POSITIVE APPROACHES:

Reducing Restrictive Practices in Social Care

Version 1, April 2016

Cyngor Gofal Cymru
Care Council for Wales
Hyder mewn Gofal - Confidence in Care

Noddir gan
Lywodraeth Cymru
Sponsored by
Welsh Government

Contact Details

Care Council for Wales, South Gate House, Wood Street, Cardiff, CF10 1EW
Tel: 0300 30 33 444 | Fax: 029 2038 4764 | Minicom: 029 2078 0680
E-mail: info@ccwales.org.uk | www.ccwales.org.uk
ISBN: 978-1-909867-83-3

Further copies and other formats

Further copies of this document are available in large print or other formats if required.

/CareCareersWales @CareCouncil

Contents

Acknowledgements

We want to thank everyone who contributed to the development of this learning 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

Care Forum Wales

Care Forum Wales Looked After Children Network (Woodlands Ltd and Prospects Care)

Care and Social Services Inspectorate in Wales (CSSIW)

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 too. 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. At these times it is important to reflect upon what is happening around us, how we are feeling and what we need to support us to do our jobs to the best of our ability.

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

This will mirror the feelings of those we offer care and support to. Because of their individual circumstances, they too, may at times feel powerless to make any changes to their lives. It is therefore important, whatever the situation, to always treat people with the same compassion, dignity, kindness and understanding that we would expect for our own families and ourselves.

This learning resource has been developed to assist social care workers should they be faced with difficult situations. It provides practical examples of a range of positive and proactive approaches and ways of working that support safe practice, and can reduce the need for restrictive practices. It should be read alongside the *Code of Professional Practice for Social Care*[1] which describes the standards of professional conduct and practice expected of those employed in the social care profession in Wales.

The resource should be worked through over a period of time; although it can be used by social care workers to independently reflect upon their own practice, it is more suited for discussions either in group situations such as team meetings or training sessions or between managers or mentors and social care workers. It is suggested that managers or those using the resource for training become familiar with its contents and select the sections that they feel are most pertinent for the learning and development of the social care workers they are supporting.

[1] Code of Professional Practice for Social Care, Care Council for Wales, 2015.

The resource will help social care workers and those involved in the provision of social care in Wales to:

- understand what is meant by taking a positive and proactive approach
- understand the range of ways people communicate and how this influences their behaviour
- consider ways of working and the impact that these may have on an individual
- 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, 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 ever 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 individual themselves.

The learning resource is underpinned by the core values and principles of practice applicable to all areas of work in social care. These are integrated into the Social Services and Well-being (Wales) Act and can be summarised as:

- People having a voice in and control of their care and support;
- Early intervention and prevention;
- Supporting people to achieve their own well-being;
- Co-production of design and delivery of services; and
- Strong multi agency partnership working.

The core values and principles should be embedded into the culture of every organisation and clearly understood by all.

It is important that organisations develop a culture of learning from incidents, implementing recommendations and good practice and avoiding the attachment of blame when things don't go as planned.

The resource is divided into four Parts to help readers find their way around.

Part 1 - sets out how the resource should be used and provides definitions of what we mean by behaviour that challenges us, together 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 is ordered to match 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 *National Outcomes Framework*.[2] 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 physical interventions and case illustrations of when they should or should not be used.

Part 3 - outlines 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 additional resources that may be useful in practice and in study.

[2] The National Outcomes Framework for people who need care and support and carers who need support, 2014-15, Welsh Government.

Part 1 - Understanding and using the learning resource

Part 1 sets out how the learning resource should be used. 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 which need to be considered if and when restrictive practices are used.

1.1 How the learning resource can be used

The learning resource is relevant to 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 which 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.

The resource uses the terms 'people' and 'individuals' throughout and these refer to both adults and children and young people equally. It is applicable across a wide range of people from cultural and ethnical backgrounds, gender and sexual identity.

The focus of the resource is on enabling and ensuring best practice and contains case examples and scenarios for illustration and reflection. It can be used in supervisions; team discussions; as part of induction; training sessions; appraisals and to inform policy; protocols; audit; quality assurance processes and commissioning specifications. It is suggested that it is worked through over a period of time to support reflection on practice.

Who should use this learning resource

Understanding how to work using positive and proactive approaches and reduce the use of restrictive practices is the responsibility of everyone who works in social care.

Although this learning resource is aimed specifically at social care workers, it also has direct relevance to people who use services and their families, as well as managers; employers; policy makers; commissioners; those in education and others who work in the community, including primary care and the emergency services.

It can be used on an individual level or in group learning situations, such as team meetings and training sessions. There are a number of case studies across a range of service areas that will help support reflection and discussion, learning from these can be applied regardless of where you work.

Social care workers

The resource will help us to:

- 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 upon and improve our practice and contribute to our ongoing learning and professional development
- reflect upon how our decisions can impact upon the balance of power between us and the individuals who 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 to aid and inform induction
- supervision, team discussions, training sessions and appraisals
- providing a tool that can help social care workers to understand what is expected of them
- providing guidance that can inform recruitment processes
- providing guidance to inform the development of policy, procedures, audit and quality assurance processes
- providing a tool that is a benchmark for existing practice
- providing a tool that can produce evidence for relevant Care and Social Services Inspectorate Wales (CSSIW) Standards.

People who use services and their families

The resource can help by:

- providing guidance on what people should expect from social care services
- providing case studies that can be used to reflect upon how support is offered
- providing case studies that can be used to challenge and change ways of working
- providing case studies that can be used to reflect upon own behaviour.

1.2 Core values and principles of practice

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

These have been integrated into the *Social Services and Well-being (Wales) Act* (the Act) which became law in 2014 with implementation from April 2016.

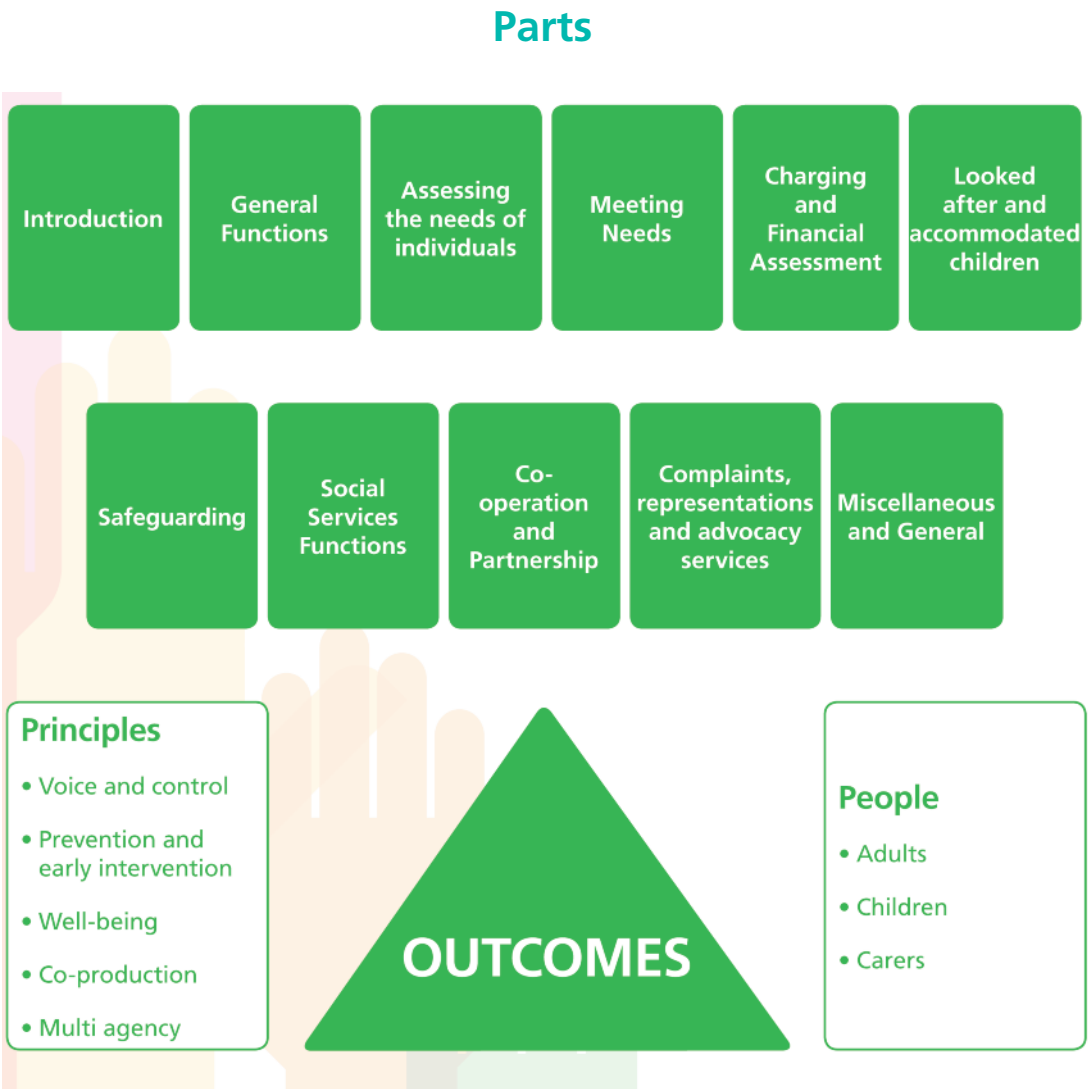
The Act covers adults (people over the age of 18), children (people under the age of 18) and carers (adults or children who provide or intend to provide care and support).

The Act modernises and brings together lots of different pieces of social care law into one simplified legal framework which consists of three elements: The Act itself, which is already in place; The Regulations (which provide greater detail on the requirements of the Act) and the Codes of Practice (which give practical guidance on how it should be implemented).

Within the Act there are Parts, Principles and People it affects.

It is useful to think of these as the '3 P's':

- People it affects
- Parts within the Act
- Principles throughout the Act.



The Act is built on a series of core principles and values. These are important as they underpin not only how services will be delivered in the future, but how we work with individuals on a day to day basis.

The core principles and values are:

- putting an individual and their needs at the centre of their care, and having a voice in, and control over reaching the outcomes that 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
- supporting individuals to achieve their own well-being in every part of their lives
- involving people in the design and delivery of services recognising the knowledge and expertise they can bring
- strong partnership working between all agencies and organisations is essential to improve the well-being of individuals 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 the statements of expectation of social care workers, outlined in the *Code of Professional Practice for Social Care*.[3]

[3] Code of Professional Practice for Social Care, Care Council for Wales, 2015

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 an individual
- 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 impact of their environment 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 which outline an individual's needs, desired well-being outcomes and the ways that they will be supported to achieve these.

Developing good relationships is fundamental, and positive and proactive approaches should be used at all times. They are essential when someone is stressed; distressed; frightened; anxious or angry and at risk of behaving in such a way that is challenging to their safety and/or to the safety of others.

Behaviours that challenge can prevent individuals from participating in social and learning opportunities and activities that they enjoy. The case example of Alice demonstrates the importance of taking a proactive approach such as Active Support and the impact that this has on the individual and those around them.

Case example: Alice

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

An assessment was completed to understand why. This showed that her behaviour occurred mostly when she was unoccupied.

Workers were trained in the Active Support Model to increase her 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 individual and their support systems to:

- try to understand what someone is feeling and why they are responding in the way they are
- where possible, undertake any required changes and intervene at an early stage to try to prevent difficult situations at all
- understand what needs to be planned and put into place to support the individual to 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 essentially requires social care workers:

- to have a positive attitude towards the people they support
- to have the right skills and knowledge
- who are well trained
- supported through 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 upon how an individual feels and behaves.

These could include:

- making changes to an individual's environment or living space such as the colour of the walls
- avoiding any sudden change or changes in routine
- using aromas to help someone to settle (for example in the bath before settling for bed)
- having calming music/or any music that an individual may like or need
- offering opportunities to engage 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. As a consequence she was often unable to get to sleep and 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 engage with activities that she enjoyed.

There are a number of frameworks and models to support the use of positive approaches and the reduction of restrictive practices. Their use will differ according to service setting, but these 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 of how to positively interact with individuals combined with a daily planning system that promotes participation and enhances quality of life and the development of independent living skills.
- **Restorative Approaches** allows an individual to reflect on their behaviour and provides an opportunity to put what has happened right or empathise with others' emotions and feelings. It aims to manage conflict and tensions by repairing harm and building relationships.

Part 4 contains a more detailed description of each of the frameworks / approaches and how they can be used.

What do we mean by behaviour that challenges us?

There are a number of definitions of the term 'behaviour that challenges us' or 'challenging behaviour', some of these focus upon the seriousness of the behaviour, the length of time it goes on for, and the risks that it presents to the individual, family, social care workers or others.

How we recognise and support people with behaviour that challenges can vary depending upon the frequency, severity, intensity and presenting risks of that behaviour. It may also be dependent upon how the behaviour in question affects us or others around us. This may differ, as one social care worker may not mind being asked the same question repeatedly by an individual, whilst their colleague may find it difficult and stressful and as a result may try to avoid spending time with them.

Behaviour that challenges may include behaviours that are: aggressive; anti-social; disruptive; isolating, such as withdrawal; repetitive; obsessive; verbally abusive and put the physical safety of the individual or others in serious jeopardy or are likely to seriously limit the individual's use of ordinary community facilities.[4]

You will have your own examples but some of these behaviours could be:

- swearing
- threatening
- grabbing, scratching, biting and pinching
- spitting
- shouting or screaming for long periods of time
- sexually disinhibited behaviour such as: exposing genitals, removing clothing and making sexual comments and gestures
- wandering
- banging of the head
- asking repetitive questions.

Attempting to understand the meaning of such behaviour and what the individual is trying to communicate is important.

This may not always be possible straight away as the situation may need an immediate response to keep the individual or others safe. However, reflection and discussion with family members, close colleagues and multi-disciplinary team members after the event or incident will help us develop a better understanding.

[4] SCDLMCB8 Lead and mange provision of care services that support the development of positive behaviour

The learning resource explores ways of understanding behaviour in Part 2 but in the meantime; consider the case study of Aabdar below. In this example, we are offered one explanation for his behaviour, there may be others.

Case study: Aabdar

When reading the case study of Aabdar below, please reflect upon your own experiences and consider:

- **Why Aabdar might be behaving this way, and**
- **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 recognised a pattern to his behaviour; they spoke to Aabdar and consulted with his community learning disabilities nurse. They realised that he was experiencing severe headaches and the banging was an attempt to manage the pain.

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

1.4 What we mean by 'restrictive practices'

Restrictive practices

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

They should be understood as part of a continuum, 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.

Whilst considering what we mean by restrictive practices, it is important that we understand how to work using positive and proactive approaches to reduce their use.

Case study: Megan

The case study of Megan shows how people are sometimes prevented from doing or having things that 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 term history of making herself physically unwell with caffeine overdoses, resulting in numerous admissions into hospital.

She 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 drink caffeine free drinks.

Initially in her new home, it was not safe to introduce her into the kitchen to make drinks as she became very stressed and aggressive when not able to access the jars of coffee and teabags that were freely available.

Social care workers have now made gradual progress with her; she is accessing the kitchen with support and is able to make her own drinks using sachets of coffee rather than coffee from a jar.

There are occasional blips, where there is a breakdown in communications between herself and a social care worker, but generally this is working well. She is able to make herself drinks, which is important to her, and to keep physically well too, which is important for her.

Case example: John

John, a young man with autism and obsessive compulsive disorder, 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 individuals they support they should report their concerns immediately to senior staff within the organisation or follow the organisation's whistleblowing policy.

Introduction to restrictive interventions

Restrictive interventions are part of the continuum of restrictive practices and unless part of an agreed behaviour support plan, should only ever 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.

Restrictive interventions can be a useful way to help an individual learn to manage their behaviour, when their use is planned and reviewed appropriately. However they can pose a risk to an individual'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 restrictive interventions are used in an emergency, or if an individual is going to seriously harm themselves or others, they should always:

- be used for no longer than necessary
- be proportionate to the risks and the least restrictive option
- be legally and ethically justifiable
- be well thought through and considered when all other options have been tried or are impractical
- be made in a manner transparent to all, with clear lines of accountability in place
- be openly acknowledged and never hidden
- be determined by local policy and procedures
- be recorded appropriately
- be monitored, planned and reviewed to find a more positive alternative on a longer term basis
- include debriefing and support offered to all involved.

Restrictive interventions, other than those used in an emergency, should always be planned in advance and agreed by a multi-disciplinary team and wherever possible, the individual, and included in their behaviour support or behaviour management plan. They should always be recorded in an individual's care plan.

The definitions of the range of restrictive interventions and case illustrations of when they should or should not be used can be found in Part 2 of the resource.

Legislative framework and guidance

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

There may be some instances when an individual is distressed; anxious; ill; angry; confused or 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 and remember that you should never make a decision to restrict anyone on your own other than in exceptional circumstances which constitute 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.

The example of Billy highlights the circumstances where the decision to use a restrictive intervention in an emergency, is appropriate. However, restrictive interventions should only be used in one off situations and should not become common practice, unless it is part of an individual's care and support plan.

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

Part 4 provides more information about key legislation and national guidance. These should be reflected in the local guidance and policies and procedures that you are expected to follow where you work.

How to identify when a practice is a restrictive practice

The following brief scenarios are illustrations of situations that social care workers may find themselves in. The scenarios cover a wide 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 do not work alone, and any decision made to restrict an individual should be based upon discussions with others; including the individual themselves and their families and those who know them well.

When reading the scenarios please think about your own work experiences and consider the following questions, it will be helpful to discuss and debate these within your team and with your manager:

- What type of restrictive practice do you think has been used?
- Do you think that the use of the restrictive practice was intentional or non- intentional?
- Do you think that 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 cannot 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 whilst he is being supported with his personal care. He is without them until lunchtime.
Scenario 3	A young man with mild/moderate learning disabilities is out on a group trip to Thorpe Park. His case history indicates infantile and pre-school seizures, although he has not experienced anything recently. The group leader decides he is not allowed on any of the 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 turns the television over whilst saying "John, shall we watch EastEnders?" John uses symbols for communication and did not understand the verbal question. John starts to become 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 will be suspended if he facilitates this, on grounds of "Health and Safety".
Scenario 8	A young woman living in a residential children's home has been prescribed a new contraceptive pill. She is promiscuous and at risk of having an unwanted pregnancy. She is grounded by her social care worker until she agrees to take it.

Scenario 9	A young man with autism is physically restrained by three social care workers following an incident where he bit and scratched a member of his care team.
Scenario 10	Social care workers in a residential care home switch off the television in the communal lounge at 10.30pm to encourage people living there to go to bed.
Scenario 11	Social care workers realise that a resident in their nursing home is now 'informal' as his Mental Health Act paperwork has 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 has 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 is not able to get up from the floor and has therefore stopped wandering.
Scenario 14	Bedroom doors are routinely locked to stop people going back to bed in the day.
Scenario 15	A young person with Autistic Spectrum Condition uses a Picture Exchange Communication System (PECS) communication book. The staff supporting him to get ready for school cannot find the PECS book and the young person goes off to school without it. The young person is very unsettled all day and cannot make his needs known. This resulted 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 have developed a range of case examples and case studies to help you think about what you can do or should consider 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 on a daily basis, but some of it may be completely new to you. When reading the case examples and case studies, it would be useful to reflect upon any similar situations you have encountered and how the approaches used could be transferred to your own workplace.

The content has been divided into smaller sections using headings based upon the values and principles which 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

These sections have also been mapped to the relevant wellbeing statements taken from the *National Outcomes Framework*,[5] which describe what people expect from care and support services to achieve well-being and lead fulfilling lives.

[5] The national outcomes framework for people who need care and support and carers who need support, 2014-15, Welsh Government.

2.1 Voice and Control

Not being listened to or feeling that you do not have a say or any control over what is happening to you, can be a frightening and distressing experience. Ensuring that social care workers are able to fully listen to individuals and their families and carers and enabling them to have the maximum control over their lives and support systems, is central 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 any restrictions it is important to try and understand the meaning behind their behaviour.

It may help to imagine yourself in the same situation as those you are 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 an individual'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 is important to keep an open mind. There are a range of factors but all of them relate to not having control over one's situation.

Behaviour can

- serve an important function for an individual, for example hitting out to stop someone doing something that 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 an individual's actions
- be influenced by an individual'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 need
  - demands
  - change
  - transitions
  - recent significant events such as 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 at the end of contact by his parents. Each time, he refuses to get out of the car and gets very upset and agitated.

The foster carers suggest that they start to meet him with his parents for handover at a neutral venue.

As a result, Shane is now happy to go back home with his foster carers and does not get agitated.

Case study: Sarah

When reading the following case example of Sarah

- Try to put yourself in her shoes and think about why she might be behaving as she is during the night; and
- Consider whether 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 that 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 does not respond. The social care worker removes the mat for washing and cleans the floor.

She leaves Sarah in her room whilst she supports Menna to make her bed.

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

Sarah has virtually no sight without her glasses.

We will pick up on Sarah's story again later in this section.

Listening and supporting communication / expression

Understanding the way that an individual communicates and responds to them appropriately is essential to supporting people to have a voice and ensuring that they are heard.

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

- asking people what they want in a way that they are best able to understand, taking into consideration their preferred language and communication styles
- listening carefully and actively giving people your full attention
- using non-verbal communication techniques such as gestures, facial expressions and written communication including images, pictures, symbols
- always making plenty of time for the individual, 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 that you are able to 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" but being supportive and encouraging
- drawing upon the knowledge and experience of others who know the individual well
- using the individual's past experiences and life story to support communication
- understanding how an individual's condition, such as a response to an acute illness, infection, substance misuse or feelings affect the way they communicate
- making sure that there is a detailed description of how best to communicate with individuals in their records which is easily available.[6]

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

It is important that where an individual has limited or no verbal communication skills, that everyone involved in their lives work together to understand their behaviour.

Case example: Lucy

Lucy is 16 years-old; she stays at residential short breaks two days each month – usually mid-week.

Lucy has autism and does not have any verbal communication. She has become increasingly agitated over the past three months and on the most recent visit, this 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 is little direct contact with her parents.

At the meeting, it is established 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. However, 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 following case study of Mr Thomas and Cerys consider:

- What difference do you think there may have been in Cerys' approach as a result of her knowing that Mr Thomas had been her head teacher?
- How do you think this might that have impacted upon his behaviour?
- How do you think that the way that we value and perceive people has an impact on the way that they behave?

Mr Thomas lives in a small flat in apartments overlooking the sea. Little was known about him because he is confused and will not speak to the social care workers. However, it was understood he and his wife had moved to the area recently and that she had cared for him until she died suddenly two months previously.

The couple did not have any known family or visitors and those neighbours who did recognise him had never spoken to him.

Mr Thomas' care 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 had been 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 had been communicative and pleasant during the twenty minute visit and had agreed to let her assist him to shave.

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

She asked Cerys to describe exactly what had happened during the visit. This did not 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 to identify triggers to their behaviour and allow changes to be made to prevent recurrences.

Case study: Sarah

We are using the story of Sarah to show how a different approach by a social care worker, meant that the she was able to talk about what was worrying her during the night and how making simple and achievable changes helped Sarah

- How do you think that the social care worker helped Sarah to 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 that her mat is soaking wet.

She tells Sarah not to worry about it and asks her to get the mop and bucket so that 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 to clean up.

She suggests that they sit down and have a cup of tea and whilst they are 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 that she is afraid of the dark.

The social care worker asks if she would like her bedroom lamp left on, she 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 maximise decision making and control over their lives in safe ways

Providing access to independent up to date information, advice and advocacy is essential to enabling people and their families and carers to exercise choice and control, and maximise their opportunity and ability to make their own decisions, however small.

Social care workers must always presume that an individual has the capacity to make decisions for themselves. If there are any concerns about an individual's capacity this needs to be discussed within the wider team and plans put in place using relevant legislation such as the Mental Capacity Act 2007 and the Children Act 2004.

When supporting people to make decisions, we should always start by asking them what support they need if any. It is useful to consider all or some of these:

- providing accessible advice and information in a format and communication style of the individual's choice
- supporting the individual to 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 is possible, even the smallest decision is important to maintaining dignity and will enable the individual to feel involved and in control of their own lives
- making sure that there is enough time to allow people to be fully involved in any decision making process
- involving a family member, friend or advocate, if appropriate
- using any risk assessment positively to work with the individual 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 an individual 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 individual and, where relevant, their families and support networks.

Case study: Chelsea

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

- Do you think that Chelsea should 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 as a result of his inappropriate behaviours. This has to be supervised by her social care workers as he often tries to give her cigarettes and on one occasion has 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 enable individuals to deal with situations that they find difficult, and prevent them 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 that we can miss the traffic, or packing an extra snack for a child who is always hungry when they finish school and consequently badly behaved.

Early intervention therefore depends upon knowing people, their trigger points and enabling them to 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

There are many things that affect the way that we behave: 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 and what we eat to name but a few.

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

Case study: Tareeq

Consider the case study of Tareeq and think about:

- **Changes that could be made to his existing home environment to help him whilst he waits for the move to his new home.**
- **Other factors that should be considered in Tareeq's circumstances.**

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

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

He is 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 thinking about early intervention and prevention, you may also want to consider 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 that they might find distressing or anxiety provoking such as:
  - a visit to the doctor or dentist
  - going on holiday
  - contact with family, or
  - a change of social care worker
- changing the environment in which an individual lives or spends time, to meet their needs
- supporting people to participate 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 assist people to develop skills to increase independence and their ability to cope.

Case example: Crystal

Crystal 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.

Crystal 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 during the week before, she is aggressive, abusive and is involved in a number of violent incidents that result in restrictive physical interventions.

As a result of gaining this understanding; Crystal's social care workers are able to assist her with coping strategies in the run up to her siblings' birthdays; frequently checking out how she is feeling; encouraging her to leave the room if she starts feeling upset and agitated and also writing a journal.

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

Over time Crystal's level of agitation and the use of physical restrictive interventions during this period of the year has reduced significantly.

2.3 **Well-being**

The core purpose of all care and support is to help people to achieve the outcomes that matter to them in their life. In doing so we must all promote an individual's well-being when carrying out any of their care and support functions.

Well-being is a broad concept including:

- 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, and
- securing rights and entitlements.[7]

It might help to understand what it means by thinking about the things that contribute to your well-being in your life. It could be seeing your friends and family when you want to; 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 of course applies particularly to each individual.

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 participate
- I am safe and protected from abuse and neglect

[7] Code of Professional Practice for Social Care, Care Council for Wales, 2015.

Person centred practice

The principles of person centred practice ensure that social care workers focus upon enabling people to achieve the goals and aspirations that have an impact upon their well-being.

Person centred practices are those that recognise the uniqueness of the individual and use this as the basis for the planning and delivery of care and support.[8]

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

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

[8] National Occupational Standards for Health and Social Care.

Case example: Nia

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

Now ten years after the accident, she has moved again to a new residential home for people with Acquired Brain Injury (ABI). She is unable to weight bear and is no longer able to communicate her wishes easily.

Whilst she enjoys having her hair done and wearing fashionable clothes and make-up, she will not 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 spits.

Although she is very upset during all personal care, she is less agitated with some workers.

The management team, who were updating her risk assessment and behaviour support plan, began a close analysis of 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 her and found some had hardly any issues but others were afraid of her; some could understand what she was communicating whereas others said she could not communicate at all.

Following a detailed investigation, changes were made to training, the rotas, team / shift balance and a communication profile developed.

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

Case study: Mrs Gupta

Consider Mrs Gupta.

- What do you think the key issues may be here 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 has advanced, she has reverted to only understanding and speaking Gujarati.

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

Active participation; engagement / involvement and 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'[9]

Having the opportunity to do the things that we enjoy, be engaged in meaningful activities and have good social relationships is important to all of us. 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 participate in all aspects of their lives when they need some assistance to do this.

Feeling that we are in control of our life and situation has a massive impact on our behaviour. It is when this is not the case that 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 much more likely that we will achieve our goals and be satisfied with the quality of our lives.

As well as support to participate and engage in the activities that individuals have identified as important to them, it is important to ensure they are involved as much as possible in any meetings and reviews that concern their lives.

There are many ways to do this and the methods used will depend upon the preferences, communication needs and circumstances of each individual.

[9] National Occupational Standards and Code of Professional Practice for Social Care, 2015.

Case study: Elizabeth

The following case study illustrates the importance of enabling people to feel engaged and in control of what is happening around them. As you read the two versions of Elizabeth's Person Centred Planning (PCP) meetings reflect:

- upon the pros and cons of each of the methods used, and
- the impact of each of these on Elizabeth.

Elizabeth is 60 years old. She has lived in supported living accommodation for the past twenty years. Prior to 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 have supported her over the years. She also has regular contact with her family – three younger siblings and their children.

Version one

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

Friends that she had lived with in the institution have never been invited as it is assumed they will not 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. Plans are usually then 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

Elizabeth has a key worker, each year, at the time of her PCP review; they go out for coffee and talk about what she has done over the last year, what she has enjoyed, and what has worked well and not so well.

They talk about what is important to her and start thinking about what she would like to continue doing; as well as new activities that she may want to try. They carry on with this conversation over the next couple of weeks and work out the type of support that she would need to do these.

They arrange a tea time meeting with her family and talk about her plans and how they may be able to support her with some of these. 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 of 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 that she is happy with the contents.

At regular intervals throughout the year, they have a chat to review how well the plan is working and make adjustments where these are needed.

When planning how to involve individuals in meetings that concern their lives, to maximise their participation it is important to think about the following:

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

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 do not and cannot live in a world that is free from any risk or harm and it is important that we are all able to 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 an individual's behaviour to safeguard an individual's welfare. The case studies in this section will help to explore this.

Case study: Ffion

Consider the situation that the social care team is facing with Ffion:

- **Do you think that 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 a 15 year old young person living in a two bedded children's home which is located in a medium size market town. She has lived there for six months and is keen to make the most of her last year in school where it is thought she has the potential to do well in her GCSEs.

Approximately six weeks ago Ffion told staff she now had a boyfriend who she had 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 would like to meet him. However, 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 had told them that her boyfriend was actually 31 years old and that she was having fun hanging out with him and his mates. This information raised the concerns of the social care workers who made further attempts to discuss this with Ffion but without success. One evening it was decided that staff would follow her when she went out and after a short walk away from the home 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 these concerns. It was agreed to monitor the situation while the police made enquiries based on the information staff had now gathered about the man she was seeing including the registration number of the car. In the meantime staff continued to try and engage Ffion in discussion about the need to keep herself safe.

Ffion eventually admitted that her boyfriend was older than her but insisted that 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 continued to become more distant from staff and refusing any offers of advice or guidance. She insisted that she had never been happier as well as declining the suggestion that she at least spends two evenings in and that her boyfriend visit her at the home.

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

This leads to her becoming very challenging both verbally and physically which on occasions results in her being held. The social care workers are now concerned about the frequency of the physical confrontations each time they attempt to prevent Ffion from leaving the home and the distress this is causing her.

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

Case study: Mike

Consider Mike's situation below and think about:

- What you would want if you were in Mike's position, and
- What you would 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 has led to frequent admissions to hospital, sometimes under the Mental Health Act 2007. He has also been reluctant to take his medication which has resulted in further breakdowns and admissions to hospital.

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

Shortly after moving there, Mike started drinking again, returning home late at night or in the early hours of the morning; apparently intoxicated. He was unable to take his prescribed medication when he had been drinking as it caused some side effects and as a result his mental health deteriorated.

The situation was discussed with Mike, the residential service team and Mike's care co-ordinator. Mike recognised that the situation was getting worse and agreed a plan, intended to help him manage better. He had capacity and was certain that he did not want to return to hospital.

While the social care team are not in a position to prevent him from going out or drinking, Mike did agree that if he was out, he would ring in 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 pattern of returning home by 11pm. As part of the care plan, he also agreed to take a breathalyser test to check whether 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 was able to see that his life was becoming more under his control 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, and although staff thought he may have been drinking, the breathalyser test was negative and he was able to take his medication. This was important in building trust between Mike and the team.

The care team were unable to say that Mike couldn't leave the residential facility or control his access to alcohol or drugs. However, 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 had considerably reduced and he had developed a different attitude to taking medication.

He has now moved into his own flat with support from social care workers.

Case study: Jillian

When reading the following case study consider:

- Why you think that Jillian has started self-harming?
- What advice would you seek and who from?
- What are the underlying issues that may help us to 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 allowed to carry her own money?

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

During her time at the residential children's home she began to self-harm and on one occasion was taken into hospital following an attempt to end her life. This involved taking a large amount of paracetamol tablets, which she purchased out of her own pocket money.

As a consequence she is now being supervised when out in the community including how 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 equal partnerships between people, families, carers and professionals whereby everybody works together on an equal basis to create a service or come to a decision which works for them all. It is built on the principle that those who use a service know what works, so are best placed to help design it.[10]

People expect the following from their care and support:

- I can engage and participate
- I feel valued in society

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

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

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

It is important to ensure that people are supported to engage constructively in the process as equal partners and that a range of methods are used to facilitate this. Part 2 provides some suggestions.

[10] Think Local Act Personal: Ten top tips for coproduction: http://www.thinklocalactpersonal.org.uk/_library/COPRODUCTION/1_page_profile_for_coproduction_2.pdf

Case study: Jane

Whist reading Jane's story consider:

- **What might have happened if neither she nor her mother were so actively involved in planning her services?**
- **The impact that this has had on Jane's quality of life and that of her family?**

Jane a young woman of 23 was referred to her local Community Learning Disability Team (CLDT).

Jane, who has Down's Syndrome, was bored at home. She was continuously over eating 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 that she 'didn't like them, and didn't want to go there'.

The social care worker discovered from discussions with Jane and her mum; that she liked art, and was good at colouring and painting.

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

Three years on, she 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 has also started going out with Mavis from the keep fit class a few days each week to walk her dog with her.

The family have short breaks while Jane is at 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 has stopped over eating and is losing weight and has a better relationship with her parents.

2.5 Multi agency / partnership / collaboration and consistent approaches

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

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

People expect the following 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 prevent people becoming confused, anxious and distressed. It can be very 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 there needs to be:

- trust between all of those involved in the person's care and support
- a good understanding of each other's roles, responsibilities
- a clear expectation that people will understand their rights, how information sharing works and how they can have a say in what is shared between professionals and where appropriate, families and carers
- plans, agreed with individuals, family members or those who know the individual well and with members of the multi-disciplinary team
- coordinated support which includes details of:
  - information sharing processes
  - clear channels of communication
  - outcomes of assessment including risk assessments
  - any discharge and transition plans
  - crisis plans and advanced directives
  - behaviour support plans

- regular and routine use of individualised communication tools for example: 'This is me' and hospital passports for when someone needs an admission to a general hospital.

We are all pieces of a jigsaw puzzle that should fit together to provide a whole picture with the individual as the central piece.

Consistent approaches

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

Offering consistent support is essential so that people can get to know and trust the workers caring for them and they in turn are aware of and able to implement any approaches or techniques that have been planned to avoid difficult situations and the need for restrictions.

Case study: Dave

Consider Dave's situation:

- What do you think helped Dave to make his decisions?
- Why do you think that 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 52 year old man with a long history of mental illness, leading to lengthy hospital admissions. Following 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 is currently not working, he is dependent on benefits which are paid regularly into his bank account. However, once they have been paid, Dave withdraws the whole amount and visits a long standing lady friend, returning penniless.

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

He also approaches staff for money and for loans from petty cash and has 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 are unwise. They have no power to prevent him from what he is doing.

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

Together with Dave, they agree on a plan in which he continues to see his friend, but gives her a smaller amount of money. This means Dave does not need to pester people or beg, and has some money left to buy food for meals which 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 phoning him on his mobile phone. When Dave does not 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 wide range of activities that stop individuals from doing things that they want to do or encourages them do things that they don't want to do. They can be very obvious or very subtle.

They should be understood as part of a continuum, 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 continuum of restrictive practices and unless part of an agreed behaviour support plan, should only ever 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.

Restrictive interventions can be a useful way to help an individual learn to manage their behaviour, when their use is planned and reviewed appropriately. However they can pose a risk to an individual'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 restrictive interventions are used in an emergency, or if an individual is going to seriously harm themselves or others, they should always:

- be used for no longer than necessary
- be proportionate to the risks and the least restrictive option
- be legally and ethically justifiable
- be well thought through and considered when all other options have been tried or are impractical
- be made in a manner transparent to all, with clear lines of accountability in place
- be openly acknowledged and never hidden
- never be used as a punishment or for the sole intention of inflicting pain, suffering, humiliation or to achieve compliance
- be determined by local policy and procedures
- be recorded appropriately
- be monitored, planned and reviewed to find a more positive alternative on a longer term basis
- include debriefing and support offered to all involved.

Restrictive interventions can take a number of forms and these are described below with case scenarios to illustrate when the intervention could be used and when it should not. When reading through each scenario, try to relate the situations to your own experiences.

2.7 Definitions and examples of restrictive interventions

These can be understood as a broad set of techniques which can be known as reactive strategies. These include the use of distraction; diffusion; breakaway techniques and safe holding. They are only intended to establish rapid and safe control over behaviours that can cause danger.[11]

Physical restraint

Physical restraint is defined by the Welsh Assembly 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'[12]

When it is appropriate to use a physical restraint

Halina loves sunglasses, and when out with social care workers she will often attempt 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 are not quick enough.

On these occasions, they link arms with Halina and move her gently away to stop her from grabbing glasses.

When it is not appropriate to use a physical restraint

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

She is 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 at home where she was happy. She says she feels as though she is 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 sixty years ago not the one she lives in now.

She does not 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 thirty 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 that they have abandoned her and that she never sees them. Some children visit her; they are very young; she often thinks her great granddaughter is her daughter.

Every night two social care workers come to put her 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 is 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 whilst the other strips her lower half and gives her a good wash down below.

[11] Guidance on the use of Physical Interventions: Directorate of Learning Disability Services; 2013.
[12] Framework for Restrictive Physical Intervention Policy and Practice: Welsh Assembly Government, 2005.

Mechanical restraint

Mechanical restraint can be described as the:

'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'[13]

Examples of mechanical restraint might include: the use of arm splints; cushioned helmets; wheelchair lap straps and the misuse of mobility aids, such as sliding sheets and handling belts or raised bed sides.

When it is appropriate to use a mechanical restraint

Ajay has a tendency to get out of his seatbelt when travelling in the car and 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 it was agreed that a safety harness could be used but the team were to gradually introduce this to Ajay as well as using the normal seatbelt.

The harness was purchased and Ajay has used it with no problems over the past 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.

This was tested and as Ajay will now wear the normal seatbelt without removing it, the harness is no longer required.

When it is not appropriate to use a mechanical restraint

Amy has limited mobility but is able to walk with assistance. Whilst at the day centre she is required to wear a wheelchair lap strap to prevent her getting up and walking around the room as there are not enough social care workers on duty to assist her. Amy is losing her mobility as a result of this.

[13] 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'[14]

Examples include the use of medication: as required medication, rapid tranquilisation, long term tranquilisation and sleeping tablets.

When it is 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 has started refusing food and doesn't want to drink as it is so painful.

She won't open her mouth to allow anyone to look at her teeth not even her daughter who visits regularly.

A best interest meeting was held with her family, the care team and her GP. Those attending the meeting agreed that it was in Mrs Adeyemi's best interest to be prescribed sedation to be administered prior to the visit from a dentist so that they can extract her broken tooth.

When it is not appropriate to use medication as a restraint

Griff is a twelve year old boy with a mild learning disability, who attends his local leisure project. When he is there he is always tired, listless, and lacking any focus on the activities available, including things that he enjoys.

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 that Griff has Attention Deficit Hyperactivity Disorder (ADHD) and had been utterly uncontrollable at home until the GP prescribed Ritalin. She said that the original dose had not made much difference, so she had raised the dose. She had 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 that she revert to the original Ritalin dose for Griff on the days he attended the project.

Mum did this, a bit reluctantly, and was prescribed medical help with sleeping, offered counselling for her depression and other 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 completely stopped.

He is now a happy and well-mannered twenty year old in college studying carpentry.

[14] Ibid

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'.[15]

It is important that any sanctions used are appropriate and are directly relevant to the specific unwanted behaviour. They should be used as a short term response to negative behaviours and part of a longer term process to help the individual understand the impact of their behaviour and why it might be unacceptable or dangerous.

Sanctions should not be given in the heat of the moment; the social care worker needs to be able to reflect on an appropriate sanction and discuss with colleagues and / or their manager. They should be imposed within a reasonably short time after the event.

When it is appropriate to use sanctions

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

Kelly has a history of getting drunk, she is a vulnerable young person and this puts her safety at risk. It has 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' i.e. not allowed to engage in any social activities with her friends. The extent of the 'grounding' depends on the extent of her behaviour.

On one occasion Kelly drank too much and failed to return to the home. She did not answer her telephone 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 tried to grab the steering wheel causing the social care worker to swerve. The behaviour continued when she got back home, and she took several hours to calm down and go to bed. As a result of the extent of her behaviour, she was grounded for seven days.

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

On a following occasion, she was out with friends and got drunk again but this time she called up the house asking to be picked up. She was collected by two social care workers. Kelly was crying and upset 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 that this would be reduced to one day, if her attitude to what had happened continued to be positive.

[15] 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 is 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 all of the way through the house.

Lloyd is feeling really grumpy and tells the worker to …. off. The worker immediately gives him twenty lines 'I must not swear' as a sanction, this annoys Lloyd and he continues swearing; the number of lines is increased to one hundred and then two hundred.

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

Lloyd responds by smashing a cup and is told that 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 an individual to a quiet or different area, when they are upset or are being agitated by others or the environment, can be a good strategy, if the individual has the ability and skills to calm themselves. This offers the opportunity for them to regain control in an area where they can be quiet, calm down and where possible think about what has happened. It will also prevent the situation from escalating.

Time out or time away does not mean isolation and banishment. The individual should be supported in a quiet area with a calm and caring social care worker.

When it is 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 have recognised that when the environment becomes too noisy or busy Geraint starts "flapping" his hands and biting them. This frequently leads to him starting to bang his head on the floor.

At a meeting to review the Positive Behaviour Support plan, it was agreed that when Geraint starts to flap his hands, he will be provided with a symbol offering the quiet room and he is supported to leave the noisy environment and go to the quiet area to calm down and regain control.

When it is 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 into the quiet room and shut the door leaving him on his own to calm down.

Environmental Interventions

Environmental restraints describe changes or modifications to an individual's surroundings to restrict or control movement; for example, a locked door or handles placed out of reach of residents.

When it is 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 allow them to take their relatives for a walk.

Mr Jones, who has dementia, was one of the residents who liked to wander both during the day and night time. It was not felt that he had capacity so was not given a fob. When he asked to leave, a social care worker would try to accompany him for a walk, but this was not 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 is not appropriate to use environmental interventions

Mr Jones lives in a residential care home. He likes to sit outside in the garden. The social care workers are concerned that as he has dementia, it is too risky to let him do this on his own. His entrance and exit to the building were restricted by the installation of baffle locks: i.e. handles at different heights on the doors turning in different directions to prevent people with confusion from leaving.

This amounted to a defacto detention, even though the majority of the residents expressed no desire to leave the premises.

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 as a result of:

- a lack of a coherent person centred assessment of an individual and their behaviour and needs
- a lack of effective leadership and understanding of positive and preventative approaches
- a of training and opportunities to develop an understanding of positive approaches
- an organisational culture which is 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 provision of positive and proactive services.

3.1 Supervision

Supervision is essential to the ongoing support and training of social care workers to enable them to 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 individual social care workers. It is a way of regularly monitoring an individual's performance, setting targets, checking workloads and responsibilities, celebrating success and achievement, and highlighting any development needs.[16]

More importantly supervision is an opportunity for essential reflection on practice and any feelings that are brought up.

Supervision should be:

- used to support positive practice
- prioritised, with protected time for it to happen and in a quiet place with no opportunity for interruptions
- regular, planned in advance but also available informally when needed
- high quality, undertaken by someone who has been trained to provide supervision, including specialists as required
- structured around a shared agreed agenda.

[16] Supervising and Appraising Well, A Guide to Effective Supervision and Appraisal for those working in Social Care: Care Council for Wales, 2012.

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

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

3.2 **Debriefing**

It is essential to offer support and debriefing in all situations where restrictive interventions have been used or their use 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 and other people being supported if relevant.

It is an opportunity to identify any learning or good practice that can inform or amend the existing person centred care plans and / or restrictive practice reductions plans.

Debriefing of social care workers following an incident or a 'near miss' should:

- be led by the needs of the worker
- be undertaken by a skilled and trained practitioner with a 'no blame' attitude, emphasising any learning and considering the psychological impact on the people involved
- identify any further or on-going support and learning that is needed.

3.3 Monitoring and recording

Any use of any restrictive interventions must be monitored and clearly recorded on both an individual and organisational level.

Social care workers should write a clear account of the incident in accordance with organisational policies and procedures as soon as possible after the event. This will help individuals, teams and organisations to reflect upon what has taken place and learn from incidents to develop good practice.

Those working in residential children services are also required to complete a detailed report when a restrictive physical intervention has been used, which is shared with the young person's social worker.[17]

Data on the use of on restrictive practices must be collected in an effort to ensure its' appropriate use and to ultimately demonstrate that they have reduced over time by the use of individualised positive approaches.

3.4 Training, learning and skills development

Any training and learning activities required will vary according to the service and the role of those employed within it. It is essential that any 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.

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

- be part of a structured learning pathway, based on evidence of best practice
- take a long-term view of the learning and development which social care workers will need including:
  - induction training for new workers
  - ongoing refresher and update learning as needed
  - training determined by policy and career development
- be delivered by someone who is qualified to deliver the training and is occupationally competent
- be inclusive of the perspectives of people being supported by the service, this could be through face to face delivery or in the design and development process
- be essential for 'bank', casual and agency workers as well as regular employees

[17] The Children's Homes (Wales) Regulations 2002 and The Regulations and National Minimum Standards: Children's Services - Care and Social Services Inspectorate Wales (CSSIW).

- be evaluated with robust quality assurance processes in place to ensure that learning is embedded into practice.

Training in restricted physical intervention should be:

- designed to meet the needs of particular individuals
- designed based on the needs indicated by a behaviour audit, training needs analysis and risk assessment
- essential to all social care workers if there is a possibility of them having to use a restrictive physical intervention in the workplace
- risk assessed by an independent individual or organisation that can demonstrate appropriate expertise in professional assessment of risk; manual handling and health and safety legislation; understanding of biomechanics[18] and physiology (relevant to child and adult anatomy); psychological assessment
- inclusive of an evaluation of the foreseeable risks associated with all physical techniques included within their curriculum
- updated and refreshed regularly as per organisational policy, but every twelve months, as a minimum[19]
- have established systems in place for learning providers to feed back when learners are seen as not competent to practice.

Currently there are no 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.

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 outline how different aspects of an individual's work need to be set out. They illustrate effective performance within 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.

Units can be taken 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.

Additional information on recruiting and developing the workforce can be found 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.*[20]

[18] Biomechanics refers to the study of the mechanical principles of living organisms, particularly their movement and structure. Oxford English Dictionary, Third Edition, November 2010.
[19] 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.
[20] 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: DH-Skills for Care and Skills for Health.

Part 4: Information and resources

This part contains additional information and resources on key topics and areas of practice that may be useful to your work.

These include further detail of the three positive approaches frameworks / models outlined in **Part 2**. The frameworks and models are included as examples of practices, which evidence shows, supports the reduction in the use of restrictive practices. There will be others that are used within your services, which you will also be able to draw upon.

Part 4 also contains links to key pieces of legislation and policy, as well as some 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 which starts with a good understanding of each individual, their strengths, needs and wishes. It provides a personalised and enduring system of support to meet needs, build upon strengths and enhance an individual's quality of life.

It is an inclusive approach which depends upon the involvement of the individual themselves and the key people in their lives, including families and social care workers.

PBS is not 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. These 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 an individual presents with behaviour that challenges
- making changes to the environment to reduce the need for an individual to use challenging behaviour to control their life
- teaching the individual new skills and alternative ways to communicate their needs
- creating the cultural change necessary for services to respond positively and respectfully to the individual.

What are the different components?

There are three stages to PBS:

Primary prevention

This is the most important part of PBS because it has the greatest impact upon 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 an individual lives or spends time to meet their needs
- changing triggers that lead to behaviours that challenge
- changing reinforcements that maintain behaviours that challenge
- supporting people to participate to achieve a typical lifestyle
- teaching skills to increase independence and 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 - All of us show signs when we are getting distressed or angry- for example going very silent, avoiding eye contact, pacing the floor and so on. Identifying the individual's early signs is a first important step in helping them to avoid becoming too agitated.
2. Active listening - Closely monitoring their mood to note any early signs of agitation.
3. Taking action - Intervening early by removing triggers, distracting the individual with something they enjoy, giving them some space and, if necessary, moving other people away. It is important not to rush in, panic, threaten or challenge people when they are showing signs of agitation.

Another important thing is for carers themselves to remain calm to prevent the situation escalating and getting out of control, and to ensure they can get a safe distance from the individual if they need to.

Reactive strategies

Reactive strategies are not a treatment, but are sometimes necessary when primary and secondary strategies have not prevented an individual from presenting behaviour that is challenging.

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

There are four levels of reactive strategy, and the least intrusive one necessary for each incident should be used:

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

What needs to be in place to support its use?

Several elements need to be in place for PBS to be delivered appropriately:

1. Functional analysis – To clearly identify the reasons an individual presents behaviours that challenge, their strengths and preferences, their health and communication needs.
2. PBS plan – To specify all that social carer workers need to know and do to support the individual, based on the results of the functional analysis. This should focus mainly on primary prevention and also include the secondary prevention and appropriate reactive strategies that have been identified for the individual.
3. Training for social care workers – To ensure they understand the PBS plan and are skilled in all the things they need to do to support the individual. Training should be in three stages: verbal competence (they can explain what is 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 individual so they can act as role models for workers and give them regular feedback on how well they are carrying out the PBS plan.

4.2 Using Active Support to reduce the use of restrictive practices

Active Support is a person-centred model of how to positively interact with individuals combined with a daily planning system that promotes participation and enhances quality of life and the development of independent living skills.

The model aims to provide a structure that helps individuals who are not fully independent to be able to engage in the typical mixture of meaningful activities and personal pursuits that provide everyone with their purpose in life.

The Active Support Model was developed initially as a means of providing support to people with learning disabilities to lead a full and fulfilling life; it is however, applicable to any person who needs care and support for their well-being.

The model is designed to provide a structure that increases the opportunities for individuals to participate in a valued range of activities. It includes working with individuals to develop and implement daily plans to ensure that a good balance of activities that contribute to their well-being are available throughout the day, avoiding lengthy periods of disengagement. Graduated levels of assistance are used from simple verbal prompts to actual physical guidance such as hand on hand support, these enable individuals to develop and maintain the skills that they need to participate in activities that are both important to them and for day to day living.

The Active Support Model is an approach that can be used to reduce the use of restrictive practices.

4.3 Using Restorative Approaches to reduce the use of restrictive practices

Restorative practice allows an individual to reflect on their behaviour. It gives them an opportunity to put what has happened right or empathise with others emotions and feelings.

The use of Restorative Approaches is increasingly used within children's residential environments to manage conflict and tensions by repairing harm and building relationships. This 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 that the process is fair, a safe environment is needed with clear meeting protocols around dignity and respect. The participants will need to be free to express their emotions, even those which 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 different 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 within a group of young people
- with a group of social care workers who have found it difficult to agree with a decision.

There are five main methods to the use of this approach:

1. Open with affective statements - Brief comments on the behaviour and how others were impacted upon by the person's behaviour. It is important to have all the facts and information and not to surmise.
2. Affective questions - Asking the 'wrong doer' for their version of events and who was affected and how etc.
3. A small impromptu meeting - Where 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 - Which allows everyone to take turns to have their say.
5. Formal Conference - A more planned, structured meeting which requires preparation and completion with the 'wrong doer' and an action plan in place for all involved.

It is 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 is a voluntary process that is confidential, so for a restorative meeting consent is needed from all parties.

However, using the questioning technique that uses an array of open questions it is 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 remain totally impartial throughout the process.

It is often an ongoing process throughout 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, this may be when the young person is in a calmer state of mind and is showing possible signs of remorse.

Case examples:

Below are 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 in the approach.
- 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 would not catch an earlier bus from her boyfriends' which meant she would not be home until midnight. She had been struggling with her school work recently as she is over tired.

Restorative Approach

Social care workers discussed the implications of her late returns and the risks involved of traveling 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 is less tired and able to focus on her school work. 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 accommodated in a residential home were in constant conflict with each other (verbal altercations recorded daily).

Restorative Approach

Social care workers discussed what was being observed. 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 did become defensive during the meeting and discussions at times became quite heated.

Outcome

The young people all came to an agreement that they did not 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 his behaviour and the impact that it was having on others.

Outcome

Josh told social care workers impolitely that they can do what they like as he did not care.

It is 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 teaches us to:

1. Respect others opinions and learn to value them.
2. Take responsibility for our own actions.
3. Repair relationships between oneself and ones community.
4. Ensure behaviour is not repeated.
5. Identify and develop interpersonal skills.
6. Reduce restrictive practices.

This process empowers and enables individuals to take responsibility for what happens in their lives. Even more so than that, it allows them to make the decisions needed to make their lives better.

4.4 Legislation, policy and practice

There are a number of key pieces of legislation and policy that guide all of us who work in social care. These were current and up to date at the time of publication.

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

- The Human Rights Act 1998 and the European Convention on Human Rights: http://www.equalityhumanrights.com/your-rights/human-rights/what-are-human-rights/human-rights-act
- The Social Services and Well-Being (Wales) Act 2014: http://www.legislation.gov.uk/anaw/2014/4/contents
- The Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999: http://www.hse.gov.uk/legislation/hswa.htm
- Framework for Restrictive Physical Intervention Policy and Practice: Welsh Assembly Government (2005): http://gov.wales/caec/publications/childrenandyoungpeople/physicalintervention/frameworken.pdf?lang=en
- Code of Professional Practice for Social Care: http://www.ccwales.org.uk/code-of-professional-practice/
- Practice Guidance for the Social Care Manager: http://www.ccwales.org.uk/practice-guidance-for-managers/
- Carers Rights and Legislation: Skills for Care: http://www.skillsforcare.org.uk/Skills/Carers/Carers.aspx
- Health and Care Standards Wales, 2015: http://gov.wales/docs/dhss/publications/150402standardsen.pdf
- Continuing NHS Health Care Framework for Implementation in Wales, 2014: http://www.wales.nhs.uk/continuingnhshealthcare

Specific legislation and policy for children and young people

- The Children Act 2004: http://www.legislation.gov.uk/ukpga/2004/31/contents#pt3
- Children and Adoption Act 2006: http://www.legislation.gov.uk/ukpga/2006/20/contents
- United Nations Convention on the Rights of the Child: http://www.unicef.org.uk/UNICEFs-Work/UN-Convention/
- Children and Young Person Act 2008: http://www.legislation.gov.uk/ukpga/2008/23/contents
- Education and Inspections Act 2006: http://www.legislation.gov.uk/ukpga/2006/40/contents

- Regulations and National Minimum Standards for Children's Services: http://cssiw.org.uk/providingacareservice/regs-nms/children-services/?lang=en
- Leaving Care Act Wales: http://gov.wales/topics/health/publications/socialcare/guidance1/children-care-act-guidance/?lang=en.
- Child Care Law: http://www.ccwales.org.uk/child-law/
- Children's Rights in Wales: http://www.childrensrightswales.org.uk/childrens-act-2004.aspx
- Practice Guidance for the residential child care worker: http://www.ccwales.org.uk/practice-guidance-for-residential-child-care-workers/

Specific legislation and policy for adults

- The Mental Health Act 1983 as amended by the Mental Health Act 2007: http://www.legislation.gov.uk/ukpga/2007/12/contents
- The Mental Health Act 1989, Code of Practice for Wales, 2008: http://www.wales.nhs.uk/sites3/page.cfm?orgid=816&pid=33960
- The Mental Capacity Act 2005 and the Deprivation of Liberties Safeguards (DOLS): http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/socialcare/deliveringadultsocialcare/mentalcapacity/mentalcapacityactdeprivationoflibertysafeguards/index.htm
- The Mental Health (Wales) Measure, 2010, Welsh Government: http://gov.wales/topics/health/nhswales/healthservice/mental-health-services/measure/?lang=en
- Regulations and National Minimum Standards for Adults Services http://cssiw.org.uk/providingacareservice/regs-nms/adult-services/?lang=en including:
    - Care Homes
    - Adult Placement Schemes
    - Domiciliary Care Agencies
    - Nurses' Agencies

4.5 National Occupational Standards (NOS)

NOS are documents that outline how different aspects of an individual's work need to be set out. They illustrate effective performance within 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 pertinent to 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 within the diploma 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 key units have been listed below; these can be accessed from the Care Council website: http://www.ccwales.org.uk/qualifications-and-nos-finder/

Unit Number	Name	Level
DEM 211	Approaches to enable rights and choices for individuals with dementia whilst minimising risks	2
HSC 2031	Contribute to support of positive risk-taking for individuals	2
HSC 026	Implement person centred approaches in health and social care	2
LD 203	Provide active support	2
HSC 2012	Support Individuals who are Distressed	2
LD 202	Support person centred thinking and planning	2
MCA01	Awareness of the Mental Capacity Act 2005	3
DEM 304	Enable rights and choices of individuals with dementia whilst minimising risks	3
LD 302	Facilitate person centred assessment, planning, implementation and review	3
HSC 3045	Promote positive behaviour	3
SCMP2	Promote the well-being and resilience of children and young people	3
CYP M3.7	Understand how to support positive outcomes for children and young people	3
CYP M3.5	Develop positive relationships with children and young people and others involved in their care	3
CYP M3.2	Promote child and young person development	3
DEM 312	Understand and enable interaction and communication with individuals who have dementia	3
LD 303	Promote Active Support	3
HSC 3066	Support positive risk taking for individuals	3
HSC 3065	Implement the positive behavioural support model	4
LM 503	Lead practice which supports individuals to take positive risks	5
O36	Lead practice in promoting Implement person centred approaches in health and social care the well-being and resilience of children and young people	5
MU 5.3	Lead practice that supports positive outcomes for children and young people	5
DEM 501	Lead and manage practice in dementia	5
LD 504	Active Support: Lead interactive training	5
LD 503	Promote Active Support	5
HSC M1	Lead person centred practice	5
O32	Lead positive behavioural support	7

Qualifications that support the use of PBS

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

4.7 Useful resources for supporting people with autism

- Autistic Spectrum Disorder information: www.ASDinfoWales.co.uk
- Autism services directory: http://www.autism.org.uk/directory.aspx
- The National Autistic Society: www.autism.org.uk
- 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: http://www.rcslt.org/news/docs/good_comm_standards

4.8 Useful resources for supporting children and young people

- Action for Children and Who Cares Trust, 2015 - Children's Homes Quality Standards Partnership - Practice Paper 2: Restriction of Liberty. Available at: www.childrenshomesqualitystandards.org.uk/resources/practice-papers
- Allen, B (2014) Improving Guidance on Managing Risk and Restraint in Children's Services. Available at: www.steaming-training.co.uk
- Care Forum Wales - Looked After Children Network, 2014 - Charter for Looked After Children and Care Leavers: http://www.careforumwales.co.uk/members/groups/13
- Carson, G (2010) How children's home consigned restraint to history. http://www.communitycare.co.uk
- 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: http://www.ncb.org.uk
- 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: http://strathprints.strath.ac.uk/7903/

- Hart, D; Howell, S (2004) - Report on the use of Physical Intervention across Children's services. National Children's Bureau, London: http://www.ncb.org.uk
- Ofsted (2012) Children's views on restraint. Reported by the Children's Rights Director for England. Ofsted. Manchester. Available at www.rights4me.org
- Ramsay, S (2010) Restrictive physical intervention and therapeutic holding for children and young people: Guidance for nursing staff. RCN Direct. London. https://www2.rcn.org.uk/__data/assets/pdf_file/0016/312613/003573.pdf
- 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: https://pure.strath.ac.uk/portal/files/227969/strathprints004720.pdf

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

- Positive Behavioural Support Resources, PBS Academy, www.pbsacademy.org.uk
- A Human rights perspective on reducing restrictive practices in intellectual disability and autism, BILD, Edited by Sam Karim: http://www.bild.org.uk
- Physical Interventions A Policy Framework, BILD, Prepared by John Harris, Marion Cornick, Alan Jefferson and Richard Mills: http://www.bild.org.uk
- 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: http://www.bild.org.uk
- 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: http://www.rcslt.org/news/docs/good_comm_standards
- Think Local Act Personal: New guidance to support integrated and person-centred care for people with health and social care needs: http://www.thinklocalactpersonal.org.uk
- 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: https://www.nice.org.uk

- 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: https://www.kent.ac.uk/tizard/research/research_projects/dh2007mansellreport.pdf
- The Active Support Model - Association for Real Change- supporting excellence: http://arcuk.org.uk/activesupport/

4.10 Useful resources for supporting people living with dementia

- Practical Guidance - Supporting the Social Care Workforce to Deliver Person Centred Care for People with Dementia: http://www.ccwales.org.uk
- Common Core Principles for supporting people with Dementia: Skills for Health: http://www.skillsforhealth.org.uk
- SCIE – Social Care Institute for Excellence (Dementia Resources): Open Dementia e-learning Programme: http://www.scie.org.uk
- Alzheimer's Society Awareness Training Resources: www.alzheimers.org.uk; dementiatraining@alzheimers.org.uk
- Dementia Friends awareness: www.dementiafriends.org.uk
- Giving Voice for People with Dementia: http://givingvoiceuk.org
- Dementia Care Mapping: Approaches based on the work of Professor Tom Kitwood: http://www.nursingtimes.net /dementiacaremapping
- This is me: http://www.rcn.org.uk
- National Institute of Health and Clinical Excellence (NICE) (2010) Dementia Quality Standards. https://www.nice.org.uk/guidance/qs30/chapter/quality-standard-for-dementia
- National Institute of Health and Clinical Excellence (NICE) Public Health Intervention Guidance: http://www.nice.org.uk
- Occupational therapy intervention and physical intervention to promote the mental health and well-being of older people in primary care and residential care: http://www.nice.org.uk/Guidance/PH16
- Life Story Work: http://www.dementiauk.org/informationsupport/life-story-work
- Values, Individuals, Perspective, Social (VIPS) tools and resources, University of Worcester: http://www.carefitforvips.co.uk

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: http://www.mind.org.uk news-campaigns/mind-cymru-campaigns/time-to-change-wales/
- 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: http://www.mentalhealthwales.net
- Mental health crisis care: physical restraint in crisis. A report on physical restraint in hospital settings in England. June 2013: http://www.mind.org.uk
- People with personality disorders: The National Personality Disorder Development Programme has developed the Knowledge Understanding Framework (KUF) with the aim of improving the quality of service user experience by developing practitioner attitudes, skills and behaviours: https://www.personalitydisorderkuf.org.uk
- Working with personality disordered offenders A practitioners guide: https://www.justice.gov.uk
- The Mental Health (Wales) Measure, 2010, Welsh Government: http://gov.wales/topics/health/nhswales/mental-health-services/measure/?lang=en

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: The National Action Plan to Reduce Suicide and Self Harm in Wales 2009-2014: http://gov.wales/topics/health/improvement/index/talk/?skip=1&lang=en

4.13 Useful resources for supporting the Welsh language

- Mwy na Geiriau: http://gov.wales
- Iaith Gwaith/Working Welsh Scheme - Wales: https://www.gov.uk/iaith-gwaith-working-welsh-scheme-wales
- Welsh Language Act: http://www.legislation.gov.uk/ukpga/1993/38/contents
- Working in Welsh resources, Care Council for Wales: http://www.ccwales.org.uk/working-in-welsh/