkbox"/> Use the collated information to Assess, Plan, Do, Review. <input type="checkbox"/> Where further intervention is needed, move to Predict & Prevent.
<p>Specialist Predict, Prevent & Progress</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Update Early Prognosis document. <input type="checkbox"/> Complete Risk Calculator. <input type="checkbox"/> Identify any protective consequences needed. <input type="checkbox"/> Identify educational consequences needed. <input type="checkbox"/> Complete Subconscious and Conscious checklists. <input type="checkbox"/> Complete Anxiety Analysis over a period of time. <input type="checkbox"/> Identify factors the child can't cope with and which they can't cope without. <input type="checkbox"/> Use all preceding analysis to create a Predict, Prevent & Progress plan. <input type="checkbox"/> Review the plan regularly. <input type="checkbox"/> Where further intervention is needed move to Therapeutic Plan.
<p>Specialist Plus Therapeutic Plan</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Ensure all preceding analysis documents are updated (Early Prognosis, Risk Calculator, Subconscious & Conscious checklists, Anxiety Analysis). <input type="checkbox"/> Complete the Therapeutic Tree for the individual pupil, taking into account all the preceding analysis when populating the planned pro-social experiences and planned pro-social behaviours. <input type="checkbox"/> Complete a Therapeutic Plan as a result of the completed analysis documents. <input type="checkbox"/> Continue Assess, Plan, Do, Review cycles. <input type="checkbox"/> Involve multi-agency colleagues in a review of the effectiveness of meeting need.



Targeted Plus Early Prognosis

- Describe the behaviour factually and unemotionally.
- Gather appropriate and authentic pupil voice.
- Gather information from relevant parties, including multi-agency colleagues, in respect of:
 - Function of behaviour
 - Health and wellbeing
 - Context
 - Cultural expectations
- Use the collated information to Assess, Plan, Do, Review.
- Where further intervention is needed, move to Predict & Prevent.

Specialist Predict, Prevent & Progress

- Update Early Prognosis document.
- Complete Risk Calculator.
- Identify any protective consequences needed.
- Identify educational consequences needed.
- Complete Subconscious and Conscious checklists.
- Complete Anxiety Analysis over a period of time.
- Identify factors the child can't cope with and which they can't cope without.
- Use all preceding analysis to create a Predict, Prevent & Progress plan.
- Review the plan regularly.
- Where further intervention is needed move to Therapeutic Plan.

Specialist Plus Therapeutic Plan

- Ensure all preceding analysis documents are updated (Early Prognosis, Risk Calculator, Subconscious & Conscious checklists, Anxiety Analysis).
- Complete the Therapeutic Tree for the individual pupil, taking into account all the preceding analysis when populating the planned pro-social experiences and planned pro-social behaviours.
- Complete a Therapeutic Plan as a result of the completed analysis documents.
- Continue Assess, Plan, Do, Review cycles.
- Involve multi-agency colleagues in a review of the effectiveness of meeting need.



Describe the behaviour



Non-judgemental accurate descriptions

In order to create accurate behaviour plans we need to start by accurately describing the behaviour, including severity and frequency.

‘Your child has used homophobic language including the words queer and bender directed towards another child. This is the first time we have experienced this’

‘Peter, you stood in front of Jason and punched him in the stomach, leaving a red mark. This is the third time this week you have punched another child.’

Behaviour descriptors checklist

- Check the accuracy of behaviour described - does the verbal or written description create a clear and unambiguous picture of the behaviour experienced or witnessed?
- Has judgmental emotive language been used? e.g. disgusting, unacceptable, intolerable. If so, rephrase or remove.
- Has nonspecific exaggerated language been used? e.g. wrecked, destroyed, assaulted. If so, rephrase or remove.

Behaviour descriptors tutor checklist

- Has vague nonspecific language been used? E.g unkind, unhelpful. If so, rephrase or remove.
- Has the description clarified frequency? E.g 2nd time this week, first time this term, every break time
- Has the severity (resulting harm) been communicated? E.g resulting in a 3cm bruise to the shin, resulting in a cracked window, 10 minutes of teaching lost for 30 pupils



Consider the function of the behaviour



Sensory

- Meeting a known or unknown sensory need
- May be blocking a sensory experience or seeking a sensory experience
- Responding to impact upon one or more of the senses (8 sensory systems)
- Sensory behaviour likely to happen in a variety of situations, even if there is minimal interaction and engagement

8 sensory systems

- Olfactory (smell)
- Gustatory (taste)
- Auditory (sound)
- Visual (sight)
- Tactile (touch)
- Proprioceptive (body position)
- Vestibular (movement)
- Interoceptive (internal)



Escape / Avoidance

Escape

- When experiencing anti-social feelings there is a conscious or subconscious desire to leave. The behaviour relieves the anti-social feelings.

Avoidance

- When predicting the anti-social feelings will be experienced there is a conscious or subconscious desire to avoid the experience. The behaviour protects the individual from perceived anti-social feelings.



Attention

- Behaviour enables interaction with or reaction from another. The attention needed may be verbal, physical, social or related to proximity.
- Individuals may predict the desired attention from either their pro-social or anti-social behaviour.

Tangible

- Behaviour occurs as a way of gaining access to a person, location, item or activity.
- When behaviour enables access to someone or something desirable then it is an incentive to repeat that behaviour.



Early Prognosis

Formalising available information relevant to the behaviour



Early Prognosis

Date: _____
 Staff member: _____

The behaviour *Unemotional, non-judgemental, factual description, including severity and frequency.*

- _____

Pupil voice

- _____

Function	Sensory	Do we still need more information? ↓	
	Escape or Avoidance		
	Attention		
	Tangible gain		

Health & wellbeing *Including diagnoses, diagnostic pathways being explored, physiological responses, mental health factors, additional medical needs, barriers etc.*

- _____

Do we still need more information? ↓

Context	Home	School	Community
	_____	_____	_____

Do we still need more information? ↓

Cultural relevance

- _____

Do we still need more information? ↓





Early Prognosis

Date:

Staff member:

**The
behaviour**

Unemotional, non-judgemental, factual description, including severity and frequency.

-

Pupil voice

-

Do we still need more information? ↓

Function

Sensory	
Escape or Avoidance	
Attention	
Tangible gain	



Do we still need more information? ↓

Health & wellbeing

Including diagnoses, diagnostic pathways being explored, physiological responses, mental health factors, additional medical needs, barriers etc.

-

Do we still need more information? ↓

Context

Home

School

Community

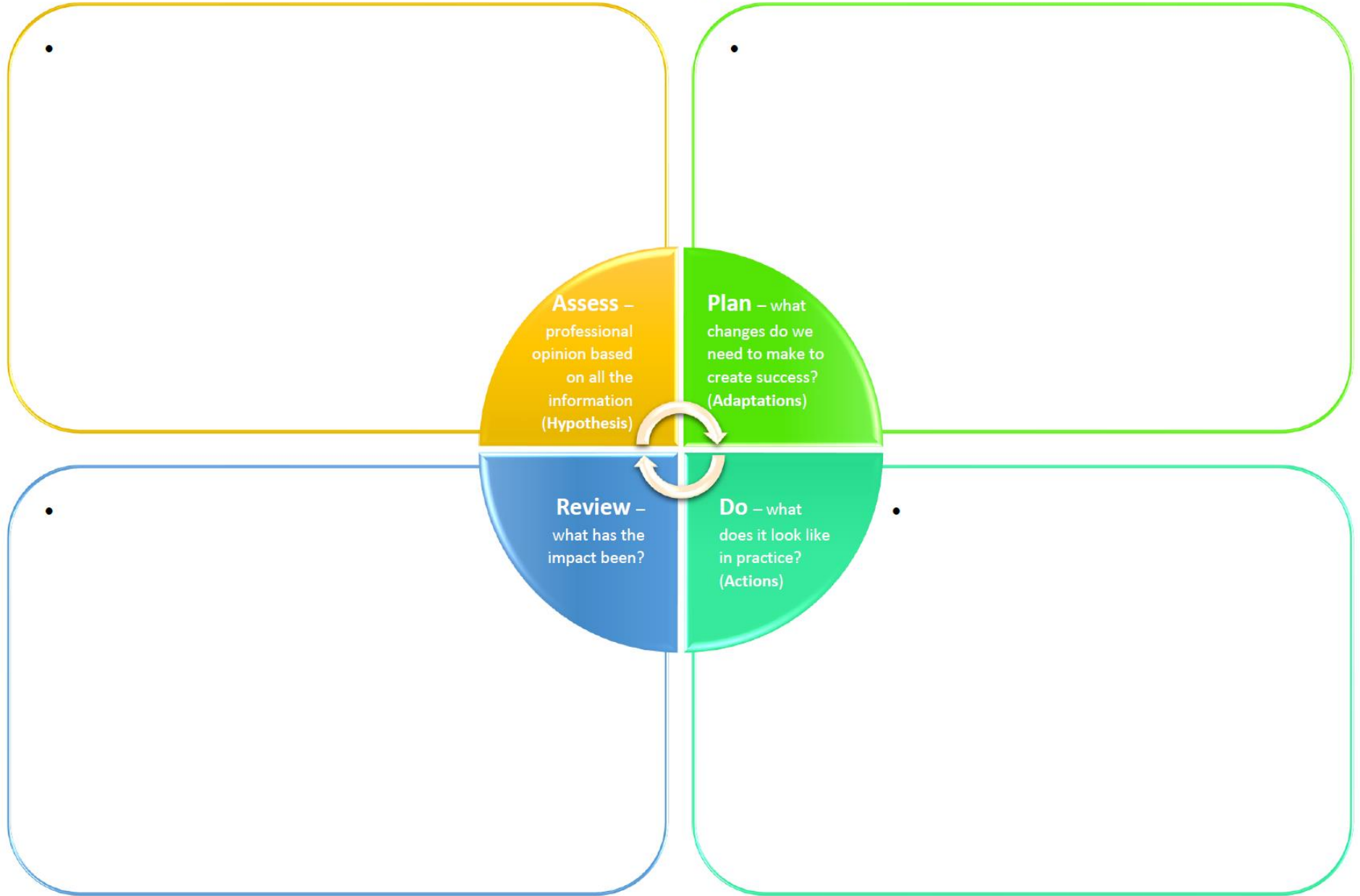
Do we still need more information? ↓

Cultural relevance

-



Early Prognosis



Early prognosis checklist

- Has the behaviour been described accurately?
- Has the child, parent /carer, class teachers, SENDCO, other professionals etc. who all may all hold individual pieces of information that can help us to understand the behaviour and differentiate to meet the child's needs been consulted?
- Have we ensured each person's contribution is independent and unbiased by using a blank version of the form?

Early prognosis checklist

- Has a named person drawn together all the information onto a single early prognosis document?
- Has a named person used the information to form a hypothesis and action based on the above analysis?
- Has the named person accessed a range of professional inputs where they are unable to form a hypothesis or plan suitable action?



Risk Calculator

Analysing if the behaviour is difficult or dangerous within the context



Harm/Behaviour	Opinion Evidenced	Seriousness Of Harm A	Probability Of Harm B	Severity Risk Score
	O/E	1/2/3/4	1/2/3/4	A x B
Harm to self				
Harm to peers				
Harm to staff				
Damage to property				
Harm from disruption				
Criminal offence				
Harm from absconding				



Seriousness	
1	Evidence of upset or disruption
2	Evidence of needing support internally from our school resources – e.g. first aid, nurture, budget allocation
3	Evidence of needing intervention from external agencies outside of school resources – e.g. hospital, professional counselling or group work, insurance claim
4	Evidence of harm that cannot be resolved – e.g. disability, sectioned mental health, loss through arson
Probability	
1	Incidents were more than a year ago with no identified triggers remaining. There is evidence of historical risk and no evidence of current risk.
2	Incidents occur approximately on a monthly basis. The risk remains relevant.
3	Incidents occur approximately on a weekly basis. The risk is likely to occur again
4	Incidents are daily or constant. The risk is persistent

Risk calculator checklist

- Has the potential harm or victim been identified? E.g are staff safe, but peers at risk. Is property at risk but not people?
- Are staff completing required reporting and recording to build an evidence base for differentiation? (this could become extremely important if challenged in regard to disability discrimination etc.)
- Have staff used recorded evidence to complete the severity and frequency?

If the risk calculator identifies the behaviour as dangerous, implement immediate protective consequences before proceeding.



Protective and educational consequences



Protective consequences

(removal of a freedom to manage harm)

Protective consequences are necessary measures to manage the risk of harm. Protective consequences may limit freedoms.

Educational consequences

(the essential learning, rehearsing or teaching to enable behaviour change)

Educational consequences progress the child's understanding and engagement. Where protective consequences are necessary educational consequences should allow the gradual removal of adaptations. Educational consequences return freedoms.

Protective consequence tutor checklist

- Have they identified who or what needs protecting?
- Have they considered which available differentiation (locations, staff, peers or activities) will provide necessary protection?
- Have we ensured the differentiated provision provides quality education and broad curriculum.
- Are we monitoring to identify where differentiated provision better meets the child's needs?
- Have we communicated with everybody the necessary differentiation may only be needed whilst educational consequences are being implemented?

Protective consequence tutor checklist

- Through de-brief, can protective consequences be used to motivate behaviour change, where the behaviour is conscious?
- Have we planned a gradual reintroduction of normal expectations and routines to maximise the child's chances of success

Educational consequence tutor checklist

- Have staff identified whether the behaviour is conscious or subconscious?
- Where the behaviour is subconscious will the education consequence build skills such as communication, awareness and strategies.
- Where the behaviour is conscious will the educational consequences challenge beliefs, motivate change or inspire empathy
- Are these educational consequences differentiated to focus on the specific strengths, needs and abilities of this child?
- Are the educational consequences subject to assess, plan, do and review cycle? (is there is evidence of behaviour change?)



Conscious and subconscious analysis

Subconscious behaviour

Present without any thought or planning triggered by overwhelming feelings; a behaviour a person is unable to contain - (unable to moderate or self-regulate)

Conscious behaviour

A result of thought and planning; a behaviour chosen by the child in order to secure a desired outcome or meet a specific need - (unwilling to moderate or self-regulate)



Subconscious behaviour

Question	Detail
Medical factors?	
Habitual factors?	
What is causing the sadness? <i>What are the associated feelings? E.g., rejected, lonely, despondent</i>	
What is causing the anger? <i>What are the associated feelings? E.g., frustrated, embattled, undermined</i>	
What is causing the fear? <i>What are the associated feelings? E.g., worried, petrified, reluctant</i>	
What is causing the disgust? <i>What are the associated feelings? E.g., reluctant, avoidant, cautious</i>	
What is causing the surprise? <i>What are the associated feelings? E.g., confused, shocked, panicked</i>	
What is causing the happiness? <i>What are the associated feelings? E.g., excited, enthusiastic, engaged</i>	



Conscious behaviour

Question	Detail
What are the perceived gains of the anti-social behaviour?	
Why do they believe their anti-social behaviour will be successful?	
Why do they believe pro-social behaviour will not be successful?	
Is the expected adult response preferable to their current experience?	
Is the expected adult response motivating the behaviour?	

Subconscious and conscious checklist

- Has each behaviour been analysed on the checklist to explore whether they are rooted in conscious or subconscious behaviours?
- Is there evidence of how the child/young person is protected from feelings which overwhelm them? (unable to moderate/self-regulate).
- Is there evidence of how the child/young person is supported to enable behaviour change? (unwilling to moderate/self-regulate).



Anxiety analysis

To formalise through observation the variables the child cannot cope with, or the variables the child cannot cope without



Dangerous behaviours

Difficult behaviour
(affecting others, externalising)

Difficult behaviour
(affecting self, internalising)

Limit of self-management

Comfortable self-management

Neutral

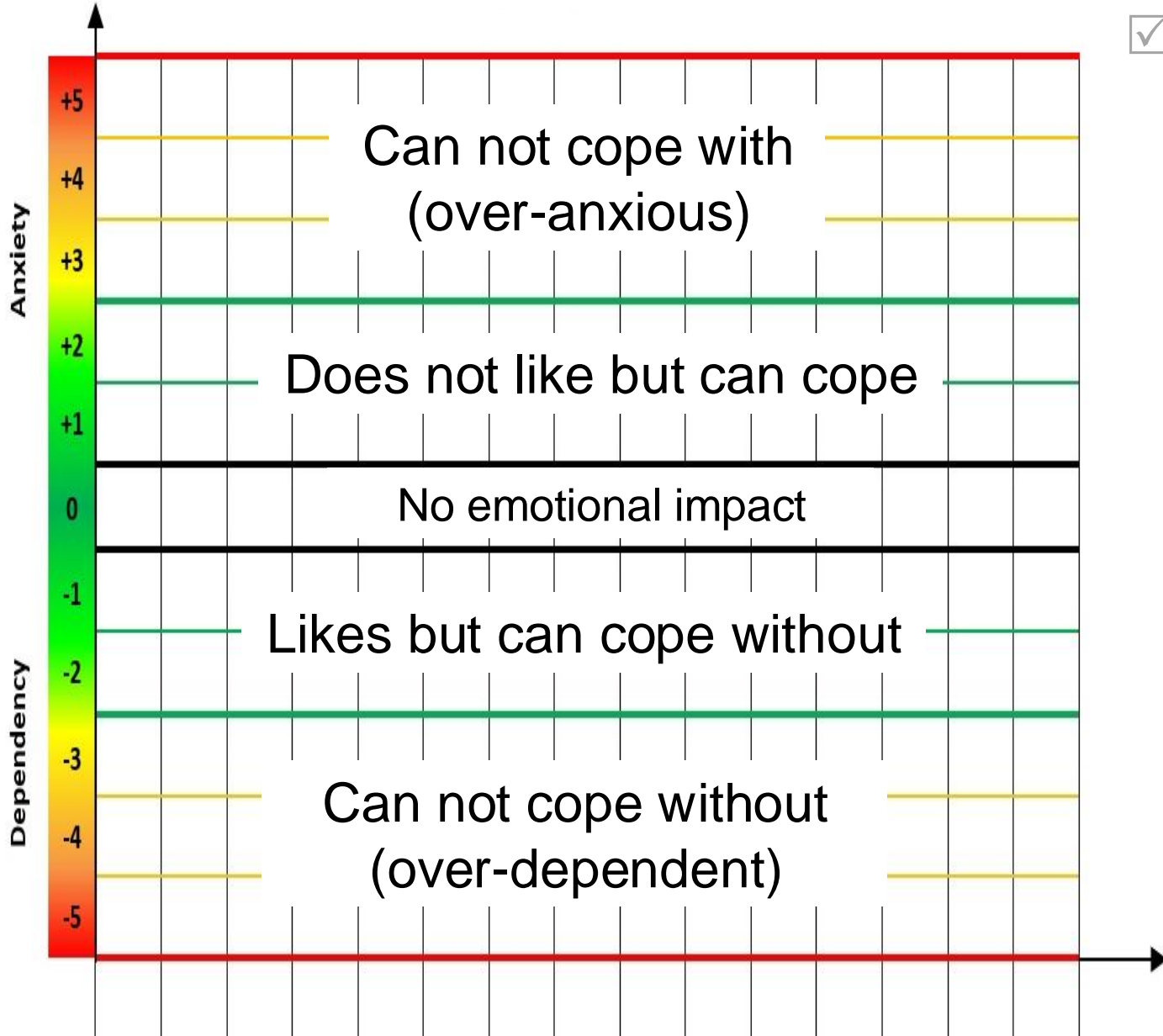
Comfortable self-management

Limit of self-management

Difficult behaviour
(affecting self, internalising)

Difficult behaviour
(affecting others, externalising)

Dangerous behaviours



Anxiety analysis checklist

- Are the conclusions based on evidence or opinion?
 - Are variables scored at 3 or 4 evidenced at being directly responsible for difficulty or disruption
 - Are variables scored at 5 evidenced at being directly responsible for dangerous outcomes (recorded harm)
- Have a range of factors or variables been analysed?

Anxiety analysis checklist

- Is the information up to date and current? Have these been reviewed and revised over a period of time?
- Has each anxiety analysis been considered in regard to the overall picture? (e.g., is the child experiencing low level anxiety in regard to staff, location and activity resulting in being overwhelmed.)



Predict, prevent and progress plan

To formalise differentiation to protect the child from what they can't cope with or what they can't cope without



Predict, prevent and progress

	Score	Predict Staff/Location/Activity/Peers/Time	Prevent Adaptations (including protective consequences)	Progress Adaptations (including educational consequences)
Increased Anxiety	+3 - +5	Unable to cope with: 1. 2. 3. 4. 5.	What will manage the over-anxiety: 1. 2. 3. 4. 5.	How will we teach and monitor the management of over-anxiety: 1. 2. 3. 4. 5.
	+2	Vulnerable to being unable to cope with: 1. 2. 3.	Monitoring needed: 1. 2. 3.	Adaptation or contingency needed: 1. 2. 3.
	0			
Increased dependency	-2	Vulnerable to being unable to cope without: 1. 2. 3.	Monitoring needed: 1. 2. 3.	Adaptation or contingency needed: 1. 2. 3.
	-3 - -5	Unable to cope without: 1. 2. 3. 4.	What will manage the over-dependency: 1. 2. 3. 4.	How will we teach and monitor the reduction of over-dependency: 1. 2. 3. 4.

Predict, prevent and progress checklist

- Have we been specific around adaptations, including timings, staffing, provision and resourcing etc?
- Have we ensured a planned response for all variables outside of the green section?
- Is there evidenced adaptations to mitigate a child/young person becoming overwhelmed/over-dependent?
- Is there evidence of planned progression in order to reduce adaptations and support inclusion?



Therapeutic Tree

To analyse the experience and feelings responsible for behaviour.



Therapeutic understanding

Anti-social experiences create anti-social feelings.

Anti-social feelings create anti-social behaviour.

Pro-social experiences create pro-social feelings.

Pro-social feelings create pro-social behaviour.

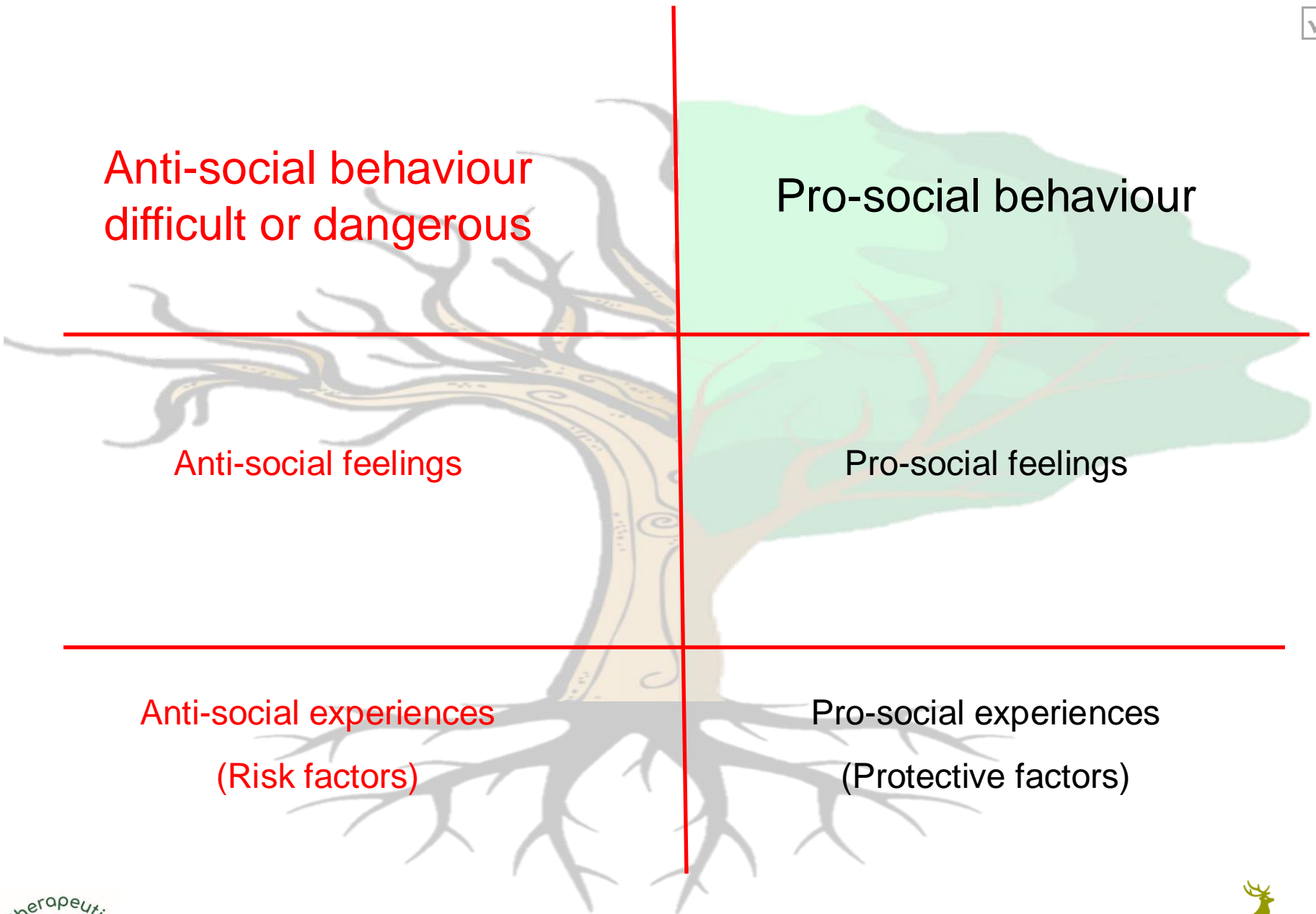


Behaviours

Feelings

Experiences





Anti-social behaviour
difficult or dangerous

Pro-social behaviour

Anti-social feelings

Pro-social feelings

Anti-social experiences
(Risk factors)

Pro-social experiences
(Protective factors)



**Anti-social
behaviour - difficult
or dangerous**

Pro-social behaviour

Labelled Blamed Shamed
Ignored Humiliated Targeted
Rejected Unimportant
Isolated Irrelevant Ignored

Comfortable Respected Included
Safe Motivated Involved
Consulted Rewarded Needed
Inspired Liked Appreciated

DEFAULT



**Anti-social
behaviour - difficult
or dangerous**

Pro-social behaviour

↓ ↓

Labelled Blamed Shamed

Ignored Humiliated Targeted

Rejected Unimportant

Isolated Irrelevant Ignored

↑ ↑

Comfortable Respected Included

Safe Motivated Involved

Consulted Rewarded Needed

Inspired Liked Appreciated

↓ ↓

Exclusion Missing out on stuff

Public Shame Labelled Blamed

Abuse Neglect Poverty

Bereavement Difference CLA

EAL

**Pro-social
experiences**

Therapeutic tree checklist

- Have we acknowledged the child's behaviour may be rooted in current experiences but also in experiences based in the past? (trauma, ACEs, attachment, mental health and wellbeing etc.)
- Have we acknowledged the child's behaviour may be rooted in current feelings and acknowledged that the child's feelings may not be logical to others?
- Are the anti-social behaviours described factually and unemotionally?
- Are the child's current pro-social behaviours acknowledged and analysed?

Therapeutic tree checklist

- Are the pro-social behaviours we are aiming to create small, measurable, achievable and realistic?
- Have we acknowledged successful strategies already in place?
- Will any listed pro-social experiences predictably create more pro-social feelings?

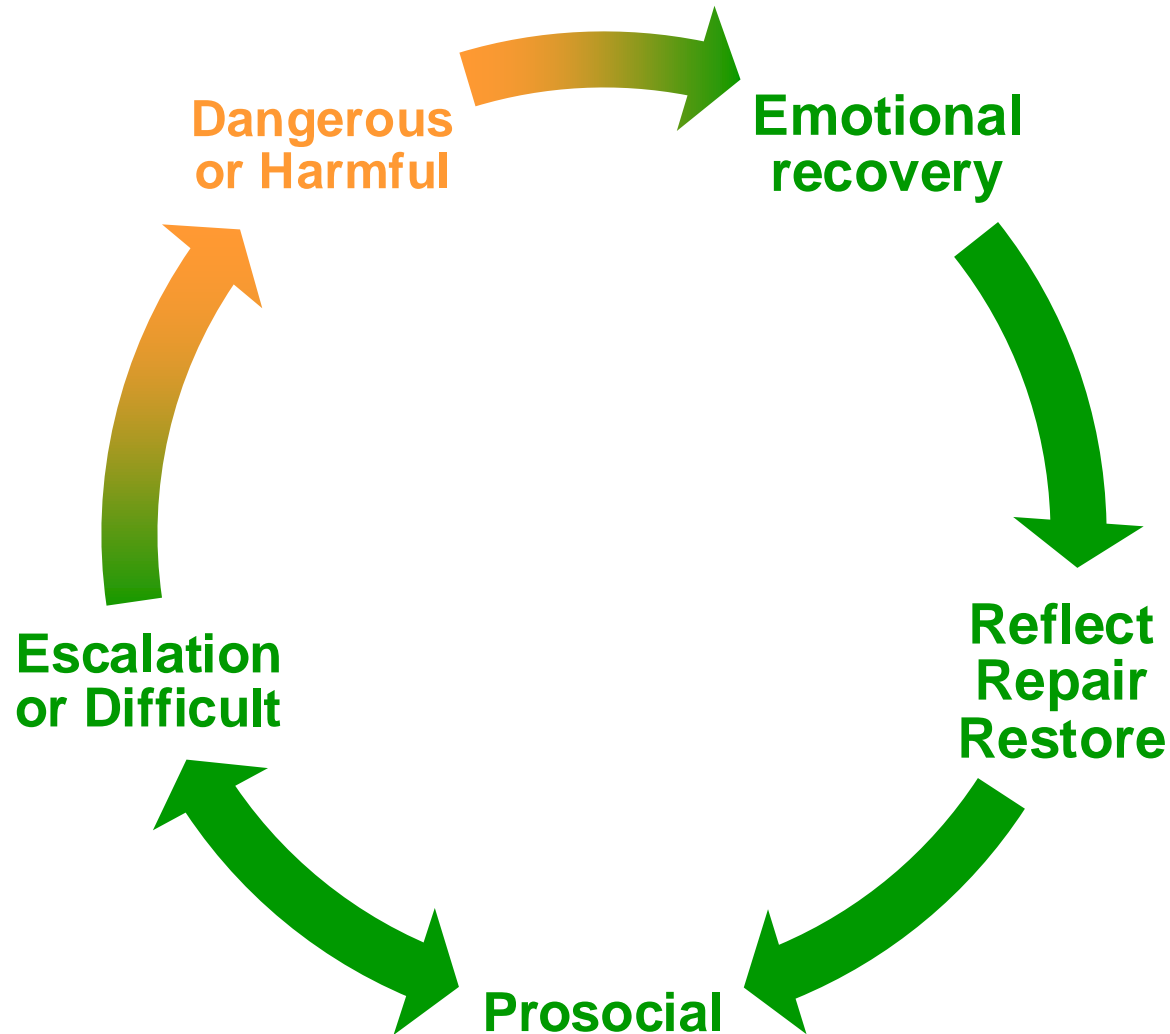
The therapeutic tree can also be used to consider how a punitive response to behaviour risks creating feelings directly responsible for anti-social behaviour



Therapeutic Plan

To formalise all elements of differentiated experience to establish consistent practice.

Planned responses





Therapeutic plan

Name	DOB	Date	Review Date
-------------	------------	-------------	--------------------

Photo	Differentiated measures.
--------------	---------------------------------

Pro social behaviours	Strategies to respond
------------------------------	------------------------------

Difficult behaviours	Strategies to respond
-----------------------------	------------------------------

Dangerous behaviours	Strategies to respond
-----------------------------	------------------------------

Debrief Notes (reflect, repair and restore)

Populating the therapeutic plan

Name	DOB	Date	Review Date
------	-----	------	-------------

Photo	<p>Differentiated measures.</p> <p>Pro-social experiences (bottom right) from Therapeutic Tree as identified through early prognosis, and predict, prevent & progress.</p> <p>Planned protective and educational consequences.</p>
-------	--

<p>Pro-social behaviours</p> <p>Copy from Therapeutic Tree (top right)</p>	<p>Strategies to respond</p> <p>What should staff say and what should staff do when they observe each behaviour happening - the 'in-the-moment' response?</p>
--	---

<p>Difficult behaviours</p> <p>Copy from Therapeutic Tree (top left)</p>	<p>Strategies to respond</p> <p>What should the staff response be to the first signs the CYP is no longer displaying the pro-social behaviours listed above? Early identification and intervention can avoid escalation</p> <p>What should staff say and what should staff do when they observe each behaviour happening - the 'in-the-moment' response?</p>
--	--

Populating the therapeutic plan

Dangerous behaviours
Copy from
Therapeutic
Tree (top left)

Strategies to respond

What should staff do when the opportunity to de-escalate is missed? These responses should focus on de-escalation and relationship reinforcers to enable emotional recovery before being redirected to activity/place/task.
What should staff say and what should staff do when they observe each behaviour happening - the 'in-the-moment' response?

Debrief Notes (reflect, repair and restore)

What should the recovery time look like? Where, how long for, who with, activities that will aid regulation etc?

Script the debrief process – how do we start the conversation about what happened?

Therapeutic plan checklist

- Is the plan populated as a result of completing analysis? (early prognosis; subconscious & conscious behaviour; anxiety analysis; predict, prevent and progress; therapeutic tree)
- Has the dangerous behaviour box been left blank if there is no evidence of significant harm? (risk calculator)
- Have we provided detail around adaptations, including timings, staffing, provision and resourcing etc?
- Does the plan provide sufficient clarity for a member of staff who has no working knowledge of the child to implement?
- Does the de-brief section include an educational consequence?

Document tracker



Therapeutic Thinking Analysis & Planning Document Tracker

		Enter the date each document was last reviewed and updated								
Name	Year group / Class	Early Prognosis	Risk Calculator	Subconscious checklist	Conscious Checklist	Anxiety analysis	Predict, Prevent & Progress Plan	Therapeutic Tree	Therapeutic Plan	Audited Need
Jenny	Blue	04-Mar-22	10-Dec-22	01-Jul-22	01-Jul-22	01-Jul-22	20-Nov-22	21-Nov-22	10-Dec-22	01-Jan-23
Jason	Yellow	14-Feb-23	04-Mar-23	04-Mar-23	04-Mar-23	06-Jun-23	06-Jun-23	13-Sep-23	14-Sep-23	N/A

Key

- Within the last 3 months
- Within the last 6 months
- More than 6 months ago

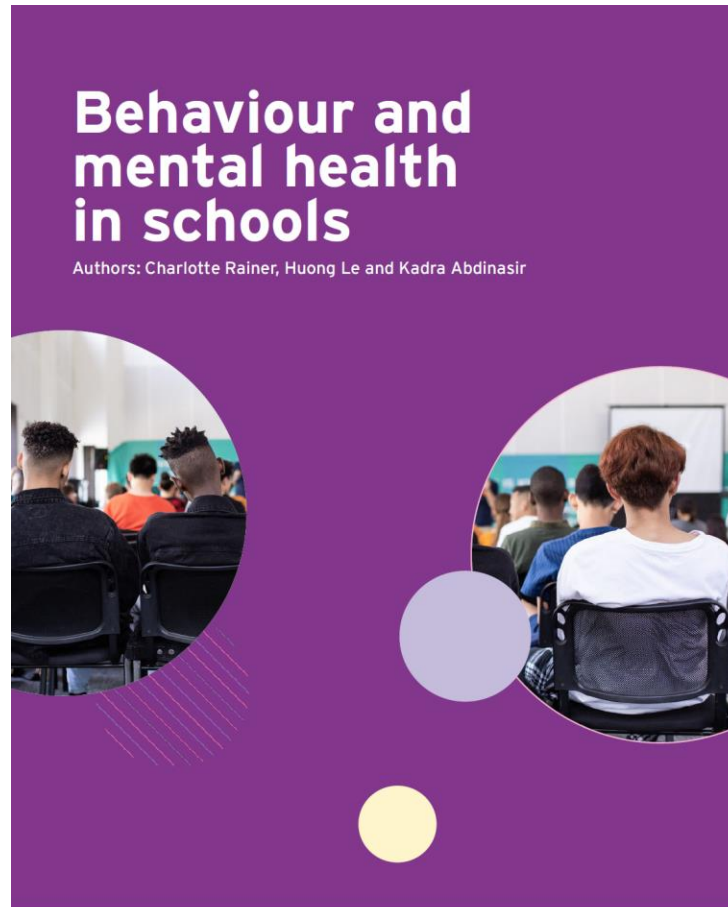


Developing policy and plans





Mental health



The impact of behaviour management techniques on mental health

- Young people, parents and carers regarded removal rooms to be the most harmful behaviour management technique deployed by schools.
- The use of fines or penalties for non-attendance and lateness, suspension and whole-class punishment were also seen to be harmful to mental health, as reported by the young people, parents, carers and professionals who responded to the call for evidence.

The impact of behaviour management techniques on mental health

- We were told how experiences of these techniques can evoke negative feelings in young people, can lead them to dislike school, and can increase feelings of anxiety, particularly in relation to school attendance. In some cases, we heard about experiences of self-harm and suicidal thought.
- It was noted that in the long term, punitive measures are not effective in changing behaviour. This is because they respond to the presenting behaviour and not the child's underlying needs, meaning the root causes of the behaviour are never actually addressed.

What needs to change?

- ... We heard about the importance of teaching pupils positive behaviours to help them to thrive in the school environment. This should be coupled with a supportive, nurturing and inclusive school environment, where every child is valued. Many schools have taken steps to prioritise and embed relational and restorative approaches in order to improve both behaviour and mental health.
- ... A culture shift is needed in how behaviour is viewed in schools. We need to move beyond a place where behaviour is seen as problematic and something that needs to be managed, to a much more concerned and curious place

Example policy statements

- We believe that all our CYPs and visitors need to be safe and to know that the staff around them are able to manage them safely and confidently
- Only for a very small minority of CYPs will the use of restrictive physical intervention be needed. On such occasions, trained and authorised forms of intervention must be used.
- Trained or untrained staff have a duty to act in an emergency (unforeseeable risk of imminent harm)

Example policy statements

- Restrictive physical interventions will only be used when all other strategies have been considered and therefore only as a last resort
- There are situations when restrictive physical intervention may be necessary, for example in a situation of clear danger and extreme urgency

Example policy statements

- Restrictive physical intervention is an act of care and control, not punishment. It is never used to force compliance with staff instructions
- Restrictive physical intervention will only be used in circumstances where it prevents a crime being committed, or prevents significant harm to people or critical damage to property
- Staff will only use it when there are good grounds for believing that immediate action is necessary

Example policy statements

Commonly shared justifications for restraint:

- To prevent a CYP from committing a criminal offence
- To prevent a CYP from injuring self or others
- To prevent or stop a CYP from causing serious damage to property

Example policy statements

Additional justification for teachers:

- To stop the CYP from engaging in any behaviour that is prejudicial to maintaining the good order and discipline

The inclusion that restraint in education can routinely be justified by the above statement is not supported by Therapeutic Thinking Hertfordshire.

Example policy statements

- There is no legal definition of “reasonable force”:
 - the use of force can be regarded as reasonable only if the circumstances of an incident warrant it
 - the degree of force must be in proportion to the circumstances of the incident and the seriousness of the behaviour or consequences it is intended to prevent

Example policy statements

The definition of restrictive physical intervention also includes the use of:

- mechanical devices (e.g., splints on the CYP prescribed by medical colleagues to prevent self-injury)
- forcible seclusion or use of locked doors

It is important for staff to note that, although no personal physical contact may be made in the latter situations, this is still regarded as a restrictive physical intervention

Example policy statements

- Training in practical techniques of restrictive physical intervention will be required for staff only where there is a significant likelihood of them needing to intervene using RPI to manage dangerous behaviour
- Where there is an identified need for such training, staff will be trained by a certificated Therapeutic Thinking tutor

Example policy statements

- If a CYP is identified for whom it is felt that restrictive physical intervention is likely, the flowchart should be followed to ensure individual, differentiated, analysis and planning
- The 'audit of need' provides a checklist to ensure the principle of last resort and compliance with health and safety legislation in this area



Touch policy

Needs to define if, when, why and how we use:

- Lap sitting (early years and primary)
- Physically separating a CYP from their parent
- Carrying
- Physically comforting a CYP
- Steering, guiding or escorting a CYP
- Physical prompts
- Intervention in fights and assaults
- Restrictive physical intervention (RPI) or restraint



Planned restrictive physical intervention

Should be:

- Agreed in advance by professionals engaged in the CYP's wellbeing and care in consultation with the CYP and his or her carers or advocates
- Planned in advance including broader strategies for addressing the CYP's needs
- Under the supervision of an identified advocate
- Subject to recording, reporting, monitoring and, where necessary, investigation



Planned restrictive physical intervention

Planning should:

- Involve family, carers and the CYP to ensure they are clear about what specific action the staff may take in response to a range of behaviours
- Include a risk assessment/audit of need to ensure the risk is foreseeably manageable with available resources
- Include individual therapeutic plans/risk reduction plans which include options that have been examined and discounted, as well as those currently advised



Planned restrictive physical intervention

Planning should:

- Identify training needs
- Describe the behaviours, analyse the function and give specific unambiguous responses
- Identify triggers and the differentiation that will protect the CYP from those triggers
- Explore every opportunity to defuse or de-escalate



Planned restrictive physical intervention

- Should describe the point at which restrictive physical intervention is to be employed and state the harm that will be prevented
- Consider and plan to protect those with emotional or medical needs, including, respiratory and cardiac conditions, muscular or skeletal conditions
- Be acknowledged and signed by the service, the CYP, advocates and the broader community of professionals working with the CYP



Intimacy

- Physical intervention should be in the CYP's best interest and should be conscious of the need to differentiate the attachment to staff from the attachment to key adults such as parents and siblings
- Regardless of age, physical intervention should not provide intimacy within a transient relationship
- Touch with no communication, sustained physical closeness, sustained eye contact can all develop intimacy



The basics





Unsafe touch





There are only three components that are WRONG

When considering the use of physical intervention or restrictive physical intervention there are only three components that can be judged as wrong

- A negative impact on the process of breathing
- Pain as a direct result of the technique
- A sense of violation

Restricting breathing (hyperflexion)

A CYP or adult held in any way which results in their shoulders being held forward of their hips, will start to impact on the natural movement of the abdomen, diaphragm and chest. This can lead to restricted breathing

This is specifically relevant where the CYP may be seated in chairs or held seated on the floor

Factors such as height, weight, obesity, breathing difficulties and heart conditions could all increase the risk of hyperflexion



Staff holding removed for clarity

Restricting breathing (basket-type holds)

Basket-type holds rely on the CYP being restricted around their abdomen, diaphragm or chest

Restricted breathing could occur when adult arms, the CYP's own arms or their clothing is held in a way that could restrict the free movement

Factors such as development, height, weight, obesity, breathing difficulties and heart conditions could all increase the risk

Wrap-type holds were used historically and are increasingly considered to carry unacceptable levels of risk





Pulling and dragging

Pulling and dragging would be where staff attempt to move a CYP holding a hand or wrist and pulling on an extended arm

Factors such as instability of joints, muscle tone and balance could all increased risk

Small, young and developing CYP would have increased risk of injury

Where CYP are held or moved, we should aim to maintain a 'Penguin Shape' where the CYP's arms are by their sides, and nothing is impacting on the abdomen, diaphragm or chest



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Elevated risk

The following can all result in a sense of violation, pain or restricted breathing:

- The use of clothing or belts to restrict movement (wheelchairs/pushchairs)
- Holding a CYP lying on their chest or back
- Pushing on the neck, chest or stomach
- Extending or flexing of joints (pulling and tugging)



Elevated risk

The following can all result in significant injury:

- Forcing a CYP up or down steps or stairs
- Dragging a CYP from a confined space
- Lifting and carrying ,including carrying CYP capable of walking
- Seclusion, where a CYP is forced to spend time alone against their will (requires a court order except in an emergency)



Seclusion

- Seclusion, where a CYP is forced to spend time alone against their will
- The use of seclusion can only be a planned response within specialist settings such as sectioned mental health
- To consider an incident an emergency it would need to be dangerous behaviour that could not have been foreseen



Seclusion

- Where dangerous behaviour is unforeseen seclusion should only be considered where the use of RPI is not possible and all other options have been considered
- There are complex nuances around the use of force to impose
 - Secured tent-type structures
 - Contained outside spaces
 - Etc.

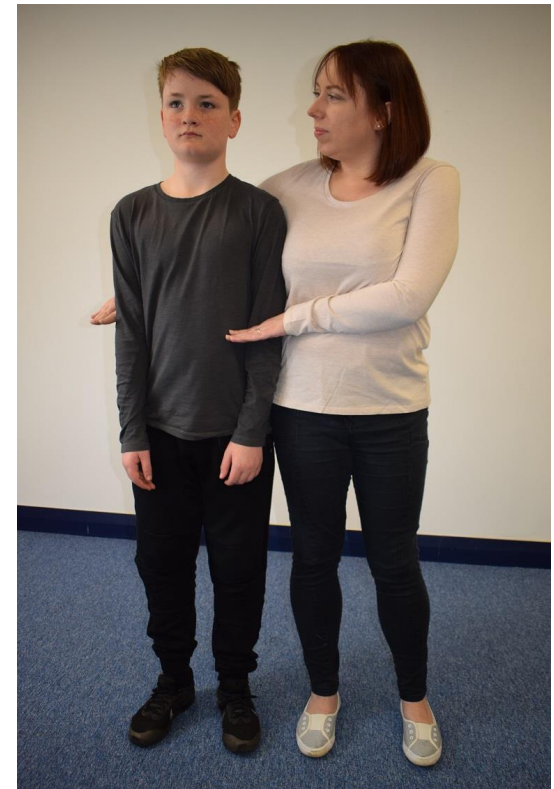


Stance

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Stance describes the adult standing in a way that:

- Maximises balance
- Protects the back
- Is aware of hip security
- Is aware of head safety
- Avoids bending or twisting



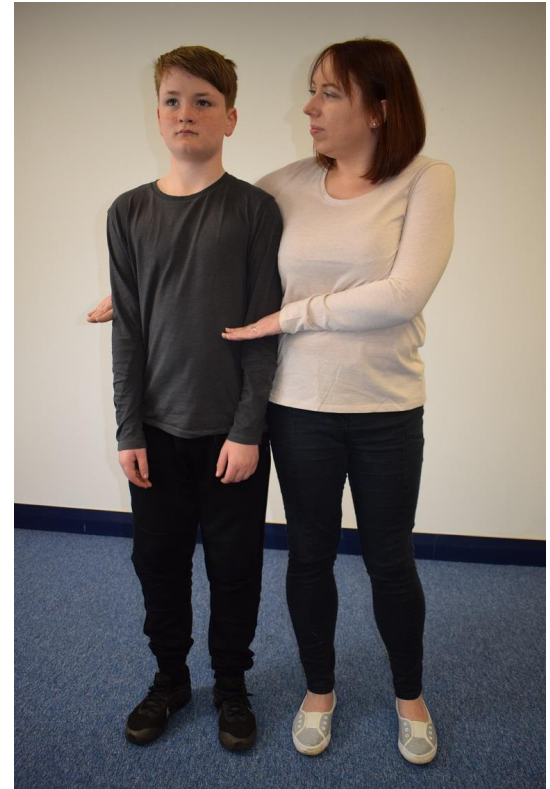


Stance

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Stance

- Feet set at least shoulder width apart
- Soft knees
- Contact at the hip
- Head aware
- Body aligned, no unnecessary twist or bend





Stance L shape

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Stance

- Feet set at least shoulder width apart
- Soft knees
- Adult's feet makes an L shape with CYP's feet. Head aware
- Body aligned, no unnecessary twist or bend

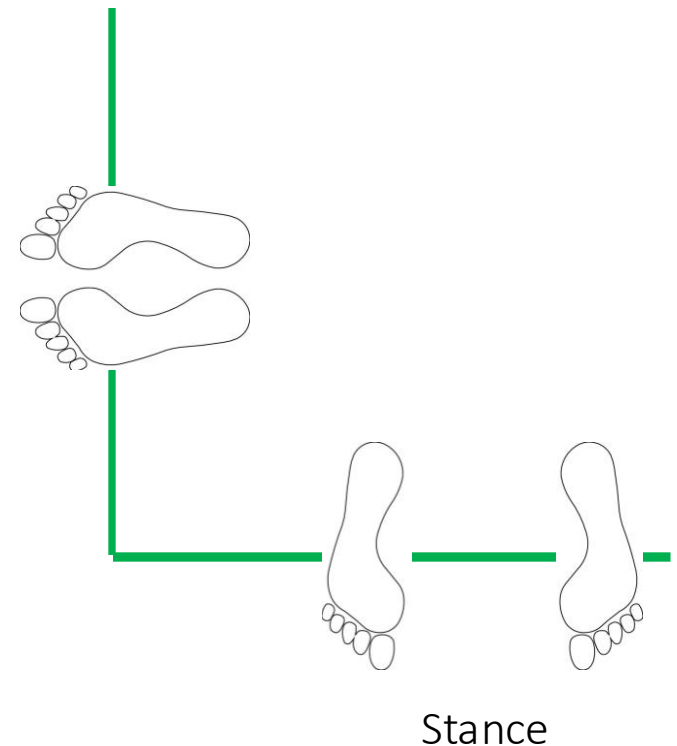


Stance L shape

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Stance L shape

- Feet set at least shoulder width apart
- Soft knees
- Adult's feet make an L shape with CYP's feet. Head aware
- Body aligned , no unnecessary twist or bend





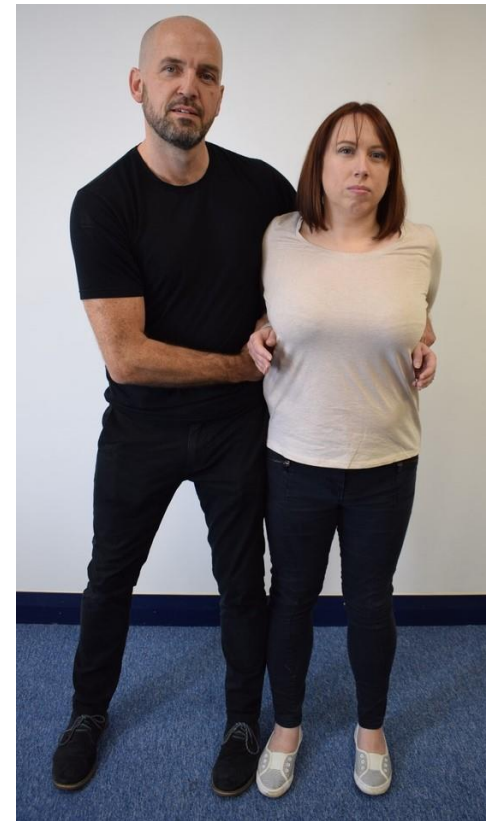
Stance A shape

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Stance A shape

Refers to widening the stance for extra balance and security

- Wide stance
- Hip security
- Soft knees
- Avoid bending or twisting



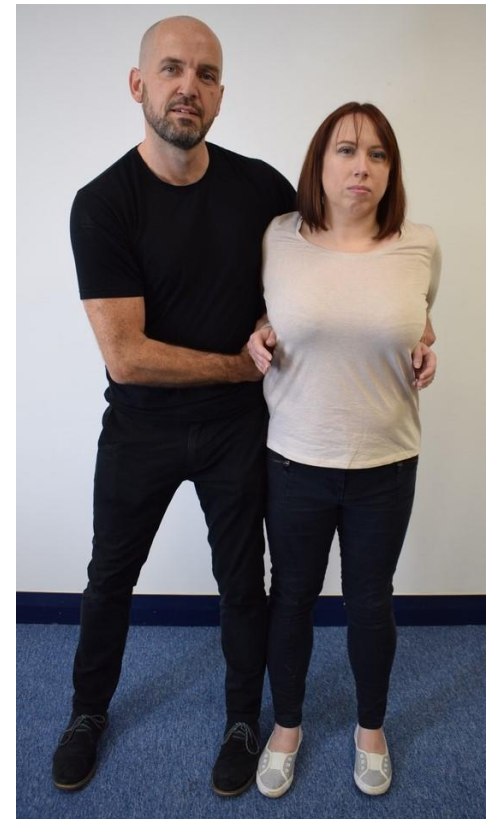


Adult shape

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Adult shape refers to checking

- Stance
- Hand shape (mittens)
- Adults position
- Adult head safety
- Adult hip position
- Checking for bend and twist





Hip to hip

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Hip to hip

Refers to standing beside a CYP ensuring the hip is in contact with the CYP as close to their hip as possible. To achieve this staff may need to kneel or even sit on the floor when working with small CYP





Hip to hip

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Hip to hip, slightly behind

Refers to standing beside a CYP ensuring the hip is in contact with the CYP as close to their hip as possible

Slightly behind suggests tucked just behind the CYP to aid forward movement





Nudge

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Nudge refers to leading with the shoulder that passes behind the CYP. Leading with the shoulder encourages walking without any sense of dragging, pushing or forcing

The CYP walks with you





Octopus shape

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Octopus shape

Refers to a CYP who is physically struggling with arms and legs moving and twisting

A struggling CYP held by hands or wrists or held in a way that allows their body to twist and bend puts strain on joints and can lead to abrasion and bruising





Penguin shape

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Penguin shape

Refers to a CYP held so they are not twisting and turning putting strain on vulnerable joints

- Arms safely secured by their sides
- Held hip to hip
- Maintained standing where possible



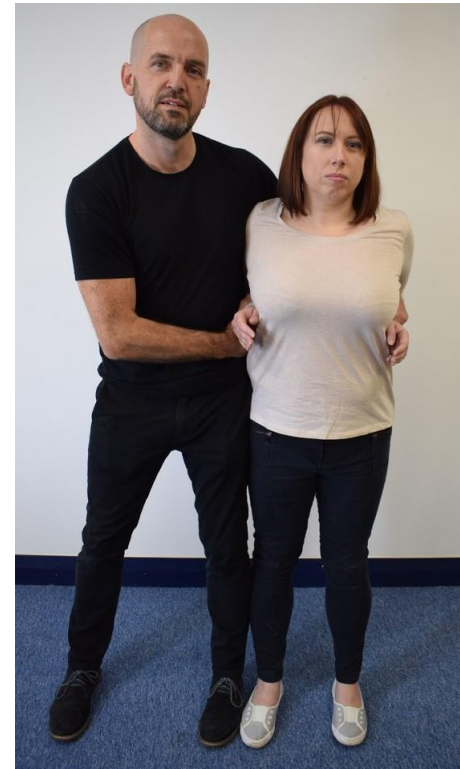


CYP shape

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

CYP shape refers to checking

- Checking no restricted breathing
 - Hyperflexion
 - Basket-type holds
- Checking no pulling and dragging
- Checking for symmetry (shoulders held level)
- Checking for bend and twist





Communicate intention

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Communicate intention

Refers to communicating with the CYP what is happening, where we are heading. It can include reassurance 'I am here to help' and positive phrasing 'breathe with me, take a big breath, look at Mrs. Smith' etc. (Think of it as a running commentary)

It is essential that we plan to communicate with CYP with adaptive communication to ensure they are aware of what is happening



De-escalation script

The de-escalation script should be used like a 5-point menu. Any element can be chosen as an appropriate response to the aggression or challenge presented by the CYP

De-escalation script is designed to remove heat from a situation and create space and time





De-escalation script

- CYP's name
- I can see something has happened
- I am here to help
- Talk and I will listen
- Come with me and...

Closed mitten

Used to draw a CYP close

- Fingers and thumb together

The hand should remain in a mitten to avoid the possibility of gripping. Gripping hands can result in bruising consistent with poor practice



Offering an arm

To support, guide or escort

- Stance
- Hip to hip
- Arm is offered – explicit teaching
- CYP accepts the invite
- Communicate intention
- Draw elbow in for extra security



Supportive hug

To support, guide or escort or to communicate comfort or reward

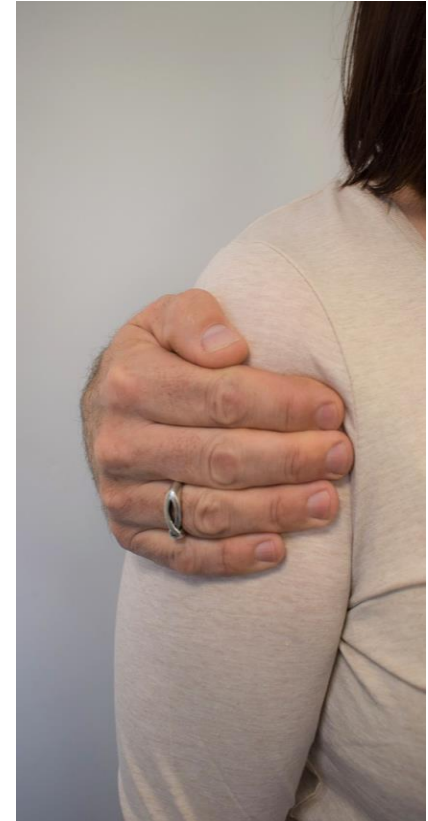
- Stance
- Hip to hip
- Closed mittens around each shoulder
- Communicate intention, consider de-escalation script



Supportive hug

To support, guide or escort or to communicate comfort or reward

- Stance
- Hip to hip
- Closed mittens around each shoulder
- Communicate intention, consider de-escalation script



Supportive arm

To support, guide or escort

- Stance
- Maintain penguin shape
- Hip to hip
- Closed mittens above or around each elbow
- Communicate intention, consider de-escalation script



Supportive arm

To support, guide or escort

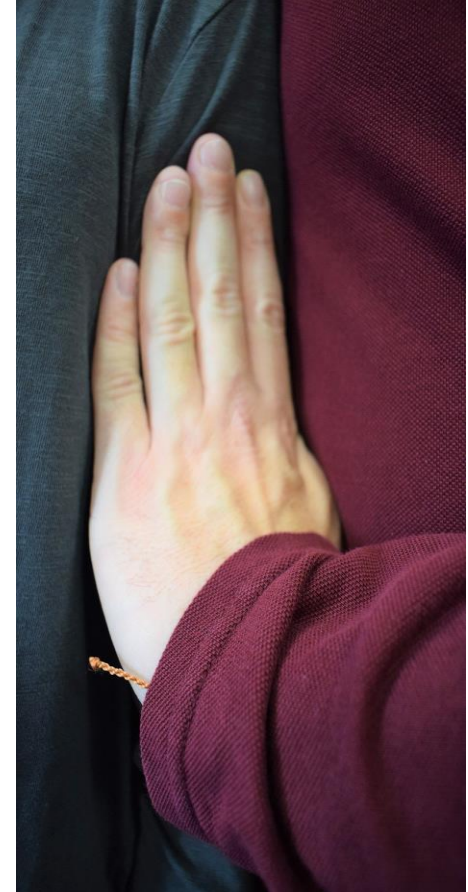
- Stance
- Maintain penguin shape
- Hip to hip
- Closed mittens above or around each elbow
- Communicate intention, consider de-escalation script



Supportive arm

To support, guide or escort

- Stance
- Hip to hip
- Closed mittens above or around each elbow
- Communicate intention, consider de-escalation script



Supportive arm paired

To support, guide or escort

- Stance
- Maintain penguin shape
- Hip to hip
- Closed mittens around each shoulder
- Communicate intention, consider de-escalation script



Staff have lowered to kneeling to maintain stance

Supportive arm paired

To support, guide or escort

- Stance
- Maintain penguin shape
- Hip to hip, slightly behind
- Closed mittens around each shoulder
- Communicate intention, consider de-escalation script





Open mitten

To support, guide or escort, used to move a CYP away

- Fingers together
- Thumb away from fingers
- Palms parallel to floor

The hand should remain in a mitten to avoid the possibility of gripping. Gripping hands can result in bruising consistent with poor practice



Open mitten guide to communicate

To support, guide or escort

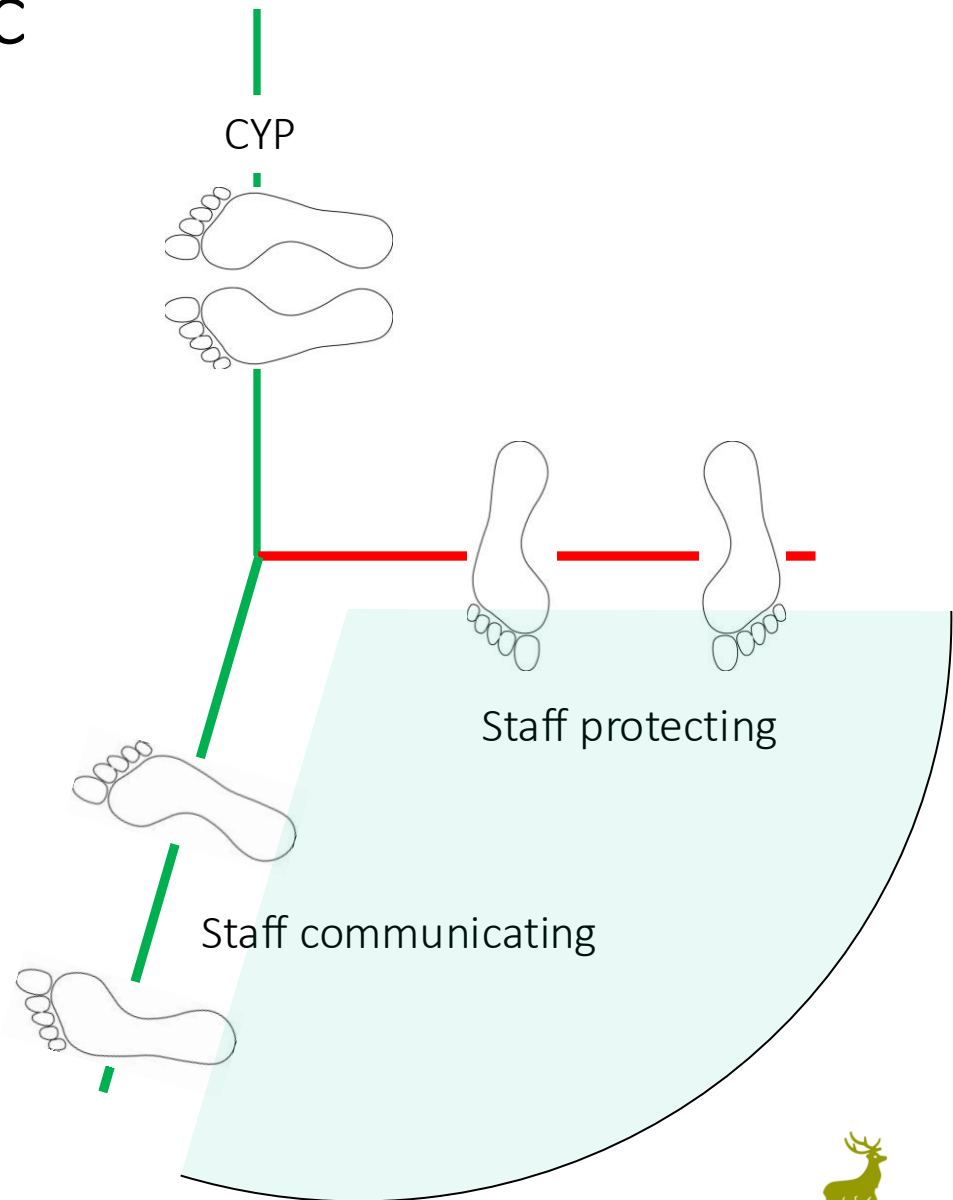
- Stance
- Contact just above elbow
- Intermittent eye contact
- Free hand reassuring or directing
- Communicate intention, consider de-escalation script



Open mitten guide arc

As the danger increases, staff should arc from beside the CYP to stance L shape

- Side by side to communicate
- Stance L shape to protect



Open mitten guide

To support, guide, escort, or protect,
used to move a CYP away

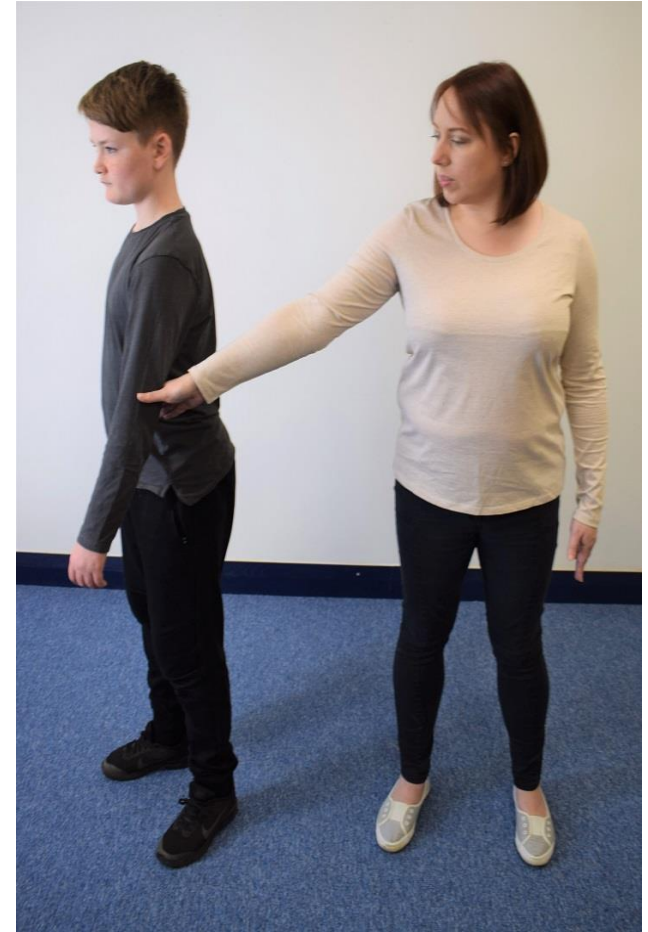
- Stance L shape
- Maintain penguin shape
- Palm parallel to the floor
- Staff positioned behind with extended arm to protect
- Communicate intention, consider de-escalation script



Open mitten guide

To support, guide, escort, or protect,
used to move a CYP away

- Stance L shape
- Maintain penguin shape
- Palm parallel to the floor
- Staff positioned behind with extended arm to protect
- Communicate intention, consider de-escalation script



Open mitten guide – paired



Open mittens – many uses

Open mitten can be used:

- To provide low level protection when close to a CYP
- To turn a CYP away from a stimulus
- To guide a CYP in a preferred direction
- To guide a CYP away from physical or verbal conflict
- To encourage

Open mitten escort

To support, guide or escort

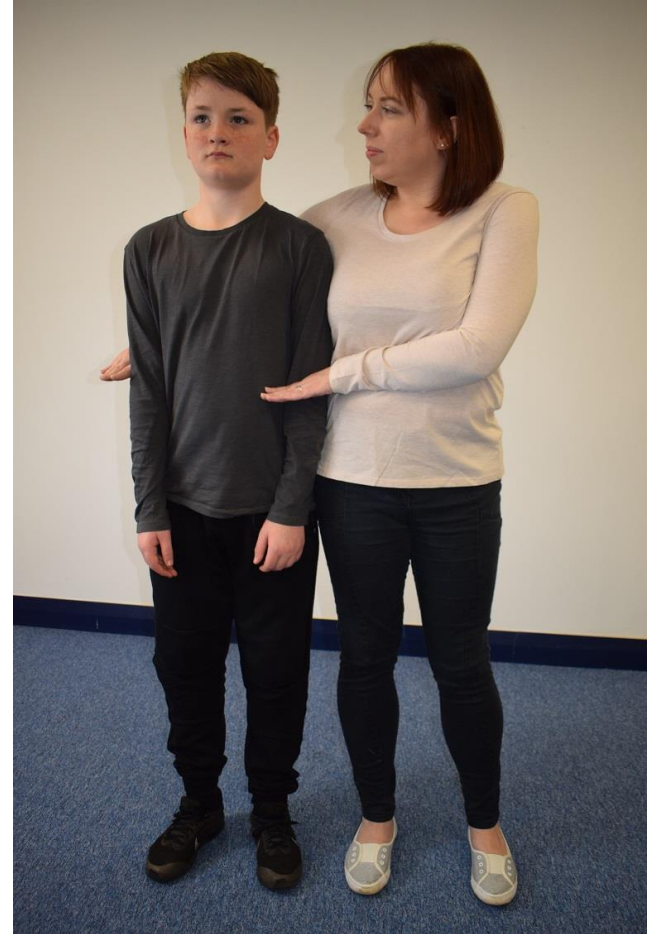
- Stance
- Hip to hip
- Open mittens above each elbow
- Palms parallel to floor
- Nudge
- Communicate intention, consider de-escalation script



Open mitten escort

To support, guide or escort

- Stance
- Hip to hip
- Open mittens above each elbow
- Palms parallel to floor
- Nudge
- Communicate intention, consider de-escalation script



Open mitten escort

To support, guide or escort

- Stance
- Hip to hip
- Open mittens above each elbow
- Palms parallel to floor
- Nudge
- Communicate intention, consider de-escalation script



Open mitten escort – paired

To support, guide or escort

- Stance
- Hip to hip
- Open mittens above each elbow
- Palms parallel to floor
- Nudge
- Communicate intention, consider de-escalation script



Open mitten escort – paired

To support, guide or escort

- Stance
- Hip to hip
- Open mittens above each elbow
- Palms parallel to floor
- Nudge
- Communicate intention, consider de-escalation script



Open mitten escort – principle

CYPs who are allowed to plant their feet may drop or kick or spit at staff. Keeping the feet occupied with movement occupies the brain and reduces the disruptive options

Remember the desired outcome is SAFETY NOT DESTINATION

Intervention

Physical intervention therapeutic thinking (Step On)

- Space and stance
- De-escalation script
- Supporting, guiding and escorting

Principles of restraint reduction and elimination (Step Up)

Emergency intervention (common law)

Restrictive physical intervention (RPI)





Responsibility for health and safety

- Participants should remain focused and professional throughout including keeping the noise level down, following instructions and responding immediately to the lead
- Participants must be encouraged to communicate any known risk to the people they are working with
- Participants should monitor their own wellbeing and opt out if there is any signs of emotional or physical harm and speak with the tutor before continuing



Responsibility for health and safety

- Everybody should participate in a way that means others are protected from harm
 - Nobody should make sudden unannounced movements
 - Nobody should resist against a technique unless specifically asked to do so by the lead
 - Anybody aware of a health and safety risk should immediately inform the lead



Professional conduct

- Training in physical techniques will, by its nature, take people outside of their normal comfort zone and involve a degree of touch and close contact unusual in a professional arena
- Staff should not use this as an opportunity for humour that could in any way be considered prejudicial or inappropriate in terms of a professional environment
- Everybody should participate in a way that means others are protected from harm



Professional conduct

- Staff should seek permission before touching
- Staff should release any hold immediately if asked
- Staff should practise with groupings that maximise emotional wellbeing, some may choose to remain in a gender-specific group or with their own class group. The lead may suggest groupings based on physical size or other factors but nobody should feel pressurised to join a specific group

RPI

All involved must robustly challenge the need for any restrictive physical intervention (RPI) included within Principles of Restraint Reduction and Elimination (Step Up) training

RPI IS ONLY JUSTIFIABLE WHEN ALL OTHER OPTIONS HAVE BEEN CONSIDERED (LAST RESORT PRINCIPLE)

All Principles of Restraint Reduction and Elimination (Step Up) training is based on audited need, so should only be used where there is full documentation based on the graduated response to evidence analysis and planning

Unacceptable outcomes of RPI

When considering the use of restrictive physical intervention there are three outcomes that can be considered unacceptable or wrong

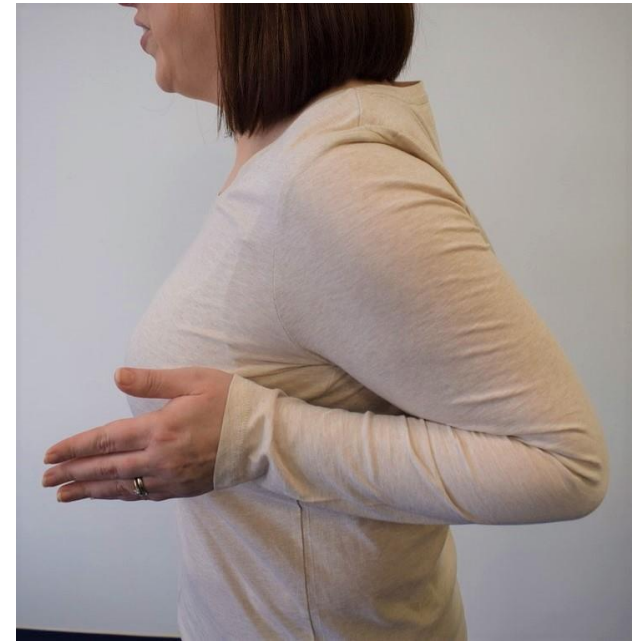
- A negative impact on the process of breathing
- Pain as a direct result of the technique
- A sense of violation

Elbow tuck

Certain terminology will be repeated often when we consider the use of physical intervention or restrictive physical intervention

Elbow tuck describes the shape of the CYP being held

- Arms held beside the CYP not around the CYP
- Forearms parallel to the floor
- CYPs elbows drawn back
- Shoulders in a natural position (no lift)



Elbow tuck – rescue shape



Elbow tuck – rescue shape

Context:

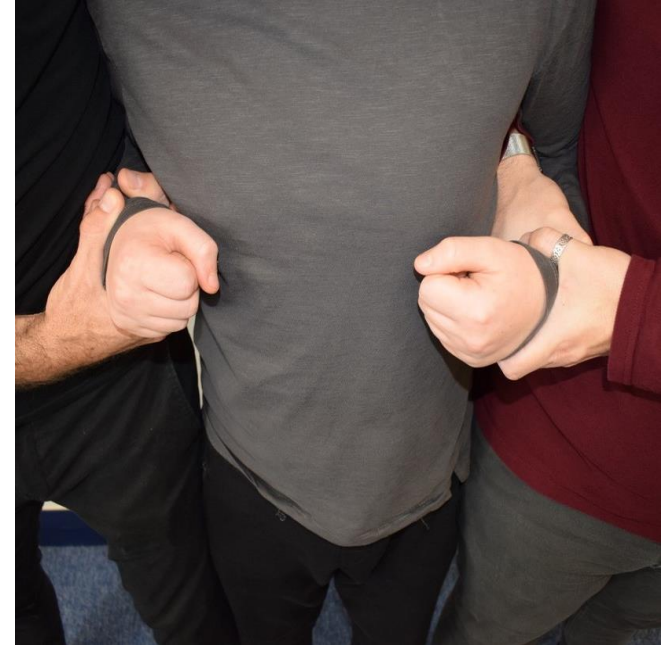
The rescue shape is not designed to be maintained but is used as a familiar shape to return to between transitions



Elbow tuck – rescue shape

Elbow tuck shape:

- Staffs' arms pass either side of the CYP's arm
- Thumbs on top, over or above the wrist (avoid holding the hand)
- Check CYP shape
- Check adult shape
- All elbow tucks can start from this rescue shape



Elbow tuck – figure of 4



Elbow tuck – figure of 4

Context:

Elbow tuck figure of 4 is extremely versatile and has high social validity. It is predominantly to control arm movement but can also be used for coaching and damping of movement



Elbow tuck – figure of 4

- Stance
 - Hips to hip, slightly behind
 - Elbows tucked
1. Both hands thumb on top
 2. Inside hand goes over CYP's arm and holds onto own arm
- CYP shape
 - Adult shape
 - Communicate intention, consider de-escalation script



Elbow tuck – figure of 4

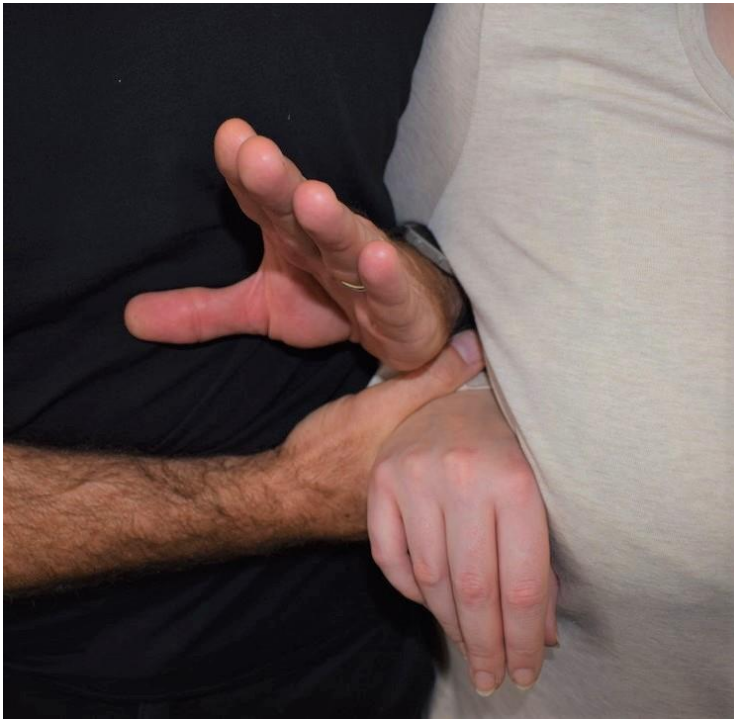


- Outside hand thumb on top
- Inside hand reaches over forearm



- Hold CYP without grip
- Adult holds own arm with a secure grip

Elbow tuck – figure of 4



- Outside hand thumb on top
- Inside hand reaches over forearm



- Hold CYP without grip
- Adult holds own arm with a secure grip

Figure of 4 – multiple uses

Figure of 4 can be used:

- To support a CYP with dangerously exaggerated movement or grabbing to transition within a building or community
- As a secure form of guiding where risk is elevated
- To coach hand movement or hand-on-hand activity
- To support a CYP seated with staff kneeling beside

Elbow tuck – figure of 4

CYPs who are allowed to plant their feet may drop, kick or spit at staff. Keeping the feet occupied with movement occupies the brain and reduces the disruptive options

If the CYP digs their feet in resist the temptation to oppose the force, relax, give a little and the CYP will reduce resistance

Remember the desired outcome is SAFETY NOT DESTINATION

Care must be taken to ensure the CYP's arms are held against their sides not against stomach or chest

Elbow tuck – lone worker



Elbow tuck – lone worker

Context:

Elbow tuck lone worker presents an increased risk to the backs of adults

Lone worker should be used only where staff have a height and weight advantage and only where the assistance of another adult is not possible



Elbow tuck – lone worker

- Stance
 - Hips to hip, slightly behind
 - Elbows tucked
1. Far hand closed mitten
 2. Near hand open mitten, thumb on top
- CYP shape
 - Adult shape
 - Nudge
 - Communicate intention, consider de-escalation script



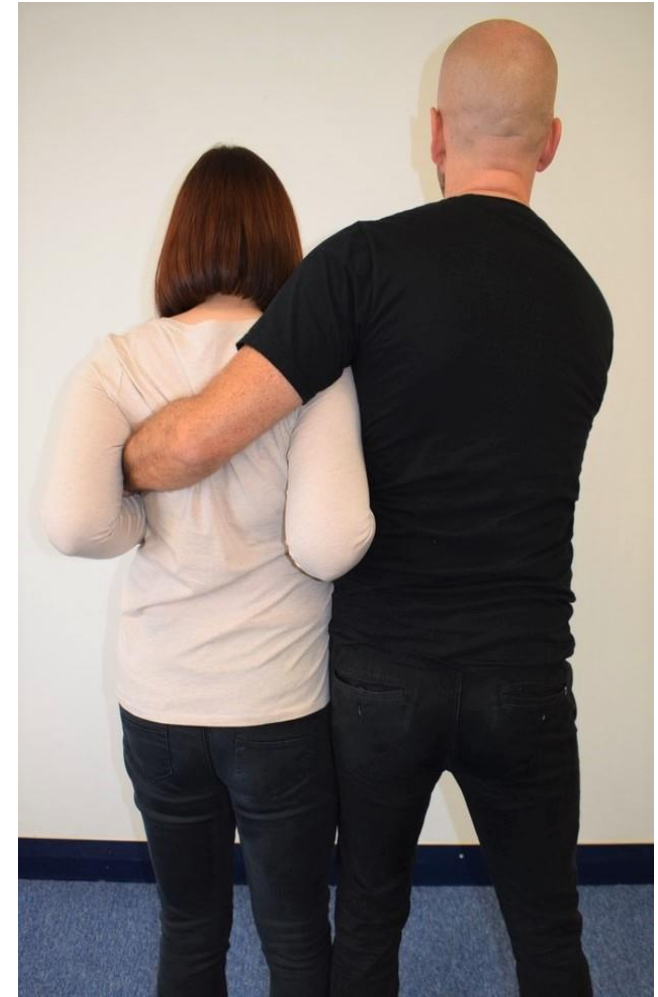
Elbow tuck – lone worker

- Stance
 - Hips to hip, slightly behind
 - Elbows tucked
1. Far hand closed mitten
 2. Near hand open mitten, thumb on top
- CYP shape
 - Adult shape
 - Nudge
 - Communicate intention, consider de-escalation script



Elbow tuck – lone worker

- Stance
 - Hips to hip, slightly behind
 - Elbows tucked
1. Far hand closed mitten
 2. Near hand open mitten, thumb on top
- CYP shape
 - Adult shape
 - Nudge
 - Communicate intention, consider de-escalation script



Elbow tuck – lone worker

The hand passing around the back must be kept in a closed mitten

An open mitten could result in reducing the safety and effectiveness of the technique



Elbow tuck – lone worker

CYPs who are allowed to plant their feet may drop, kick or spit at staff. Keeping the feet occupied with movement occupies the brain and reduces the disruptive options

If the CYP digs their feet in resist the temptation to oppose the force, relax, give a little and the CYP will reduce resistance

Remember the desired outcome is SAFETY NOT DESTINATION

Care must be taken to ensure the CYP's arms are held against their sides not against stomach or chest

Elbow tuck – braced



Elbow tuck – braced

Context:

Elbow tuck braced is the most secure of the elbow tucks and as such has lower social validity. It should be used where the mobility and hip movement means that elbow tuck – figure of 4 would fail to keep the situation safe



Elbow tuck – braced

- Stance A shape
 - Hips to hip, slightly behind
 - Elbows tucked
1. Far hand closed mitten
 2. Near hand open mitten, thumb on top
- CYP shape
 - Adult shape
 - Nudge
 - Communicate intention, consider de-escalation script



Elbow tuck – braced

- Stance A shape
 - Hips to hip, slightly behind
 - Elbows tucked
1. Far hand closed mitten
 2. Near hand open mitten, thumb on top
- CYP shape
 - Adult shape
 - Nudge
 - Communicate intention, consider de-escalation script



Elbow tuck – walking and turning

- Move assertively (prevents kicking / dropping)
- Hips in (slightly behind if necessary)
- Slow down on the turn
- Pivot on the inside of a turn – walk around CYP – pictures
- Drive through the hips on the outside of a turn
- Staff hands on CYP's shoulders if braced

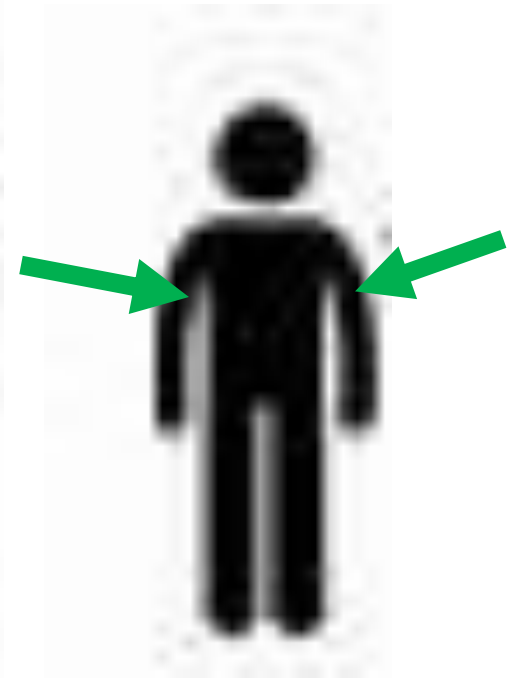
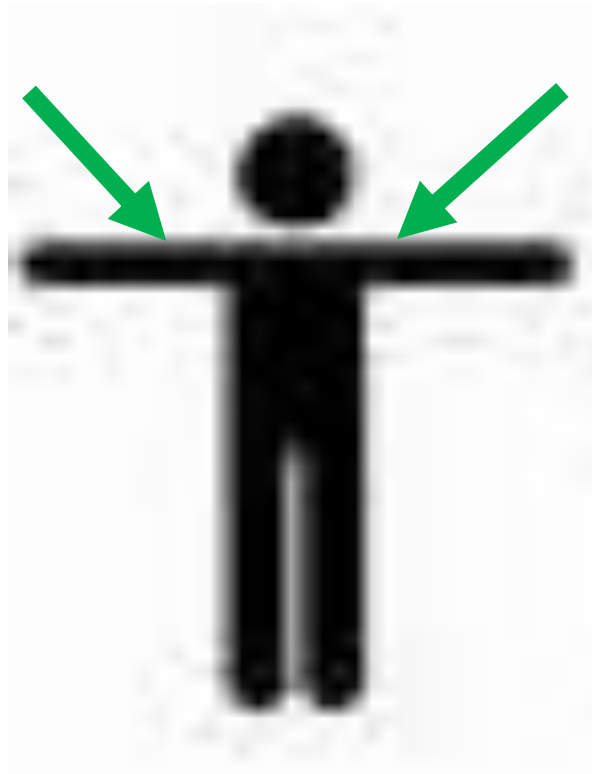
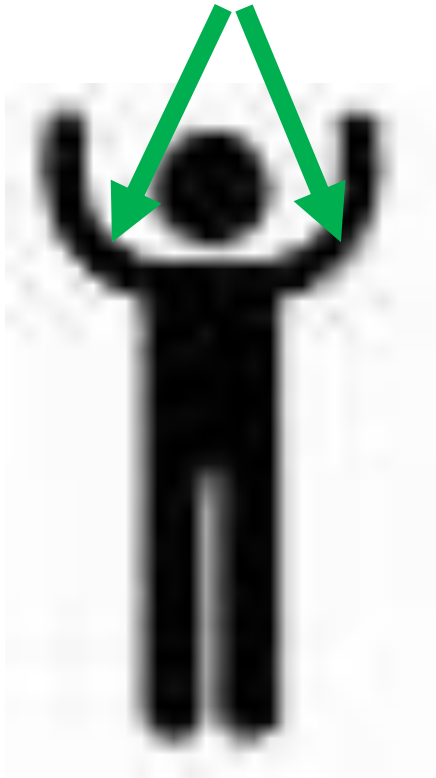
Elbow tucks – engage

Often the greatest risk when considering RPI is engaging and disengaging

Engaging is based on managing and closing down the arms by closing in on the upper arm close to the elbow before attempting to hold

Only when close to static should staff attempt to find the rescue shape on the lower part of the arm before moving to a more secure elbow tuck

Elbow tucks – engage

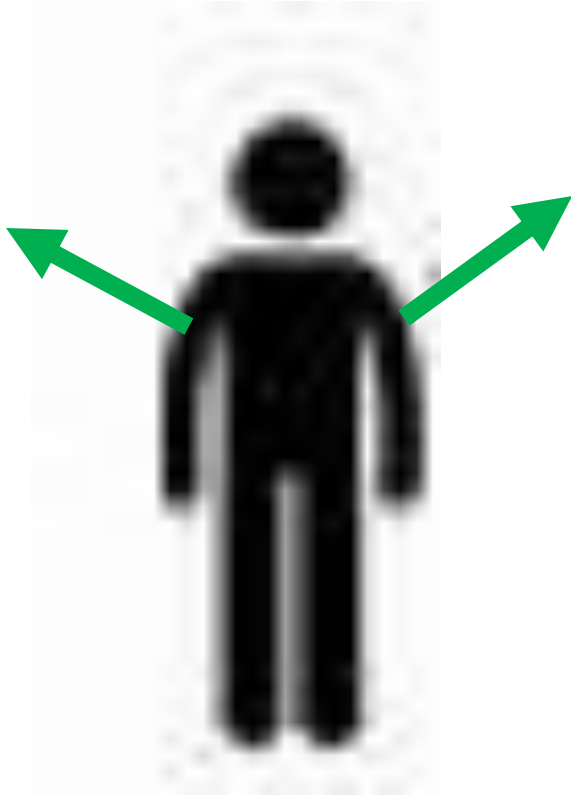


Elbow tucks – disengage

Often the greatest risk when considering RPI is disengaging

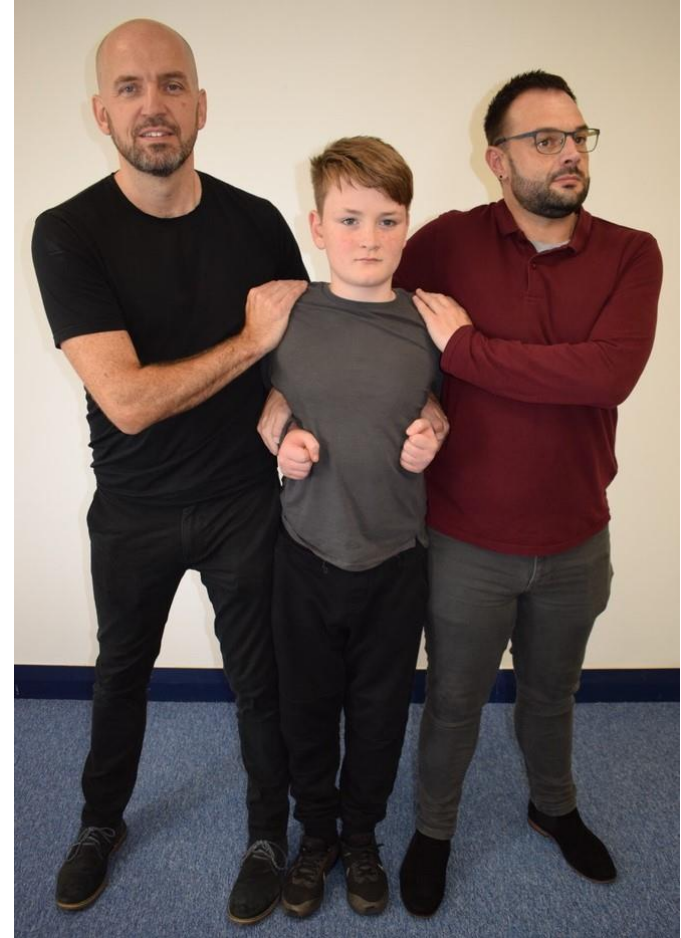
Disengaging is based on managing and moving away from the upper arm as a last element of de-escalation, after releasing the elbow tuck the penguin shape is maintained

Elbow tucks– disengage



Elbow tuck – additional support

A closed mitten can support the shoulder to restrict forward movement or biting



Elbow tuck – support to kneeling



Elbow tuck – supporting to kneeling

- Stance A shape
- Hips to hip
- CYP shape
- Adult shape
- Follow CYP's direction to kneeling
- Recheck CYP shape
- Recheck adult shape
- Communicate intention, consider de-escalation script



Elbow tuck – supporting to kneeling

- Stance A shape
- Hips to hip
- CYP shape
- Adult shape
- Follow CYP's direction to kneeling
- Recheck CYP shape
- Recheck adult shape
- Communicate intention, consider de-escalation script



Elbow tuck – supporting to kneeling

Once kneeling, staff should transition back through rescue shape

- Hips to hip
- CYP shape
- Hands held low to secure hips
- Adult shape
- Hand to shoulder to control movement
- Communicate intention, consider de-escalation script



Elbow tuck – supporting to kneeling

- CYPs hands should remain low in their lap
- If the CYP pulls forward staff tilt their head back
- If the CYP pulls back staff tilt their head back
- If the CYP pushes upwards secure the hands in the CYP's lap and support the shoulders
- Staff must constantly monitor the CYP to ensure the shoulders are not being held forward of the hips as this will start to impact on the natural movement of the abdomen, diaphragm and chest
- Additional staff may scaffold the ADULTS but not the CYP

Restricting breathing (hyperflexion)

A CYP or adult held in any way which results in their shoulders being held forward of their hips will start to impact on the natural movement of the abdomen, diaphragm and chest. This can lead to restricted breathing

This is specifically relevant where the CYP may be seated in chairs or held seated on the floor

Factors such as height, weight, obesity, breathing difficulties and heart conditions could all increase the risk of hyperflexion.



Staff holding removed for clarity

Personal safety responses



Audit of need

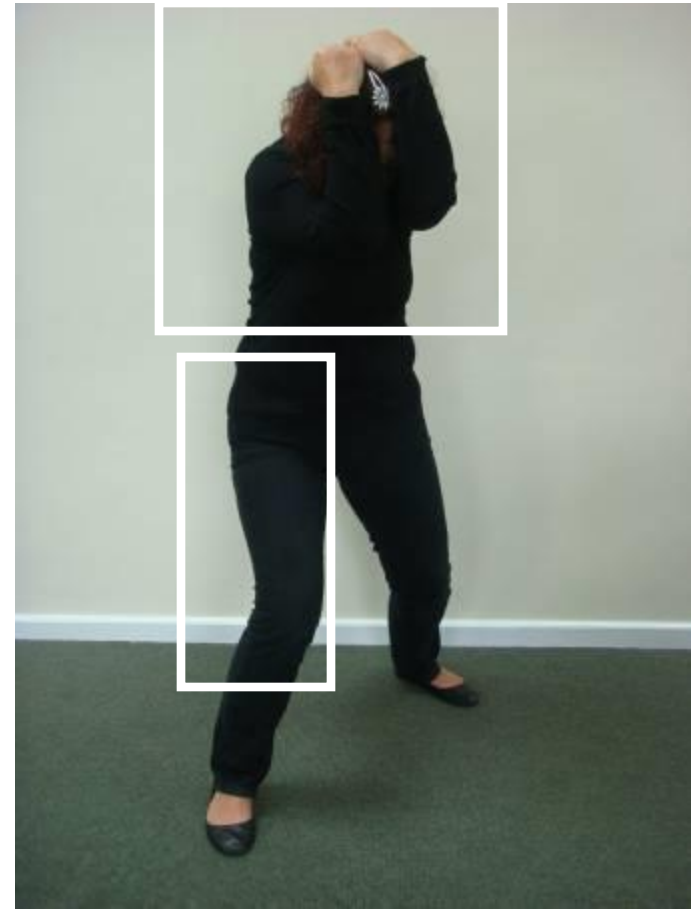
Complex personal safety responses should not be taught where elbow control or fix and stabilise would be sufficient

All Principles of Restraint Reduction and Elimination (Step Up) is based on audited need

Protective stance



Protection from missiles stance



Protective stance

- Protective stance is about minimising the vulnerable areas exposed to physical assault through punches, kicks or missiles
- Staff should aim to protect the head with the arms and turn 'side on' to protect the vulnerable organs
- Staff should move away if able and move in close if trapped
- Staff should maintain an A shape stance
- This is an emergency response designed to minimise not prevent injury

Personal safety – fix and stabilise

Once fixed and stabilised the risk of injury is greatly reduced

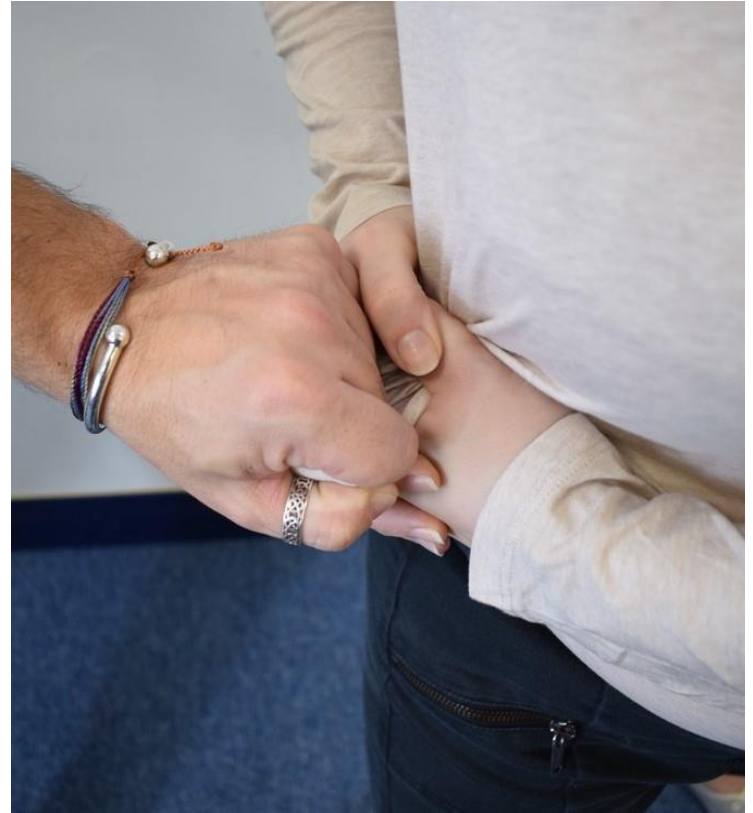
There is no rush to disengage and any additional staff should act in the first instance to secure any free arm that may present a further risk of injury (often elbow tuck figure of 4).

Staff may choose to avoid restrictive physical intervention by going with, rather than resistant force and negotiating the release

Remember the desired outcome is SAFETY NOT DISENGAGE

Fix and stabilise – clothing

- Fix and stabilise (stop pulling)
- Protective stance (protect back)



Fix and stabilise – clothing

- Fix and stabilise (stop pulling)
- Protective stance (protect back)



Fix and stabilise – scarf or other neck wrap

- Fix and stabilise (stop pulling)
- Protective stance (protect back)



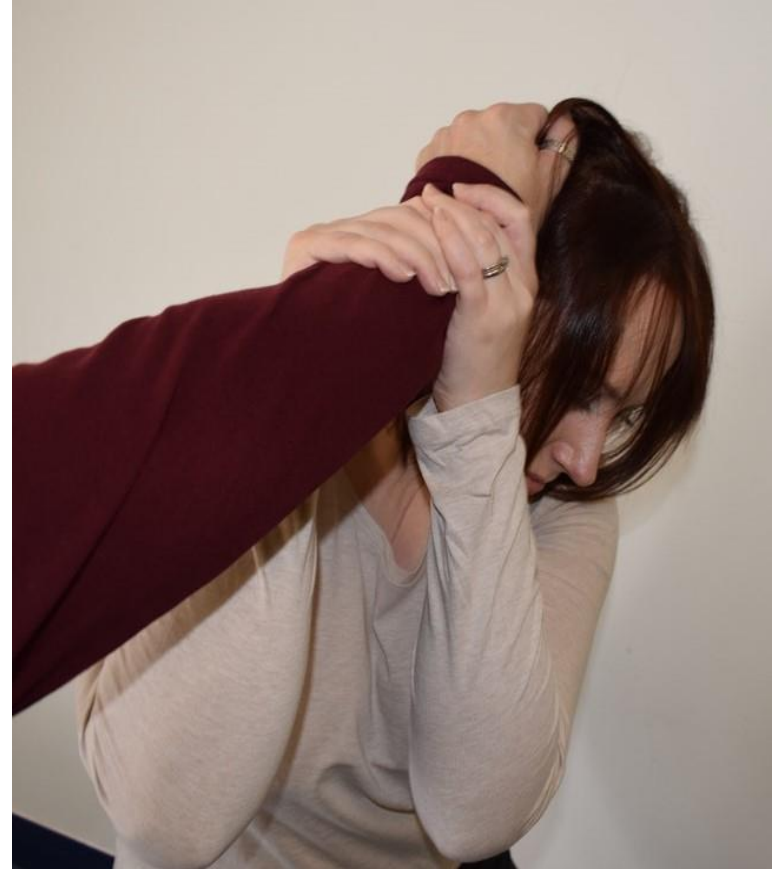
Responses to clothing grabs

- Fix and stabilise (stop pulling)
- Protective stance (protect back)
- Only use principles to release grab if the situation is becoming more dangerous (Technical releases are complex and may increase risk)

Responding to clothing grabs presents a moderate risk to CYP's fingers; this is minimised by ensuring the clothing is removed through the line of the fingers

Fix and stabilise – hair

- Fix and stabilise (stop pulling)
- Protective stance (protect back)



Fix and stabilise – hair

- Fix and stabilise (stop pulling)
- Protective stance (protect back)



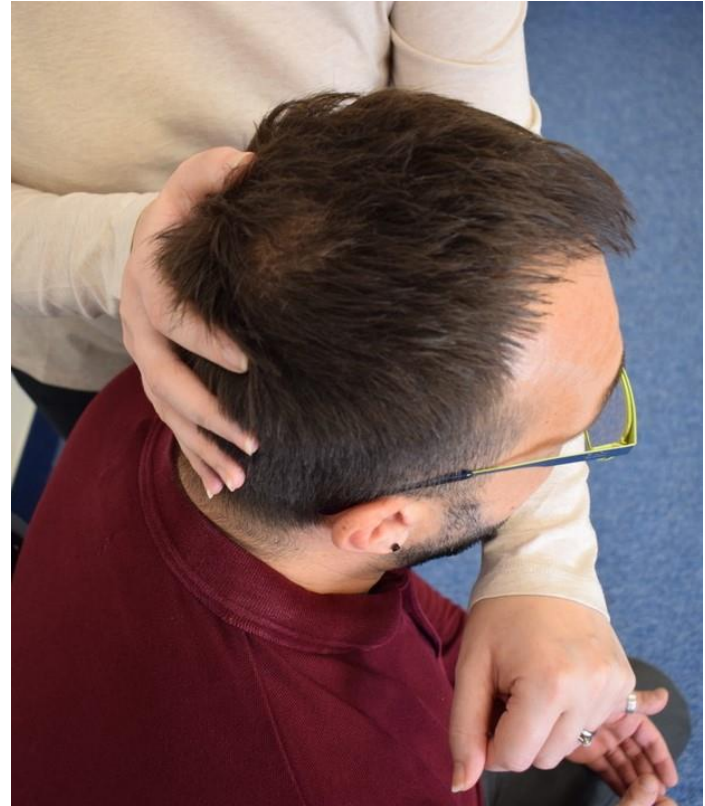
Responses to hair grabs

- Fix and stabilise (stop pulling)
- Protective stance (protect back)
- Only use principles to release grab if the situation is becoming more dangerous (Technical releases are complex and may increase risk)

Hair grabs are high risk as sudden movements of the head of the CYP being held can result in serious harm to the neck

Fix and stabilise - bites

- Fix and stabilise (stop pulling)
- Protective stance (protect back)



Responses to bites

- Fix and stabilise (stop ripping)
- Protective stance (protect back)
- Only use principles to release grab if the situation is becoming more dangerous (Technical releases are complex and may increase risk)

Services should consider the need to protect staff against infection where bites are foreseeable. The greatest danger from a bite is from infection



Restorative de-brief





A restorative approach

An approach to inappropriate behaviour which puts repairing harm done to relationships and people over and above the need for assigning blame and dispensing punishment.

Professor George Wright 1999

Conversation and exploration





Restorative debrief

Debrief is a necessary component of a behaviour curriculum. It is essential for behaviour change.

Restorative debrief needs to be curious, not critical.

Without teaching there is no learning; without learning there is no progress.

Debrief creates a system of evaluation and review to establish what happened, how it happened, and how we use teaching and learning to develop the skills and motivation to enable behaviour change.



Process of a restorative de-brief

- Establish an authentic connection. Ensure the child feels comfortable and supported.
- Explore what happened. Allow them to tell their story. What situations, relationships and dynamics led to a reaction?
- Support their story with non-judgmental accurate descriptions
- Explore what people were thinking and feeling before, during and after the incident.



Process of a restorative de-brief

- Identify who has been affected and how.
- Consider how we can repair relationships.
- Plan for a different response to the same experiences or feelings re-occurring.

Additional restorative de-brief questions

- What would you like to happen next?
- How can we make things better for you?
- How can you help to put this right?
- How can we make it ok for you to go back to class?
- What do you think others might need?

Differentiated restorative de-brief resources

- Social stories
- Role-play with dolls/ teddies/animals/pets
- Comic Strip Conversations
- Signing or signalling
- SEAL resources
- Complete a Therapeutic Tree

Debrief checklist

- Has the child had sufficient time and support to normalise their feelings before the de-brief process starts?
- Has the child had an opportunity to share their experience, including what happened before, during and after an incident
- Has the child been helped to identify their feelings before, during and after an incident?
- Has the child been helped to empathise with the experience and feelings of others?
- Has the child been helped to understand and accept the need for any protective consequences?

Debrief checklist

- Has the child been helped to engage in the need for educational consequences?
- Has the child been helped to identify how relationships can be rebuilt?
- Has the child been helped to rebuild those relationships?
- Has the child been helped to develop strategies to respond differently when faced with the same situation?
- Have we documented, actioned and reviewed outcomes and next steps?
- Has everybody involved in the incident received support?

Summary – what will you take away from this training?



Thanks for your evaluations

Thanks for joining in

Thanks for listening

Have a safe journey home

Delivery protocols



The following notes for tutors are for reference only and should not be used within training or supervision

These notes form the agreed protocols under which tutors use the Therapeutic Thinking PowerPoint and supporting materials

Notes for tutors

Settings should aim to build a team of tutors who can support staff with Therapeutic Thinking. Where one of the tutors is a member of the SLT there is greater evidence of impact on important data such as restraint reduction and exclusion reduction

Tutors must complete the certificated three-day Therapeutic Thinking course and attend an annual one-day refresher to deliver training and supervision using the materials contained within the Therapeutic Thinking PowerPoints. Those delivering Principles of Restraint Reduction and Elimination must complete a further two days training and attend additional refreshers

Notes for tutors

Tutors must keep training grids for all training, professional development and supervision which is delivered, using the materials contained within the Therapeutic Thinking PowerPoints

Tutors do not lead training outside of their school or service without permission being granted by the local lead

Multi-academy trusts (MATs) and federations should aim to have a minimum of one tutor per school who may network across the MAT or federation

Notes for tutors

Training and supervision using materials contained within the Therapeutic Thinking PowerPoints must only be delivered where the Headteacher/Principal or employer is aware of the content and fully supports the messages and information delivered within the session

The Headteacher/Principal or employer accepts that the materials have no independent authority and only carry the authority granted through policy

Notes for tutors

Tutors are responsible for ensuring the quality and health and safety of training they deliver

Tutors should aim for a minimum of six hours Therapeutic Thinking initial training to embed the principles of Therapeutic Thinking. The minimum annual refresher should be three hours

Those delivering Principles of Restraint Reduction and Elimination must complete the theoretical components of the training (ticked slides) before training any physical skills. There is no specific time requirement for teaching skills and tutors must not certificate until they are confident with the knowledge, skills and understanding

Notes for tutors

Slides marked with a tick are essential elements of a module, essential for understanding a therapeutic approach. These slides should form the foundation for any training or supervision delivered using materials contained within the Therapeutic Thinking) PowerPoints

Notes for tutors

All other slides are optional and should be used where the information will further promote understanding

There must be no material changes or additions made to the Therapeutic Thinking PowerPoint

Additional information can be presented as professional opinion but must not be added to the Therapeutic Thinking PowerPoint

Slides and sections may be re-arranged or delivered in a different order to personalise delivery

Notes for tutors

The decision to use additional material alongside the materials contained within the Therapeutic Thinking PowerPoint, or to state personal opinions within training or supervision, is the responsibility of the tutor

Tutors will attend a minimum of six hours' refresher training annually and cease using the materials contained within the Therapeutic Thinking PowerPoint if certification lapses

Tutors are free to use elements of the Therapeutic Thinking PowerPoint or the supporting materials to influence and help staff, parents, CYP and other professionals. Only training recorded on the training grids will be considered official Therapeutic Thinking training, all other uses will be considered sharing of good practice

Notes for tutors – refreshers

Therapeutic Thinking refreshers must be a minimum of three hours of recorded training annually

Only staff who have recorded initial six-hour training can attend three-hour refresher training

Those delivering Principles of Restraint Reduction and Elimination must refresh the theoretical components (ticked slides) annually for certification

Evidence of more frequent skill checks will strengthen the legal defensible position for practitioner and leadership.

Notes for tutors – refreshers

The most effective refreshers often focus on developing analysis and planning for named CYP or young people

When completing the Therapeutic Thinking course record, only the columns for content covered need to be recorded

Notes for tutors

Training ratios for Principles of Restraint Reduction and Elimination do not exceed 6:1, with a minimum of two tutors present. Training of groups above 24 for Principles of Restraint Reduction and Elimination should be discussed with the local Therapeutic Thinking Lead

Principles of Restraint Reduction and Elimination is best delivered to small groups such as class teams. Large groups should be subdivided for training

The employer must be aware of the course contents and support its principles. They accept responsible for the actions and health and safety of their tutors and practitioners

Notes for tutors

Principles of Restraint Reduction and Elimination training will only be delivered to employees with a valid Therapeutic Thinking certificate. Principles of Restraint Reduction and Elimination training is invalid when no longer supported by a Therapeutic Thinking certificate

The lead is responsible for assessing the knowledge and skills of tutors within the tutor course. Tutors are responsible for ensuring the quality of training they deliver. Free supervision is available from the local Therapeutic Thinking Lead to support quality

Any injuries or issues relating to Principles of Restraint Reduction and Elimination training, or the direct use of Therapeutic Thinking strategies and techniques, should be reported to the local Therapeutic Thinking Lead for monitoring purposes

Notes for tutors

Slides marked with a are compulsory unless prior permission is granted by the local Therapeutic Thinking Lead

All other slides are optional and may be turned off

Slides may be rearranged or delivered in a different order to personalise delivery

Notes for tutors

Any material changes to the PowerPoints requires permission from the local Therapeutic Thinking Lead

The decision to use additional material or to state personal opinions within training is the responsibility of the tutor delivering. Messages within additional video clips, poems etc. used by a tutor may be subject to restrictions such as copyright and any resultant legal challenge is the responsibility of the tutor using these additional materials

Notes for tutors

All Principles of Restraint Reduction and Elimination training must be evaluated using official evaluation forms

Training records are to be forwarded within two weeks of completing training.

Therapeutic Thinking issues all certificates centrally. Only certificated training is recognised by Therapeutic Thinking

Tutors will attend tutor refresher training annually and cease training under the name of Therapeutic Thinking if certification lapses

Notes to tutors delivering Principles of Restraint Reduction and Elimination

Tutors should only deliver physical skills based on audited need and training needs analysis (TNA)

Tutors should use the PowerPoint and ensure participants see the images and the descriptions as this will form part of the evidence if a legally defensible position is needed

Slides from the PowerPoint should be made available to services for use in documentation policy and planning

Notes to tutors delivering Principles of Restraint Reduction and Elimination

Tutors must only provide Principles of Restraint Reduction and Elimination strategies to staff who have a current valid Therapeutic Thinking certificate

If the Therapeutic Thinking certificate becomes invalid the certification for Therapeutic Thinking also becomes invalid

Tutors must robustly challenge settings and individuals to ensure they have a genuine need for any restrictive physical intervention skills

Notes for tutors

RPI is only justifiable when all other options have been considered and evidenced to be insufficient (LAST RESORT PRINCIPLE)

All Therapeutic Principles of Restraint Reduction and Elimination training is based on audited need. Therefore, restrictive physical intervention should only be a planned response for CYP who have full differentiated planning influenced by analysis (graduated response)