Gofal Cymdeithasol **Cymru**
Social Care **Wales**

Noddir gan **Lywodraeth Cymru**
Sponsored by **Welsh Government**

Positive approaches: Reducing restrictive practices in social care

Version 2, November 2021

Contact details

Social Care Wales
South Gate House
Wood Street
Cardiff
CF10 1EW

Tel: 0300 3033 444
Minicom: 029 2078 0680
Email: info@socialcare.wales

socialcare.wales

Twitter: @SocialCareWales

Other formats:
This document is also available in Welsh. Copies of this document are available in other formats, if required.

Contents

Acknowledgements

We want to thank everyone who contributed to the development of this resource. In particular, we want to acknowledge the advice, guidance and support from the following organisations:

- Abertawe Bro Morgannwg University Health Board
- Action for Children
- All Wales Forum for Parents and Carers of People with a Learning Disability
- Alexander House (Mental Health Care)
- Amanda Hall Associates Limited
- British Institute of Learning Disabilities (BILD)
- Care Forum Wales
- Care Forum Wales Looked After Children Network (Woodlands Ltd and Prospects Care)
- Care Inspectorate Wales (CIW)
- D&S Care Homes
- Gwalia Care and Support
- Learning Disability Advisory Group – Transforming Care Sub-group
- Orbis Education and Care
- Newbridges Specialist Care
- Newbridge House (Bridgend County Borough Council)
- Pendine Park

Introduction

Working in social care settings can be one of the most rewarding and enjoyable experiences anyone can have. However, just like any job, at times it can be difficult and demanding. Offering care and support to vulnerable people, who may be distressed, frightened, angry, stressed, confused and who can display behaviours that challenge us, can leave us feeling powerless, frightened, angry, anxious and out of our depth. In these times, it's important to reflect upon what is happening around us, how we are feeling and what we need to help us do our jobs to the best of our ability.

Feeling what we say has been heard and understood, and being in control of our lives, has a massive impact on our behaviour. When this is not the case, we are more likely to feel powerless and distressed, and engage in behaviour that challenges others.

This will also be the case with people we offer care and support to. Because of their circumstances, they too, may at times feel powerless to make any changes to their lives. So, whatever the situation, it's important we always treat people with the same compassion, dignity, kindness and understanding we would expect for our own families and ourselves.

This resource has been developed to help social care workers when they are faced with difficult situations. It provides practical examples of positive and proactive approaches and ways of working that support safe practice and can reduce the need for restrictive practices. You should read this resource alongside the Code of Professional Practice for Social Care, which describes the standards of professional conduct and practice expected of those employed in social care in Wales.

In July 2021, the Welsh Government published the Reducing Restrictive Practices Framework. This sets out a "common framework of principles and expectations" that is informed by a human rights approach. This resource is in-line with the framework's principles and expectations.

This resource will help social care workers and those involved in providing social care in Wales:

- understand what taking a positive and proactive approach means
- understand the range of ways people communicate and how this influences their behaviour
- think about ways of working and the impact they may have on a person
- develop a range of positive and proactive approaches and ways of working to support people when they are feeling stressed, distressed and/or angry to reduce the use of restrictive practices
- understand the range of restrictive practices and physical interventions and how they may be used as a last resort, based upon assessment of risk and person-centred care planning
- understand the legal and ethical justifications for the use of restrictive practices where this is applicable
- know that any form of restrictive practice and restrictive intervention is only used in an emergency situation, or as part of a planned response that has been agreed by a multi-disciplinary team and wherever possible, the person themselves.

This resource is underpinned by the core values and principles of practice that apply to all areas of social care. The core values reflect the human rights and freedoms that apply to everybody, as defined by the United Nations Conventions on the Rights of the Child and Rights of Persons with Disabilities and the United Nations Principles for Older People. The Welsh Government framework refers to principles set by the Human rights framework for restraint, Equality and Human Rights Commission.

The core values and principles should be embedded into the culture of every organisation and everyone should clearly understand them.

Organisations should also develop a culture of learning from incidents, implementing recommendations and good practice, and avoiding blame when things don't go as planned.

The resource is divided into four parts to help you find the information you need:

Part 1: sets out how the resource should be used and provides definitions of what we mean by behaviour that challenges us, along with positive and safe ways of working and restrictive practices. It also gives an overview of current legislation and ethical considerations in the use of restrictive practices.

Part 2: provides advice and guidance on ways to take a positive approach to work with anyone who uses social care services. The content's order matches the core values and principles of the Social Services and Well-being (Wales) Act. It is also mapped to the relevant well-being statements in the Welsh Government's National Outcomes Framework. The well-being statements describe the most important outcomes that people who need care and support, and carers who need support, expect to achieve well-being, and lead fulfilled lives.

Part 2 also includes definitions of the range of restrictive practices and features examples of when they should or should not be used.

Part 3: provides guidance for ongoing support and training for social care workers, to enable them to reflect upon their role and practice, and to work positively and safely.

Part 4: contains additional information and resources including a more detailed description of a range of positive approaches and /or frameworks, links to key legislation, policy and guidance, and other resources that may be useful in practice and in study.

Part 1 – Understanding and using this resource

This part sets out how you should use this resource. It provides a definition of what we mean by behaviour that challenges us and describes positive and safe ways of working to reduce the use of restrictive practices. It also gives an overview of current legislation and the ethical issues we need to consider when we use restrictive practices.

1.1. How to use this resource

The resource focuses on supporting you to make sure you provide best practice, and it contains examples for illustration and reflection. You can use it in:

- supervision
- team discussions
- as part of induction
- training sessions
- appraisals, qualification attainment and to inform policy
- protocols
- audit
- quality assurance processes
- commissioning specifications.

We suggest you work through it over a period of time to support reflection on practice. Although you can use it independently to reflect upon your practice, it is more suited to discussions in group situations, or between managers or mentors and workers. We suggest managers or those using the resource for training become familiar with its contents and choose the most relevant sections for the learning and development of the workers they're supporting.

We use the terms 'people' and 'individuals' throughout this resource and we use them to refer to adults and children and young people.

Who should use this resource?

Everyone who works in social care is responsible for understanding how to use positive and proactive approaches in their work and reduce the use of restrictive practices.

As such, this resource is for organisations and social care workers who provide social care and support to adults, children and young people.

This includes adults and children and young people with longer term care and support needs that may be the result of an acquired brain injury, autism, dementia and/or learning disabilities. It also includes adults and children and young people with needs that fluctuate including people with mental health needs, substance misuse, and emotional and behavioural difficulties.

Although this resource is aimed specifically at social care workers, it is also relevant to:

- people who use care and support, and their families
- managers
- employers
- policy makers
- commissioners
- those in education
- others who work in the community, including primary care and the emergency services.

Social care workers

The resource will help us :

- feel more knowledgeable, skilled and confident using positive and proactive approaches in our work
- recognise situations where using a positive and proactive approach will reduce the need for restrictive practices
- reflect on and improve our practice, and contribute to our ongoing learning and professional development
- reflect on how our decisions can affect the balance of power between us and the people we work with
- appreciate the need for support, supervision and ongoing training.

Managers and employers

The resource can help us by providing:

- guidance and good practice examples we can use to support and inform induction
- a tool for supervision, team discussions, training sessions and appraisals
- a tool that can help workers understand what is expected of them
- guidance we can use to inform recruitment processes
- guidance we can use to inform the development of policy, procedures, audit and quality assurance processes
- a tool we can use as a benchmark for existing practice
- a tool we can use to produce evidence for relevant Care Inspectorate Wales regulation and statutory guidance[1] requirements .

People who use care and support and their families

The resource can help us by providing:

- guidance on what we should expect from social care services
- case studies we can use to reflect on how support is offered
- case studies we can use to challenge and change ways of working
- case studies we can use to reflect on own behaviour.

1. The statutory guidance is for service providers and responsible individuals about meeting service standard regulations for: care home services, domiciliary support services, secure accommodation services and residential family centre services

1.2. Core values and principles of practice

Everyone who works in social care needs to be aware of, and practice, in a way that reflects the values and principles that underpin care and support in Wales.

These have been incorporated into the Social Services and Well-being (Wales) Act (the Act) 2014. The Act covers:

- adults – people aged 18 years old and over
- children – people under the age of 18
- carers – adults or children who provide or intend to provide care and support.

The Act modernises and brings together different pieces of social care law into one simplified legal framework.

It is made up of three elements:

- the Act itself
- the regulations, which provide more detail about the requirements of the Act
- the codes of practice, which give practical guidance about how to implement the Act.

The Act's principles and values are important because they underpin not only how services should be provided, but how we work with people on a day-to-day basis.

The principles and values are:

- putting a person and their needs at the centre of their care, and giving them a voice in, and control over, the outcomes that will help them achieve well-being
- being able to access advice and support at an early stage, to retain a good quality of life and reduce or delay the need for longer term care and support
- helping people achieve their well-being in every part of their lives
- involving people in how services are designed and provided, recognising the knowledge and expertise they can bring
- strong partnership working between all agencies and organisations is essential to improve the well-being of people in need of care and support, and carers in need of support.

These principles can be summarised as:

- voice and control
- prevention and early intervention
- well-being
- co-production
- multi-agency working.

They are closely linked to what is expected of social care workers as set out in the Code of Professional Practice for Social Care.

1.3. What do we mean by positive and proactive approaches?

Positive and proactive (or preventative) approaches are based upon the principles of person-centred care:

- getting to know a person
- respecting and valuing their histories and backgrounds, and understanding:
  - their likes and dislikes
  - their skills and abilities
  - their preferred communication style and support structures
- understanding the effect their environment has upon them and using this to identify ways to support people consistently in every aspect of the care that they receive
- developing and monitoring plans that outline a person's needs, desired well-being outcomes and the ways they will be supported to achieve these.

Developing good relationships is crucial, and you should always use positive and proactive approaches. They are essential when someone is:

- stressed
- distressed
- frightened
- anxious
- angry

and at risk of behaving in a way that challenges their safety and/or the safety of others.

Behaviours that challenge can stop people from taking part in social and learning opportunities and activities they enjoy. The following example shows how important a proactive approach, such as Active Support, can be and the effect it has on Alice and those around her.

Case example: Alice

Alice lived in a house with two other women. Social care workers were finding it difficult to support her in her home and in her community at times, as she would often remove all her clothes, sometimes several times a day.

The team carried out an assessment to understand why Alice was behaving in this way. The assessment showed that Alice's behaviour mostly happened when she was unoccupied.

Workers were trained in the Active Support Model to increase Alice's participation in activities. This resulted in Alice being much busier and enjoying a lot of interaction with workers.

Six months after this change, Alice rarely removed her clothes inappropriately.

Positive approaches involve working with the person and their support systems to:

- try to understand what someone is feeling and why they are responding in the way they are
- where possible, make any necessary changes and intervene at an early stage to try to prevent difficult situations
- understand what needs to be planned and put into place to support the person to help them manage distressed and angry feelings in a way that reduces the need for behaviour that challenges and any restrictions.

Understanding and working in a way that promotes positive and proactive approaches means that social care workers need to:

- have a positive attitude towards the people they support
- have the right skills and knowledge
- be well-trained
- be supported by regular supervision and learning and development.

There are lots of ways of working with people using positive approaches. These can involve making small yet significant changes, which can have a big impact on how a person feels and behaves.

They could include:

- making changes to a person's environment or living space, such as changing the colour of the walls
- avoiding any sudden change or changes in routine
- using aromas to help someone settle (for example, in the bath before settling for bed)
- playing calming music or any music that someone may like or need
- giving people opportunities to take part in activities that are meaningful to them.

Case example: Jacqui

Jacqui found the pattern on her bedroom curtains unsettling as they looked a bit like dogs, and she was frightened of dogs. Because of this, Jacqui often struggled to get to sleep and was constantly tired and grumpy.

After speaking to Jacqui and her mother, the social care team were able to identify what was upsetting her and stopping her from getting to sleep.

When the curtains were changed to ones that Jacqui liked, she was able to sleep better, was less tired and more able to take part in the activities she enjoyed.

There are a number of frameworks and models to support the use of positive approaches and reduction of restrictive practices. The way they are used will vary according to the setting, but here are some examples of evidenced-based models currently used in Wales:

- **Positive Behaviour Support** (PBS) is a framework used to support people with a learning disability. The values and principles that underpin PBS can be used across the sector.
- **Active Support** is a person-centred model that combines how to positively interact with people with a daily planning system that encourages participation, improves quality of life and develops independent living skills.
- **Restorative Approaches** allows people to reflect on their behaviour and gives them an opportunity to put what has happened right or empathise with other people's emotions and feelings. It aims to manage conflict and tensions by repairing harm and building relationships.

Part 4 has a more detailed description of each approach and how you can use them.

What do we mean by behaviour that challenges?[2]

You may hear a number of different terms used, including:

- 'behaviours that challenge'
- 'behaviours of concern'
- the older term 'challenging behaviour'.

These terms are sometimes misunderstood. They basically mean not blaming the person for what they do, but thinking about the behaviours as a challenge for us – to understand why they happen and how to improve the person's environment and well-being, so they no longer need to behave in challenging ways. It's based on scientific evidence and ethical values, and encourages a way of thinking that forms the basis of modern, person-centred approaches such as Positive Behavioural Support.

Behaviour means what we do, our actions, and is influenced by many things. There are two main types:

1. Things that are inside us or internal, such as our personal characteristics. For example:

- our thoughts and emotions
- our physical and mental health
- if we are in pain, anxious, tired or hungry
- our past experiences
- our skills and abilities
- how we communicate
- how much we understand
- if we have impairments or genetic conditions.

2. Things that are outside us or external, such as our physical and social environments. For example:

- if they're too hot, noisy, overcrowded, small or boring
- how easily we get the things we want or get away from things we don't like
- who else shares our environment
- how people treat and communicate with us
- the things we have to do
- how much help we get.

Our actions are a result of how these internal and external factors affect one another. We are more likely to be friendly, happy and calm when we are not in pain or anxious, and are in a comfortable environment with familiar people we like, who help us get what we need. We are more likely to get annoyed and aggressive when we are tired, hungry, have a headache and are in an unfamiliar place, with strangers who don't understand us and can't help us get what we need. In both cases, the behaviour didn't just happen because of internal things, but because of a combination of internal and external things.

2. Jones, E. (2019) Chapter 1: What is behaviour that challenges? In P. Baker and A. Osgood (Eds) Understanding and Responding to Behaviour that Challenges in Intellectual Disabilities (2nd edition) A handbook for those that provide support. Pavilion: Shoreham by Sea, UK.

Behaviours become considered challenging when other people think it's socially unacceptable, difficult or dangerous. It increases the likelihood the person will be rejected, have a poor quality of life and be treated badly. This social definition can include a range of behaviours, such as:

- shouting
- threatening
- hurting other people
- hurting yourself
- destroying things.

All behaviour has meaning and happens for a reason, often as a reaction to the person's environment. This also applies to behaviours that challenge – they can be a way to communicate, and to get or avoid things. Everyone is different, so to understand the reasons why someone behaves in a particular way we have to take a person-centred approach. We use the term 'challenging' because we know it's possible, but not always easy, to understand why certain behaviour happens and to improve environments, so the person has the support they need to have a good quality of life and get what they need, without having to behave in challenging ways.

Intellectually disabled people who behave in ways that other people find challenging are one of the most disadvantaged groups in society. The words we use have the power to harm or help vulnerable people because they influence attitudes. Challenging behaviour is not a medical diagnosis in the same way as, for example, measles or salmonella are diseases caused by a virus or bacteria inside the person. Challenging behaviour shouldn't be used to label and blame the person or imply that everyone who may behave in challenging ways are the same.

Definitions of challenging behaviour

"Culturally abnormal behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour that is likely to seriously limit use of or result in the person being denied access to ordinary community facilities."
Emerson (1995, 2011)

"Behaviour of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion."
The Royal College of Psychiatrists (2007)

Key point: The definitions are similar and complement each other.

The definitions are similar. They include the danger of harm to the person or other people, and consider behaviours challenging because they make it more likely the person will be punished, restrained or excluded. They're 'social definitions' that highlight intensity, frequency or duration:

- intensity is about the behaviour's impact – for example, we may smash a plate in temper but to smash every window would be severe and challenging
- frequency means how often a behaviour occurs – everyone occasionally loses their temper, but if this happens much more frequently, such as several times a day, then it's challenging
- duration means how long the behaviour lasts – most people may behave in a particular way for short periods of time, for example, shouting for a few minutes, but asking the same question repeatedly for hours on end can be challenging.

Key points

- Challenging behaviour is not a medical diagnosis.
- What makes a behaviour challenging depends on what people consider socially acceptable, as well as how severe, frequent or how long it lasts.
- Challenging behaviour can harm the person or those around them and make it more likely the person is punished, restricted, restrained, over-medicated or excluded from society.
- All behaviour happens for a reason and is as a way of communicating, or getting or avoiding things that are important to the person.
- The challenge is for us to understand a person's behaviour and provide an environment where they have a good quality of life and their needs are met in non-challenging ways.

We look at ways of understanding behaviour in Part 2.

Take a look at the case study about Aabdar below. Here, we're given one explanation for his behaviour, but there may be others.

Case study: Aabdar

Read the case study, then reflect on your own experiences and think about:

- why Aabdar might be behaving this way
- what else could be put in place to enable him to change this potentially risky and distressing behaviour?

Aabdar, aged 25, regularly used to bang his head against a wall in his home.

The social care workers noticed a pattern to his behaviour. They spoke to Aabdar and consulted with his community learning disabilities nurse. They realised he was experiencing severe headaches and the banging was an attempt to manage the pain.

The social care team sought medical advice and Aabdar is now given pain relief as soon as he starts to bang his head. The behaviour, which was distressing to all, has significantly reduced.

1.4. What do we mean by 'restrictive practices'?

Restrictive practices

Restrictive practices are a range of activities that stop people from doing the things they want to do or encourages them to do things they don't want to do. They can be obvious or subtle.

They should be understood as part of a spectrum – from limiting choice to a reactive response to an incident or emergency, or if a person is going to seriously harm themselves or others.

When thinking about restrictive practices, it's important we also understand how to use positive and proactive approaches to reduce their use.

Case study: Megan

This case study shows how people are sometimes prevented from doing or having the things they would like – sometimes for good reason.

As you read through Megan's situation:

- ask yourself how you could justify limiting Megan's choice to drink coffee and tea when she wanted.

Megan has an acquired brain injury and a long history of making herself physically unwell with caffeine overdoses, which have resulted in her being admitted to hospital on a number of occasions.

Megan would drink coffee from the jars and hide tea bags to eat when she was not supervised. In her previous home, she had no access to the kitchen and could only have caffeine-free drinks.

Initially in her new home, it wasn't safe to let her into the kitchen to make drinks as she became very stressed and aggressive when she couldn't access the freely available jars of coffee and teabags.

Social care workers have now made gradual progress with Megan. She is using the kitchen with support and can make her own drinks using sachets of coffee rather than coffee from a jar.

There are occasional blips where there's a breakdown in communication between Megan and a social care worker, but generally it's working well. Megan can make herself drinks, which is important to her, and keep physically well, too, which is important for her.

Case example: John

John, a young autistic man, requests to use the telephone constantly to telephone his family and former friends. Some of these do not want him to call them. He becomes very distressed when they do not want to talk to him.

A plan was agreed with him to make a list of his friends and family who still have a relationship with him, and to agree a set time with them when to call. For example, he will call his mum 6pm each evening and a friend once a week on a Saturday night after 7pm.

This has worked for him as he feels more secure having these times set and his support staff can refer to his calendar if he becomes distressed and wanting to call at other times.

Although he does not have free access to the telephone as he wishes, his stress levels have been reduced and his family and friends are happier to talk to him at the agreed times.

If social care workers are concerned about the use of restrictive practices with the people they support they should report their concerns immediately to senior staff in the organisation or follow the organisation's whistleblowing policy.

Introduction to restrictive practices

The section is taken directly from the Welsh Government's Reducing Restrictive Practices Framework 2021

The use of all restrictive practices, including restraint, should be in line with the principles described in the Human Rights Framework for Restraint produced by the Equality and Human Rights Commission (EHRC, 2019). The term restrictive practices can apply to a number of different acts for example:

- physical restraint
- chemical restraint
- mechanical restraint
- seclusion
- social restraint
- psychological restraint
- long-term segregation.

Restrictive practice does not necessarily require the use of force, it can also include acts of interference. For example, moving someone's walking frame out of reach.

Any act of restrictive practice has a potential to interfere with a person's fundamental human rights and everyone has an obligation to respect human rights.

All acts of restrictive practice must be lawful, proportionate and the least restrictive option available. Restrictive practices should only be used within the appropriate legal frameworks, and each agency should ensure that they are aware of and operating within the parameters of the legislation and guidance relevant to them, to the people they support and those for whom they provide services.

The best way to avoid restrictive practices is to work preventatively and meet needs before crisis arises. However, there may be rare occasions when it is necessary to use restrictive practices to prevent harm to an individual or others. It is never lawful to use restraint to humiliate, degrade or punish people.

The Welsh Government is clear that the focus of policy and practice should be on the reduction of restrictive practices as part of person-centred planning. However, organisations should ensure that where restrictive practices are used as a last resort this is within a framework that supports human rights.

Organisations should have a policy that outlines conditions for the use of restrictive practices in any of their services. This policy should be agreed by senior leadership for the organisation and/or setting and should reflect up to date statutory requirements placed on them through legislation and guidance.

This policy should:

- reference human rights and legal frameworks relevant to the sector and setting
- ensure that definitions of restrictive practices are easily available and embedded through workforce development mechanisms, organisational messages and policy
- have clear protocols and governance guidelines for the use of restrictive practices as a last resort, and for monitoring of people during and after use, including the requirements for medical checks
- be easy to understand and apply, and should be communicated to all practitioners, paid carers,

people being supported and the families, unpaid carers and external agencies that the organisation works alongside
- make clear that it is never acceptable to use coercion and other forms of social and psychological restraint
- contain guidance about risk assessments, which must be undertaken before using any restrictive practice. The risks to the individual should be considered in advance, and any restrictive practice, which increases the risk to the individual, should not be used. The individual's environment should be risk assessed to ensure that there is nothing within it that would cause risk during the use of restrictive practices
- provide clear guidance for recording information following the use of any restrictive practice in relation to what is to be recorded when, by whom, and the purpose of the recording
- make clear that any use of a restrictive practice should be recorded even if its use is prescribed in a personal plan
- outline the process for the collection of this data from all their services – it should be available to external organisations on request
- provide guidance for seeking consent for use of restrictive practices as a last resort to prevent harm to an individual or others.

Any intended use of restrictive practices as a last resort should be in the individual's behaviour support guidelines in their individual plan and should be reviewed regularly. Any use of a restrictive practice that is not in the individual's personal plan should trigger an immediate review. There should be guidelines in the individual's personal plan of how the use of the restrictive practices will be reduced in the future.

Decisions about the use of restrictive practices should take into account any cultural or religious factors for individuals.

Restrictive practices must be part of an overall person-centred approach and should be tailored specifically to the individual for whom it is being used, in particular for individuals who are at greater risk due to age, frailty, health problems, trauma history or other risk factors. It should be clear within the behaviour support guidelines why that intervention is most appropriate for them. Restrictive practices should be used within the context of an overall therapeutic relationship and never used as punishment. Children and people are at particular risk physically and psychologically and the principles for upholding children's rights should be followed.

Restrictive practices should never be used to compensate for staff shortages or other resource difficulties.

Following any occurrences of restrictive practices being used, the relevant people/bodies should be informed, in line with the personal plan. Family members/unpaid carers should be informed unless the personal plan indicates otherwise

You can find definitions for the range of restrictive interventions and examples of when they should or shouldn't be used in Part 2.

Legislative framework and guidance

Social care workers should always support and care for people in ways that are enabling and empowering, and respect the person's human rights.

There may be some instances where a person is:

- distressed
- anxious
- ill
- angry
- confused
- lack understanding of their situation

and the use of a restriction is the only thing to do to keep them and/or other people safe.

If in doubt, always check with your supervisor and team. Remember, you should never make a decision to restrict anyone on your own, except in exceptional circumstances that form an emergency.

Case example: Billy

Billy lives in a residential children's home. He comes home from college distressed and agitated after a difficult meeting with his college tutor. Later that evening an argument breaks out with another young person in the living room over a television programme. Social care workers support them to resolve the disagreement.

The next morning, Billy comes down to breakfast and unexpectedly attacks the other young person and has to be physically restrained.

This example highlights an occasion where the decision to use a restrictive intervention in an emergency is appropriate. But restrictive interventions should only be used in one-off situations and shouldn't become common practice, unless it's part of someone's care and support plan.

If this is the case, it's important any decisions to use restrictive practices are openly acknowledged, legally and ethically justifiable, and reviewed on a regular basis. Social care workers need to make sure they are always working within the law and current policies and procedures, and they can justify the actions they take.

Part 4 has more information about key legislation and national guidance. They should be reflected in the local guidance and policies and procedures you're expected to follow at work.

How to identify if a practice is a restrictive practice

The brief scenarios below feature situations that social care workers may find themselves in. The scenarios cover a range of restrictive practices including restrictive interventions.

Some of the scenarios are more obvious than others. But as you go through them, remember that in real life we don't work alone and any decision to restrict a person should be based on discussions with others, including the person, their families and those who know them well.

When you read the scenarios, think about your work experiences and consider the following questions (it'd be helpful to discuss and debate them with your team and your manager):

- What type of restrictive practice do you think has been used?
- Do you think the use of the restrictive practice was intentional or non-intentional?
- Do you think this was the least restrictive option?
- Was the practice contrary to the rights of the person?
- Was the practice ethically or legally justifiable?
- How might current legislation and guidance help inform decisions?
- Who should be involved in making the decision about the restrictive practice used?
- What other methods of working could have been used to reduce the need for restrictive practice?
- What steps could be taken to reduce the use of restrictive practice in the future?

Scenario 1	A young girl living in foster care is told that she can't have a lift from her foster carer to meet her friend who lives eight miles away until she has completed her chores. She has no money to catch a bus.
Scenario 2	In a residential care home, a man's glasses are moved out of his reach while he is being supported with his personal care. He is without them until lunchtime.
Scenario 3	A young man with mild to moderate learning disabilities is on a group trip to Thorpe Park. His case history lists infantile and pre-school seizures, although he has not experienced anything recently. The group leader decides he is not allowed on any rides.
Scenario 4	In a day centre, a woman is left for several hours with her dinner tray or wheelchair seatbelt on to prevent her wandering.
Scenario 5	A woman who lives in a residential care home is regularly encouraged to return to spend time in her room alone because her singing upsets other residents.
Scenario 6	John, a young person, is watching cartoons on TV in the lounge. A social care worker enters the room and changes the channel, while saying "John, shall we watch EastEnders?" John uses symbols for communication and didn't understand the verbal question. John becomes upset and agitated and begins to engage in self-harming behaviour.
Scenario 7	A man in his early twenties with learning disabilities recently lost his mother, who was his sole carer. Now living in supported accommodation, he wants a small tattoo on his arm – "MUM". A social care worker approaches his line manager, who tells him he'll be suspended if he helps the man with this because of "health and safety".
Scenario 8	A young woman living in a residential children's home has been prescribed a new contraceptive pill. She's promiscuous and at risk of having an unwanted pregnancy. She's grounded by her social care worker until she agrees to take it.

Scenario 9	A young autistic man is physically restrained by three social care workers after he bit and scratched a member of his care team.
Scenario 10	Social care workers in a residential care home switch off the TV in the communal lounge at 10.30pm to encourage people living there to go to bed.
Scenario 11	Social care workers realise a resident in their nursing home is now 'informal' as his Mental Health Act paperwork's expired. They decide not to notify the person as the psychiatrist will be calling the next day to renew the paperwork.
Scenario 12	A young man is becoming confrontational towards another young man in the supported living accommodation that they share. The social care worker steps between them and asks the young man to leave the room. He refuses and continues the confrontational behaviour. The social care worker guides him out of the room using an agreed physical intervention that holds his arm.
Scenario 13	An 87-year-old widower with Alzheimer's disease, living in a residential care home, regularly gets up in the night and wanders around disturbing other residents. As he's been trying to climb over the bed rails fitted to his bed to get up, the care home team decide to place his mattress on the floor. He's unable to get up from the floor, so has stopped wandering.
Scenario 14	Bedroom doors are routinely locked to stop people going back to bed in the day.
Scenario 15	A young autistic person uses a Picture Exchange Communication System (PECS) communication book. The staff supporting him to get ready for school can't find the PECS book and the young person goes off to school without it. The young person is very unsettled all day and can't make his needs known. This results in an incident of challenging behaviour and self-harm from the young person.

Part 2 – Values and principles of social care and support in practice

We've developed a range of case examples and case studies to help you think about what you can do or should think about when supporting a person positively to prevent behaviours that may be perceived as challenging.

Some of this you may already know and put into practice daily, but some of it may be new to you. When reading the case examples and case studies, it would be useful to reflect upon similar situations you've encountered and how you could transfer the approaches used to your own workplace.

We've split the content into smaller sections, using headings based on the values and principles that underpin the Social Services and Well-being (Wales) Act. These are:

- voice and control
- prevention and early intervention
- well-being
- co-production
- multi-agency approaches.

The sections have also been mapped to the relevant well-being statements in the National Outcomes Framework, which describe what people expect from care and support services so they can achieve well-being and lead fulfilling lives.

2.1. Voice and control

Not being listened to or feeling that you don't have a say or control over what happens to you, can be a frightening and distressing experience. Making sure social care workers listen to people and their families and carers, and help them have as much control as possible over their lives and support systems is essential to providing positive, effective person-centred care.

People expect the following from their care and support:

- my rights are respected
- I have voice and control
- I am involved in making decisions that affect my life
- I can speak for myself or have someone who can do it for me
- I get care through the Welsh language if I need it.

Understanding behaviour

To work positively with people to reduce the need for restrictions, it's important to try and understand the meaning behind their behaviour.

It may help if you picture yourself in the same situation as those you're supporting. If you were in their shoes what would you want, what would you be feeling and what would you be saying through your behaviour?

If you can understand the meaning attached to a person's behaviour, you may be able to identify any triggers, and put positive and preventative strategies in their place instead.

There are many things that influence how we behave and when trying to understand the meaning of behaviour, it's important to keep an open mind. There are a range of factors, but they all relate to not having control over a situation.

Behaviour can:

- be an important tool for a person – for example, hitting out to stop someone doing something they don't like
- be a form of communication
- be affected by feeling frustrated at not being able to understand others or make themselves understood
- be influenced by your or others' responses to a person's actions
- be influenced by a person's environment
- have underlying physical causes or be a response to:
  - chronic or acute pain
  - infection or other physical health issues
  - sensory loss
  - an acquired brain injury or other neurological condition
- be a response to:
  - fear and anxiety
  - unhappiness
  - boredom
  - loneliness
  - unmet needs
  - demands
  - change
  - transitions
  - recent significant events, such as the death of a family member
  - past events or experiences
  - abuse or trauma
  - bullying
  - over-controlling care
  - being ignored.

Additionally, some conditions, such as dementia or specific learning disabilities, may lead to loss of inhibitions, self-control and decreased awareness of rules about appropriate behaviour.

Case example: Shane

Shane is 11 years old and lives in foster care. He visits his parents every week for unsupervised contact and is returned to his foster care home by his parents at the end of the contact. Each time, he refuses to get out of the car and gets very upset and agitated.

The foster carers suggest they meet him with his parents for handover at a neutral venue. As a result, Shane is now happy to go home with his foster carers and doesn't get agitated.

Case study: Sarah

When you read the case example about Sarah:

- try to put yourself in her shoes and think about why she might be behaving as she is during the night
- think about if she has control over her situation.

Sarah – Part 1

Sarah lives in supported housing accommodation, which she shares with Menna. Sarah has moderate learning disabilities and is registered blind as she is partially sighted. Recently, Sarah has been urinating on her floor mat in her bedroom at night.

Sarah's social care worker goes into her room after breakfast to help her make her bed and notices her mat is soaking wet again. She is cross with Sarah and asks her why she keeps doing this. Sarah withdraws into herself, sits on her bed, hangs her head and doesn't respond. The social care worker removes the mat to wash it and cleans the floor.

She leaves Sarah in her room while she helps Menna make her bed.

Later that morning, the social care worker notices Sarah is not wearing her glasses. Sarah tells her they're broken. The social care worker, still cross about having to wash the mat and floor again, tells Sarah she will have to wait until the next day to go to the optician to get her glasses fixed, as she doesn't have time to take her that day.

Sarah has virtually no sight without her glasses.

We'll come back to Sarah's story later in this section.

Listening and supporting communication and expression

Understanding the way someone communicates and responding to them appropriately is essential to helping people have a voice and making sure they're heard.

People communicate in many different ways and social care workers need to be flexible and adaptable in their approach. What works for one person may not work for another, but approaches may include:

- asking people what they want in a way they can best understand, taking into consideration their preferred language and communication styles
- listening carefully and giving people your full attention
- using non-verbal communication techniques such as gestures, facial expressions and written communication, including pictures and symbols
- always making plenty of time for the person, waiting for their response and not interrupting or trying to finish their sentence
- trying to keep the environment calm and as quiet as possible, avoiding distractions so you can give the conversation your full attention
- speaking clearly using simple sentences and avoiding jargon
- not giving too much information or asking too many questions, as this can be confusing for people
- being reassuring and non-threatening in your expressions, and monitoring your tone of voice and words to avoid situations becoming difficult
- avoiding negative statements such as "Don't", and being supportive and encouraging
- drawing on the knowledge and experience of others who know the person well
- using the person's past experiences and life story to support communication
- understanding how someone's condition, such as a response to an acute illness, infection, substance misuse or feelings, affect the way they communicate
- making sure there's a detailed description of how best to communicate with people in their records and that this is easily available.[3]

3. Five good communication standards: Royal College of Speech and Language Therapists: http://www.rcslt.org/news/docs/good_comm_standards

If someone has limited or no verbal communication skills, it's important everyone involved in their lives works together to understand their behaviour.

Case example: Lucy

Lucy is 16 years old. She stays at residential short breaks two days a month – usually mid-week.

Lucy is autistic and doesn't have any verbal communication. She's become increasingly agitated over the past three months and the most recent visit resulted in an incident where another young person, Grace, and a social care worker were injured.

The social care workers have noticed that Lucy seems to have become more sensitive to high-pitched noises and is more agitated when there are noisy children staying at the same time as her.

The incident is reported, and a meeting called between the short break service, the school and Lucy's parents. Her parents are separated, and the social care workers have found it difficult to engage them in the past. As Lucy usually stays mid-week, she is picked up from and dropped back to school, so there's little direct contact with her parents.

At the meeting, it's revealed that Lucy's father and his partner had a new baby six months ago – the staff team were unaware of this. Initially, Lucy carried on staying with her father on the weekends. But as she was becoming increasingly agitated every time the baby cried, they decided to stop the weekend visits and her father now just takes her out for a few hours each Saturday.

As we can see from these suggestions, we all communicate in a huge variety of ways and verbal communication is only one small part.

Case study: Mr Thomas

When you read the case study of Mr Thomas and Cerys, think about:

- what difference there may have been in Cerys's approach because Mr Thomas had been her head teacher
- how this might have affected his behaviour
- how the way we value and perceive people has an impact on the way that they behave.

Mr Thomas lives in a small flat overlooking the sea. Little was known about him because he's confused and won't speak to the social care workers. However, they understood that he and his wife moved to the area recently and that she cared for him until she died suddenly two months ago.

The couple didn't have any known family or visitors and the neighbours who recognised him had never spoken to him.

Mr Thomas's care and support plan describes him as non-compliant and surly, especially about support with his personal care. The social care workers from the agency who provide his support are worried about his escalating self-neglect and his increasingly aggressive behaviour when they try to help him shower and dress.

Cerys is an inexperienced social care worker. She was put on the rota to visit Mr Thomas because someone had called in sick. The team manager was worried about this and asked her to phone in at the end of the call. The manager was sceptical when Cerys reported that Mr Thomas was communicative and pleasant during the 20-minute visit and had agreed to let her help him shave.

Initially, the manager wondered if this was because she spoke Welsh, but discounted the idea as she knew the team providing his care had been specifically chosen because they all spoke Welsh, like Mr Thomas.

She asked Cerys to describe exactly what happened during the visit. This didn't provide any clues to the change until Cerys casually mentioned that as soon as she saw him, she realised he was her head teacher from primary school.

Cerys stressed she hadn't said anything to him as she thought he may be embarrassed if she did.

Taking time to really listen to people, develop good relationships with them and getting to know their histories and what is bothering them, can help identify triggers to their behaviour and allow changes to be made to prevent recurrences.

Case study: Sarah

We're using Sarah's story to show how a different approach by a social care worker meant she could talk about what was worrying her during the night, and how making simple and achievable changes helped Sarah.

- How do you think the social care worker helped Sarah have control over the situation?

Sarah – Part 2

Sarah's glasses have been fixed by the optician and she goes a few nights without urinating on her mat. A different social care worker is on duty. When she goes into Sarah's room to help her make her bed, she notices her mat is soaking wet.

She tells Sarah not to worry about it and asks her to get the mop and bucket so they can clean up together. They mop the floor and Sarah is helped to put the mat in the washing machine. She thanks Sarah for helping her clean up.

She suggests that they sit down and have a cup of tea and while they're doing this, she asks Sarah if she needs any help going to the bathroom when she wakes up in the night. Sarah is silent initially and drops her head, but after a short while says she is afraid of the dark.

The social care worker asks if she would like her bedroom lamp left on. Sarah agrees, and they change the bulb to one with a lower wattage. The social care worker makes sure that the landing light is left on all night as well, and that the rest of the staff team are informed.

Supporting people to make decisions and have control over their lives in safe ways

Giving people access to independent, up-to-date information, advice and advocacy is essential to enabling them and their families and carers to exercise choice and control, and make the most of their opportunity and ability to make decisions, however small.

Social care workers must always presume that a person has the capacity to make decisions for themselves. If there are any concerns about someone's capacity, it needs to be discussed with the wider team and plans put in place using relevant legislation, such as the Mental Capacity Act 2005, (Amendment) 2019 and the Children Act 1989.

When helping people make decisions, we should always start by asking them what support they need – if any. It's useful to think about all or some of these:

- providing accessible advice and information in a format and communication style of the person's choice
- helping people understand and weigh up information
- helping people understand how to make a complaint or compliment about their service
- supporting people to make their own choices as far as possible, even the smallest decision is important to maintaining dignity and will help people feel involved and in control of their own lives
- making sure there's enough time to allow people to be fully involved in any decision-making process
- involving a family member, friend or advocate, if appropriate
- accessing support from independent advocacy
- using any risk assessment positively to work with the person to balance their rights, responsibilities and perceived risks
- trying to achieve a balance between unlimited choice and unnecessary restriction
- accepting that people are allowed to make mistakes and learn from them
- discussing, developing and recording advance directives and crisis plans when a person is well enough to do so, that their wishes and views can be included at all times
- agreeing, where possible, any restrictive practices that are to be used with the person and, where relevant, their families and support networks.

Case study: Chelsea

The case study of Chelsea presents us with a difficult situation and is typical of those that social care workers face. Reflecting upon your own experiences, either in the workplace or at home, think about:

- should Chelsea be allowed to spend more time with her father unsupervised?
- what do you need to take into account when considering her request?
- how could you involve her in the decision-making process?

Chelsea is 13 years old and lives in a residential children's home. Her father misuses substances and has spent time in jail for theft. When Chelsea was living at home, her father used to take her shoplifting with him.

Chelsea is only allowed to have contact with her father for one and a half hours each month because of his inappropriate behaviours. This has to be supervised by her social care workers as Chelsea's father often tries to give her cigarettes and on one occasion tried to slip her some cannabis.

Chelsea would like to spend more time with her father and wants this to be unsupervised, but it is not allowed to happen.

2.2. Early intervention and prevention

Intervening early and developing prevention strategies can help people deal with situations they find difficult and prevent situations from escalating and getting out of hand.

We all try to avoid situations that cause us stress, anxiety and distress – whether it be leaving a bit earlier so we can miss the traffic or packing an extra snack for a child who's always hungry when they finish school and consequently badly behaved.

Early intervention relies on knowing people, their trigger points and helping them develop coping skills or preventative strategies to avoid difficult situations.

People expect the following from their care and support:

- I know and understand what care, support and opportunities are available to me
- I get the help I need, when I need it, in the way that I want it.

Many things affect the way we behave, including:

- our environment
- our health
- specific conditions
- our relationships with our families and those we live with
- boredom
- too much to do
- lots of changes
- bullying
- what we eat.

Social care workers need to be aware of potential situations and triggers that negatively affect the people they support, so changes can be made, and difficulties avoided.

Case study: Tareeq

Read the case study about Tareeq and think about the:

- changes that could be made to his existing home environment to help him while he waits to move into his new home
- other factors that should be considered in Tareeq's circumstances.

Tareeq lives in a home with three other men, who all present with behaviour that challenges. The communal areas of the home are quite cramped, so the atmosphere is often noisy and busy.

Tareeq is quite withdrawn and shows a lot of aggressive behaviour, which sometimes results in the use of restrictive physical interventions that are distressing him and the social care workers involved. It has been noted that the behaviour is worse when he's in crowded areas of the home, but he has no easy access to a quiet area.

He's waiting to move to a more spacious house with only two other people, where he will be able to spend quiet time in his room whenever he wants.

When you think about early intervention and prevention, you may also want to think about any or all of these preventative strategies:

- changing triggers that lead to behaviours that challenge
- putting plans in place to avoid triggers or offer distractions
- offering reassurance and support to people when they are expecting something they might find distressing or anxiety provoking, such as:
  - a visit to the doctor or dentist
  - going on holiday
  - contact with family
  - a change of social care worker
- changing the environment in which someone lives or spends time, to meet their needs
- supporting people to take part in activities that help them achieve the outcomes that are important to them
- building resilience – particularly for children and young people
- providing the right level of support to help people develop skills to increase their independence and their ability to cope.

Case example: Amber

Amber has four siblings – two have been adopted by the same parents, two are in foster care – and she lives in a residential children's home.

Amber has some contact with her brother and sister in foster care but none with her adopted siblings. Their birthdays are within days of each other, and her social care workers notice that in the week before their birthdays, she is aggressive, abusive and is involved in a number of violent incidents that result in restrictive physical interventions.

Because of this understanding, Amber's social care workers can help her with coping strategies in the run up to her siblings' birthdays. They frequently check how she's feeling, encourage her to leave the room if she starts feeling upset and agitated, and to write in a journal.

They also make sure one-to-one support is available during this period and arrange extra activities that Amber enjoys as a way of acknowledging how upsetting this time is for her.

Over time, Amber's agitation and the use of physical restrictive interventions during this time of year have reduced significantly.

2.3. Well-being

Care and support is about helping people achieve the outcomes that matter to them in their life. We must all consider people's well-being when providing care and support.

Well-being includes:

- physical and mental health and emotional well-being
- protection from abuse and neglect
- support to access and receive education, training or recreation
- support for domestic, family, and personal relationships
- social and economic well-being
- having suitable living accommodation
- securing rights and entitlements.[4]

Thinking about the things that contribute to your well-being may help you understand what well-being means. It could be seeing your friends and family when you want, taking the dog for a walk, a long bath after a hard day at work, going out dancing with friends or a nice meal. The list is endless and will be different for everyone.

People expect the following from their care and support:

- I am happy
- I am healthy
- My individual circumstances are considered
- I can learn and develop to my full potential
- I can do the things that matter to me
- I am supported to work
- I have a social life and can be with the people that I choose
- I get the help I need to grow up and be independent
- I can engage and take part
- I am safe and protected from abuse and neglect.

4. Code of Professional Practice for Social Care, Care Council for Wales, 2015.

Person-centred practice

Person-centred practice makes sure social care workers focus on helping people achieve the goals and aspirations that affect their well-being.

Person-centred practice recognises the things that make each person unique and uses this as the basis for planning and providing care and support.[5]

The Code of Professional Practice for Social Care sets out the standards of practice that are expected of social care workers. The range of ways people can be placed at the centre of their care are by:

- recognising that everyone is different and unique
- taking time to get to know someone by listening to, understanding and valuing their history and life story
- supporting people to make decisions and have control over their lives
- focusing on a person's skills, abilities, resources, knowledge and wishes
- recognising and accepting people's weaknesses, as well as their strengths
- involving the person and their support network, including their family members, friends and others who know them from their community and other professionals
- considering and respecting the person's beliefs, gender, race and culture
- developing holistic, strengths-based behaviour support plans that are based on rigorous evidence
- focusing on the person's preferences and needs, the outcomes they want to achieve and 'what matters to them', and not just the services that are available.

5. National Occupational Standards for Health and Social Care.

Case example: Nia

Nia has lived in her new home for a month. In her early twenties, she was involved in an accident while driving to the airport for her first big modelling role in New York. Nia was seriously injured and spent many months in hospital because of severe brain, facial and spinal injuries, before being moved to a series of residential care homes.

Now 10 years after the accident, she's moved again to a new residential home for people with Acquired Brain Injury (ABI). She can't weight bear and can no longer communicate her wishes easily.

While Nia enjoys having her hair done and wearing fashionable clothes and make-up, she won't have a mirror in her room. Nia gets very agitated when staff, particularly the younger female social care workers, have to support her intimate personal care and will struggle, hit out, bite, scratch and sometimes spit.

Although she's very upset during all personal care, she's less agitated with some workers.
The management team, who were updating her risk assessment and behaviour support plan, began closely analysing all recorded incidents.

They identified patterns of behaviour when different workers were on duty. They found she was often less agitated with older staff of either gender. In talking to staff, they also found these behaviours had become so common that many 'minor incidents' were not being recorded.

They interviewed all the workers who supported Nia and found some had hardly any issues, but others were afraid of her. Some could understand what she was communicating, whereas others said she couldn't communicate at all.

After a detailed investigation, the management team made changes to the training, rotas, and team and shift balance, and they developed a communication profile.

Over the next few months, there was a dramatic decline in incidents. Nia was less agitated because people better understood her and why she was so distressed, and they worked as a team to support her more effectively.

Case study: Mrs Gupta

Think about Mrs Gupta:

- what do you think the issues may be in relation to:
  - culture
  - communication
  - approach?
- what steps do you think could be taken?

Mrs Gupta is an 84-year-old Hindu woman who has dementia. She has become increasingly frail and recently moved into a residential care home. Mrs Gupta speaks some English, but as her dementia's advanced, she's reverted to only understanding and speaking Gujarati.

Mrs Gupta will not let any of the social care workers remove her clothing to carry out personal care. Each time they try, she becomes agitated and hits out at them. There's no-one in the care home who can speak Gujarati.

Active participation, engagement and involvement, and having a good quality of life

Active participation is defined as:

"A way of working that regards individuals as active partners in their own care rather than passive recipients. Active participation recognises each individual's right to participate in the activities and relationships of everyday life as independently as possible."[6]

Having the opportunity to do the things we enjoy, be engaged in meaningful activities, and have good social relationships is important to us all. It contributes to our sense of well-being and feeling of belonging. Social care and support services play an important part in helping people actively take part in all aspects of their lives when they need some help to do this.

Feeling we are in control of our life and situation has a massive impact on our behaviour. When this is not the case, we are more likely to feel distressed, frustrated, angry, and potentially engage in behaviour that challenges others.

Owning our plans for the future makes it more likely we will achieve our goals and be satisfied with the quality of our lives.

As well as supporting people to take part and engage in the activities that they've identified as important to them, it's important to make sure they're involved as much as possible in any meetings and reviews that concern their lives.

There are many ways to do this. The methods you use will depend on the preferences, communication needs and circumstances of each person.

6. National Occupational Standards and Code of Professional Practice for Social Care, 2015.

Case study: Elizabeth

This case study shows how important it is to let people feel engaged and in control of what's happening around them. As you read the two versions of Elizabeth's Person Centred Planning (PCP) meetings think about the:

- pros and cons of each method used
- impact of each one on Elizabeth.

Elizabeth is 60 years old. She's lived in supported living accommodation for the past 20 years. Before that, she lived in a large institution for people with learning disabilities for 34 years. Elizabeth has a wide network of friends, many of whom lived with her in the institution and some who've supported her over the years. She also has regular contact with her family – three younger siblings and their children.

Version one

Every year, Elizabeth has her PCP review at the head office of the organisation that provides support to her. The meetings are usually held in office hours – this means her family and some of her friends (particularly those who've supported her in the past) can't attend as they're working. The meeting date is only sent out a week in advance and it makes it difficult to take time off.

The friends Elizabeth lived with in the institution have never been invited as it's assumed they won't be able to contribute.

Elizabeth tends to go along with suggestions from her social care workers at the meeting but often changes her mind afterwards, getting angry when her social care workers try to persuade her to comply with what was agreed. The plans are usually dropped, with negative feedback about Elizabeth at the next meeting.

Elizabeth is always anxious in the time running up to her review meetings and becomes verbally repetitive and aggressive towards others.

Version two

Every year, Elizabeth has a key worker at the time of her PCP review. They go out for coffee and talk about what she's done over the last year, what she's enjoyed, and what's worked well and not so well. They talk about what's important to Elizabeth and start thinking about what she'd like to continue doing, as well as new activities she may want to try. They carry on with this conversation over the next couple of weeks and work out the type of support she'd need to do them.

They arrange a teatime meeting with her family and talk about Elizabeth's plans and how they may be able to support her with some of them. They also arrange a telephone call to one of her friends who was a volunteer at the institution where she lived. She knows Elizabeth really well and often has lots of ideas of other things she might like to think about trying.

Once all these conversations have taken place, the key worker writes up the plan in simple language that Elizabeth can understand and goes through it with her to make sure she's happy with it.
At regular intervals throughout the year, they have a chat to review how well the plan is working and make adjustments where they're needed.

When you're planning how to involve people in meetings about their lives, make sure they're as involved as possible by thinking about:

- if it needs to be a formal meeting or if the conversation can happen in other ways
- if it needs to be one big meeting or if it can be a series of smaller meetings
- using methods of communication that are appropriate for the person and help them to feel their views are being listened to and are valued
- choosing an environment where the person feels comfortable and deciding with them the best time of day to hold it
- who should be present at the meeting and how others who are important to the person can feed in
- the information that needs to be made available before and during the meeting, and the format it should be presented in
- making sure the person understands what is being discussed and decided, and is happy with any decisions and plans
- where possible, focusing on the person's assets, building on what they've done and are doing well
- not using jargon or language the person can't understand
- allowing enough time for the person to contribute effectively
- arranging for an advocate, friend or family member to support the person, if it's appropriate
- being clear about actions and timescales and making sure the person understands and agrees to them.

Balancing safety from harm with freedom of choice and positive risk taking

Social care services must support people to balance safety from harm with the freedom of choice. We don't and can't live in a world that is free from risk or harm and it's important we can all make choices, take risks and learn from our mistakes.

There may be some situations where social care workers need to provide a level of control and management to a person's behaviour to safeguard their welfare. The case studies in this section explore these situations.

Case study: Ffion

Think about the situation the social care team is facing with Ffion:

- do you think the social care workers are taking the appropriate action to support Ffion in this situation and keep her safe?
- do you think other agencies should become more involved in working with the staff team?
- what other strategies could be considered?

Ffion is 15 years old and living in a two bedded children's home in a medium-size market town. She's lived there for six months and is keen to make the most of her last year in school, where it's thought she has the potential to do well in her GCSEs.

Around six weeks ago, Ffion told staff she now had a boyfriend she'd met locally. She began spending increasing amounts of time out of the home with him. The social care workers suggested to Ffion that she invite her boyfriend back to the home for tea as they'd like to meet him. But she appeared reluctant for this to happen or to say where he lived.

The other young person living in the home subsequently told staff that Ffion told them that her boyfriend was 31 years old and she was having fun hanging out with him and his mates. This information raised concern among the social care workers who made further attempts to discuss this with Ffion without success. One evening, they decided staff would follow Ffion when she went out. After a short walk away from the home, staff saw her getting into a car with at least two adult males.

At this stage, the team were increasingly concerned that Ffion could be at risk of sexual exploitation. The manager of the home arranged a multi-agency meeting to discuss the concerns. They agreed to monitor the situation, while the police made enquiries based on the information the staff had gathered about the man Ffion was seeing, including the car's registration number. In the meantime, staff continued to try and engage Ffion in discussions about the need to keep herself safe.

Ffion eventually admitted her boyfriend was older than her, but insisted she was fine and that he really loved her. She became increasingly resentful of what she considered to be the interference of staff in her life who she felt was trying to stop her from being happy.

By now, Ffion was going out every night and had begun missing some sessions in school to meet her boyfriend. She became more distant from staff and refused offers of advice or guidance. She insisted she'd never been happier. She also turned down the suggestion that she spend at least two evenings in and that her boyfriend visit her at the home.

The staff team, by now, were so concerned that it was agreed they should intervene to protect Ffion from the risk of being exploited and make attempts to dissuade her from leaving the home.

This led to Ffion becoming very challenging, both verbally and physically, and which on occasion resulted in her being held. The social care workers are now concerned about the frequency of the physical confrontations each time they try to stop Ffion leaving the home and the distress this is causing her.

We can help people balance safety from harm with freedom of choice by enabling them to think about all the known risk factors and benefits and make positive choices. This will allow them to develop their own resources and ways of dealing with situations that are difficult and risky.

Case study: Mike

Read Mike's situation and think about:

- what you'd want if you were in Mike's position
- what you'd do if you were a member of his care and support team.

Mike is a 38-year-old resident with a history of mental illness, which is made worse by regular alcohol use. This led to frequent admissions to hospital, sometimes under the Mental Health Act 1983. He was also reluctant to take his medication, which led to further breakdowns and admissions to hospital.

After his latest lengthy hospital admission, Mike moved into a 24-hour staffed, community-based reablement service, initially under a Community Treatment Order (CTO).

Shortly after the move, Mike started drinking again, returning home late at night or in the early hours of the morning, apparently intoxicated. He couldn't take his prescribed medication when he'd been drinking as it caused side effects and because of this his mental health deteriorated.

Mike, the residential service team and Mike's care coordinator discussed the situation. Mike recognised the situation was getting worse and agreed a plan that intended to help him manage better. He had capacity and was certain he didn't want to return to hospital.

While the social care team weren't in a position to prevent him from going out or drinking, Mike agreed that if he was out, he'd phone at 11pm to say where he was and what he was doing. The social care workers would, at that point, have a conversation with him about his drinking and the impact it has on his ability to take his medication and his behaviour.

As agreed, Mike rang the team and eventually got into the routine of returning home by 11pm. As part of the care plan, he also agreed to take a breathalyser test to check if it was safe for him to take his medication. Mike was soon able to see the connection between his mental state and his drinking.

As a result of the discussions with staff, Mike could see that he was beginning to get more control over his life and that he had a better chance of moving on from the residential facility if he continued with his medication and limited his drinking.

There were occasions when Mike returned where staff thought he may have been drinking, but the breathalyser test was negative and he could take his medication. This was important in building trust between Mike and the team.

The care team couldn't tell Mike that he couldn't leave the residential facility or control his access to alcohol or drugs. But by engaging with him throughout the care planning process and developing a care plan that was mutually agreed, fair and proportionate, Mike was able to change his behaviour and develop a healthier lifestyle.

Eventually Mike's CTO was removed, his alcohol consumption reduced considerably and he developed a different attitude to taking medication. He's now moved into his own flat with support from social care workers.

Case study: Jillian

Read the case study about Jillian and think about:

- why Jillian has started self-harming
- what advice would you seek and who from?
- what are the underlying issues that may help us understand her behaviour?
- what are the dangers of making assumptions about this situation?
- what considerations may be needed to allow Jillian to go out unsupervised and carry her own money?

Jillian is a 14-year-old girl from an abusive travelling background. She spent a number of months in a secure centre before moving to a residential children's home. Although she had no history of self-harm, she's witnessed other young people self-harming.

While at the residential children's home, Jillian begins to self-harm and on one occasion is taken to hospital after trying to end her life by taking a large amount of paracetamol tablets, which she'd bought with her pocket money.

Because of this, Jillian is now being supervised when she's out in the community, including when she spends her pocket money. Jillian would really like to be able to go out alone and be able to carry and spend her own money as she wishes.

2.4. Co-production

Co-production is about developing partnerships between people, families, carers and professionals where everybody works together on an equal basis to create a service or come to a decision that works for them all. It's built on the principle that those who use a service know what works and are best placed to help design it.[7]

People expect the following from their care and support:

- I can get involved and take part
- I feel valued in society.

Working with people, families, and advocates to design services and agree ways of working

Co-production accepts that no one is more important than anyone else in the partnership. Developing positive relationships based on mutual respect and an understanding of what each partner has to offer is crucial to its success. To work with people, families and advocates to design services and agree ways of working, it's useful to think about:

- working with people from the start to find out what they want from the service and the best way for this to happen
- developing a range of ways that people can give feedback about the services that they receive including:
  - asking people
  - group meetings
  - surveys
  - consultation exercises.

It's important to make sure people have the support they need to take part constructively in the process as equal partners and that you use a range of methods to make this happen. Part 2 provides suggestions.

7. Think Local Act Personal: Ten top tips for coproduction

Case study: Jane

Read Jane's story and think about:

- what might have happened if neither she nor her mother were so actively involved in planning her services?
- the impact it's had on Jane's quality of life and that of her family?

Jane, who's 23 years old and has Down's Syndrome, was referred to her local Community Learning Disability Team (CLDT).

Jane was bored at home. She was continuously overeating, and her weight was starting to cause health problems. Her parents were trying to encourage healthy eating and were restricting her access to food. This however, only resulted in Jane becoming angry and abusive towards her parents.

Jane had been offered traditional day services in the past but had declared she "didn't like them and didn't want to go there".

From discussions with Jane and her mum, the social care worker found out that Jane liked art and was good at colouring and painting.

She introduced Jane to a community art class, after first speaking to the tutor, and initially accompanied her. She also introduced Jane to a local keep-fit class to try to help her with her weight. Finally, she suggested Jane go to a weekend drama course that was run locally for young people with and without disabilities.

Three years on, Jane still attends all three activities and has made friends in the drama class who introduced her to an evening session of boccia in the local leisure centre. She's also started going out with Mavis from the keep-fit class a few days a week to walk her dog with her.

The family have short breaks while Jane is at the activities and have not needed to contact social services for some time. Jane enjoys her activities and is developing strong friendships in her local community. She's stopped overeating and is losing weight, and has a better relationship with her parents.

2.5. Multi-agency, partnership and collaboration, and consistent approaches

To provide good quality care and support to people, it's essential all professionals and multi-agency partners work together to provide person-centred services that respect the voices of people and their families and carers.

It's rare that care and support is provided by one agency alone, so working with others will make sure that discussions about options and any decision making is shared. It's important to remember we all share a common purpose, which is to support people to live their lives as they wish.

This is what people expect from their care and support:

- I have safe and healthy relationships
- I know and understand what care, support and opportunities are available to me.

Working together in a way that minimises the number of professionals, agencies and care procedures and pathways will stop people becoming confused, anxious and distressed. It can be frustrating for us all when we have to repeat our story and circumstances every time we meet someone new.

To develop good multi-agency working, you need to have:

- trust between all those involved in the person's care and support
- a good understanding of each other's roles and responsibilities
- a clear expectation that people will understand their rights, how information will be shared and how they can have a say in what is shared between professionals and, where appropriate, families and carers
- plans that are agreed with the person, their family members or those who know the person well, and with members of the multi-disciplinary team
- coordinated support that includes details about:
  - information sharing processes
  - clear channels of communication
  - the outcomes of assessments, including risk assessments
  - discharge and transition plans
  - crisis plans and advanced directives
  - behaviour support plans
- regular and routine use of individualised communication tools, such as 'This is me' and hospital passports for when someone needs to be admitted to a general hospital.

We're all pieces of a jigsaw puzzle that should fit together to provide a complete picture with the person as the central piece.

Consistent approaches

Developing good, trusting relationships with social care workers who provide care and support is really important to people, families and carers.

Providing consistent support is essential, so people can get to know and trust the workers caring for them and they in turn are aware of and can put any planned approaches or techniques in place to avoid difficult situations and the need for restrictions.

Case study: Dave

Think about Dave's situation:

- what do you think helped Dave make his decisions?
- why do you think it was so important that the multi-disciplinary team take a consistent approach in their support for Dave?
- what might have happened if the situation had been left to continue?

Dave is a 52-year-old man with a long history of mental illness, leading to lengthy hospital admissions. After his last admission, he moved into a residential mental health setting for reablement, with long-term plans to move into more independent living, which he is keen to do.

As Dave isn't currently working, he depends on benefits, which are paid regularly into his bank account. But once they've been paid, Dave withdraws the whole amount and visits a long-standing lady friend, returning penniless.

Because of this, he has no money to last him the week and has to resort to asking his fellow residents for money, either as loans or donations, until his next benefit day. The other residents find this annoying, and it can cause problems between them and Dave.

Dave also approaches staff for money and for loans from petty cash, and he's been known to beg in the streets when really desperate.

The situation is discussed with Dave and members of the multi-disciplinary clinical team who know him well. Everyone recognises that Dave has capacity and is able to make his own decisions, even if they feel they're unwise. They have no power to stop him from what he's doing.

But they're all concerned that Dave's actions aren't helpful to his mental state, or with his relationships with other residents, workers, and the police. He's clear he wants to maintain the relationship with his lady friend, even though others feel he's being exploited.

They agree on a plan with Dave, in which he continues to see his friend but gives her a smaller amount of money. This means Dave doesn't need to pester people or beg, and has some money left to buy food for meals he likes to cook.

Staff engage in a consistent discussion with Dave, particularly around benefit time, to help him think through what he really wants to do. Dave decides to continue to reduce the money he takes out each time, which leaves him more for his other interests.

Dave's lady friend begins to pursue him for the remainder of the money, initially by calling him on his mobile phone. When Dave doesn't answer, she starts to phone the residential home to speak to him. Dave asks the staff not to put her through and eventually Dave decides to end the relationship.

2.6. What we mean by restrictive interventions

Restrictive practices are a range of activities that stop people from doing things they want to do or encourages them do things they don't want to do. They can be obvious or subtle. They should be understood as part of a spectrum – from limiting choice to a reactive response to an incident or an emergency, or if a person is going to seriously harm themselves or others. Restrictive interventions are part of the range of restrictive practices and unless they are part of an agreed behaviour support plan, they should only be used as an immediate and deliberate response to behaviours that challenge or to take control of a situation where there is a real possibility of harm if no action is taken. The Welsh Government's framework refers to the Human Rights Framework for Restraint.

Restrictive interventions should only be used to keep somebody safe. They can pose a risk to a person's health and safety, and when used inappropriately, they can be distressing and, in some cases, abusive. Restrictive interventions must never be used to punish or for the sole intention of inflicting pain, suffering, humiliation or to achieve compliance. If you have to use restrictive interventions in an emergency or because someone is going to seriously harm themselves or others, you should make sure the interventions:

- aren't used for longer than necessary
- are proportionate to the risks and the least restrictive option
- are legally and ethically justifiable
- are well-thought through and considered when all other options have been tried or are impractical
- are made in a manner that's transparent to all, with clear lines of accountability in place
- are openly acknowledged and never hidden
- are never used as punishment or for the sole intention of inflicting pain, suffering, humiliation or to achieve compliance
- are determined by local policy and procedures
- are recorded appropriately
- are monitored, planned and reviewed to find a more positive alternative on a longer term basis
- include debriefing and support is offered to everyone involved.

Restrictive interventions can take a number of forms. We've described them below and included case scenarios to show when the intervention could be used and when it should not. When you read the scenarios, try to relate the situations to your own experiences.

2.7. Definitions and examples of restrictive interventions

Restrictive interventions are a set of techniques that can be known as reactive strategies. They include:

- the use of distraction
- diffusion
- breakaway techniques
- safe holding.

They're only intended to get rapid and safe control over behaviours that can cause danger.[8]

You can find definitions for the various types of restrictive practices here.

8. Guidance on the use of Physical Interventions: Directorate of Learning Disability Services; 2013.

Physical restraint

Physical restraint is defined by the Welsh Government as:

"Direct physical contact between persons where reasonable force is positively applied against resistance, either to restrict movement or mobility or to disengage from harmful behaviour displayed by an individual."

When it's appropriate to use a physical restraint

Halina loves sunglasses, and when she's out with her social care workers she'll often try to grab other people's glasses as they pass her in the street. Workers try everything they can to distract and divert her when they see someone coming wearing a pair, but occasionally they're not quick enough. On these occasions, they link arms with Halina and move her gently away to stop her from grabbing glasses.

When it's not appropriate to use a physical restraint

Mrs Probert has vascular dementia and is currently living in a residential care home.

She's often very anxious because of her memory loss and angry that she is being 'restricted' and made to stay in the residential care home. She wants to be back home where she was happy. She says she feels as though she's in a bad dream. Every night she goes to bed in a different bed, and she wakes up in strange places, horrible places. The home she wants to be in is the one she lived in over 60 years ago, not the one she lives in now.

Mrs Probert doesn't remember anything other than 'flashes' of memories from more recent years. Sometimes she remembers being a teacher, she asks where Iain her first husband is – he died 30 years ago. At times she knows she had a son and thinks she has a daughter, but she doesn't remember her when she visits. She thinks they've abandoned her and she never sees them. Some children visit her, they're very young and she often thinks her great-granddaughter is her daughter.

Every night two social care workers put Mrs Probert to bed. They try to encourage her to shower but she hates it, she says they put her in the shower three times a day and she doesn't need it. Sometimes she moans a lot but gives in, other times she gets very angry and hits out at them. When she's too difficult, they use a modified bed bath approach where one social care worker will sit facing Mrs Probert, gently leaning across her chest, holding her arms and singing to her while the other strips her lower half and gives her a good wash down below.

Mechanical restraint

The Department of Health describes Mechanical restraint as:

"Use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control."[9]

Examples of mechanical restraint might include:

- the use of arm splints
- cushioned helmets
- wheelchair lap straps
- the misuse of mobility aids, such as sliding sheets and handling belts or raised bed sides.

When it's appropriate to use a mechanical restraint

Ajay has a tendency to get out of his seatbelt when travelling in the car. The last time he did it, he fell over and hit his head.

A best interest meeting was held with his family, the staff team and his case manager, where they agreed a safety harness could be used. The team were to gradually introduce this to Ajay, as well as use the normal seatbelt.

The team bought the harness and Ajay used it without any problems over the next few weeks. Another best interest meeting was held to see if the team could reduce the use of the harness and try the normal seatbelt.

The team tested this and found Ajay will now wear the normal seatbelt without removing it, so they no longer need to use the harness.

When it's not appropriate to use a mechanical restraint

Amy has limited mobility but can walk with assistance. While at the day centre, Amy's required to wear a wheelchair lap strap to stop her getting up and walking around the room because there aren't enough social care workers on duty to assist her. Amy's losing her mobility because of this.

9. Positive and Proactive Care: reducing the need for restrictive interventions, Department of Health (DOH), 2014.

Use of medication

Use of medication refers to:

"The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formerly identified physical or mental illness."[10]

Examples include the use of medication:

- as required medication
- rapid tranquilisation
- long-term tranquilisation
- sleeping tablets.

When it's appropriate to use medication as a restraint

Mrs Adeyemi has dementia and lives in a residential care home. She recently broke a tooth and is clearly in a lot of pain. She's started refusing food and doesn't want to drink as it's so painful. She won't open her mouth to let anyone look at her teeth, not even her daughter who visits regularly. A best interest meeting was held with her family, the care team and Mrs Adeyemi's GP. At the meeting, they agreed it was in Mrs Adeyemi's best interest to sedate her before the dentist's visit so the dentist can remove her broken tooth.

When it is not appropriate to use medication as a restraint

Griff is a 12-year-old boy with a mild learning disability, who attends his local leisure project. When he's there, he's always tired, listless and can't focus on the activities, including the things he enjoys doing.

His mum is a single mother with three children, who suffers from self-admitted (but undiagnosed) depression. When a project worker visits her, she says Griff has Attention Deficit Hyperactivity Disorder (ADHD) and had been utterly uncontrollable at home until the GP prescribed Ritalin. She said the original dose hadn't made much difference, so she'd raised the dose. She'd told the GP surgery on the phone and the prescribed dose was adjusted. She said Griff was now good at home and didn't cause her any more trouble.

The worker sought advice from social services, who got in touch with his mum and suggested a doctor's visit to help with her depression. The worker also suggested she go back to the original Ritalin dose for Griff on the days he went to the project.

Griff's mum did this, a bit reluctantly, and was prescribed medical help with sleeping, offered counselling for her depression and given advice and support to help with her finances, which were a big worry for her.

Griff became more lively during his time at the project and was able to focus on all the activities, he eventually became a group leader. Within two years, the Ritalin was stopped.

He's now a happy and well-mannered 20-year-old in college studying carpentry.

10. bild

Psychosocial restraint (sanctions)

Psychosocial restraint refers to the:

"Use of coercive social or material sanctions, or verbal threat of those sanctions, in an attempt to moderate a person's behaviour."[11]

Any sanctions you use should be appropriate and directly relevant to the specific unwanted behaviour. They should be used as a short-term response to negative behaviours and as part of a longer term process to help the person understand the impact of their behaviour and why it might be unacceptable or dangerous.

You shouldn't use sanctions in the heat of the moment because you need to reflect on an appropriate sanction and discuss it with colleagues and/or your manager. They should be put in place a reasonably short time after the event.

When it's appropriate to use sanctions

Kelly is a 14-year-old living in a residential children's home. She's been there for six months.

Kelly has a history of getting drunk. She's a vulnerable young person and this puts her safety at risk. It's been agreed that Kelly will be sanctioned if she drinks too much as part of a plan to try to change this behaviour. The sanction is that Kelly will be 'grounded', that is, she won't be allowed to engage in social activities with her friends. The extent of the 'grounding' will depend on the extent of her behaviour.

On one occasion, Kelly drank too much and failed to return to the home. She didn't answer her phone when her social care workers tried to call her, and she was reported missing to the police. The police found her and one of the social care workers collected her.

On the car journey home, she was abusive and aggressive, and on occasions, she tried to grab the steering wheel causing the social care worker to swerve. The behaviour continued when she got home, and she took several hours to calm down and go to bed. Because of the extent of her behaviour, Kelly was grounded for seven days.

The issue with the car was risk assessed and it was decided Kelly would not be given lifts by the social care workers on their own if she was drunk or agitated and they would work with Kelly to help her understand the potential implications of her behaviour.

On a subsequent occasion, Kelly was out with friends and got drunk again but this time she called the house asking to be picked up. She was collected by two social care workers. Kelly was crying and apologised for drinking too much again. She went to her room for an hour on returning home to sober up.

Kelly was grounded for three days on that occasion with a promise this would be reduced to one day if her attitude about what happened continued to be positive.

11. Guidance on the minimisation of alternatives to restrictive practices in health and adult social care, and special schools, Royal College of Nursing, December 2013

When it's not appropriate to use sanctions

Lloyd is a 13-year-old living in a residential children's home. His shoes are really muddy when he gets home from school and the social care worker asks him to take them off instead of treading mud through the house.

Lloyd is feeling really grumpy and tells the worker to "…. off". The worker immediately tells him to write 20 lines "I must not swear" as a sanction. This annoys Lloyd, and he continues swearing, so the number of lines is increased to 100 and then 200.

Lloyd is getting more and more annoyed, and continues shouting and swearing, so the worker tells him he's now grounded for a week.

Lloyd responds by smashing a cup and is told he will have £3 taken from his pocket money to buy a new one. Lloyd then throws one of his muddy shoes at the worker and it hits him on the shoulder. Lloyd is physically restrained.

Seclusion

Seclusion is against the regulations and should not be used in any social care setting.

Time out or time away

Asking or steering someone to a quiet or different area when they're upset or being agitated by others or the environment can be a good strategy, if the person has the ability and skills to calm themselves. It gives them the opportunity to regain control somewhere where they can be quiet, calm down and, if possible, think about what has happened. It will also stop the situation from escalating.

Time out or time away doesn't mean isolation and banishment. The person should be supported in a quiet area with a calm and caring social care worker.

When it's appropriate to use time out or time away

Geraint has a history of engaging in self-harm when he becomes anxious and upset. Through close observations, the staff team has noticed that when the environment becomes too noisy or busy Geraint starts 'flapping' his hands and biting them. This frequently leads to him banging his head on the floor. At a meeting to review the Positive Behaviour Support plan, it's agreed that when Geraint starts to flap his hands, he'll be given a symbol offering the quiet room and he'll be supported to leave the noisy environment and go to the quiet area to calm down and regain control.

When it's not appropriate to use time out or time away

Kemal was engaging in challenging behaviour and attempting to grab and bite staff when they were changing his bed. Two social care workers escorted him to the quiet room and shut the door, leaving him on his own to calm down.

Environmental interventions

Environmental restraints describe changes or modifications to a person's surroundings to restrict or control their movement. For example, a locked door or handles that are placed out of residents' reach.

When it's appropriate to use environmental interventions

Mr Jones lives in a residential care home, which has introduced a fob system. This means that residents with capacity have fobs to allow them to come and go as they please. Fobs were also given to regular visitors to let them take their relatives for a walk.

Mr Jones, who has dementia, was one of the residents who liked to wander during the day and at night. It wasn't felt he had capacity, so he wasn't given a fob. When he asked to leave, a social care worker would try to accompany him for a walk, but this wasn't always possible, particularly at night.

Mr Jones was assessed as not having capacity and a Deprivation of Liberty Safeguards (DoLS) application was authorised.

When it's not appropriate to use environmental interventions

Mr Jones lives in a residential care home. He likes to sit in the garden. The social care workers are worried it's too risky to let him do this on his own because he has dementia. Baffle locks (door handles set at different heights that turn in different directions to stop people with confusion leaving) are installed to stop Mr Jones entering and exiting the building.

This amounts to a de facto detention, even though most residents expressed no desire to leave the premises.

Safeguarding

We all have a duty to prevent and protect children and adults from experiencing abuse, harm or neglect and the process for doing this is known as 'safeguarding'.

We must know and understand our safeguarding responsibilities and make sure we're aware of our organisation's safeguarding policy and procedures. Working in a positive, person or child-centred way with people, their families or carers will reduce the risk of abuse, harm or neglect.

If you're concerned about how restrictive practices are being used in a setting, you must report it to the relevant person identified in your safeguarding policy without delay. This expectation is set out in the Wales Safeguarding Procedures and the Welsh Government's safeguarding guidance.

You should also find out about your organisation's whistleblowing policy.

Part 3: Support and training

Valuing and supporting social care workers and recognising their individual and team strengths is essential for working with people who have care and support needs.

There are some situations where social care workers face barriers to using positive approaches. This may be because:

- there isn't a coherent person-centred assessment of a person and their behaviour and needs
- there isn't effective leadership and understanding of positive and preventative approaches
- there's a lack of training and opportunities to develop an understanding of positive approaches
- of an organisational culture that's risk averse and places greater emphasis on physical interventions to maintain safety at all times.

Developing a culture of open and transparent decision making, learning from incidents and mistakes, and sharing good practice will contribute to the provision of positive and proactive services.

3.1. Leadership

We'll succeed in reducing restrictive practices if organisations have a culture of upholding people's human rights. There's a need for strong leadership at all levels in each organisation, where the reduction of restrictive practice is clearly communicated and monitored.

The organisation's systems, policies and procedures should set out clear expectations of an approach to reduce restrictive practice. The organisation's workforce development programme should also support the implementation of the policies and procedures. Workers at all levels in the organisation should contribute to the programme by identifying their own learning and development needs, and those of others they support and manage. Service regulators can find guidance[12] about identifying and responding to closed cultures, which can have a negative impact on people's human rights.

You can find more resources and information about the leadership needed to reduce restrictive practices and a range of other resources on the Restraint Reduction Network's website including their Six Core Strategies infographic.

12. Identifying and responding to closed cultures: Guidance for CQC staff

3.2. Supervision

Supervision is essential to the ongoing support and training of social care workers so they can develop and maintain positive ways of working and reduce the use of restrictive practices.

Line management and clinical supervision is a two-way process, which supports, motivates and enables the development of good practice for social care workers. It's a way of regularly monitoring someone's performance, setting targets, checking workloads and responsibilities, celebrating success and achievement, and highlighting any development needs.[13]

More importantly, supervision's an opportunity for essential reflection on practice and to reflect on any feelings that are brought up.

Supervision should be:

- used to support positive practice
- prioritised, with protected time for it to happen in a quiet place with no opportunity for interruptions
- regular, planned in advance and available informally when needed
- high quality, carried out by someone who's been trained to provide supervision, including specialists as required
- structured around a shared agreed agenda
- used to support the well-being of the workforce.

Other forms of support may be available within services and teams. This could include:

- team meetings
- the use of peers and buddies
- coaching
- shadowing
- co-working
- mentoring from champions or specialists in your own or other services.

13. Effective supervision in Social Care, early years and childcare: Social Care Wales, 2021

3.3. Post-incident review and support

It's essential to offer review and support in every situation where restrictive practices have been used or avoided. Using restrictive interventions can be very distressing and frightening for all involved, so debriefing immediately or shortly after an event is a way to offer support and reassurance.

Debriefing should be available to the:

- social care workers involved
- the individual
- their families and carers
- the wider staff team
- other people being supported, if relevant.

It's a chance to identify any learning or good practice that can be used to inform or amend the existing person-centred care plans and/or restrictive practice reductions plans.

The debriefing of people, carers and social care workers after an incident or a 'near miss' should:

- be led by the needs of the person
- be carried out by a skilled and trained practitioner with a 'no blame' attitude emphasising any learning
- consider the psychological impact on the people involved
- identify any further or on-going support and learning that's needed.

3.4. Monitoring and recording

Any use of any restrictive interventions must be monitored and clearly recorded on an individual level. This data should also be available at an organisational level and should be summarised and analysed regularly to provide evidence to inform restraint reduction plans and monitor their impact.

Social care workers should write a clear account of the incident in accordance with their organisation's policies and procedures as soon as possible after the event. This will help workers, teams, and organisations reflect upon what's taken place and learn from incidents to develop good practice. The Reducing Restrictive Practices Framework sets out expectations for recording and using data to improve practice.

Those working in residential children's services must also complete a detailed report when a restrictive physical intervention is used, which is shared with the young person's social worker.

Organisations must collect data about the use of restrictive practices in an effort to make sure they were used appropriately and to show they've reduced over time because of the use of individualised positive approaches.

3.5. Training, learning and skills development

Any training and learning activities needed will vary according to the service and role of those employed by it. Training on the use of restrictive practices needs to be part of a broader framework of training, which emphasises the importance of positive approaches, person-centred care planning and restrictive physical interventions used as a last resort. The Reducing Restrictive Practices Framework sets out the expectations for workforce development.

All training and learning activities, whether developed and provided in-house or commissioned from external sources, should:

- be part of a structured learning pathway, based on evidence of best practice
- take a long-term view of the learning and development social care workers will need including:
  - induction training for new workers
  - ongoing refresher training and updated learning as needed
  - training that's determined by policy and career development
- be provided by someone who's qualified to provide the training and is occupationally competent
- include the perspectives of people being supported by the service, this could be by face-to-face provision or in the design and development process
- be essential for 'bank', casual and agency workers, as well as regular employees, volunteers and apprentices
- be evaluated with robust quality assurance processes in place to make sure learning is embedded into practice.

Training in restricted physical intervention should be:

- designed to meet the needs of particular people
- based on the needs indicated by a behaviour audit, training needs analysis and risk assessment
- essential to all social care workers if there's a possibility they'll have to use a restrictive physical intervention in the workplace
- risk assessed by an independent person or organisation that can show appropriate expertise in:
  - the professional assessment of risk
  - manual handling and health and safety legislation
  - understanding of biomechanics[14] and physiology (relevant to child and adult anatomy)
  - psychological assessment.
- inclusive of an evaluation of the potential risks associated with all the physical techniques included in their curriculum
- updated and refreshed regularly as per the organisation's policy, but at least every 12 months[15]
- set up to have established systems in place for learning providers to feed back when learners are not seen as competent to practice.

Currently, there aren't any nationally recognised or approved training standards for the use of restrictive interventions and practices. Some organisations, such as the British Institute of Learning Disabilities (BILD) and the National Institute of Conflict Management, have established minimum standards.

14. Biomechanics refers to the study of the mechanical principles of living organisms, particularly their movement and structure. Oxford English Dictionary, Third Edition, November 2010.
15. BILD Code of Practice for minimising the use of restrictive physical interventions: planning, developing and delivering training. A guide for purchasers of training, training organisations and trainers, 2014, 4th Edition.

There are National Occupational Standards (NOS) and a range of qualifications and units specific to positive behaviour support and to restrictive practices. NOS are documents that set out how different aspects of a person's work need to be set out. They show effective performance in a job role by describing the skills, knowledge and understanding that may be needed to perform particular tasks or work in a certain way.

NOS can be used to give managers and social care workers a recognised good practice framework to guide their work, providing benchmarks against which performance can be objectively and fairly assessed.

You can take units as part of a qualification and/or as part of continuing professional development. The learning outcomes from the units can help you structure bespoke training programmes. A list of relevant NOS, units and other qualifications can be found in Part 4 of the resource.

You can find more information about recruiting and developing the workforce in the 2014 guide A positive and proactive workforce – a guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health.

Part 4: Information and resources

This part contains more information and resources about topics and areas of practice that may be useful to your work.

They include more detail about the three positive approaches frameworks or models referred to in Part 2. The frameworks and models are included as examples of practices, which evidence shows, support the reduction in the use of restrictive practices. There will be others that are used in your services that you'll can also draw upon.

Part 4 also has links to important pieces of legislation and policy, as well as additional reading and training resources, including a list of relevant NOS, units and qualifications.

4.1. Using Positive Behaviour Support (PBS) to reduce the use of restrictive practices

What is PBS?

PBS is a comprehensive, evidenced-based, values-led approach that starts with a good understanding of each person, their strengths, needs and wishes. It provides a personalised and enduring system of support to meet needs, build upon strengths and enhance a person's quality of life.

It's an inclusive approach that depends upon the involvement of the individual and the key people in their lives, including families and social care workers.

PBS isn't a single way of working as it includes the full range of therapies and interventions required to meet people's unique needs and achieve long-term improvements in quality of life. They can change behaviour and reduce the use of restrictive practices.

PBS is a practical way of responding to people with behaviours that challenge by:

- developing an understanding of why someone presents with behaviour that challenges
- making changes to the environment to reduce the need for someone to use challenging behaviour to control their life
- teaching the person new skills and other ways to communicate their needs
- creating the cultural change necessary for services to respond positively and respectfully to the person.

What are the different stages?

There are three stages to PBS:

Primary prevention

This is the most important part of PBS because it has the greatest impact on the quality of people's lives. Primary prevention supports people to get what they need, which leads to a reduction in behaviours that challenge and reduces or even eliminates the use of restrictive practices.

Primary prevention includes five key strategies:

- changing the environment in which a person lives or spends time to meet their needs
- changing triggers that lead to behaviours that challenge
- changing reinforcements that maintain behaviours that challenge
- helping people participate to achieve a typical lifestyle
- teaching skills to increase independence and the ability to cope.

Secondary prevention

The focus of secondary prevention is to support people when they are becoming distressed or agitated to relax and prevent behaviours becoming challenging. The emphasis is on calming, redirecting, distracting and problem solving to avoid the need for physical restrictions and interventions.

Secondary prevention has three elements:

1. Knowing the early signs – we all show signs when we're getting distressed or angry, such as going silent, avoiding eye contact and pacing the floor. Identifying the person's early signs is a first important step in helping them avoid becoming too agitated.
2. Active listening – closely monitoring the person's mood to spot early signs of agitation.
3. Taking action – intervening early by removing triggers, distracting the person with something they enjoy, giving them space and, if necessary, moving other people away. It's important not to rush in, panic, threaten or challenge people when they're showing signs of agitation.

It's also important that carers stay calm to stop the situation escalating and getting out of control, and to make sure they can get a safe distance from the person if they need to.

Reactive strategies

Reactive strategies aren't a treatment, but they're sometimes necessary when primary and secondary strategies haven't stopped someone from showing behaviour that's challenging.

Reactive strategies are safe and ethical responses that are put in place after the behaviour has happened. They should be agreed by a multi-disciplinary team, and wherever possible, the person and their family, and recorded in their behaviour support plan.

There are four levels of reactive strategy. You should use the least intrusive strategy necessary:

1. Increasing personal space – people often need more space around them when they're agitated, and providing this space helps keep the person and the worker safe.
2. Self-protective and breakaway procedures – these minimise the chance of the social care worker being hurt.
3. As required medication – this should be offered to the person if the first two strategies have failed.
4. Minimal restraint – this should only be done as part of an agreed care and support plan. The techniques should be designed for someone's specific behaviours and should be checked with their GP before they're used because any physical restraint can be dangerous. These techniques must use minimum force, not cause pain and only be used for the shortest possible time to keep the person safe from harm.

What needs to be in place to support its use?

You need lots of elements in place to make sure PBS is provided appropriately:

1. Functional analysis – to clearly identify the reasons someone shows behaviour that challenges, their strengths and preferences, and their health and communication needs.
2. PBS plan – to set out everything social care workers need to know and do to support the person, based on the results of the functional analysis. This should focus mainly on primary prevention and include the secondary prevention and appropriate reactive strategies that have been identified for the person.
3. Training for social care workers – to make sure they understand the PBS plan and are skilled in all the things they need to do to support the person. Training should be in three stages:
   - verbal competence (they can explain what's in the plan)
   - role play (they can act out what they need to do)
   - in vivo (they can carry out the plan in real life).
4. Practice leadership – team leaders need to be skilled in supporting the person, so they can act as role models for workers and give them regular feedback about how well they're carrying out the PBS plan.

4.2. Using Active Support to reduce the use of restrictive practices

Active Support is a person-centred model about how to positively interact with people. It's combined with a daily planning system that encourages participation and improves quality of life and the development of independent living skills.

The model provides a structure that helps people who aren't fully independent to engage in the typical mix of meaningful activities and personal pursuits that provide people with their purpose in life.

The Active Support Model was developed initially as a means of providing support to people with learning disabilities, so they could lead a full and fulfilling life. But it can be applied to anyone who needs care and support for their well-being.

The model provides a structure to increase the opportunities people have to take part in a valued range of activities. It includes working with people to develop daily plans and to put those plans in place to make sure they have a good balance of activities that contribute to their well-being available throughout the day, avoiding long periods of disengagement. Graduated levels of assistance are used from simple verbal prompts to actual physical guidance, such as hand-on-hand support, so that people can develop and maintain the skills they need to take part in activities that are important to them and for day-to-day living.

You can use the Active Support Model to reduce the use of restrictive practices.

4.3. Using restorative approaches to reduce the use of restrictive practices

Restorative practice allows people to reflect on their behaviour. It gives them a chance to put what's happened right or empathise with others' emotions and feelings.

Restorative approaches are increasingly used in children's residential environments to manage conflict and tensions by repairing harm and building relationships. It provides a more positive and ethical approach to working instead of using restrictive practices.

If those involved in a conflict are going to reach a shared understanding and feel the process is fair, you need a safe environment with clear meeting protocols around dignity and respect. Those taking part will need to be free to express their emotions, even those that are negative.

For it to work successfully, the 'wrong doer' has to take ownership of their behaviour.

It takes people from the past to the present and on to the future. They are the driving forces where social care workers are simply the facilitators, and managers of the process.

Restorative approaches can be used in many ways with young people and staff teams. For example:

- as a key working session, working directly with a young person on a one-to-one basis
- in a group setting to resolve conflict with a group of young people
- with a group of social care workers who've found it difficult to agree with a decision.

There are five methods to using this approach:

1. Start with affective statements – brief comments about the behaviour and how others were affected by the person's behaviour. It's important to have all the facts and information and not to make assumptions.
2. Affective questions – ask the 'wrong doer' for their version of events and who was affected, how and so on.
3. A small impromptu meeting – a few people are brought together to discuss the incident, its impact and what to do next. This allows everyone's voice to be heard.
4. A group or circle – this lets everyone take turns to have their say.
5. Formal conference – a more planned, structured meeting that requires preparation and completion with the 'wrong doer' and an action plan that's put in place for all involved.

It's important to get the facts of the case, which can only come from the people involved. The restorative process opens the door for constructive not destructive conversation. It's a voluntary and confidential process, and you'll need consent from everyone involved for a restorative meeting.

Using the questioning technique that uses an array of open questions, it's possible to step into difficult situations with the ability of calming that situation down. This is called an impromptu – unplanned/unprepared step to take. The facilitator/manager should be impartial throughout the process.

It's often an ongoing process during a young person's stay in residential care. It may be more appropriate for the discussion to take place a week or so after an incident, when the young person is in a calmer state of mind and is showing possible signs of remorse.

Case examples:

Below you'll find three incidents:

- the first two illustrate when the approach was effective with a young person and a group of young people who were willing to engage
- the third shows a negative result when the young person was not ready to engage in the approach.

Case example: 1. Rhian

Action/Behaviour

Rhian was clearly stating that she wouldn't catch an earlier bus from her boyfriend's, which meant she wouldn't be home until midnight. She'd been struggling with her schoolwork recently as she's over tired.

Restorative approach

Social care workers discussed the implications of her late returns and the risks involved of travelling on a bus on her own that late at night.

Positive discussions took place. Rhian wants horse riding lessons and has been promised these if she completes her homework on time each week and gets good grades in her assignments.

Outcome

Rhian returns on an earlier bus. She's less tired and able to focus on her schoolwork. She completes her homework and gets good grades in her assignments.

Rhian now has horse riding lessons once a week.

Case example: 2. Group

Action/Behaviour

Three young people living in a residential home were in constant conflict with each other (verbal altercations were recorded daily).

Restorative approach

Social care workers discussed what they were observing. They sat with the three young people and gave them all a chance to speak. The young people listened and took turns to voice their feelings.

They became defensive during the meeting and the discussions, at times, became quite heated.

Outcome

The young people all came to an agreement that they didn't enjoy living in this volatile environment.

Action plan:

The young people have agreed to try to understand each other's thoughts and feelings.

Social care workers will monitor and sit with the young people to review fortnightly to discuss any ongoing issues.

Case example: 3. Josh

Action/Behaviour

Josh was caught smoking in the home.

Restorative approach

Social care workers tried to use the restorative approach by describing Josh's behaviour and the affect it was having on others.

Outcome

Josh rudely told his social care workers that they can do what they like as he didn't care.

It's a matter of knowing when to take on the approach and knowing when a young person will be more amenable to the discussion.

Restorative approaches teach us to:

- respect others' opinions and learn to value them
- take responsibility for our actions
- repair our relationships with our community
- make sure we don't repeat behaviour
- identify and develop interpersonal skills.
- reduce restrictive practices.

This process empowers and allows people to take responsibility for what happens in their lives. It also lets them make the decisions needed to make their lives better.

4.4. Legislation, policy and practice

There are a number of pieces of legislation and policy that guide those working in social care. The legislation, policy and guidance listed below were up-to-date at the time of publication.

Legislation, policy and guidance common to adults and children and young people

- The Human Rights Act 1998 and the European Convention on Human Rights
- Social Services and Well-Being (Wales) Act 2014
- The Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999
- Reducing Restrictive Practices Framework 2021, Welsh Government
- Code of Professional Practice for Social Care
- Guidance for the Social Care Manager
- Carers Rights and Legislation: Skills for Care
- Health and Care Standards Wales, 2015
- Continuing NHS Health Care Framework for Implementation in Wales, 2014
- Wales Safeguarding Procedures
- Human Rights Framework for Restraint
- The Regulated Services (Service Providers and Responsible Individuals) (Wales) regulations 2017
- Code of Practice on the Delivery of Autism Services 2021

Specific legislation and policy for children and young people

- The Children Act 2004
- Children and Adoption Act 2006
- United Nations Convention on the Rights of the Child
- Children and Young Person Act 2008
- Education and Inspections Act 2006
- The Regulated Services (Service Providers and Responsible Individuals) (Wales) regulations 2017
- The Care Leavers (Wales) Regulations 2015 (legislation.gov.uk)
- Family Justice
- Children's Rights in Wales
- Practice Guidance for the residential childcare worker

Specific legislation and policy for adults

- Mental Health Act 1983 (this is the 1983 Act and shows the 2007 revisions)
- Mental Health Act Code of Practice for Wales (revised 2016)
- Mental Capacity Act 2005
- Mental Capacity (Amendment) Act 2019[16]
- Mental Health (Wales) Measure 2010
- National Outcomes Framework: National Outcomes Framework Indicator Report (gov.wales)

16. The Liberty Protection Safeguards were introduced in the Mental Capacity (Amendment) Act 2019 and will replace the Deprivation of Liberty Safeguards (DoLS) system. Date of implementation of The Liberty Protection Safeguards to be confirmed

4.5. National Occupational Standards (NOS)

NOS are documents that outline how different aspects of a person's work need to be set out. They show effective performance in a job role describing the skills, knowledge and understanding that may be needed to perform particular tasks or work in a certain way.

NOS can be used to give managers and social care workers a recognised good practice framework to guide their work, providing benchmarks against which performance can be objectively and fairly assessed.

The following NOS are relevant for using positive approaches to reduce the use of restrictive practices:

NOS Number	Name
SCDHSC0226	Support individuals who are distressed
SCDHSC0336	Promote positive behaviour
SCDHSC0395	Contribute to addressing situations where there is risk of danger, harm or abuse
SCDHSC0430	Lead practice to reduce and prevent the risk of danger, harm and abuse
SCDLMCB8	Lead and manage provision of care services that supports the development of positive behaviour

4.6. List of recommended units and qualifications to support the use of positive approaches and reduce the need for restrictive practices

There are a number of units in the qualifications for health and social care that can be used to develop knowledge, understanding and skills in relation to the use of positive approaches. The main units have been listed below. You can access them on the Health and Care Learning Wales website.

Unit number	Name	Level
001	Principles and values of health and social care (adults)	2
002	Principles and values of health and social care (children and young people)	2
230	Supporting core practice in health and social care (adults)	2
233	Contributing to the support of individuals living with dementia	2
339	Positive approaches for behaviour support	2/3
330	Promoting core practice in health and social care (adults)	3
333	Promoting support for individuals living with dementia	3
365	Promoting core practice in health and social care (children and young people)	3
421	Leading support for reducing restrictive practices through positive approaches for behaviour	4
422	Leading practice with individuals living with mental ill-health	4
423	Leading practice with individuals living with dementia	4
424	Leading practice with individuals living with a learning disability and/or autism	4
425	Leading practice for disabled children and young people	4
426	Leading practice with children and young people who are looked after	4
490	Legislation, theories and models of person/child-centred practice	4
435	Develop understanding of dementia	4
436	Develop understanding of learning disability and autism	5
527	Lead and manage service provision for children and young people who are looked after	5
528	Lead and manage service provision for disabled children and young people	5
529	Lead and manage support for reducing restrictive practices through positive approaches for behaviour support	5
531	Lead and manage services for individuals living in care home settings	5
532	Lead and manage practice in dementia care	5
533	Lead and manage services for individuals living with mental ill-health	5
534	Lead and manage support for individuals with a learning disability and/or autism	5

Qualifications that support the use of PBS

Provided by Swansea Bay Health Board

- BTEC Level 3 Professional Certificate in Positive Behaviour Support
- BTEC Level 4 Advanced Certificate in Positive Behaviour Support
- BTEC Level 5 Professional Diploma in Positive Behaviour Support

Provided by British Institute of Learning Disability (BILD)

- BTEC Certificate in Positive Behavioural Support (Level 4)
- BTEC diploma Practice Leadership in Positive Behaviour Support (Level 5)

4.7. Useful resources for supporting autistic people

- Autistic Spectrum Disorder information
- Autism services directory
- The National Autistic Society
- Five good communication standards. Reasonable adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings. Royal College of Speech and Language Therapists: Microsoft Word - RCSLT Good standards v 8 Nov 13

4.8. Useful resources for supporting children and young people

- Allen, B (2014) Improving Guidance on Managing Risk and Restraint in Children's Services. Available here.
- Care Forum Wales – Looked After Children Network, 2014 – Charter for Looked After Children and Care Leavers
- Carson, G (2010) How children's home consigned restraint to history.
- Clough, R, Bullock, R, Ward, A (2006) What works in Residential Child Care: A Review of Research Evidence and the Practice Implications: National Children's Bureau, London
- Davidson, J, McCullough, D, Steckley, L, Warren, T (Eds) (2005) Holding Safely: A guide for residential child care practitioners and managers about physically restraining children and young people.
- Hart, D; Howell, S (2004) Report on the use of Physical Intervention across Children's services. National Children's Bureau, London
- Ofsted (2012) Children's views on restraint. Reported by the Children's Rights Director for England. Ofsted. Manchester. Available here.
- Ramsay, S (2010) Restrictive physical intervention and therapeutic holding for children and young people: Guidance for nursing staff. RCN Direct. London
- Steckley, L, Kendrick, A (2005) Physical restraint in residential child care: The experiences of young people and residential workers. In: Childhoods: Children and Youth Emerging and Transforming Society, June 29-July 3 2005, Oslo

4.9. Useful resources for supporting adults and children with a learning disability

- Positive Behavioural Support Resources, PBS Academy
- A Human rights perspective on reducing restrictive practices in intellectual disability and autism, BILD, Edited by Sam Karim
- Physical Interventions A Policy Framework, BILD, Prepared by John Harris, Marion Cornick, Alan Jefferson and Richard Mills
- BILD Code of Practice for minimising the use of restrictive physical interventions: planning, developing and delivering training. A guide for purchasers of training, training organisations and trainers, Fourth Edition, 2014
- Five good communication standards. Reasonable adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings. Royal College of Speech and Language Therapists.
- Think Local Act Personal: New guidance to support integrated and person-centred care for people with health and social care needs
- NICE: Challenging Behaviour and Learning disabilities, preventions and interventions for people with learning disabilities whose behaviour challenges, NICE guideline 11, methods, evidence and recommendations, May 2015
- Positive Monitoring. A method of supporting staff and improving services for people with learning disabilities, Jan Porterfield, BIMH, first published in 1987
- Services for people with learning difficulties and challenging behaviour or mental health needs: 2007, Department of Health
- The Active Support Model – Association for Real Change – supporting excellence.

4.10. Useful resources for supporting people living with dementia

- Good Work Framework: A Dementia Learning and Development Framework for Wales
- Quick Guide to Dementia: key principles of how to work with people with dementia
- All Wales Dementia Pathway of Standards
- Dementia Action Plan for Wales and companion document
- SCIE – Social Care Institute for Excellence (Dementia Resources): Search results for dementia (scie.org.uk)
- Dementia Friends awareness
- Giving Voice for People with Dementia
- Dementia Care Mapping: Approaches based on the work of Professor Tom Kitwood
- This is me
- National Institute of Health and Clinical Excellence (NICE) (2010) Dementia Quality Standards.
- National Institute of Health and Clinical Excellence (NICE) Public Health Intervention Guidance
- Occupational therapy intervention and physical intervention to promote the mental health and well-being of older people in primary care and residential care
- Life Story Work
- Values, Individuals, Perspective, Social (VIPS) tools and resources, University of Worcester
- Guidance for delivering evidence-based psychological therapy in Wales

4.11. Useful resources for supporting recovery in mental health

- Mind – National charity offering advice, information and resources to anyone with a mental health need
- Recovery based care. Recovery approaches are central to mental health care. Recovery means different things to different people and should be guided by the individual. This includes living a way of life that is fulfilling and meaningful within the limits of their mental health condition
- Mental health crisis care: physical restraint in crisis. A report on physical restraint in hospital settings in England. June 2013
- Working with personality disordered offenders A practitioners guide
- The Mental Health (Wales) Measure, 2010, Welsh Government. You can find a link to a range of policies, plans, reports, standards and guidance about mental health here
- Reducing Restrictive Practices: Learning from the collaborative

4.12. Useful resources for supporting people who self-harm

People who self-harm or who are at risk of doing so may need extra reassurance about a service being non-judgemental and confidential, so that their own uncertainty or feelings of shame do not become, in effect, restrictive practices.

- Talk to me 2: Suicide and Self Harm Prevention Strategy for Wales 2015-2020

4.13. Useful resources for supporting the Welsh language

- Using Welsh at Work
- Welsh Government More Than Just Words
- Welsh Language Commisioner

4.14. Useful resources for families

- Wellbeing Resource Pack For Parents and Carers (ysgoltreffynnon.cymru)