

Positive Handling Policy



Growth Learning Therapies

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Approved by:	Chair of the board	Date	July 2024
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Introduction

The term 'positive handling' describes preventing and managing disruptive, challenging and other hazardous behaviours by using positive behavioural support strategies that reduce the need for restrictive interventions.

This policy is designed to be read in conjunction with other Little Acorn Policies, specifically:

- School Ethos and Values [LA School Ethos.pdf](#)
- Health and Safety Policy [Health and Safety 2024.docx](#)
- Promoting Positive Behaviour Policy [LA Promoting Positive Behaviour Policy LAS005.docx](#) (LAS005)
- Child Protection Policy [Child Protection Policy 2024 .docx](#) (LAS002)

School Ethos

Little Acorns encourages children's GROWTH by teaching them to be Generous, Resilient, Optimistic, Wonderful, Thriving and Honest. We believe in advocating for children's growth academically and emotionally. We focus on teaching children's skills to promote their emotional regulation, so they can lead wonderful and fulfilling lives. Little Acorns children learn to be kind, safe, hard-working and respectful. We support children back into the classroom to access education full time through a bespoke but structured approach. Each child has a personalised learning plan which enable the children to thrive in their learning. Therapies are embedded into our curriculum to support children in communicating their feelings, supporting mental health and well-being. With an offer of outdoor education and individualised therapeutic support the children grow into respectful members of the community.



Adults and children have a shared language around the rules for Little Acorns School:

- Kind
- Safe
- Hard-working
- Respectful

These values are embedded in daily language, the reward system and sanctions and reflections.

1.Relevant legislation





The use of all forms of physical intervention and physical contact are governed by the criminal and civil law. The unwarranted or inappropriate use of force may constitute an assault. In addition, it may infringe the human rights of a child or young person.

1.1 Section 93 of the *Education and Inspections Act 2006* enables school staff to use reasonable force to prevent a pupil from:

- a. committing a criminal offence
- b. causing personal injury or damage to a property
- c. prejudicing the maintenance of good order and discipline at the school or among the pupils, whether during a teaching session or otherwise.

1.2 As included in the DFE 2010 guidance on *'The use of force to control or restrain pupils'* seclusion should only be considered in exceptional circumstances and it is an offence to lock a person in a room without a court order. Therefore, at no time should the door be locked as to do so is unlawful and can amount to the false imprisonment of a pupil.

2. Government Advice Informing This Policy

2.1 Use of Reasonable Force: *Advice for Head teachers, staff and governing bodies (July 2013)*

- The term 'reasonable force' covers the broad range of actions used by most teachers at some point in their career that involve a degree of physical contact with pupils.
- Force is usually used either to control or restrain. This can range from guiding a pupil to safety by the arm through to more extreme circumstances where a student needs to be restrained to prevent violence or injury.
- 'Reasonable in the circumstances' means using no more force than is needed.
- Control means either passive physical contact, such as standing between pupils or blocking a pupil's path, or active physical contact such as leading a pupil by the arm out of a classroom.
- Restraint means to hold back physically or to bring a pupil under control.
- School staff should always try to avoid acting in a way that might cause injury, but in extreme cases it may not always be possible to avoid injuring the pupil.

2.2 Schools can use reasonable force to:

- Remove disruptive children from the classroom where they have refused to follow an instruction to do so;
- Prevent a pupil behaving in a way that disrupts a school event or a school visit;
- Prevent a pupil leaving the classroom where allowing the pupil to leave would risk their safety or lead to behaviour that disrupts the behaviour of others;
- Prevent a pupil from attacking a member of staff or another pupil





- Restrain a pupil at risk of harming themselves through physical outbursts.
- Stop a pupil behaving in a way that is seriously disrupting a lesson, causing distress to the pupils and/or a breakdown of order

2.3 Schools cannot use force as a punishment – it is always unlawful to use force as a punishment.

This policy is based on legislation and advice from the Department for Education (DfE) on:

- [Behaviour in schools: advice for headteachers and school staff 2024](#)
- [Equality Act 2010: advice for schools - GOV.UK \(www.gov.uk\)](#)
- [Keeping children safe in education - GOV.UK \(www.gov.uk\)](#)
- [School suspensions and permanent exclusions - GOV.UK \(www.gov.uk\)](#)
- [Use of reasonable force in schools - GOV.UK \(www.gov.uk\)](#)
- [Supporting pupils with medical conditions at school - GOV.UK \(www.gov.uk\)](#)
- [SEND code of practice: 0 to 25 years - GOV.UK \(www.gov.uk\)](#)
- [Mental Health and Behaviour in Schools 2014](#)
- [Promoting and supporting mental health and wellbeing in schools and colleges - GOV.UK](#)
- [Trauma Informed Approaches](#)
- [Behaviour and discipline in schools: guide for governing bodies - GOV.UK](#)
- [SEMH-toolkit.pdf](#)

3. School Training

Every staff member is trained annually by PRICE. PRICE stands for Protecting Rights In a Caring Environment. PRICE Training is a restraint reduction network (RRN) certified training provider with approved curricula for use in education to support how to respond positively to challenging and hazardous behaviours. PRICE Training has developed a system that is rooted in trauma-informed practice and positive behaviour support that places human rights and the well-being of vulnerable children at the very heart of what they do. They help organisations develop strategies for both planned and unplanned interventions to ensure a safe environment and improve the quality of life for children. Only staff with in-date training may use the physical interventions trained by PRICE.

4. Little Acorn's Duty of Care:

4.1 To the child:

- To keep them safe from physical and emotional harm
- To take reasonable steps to protect them from foreseeable risks, including physical and emotional harm
- To prevent access to harmful materials
- To prevent them from hurting themselves or others





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- To teach and support children to regulate themselves
- To provide a safe environment
- To take reasonable steps to ensure access to learning
- To ensure every child is treated with respect and dignity
- To address changes in child's behaviour quickly and to intervene with prescribed interventions on individualised plans
- To exhaust all other prescribed strategies before restrictive measures are taken
- To only take restrictive measures when it is reasonable and proportionate
- To provide support and reflection post incident

4.2 To our staff:

- To keep them safe from physical and emotional harm
- To take reasonable steps to protect them from foreseeable risks, including physical and emotional harm
- To provide training to prevent and manage challenging and hazardous behaviour
- To support each other in preventing and managing challenging and hazardous behaviour
- To provides resources, training and support in preventing and managing challenging and hazardous behaviour
- To provide support and reflection post incident

5. Our understanding of behaviour

5.1 Little Acorn's accepted definition of challenging behaviour is:

"Behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to and use of ordinary community facilities; or behaviour that is likely to impair a child's personal development and family life and which represents a challenge to services, to families and to the children themselves, however caused." (Emerson et al 2001)

5.2 Challenging behaviour is used to describe a wide variety of behaviour:

- Distressed
- Difficult and problematic behaviour
- Absconding
- Tantrums
- Sexually inappropriate actions/comments/gestures
- Eating inedible objects
- Continual questioning

5.3 Hazardous behaviour is used to describe:

Behaviours which present a serious risk to well-being, safety and maybe life. We identify any hazardous behaviour that poses a potential risk of significant harm,





clearly so we are able to support the child to manage the risk safely.

These can include:

- Grabbing
- Hitting
- Kicking
- Biting
- Spitting
- Self-injury
- Smashing inanimate objects/property
- Throwing things
- Trying to undress themselves or others
- Use of a weapon
- Threats of violence
- Absconding to an unsafe area

6. Preventing Challenging or Hazardous Behaviours

6.1 Understanding behaviour:

In order to prevent challenging or hazardous behaviours, the first step is to understand why the behaviours occur in the first place. Primary preventative strategies focus on the following key areas:

- Identifying the root causes, influencing factors and functions of behaviour; and understanding individual characteristics
- Ensuring young people's needs are met so they are less likely to develop distressed, or other, behaviours of concern
- The use of evidence-based frameworks such as Positive Behavioural Support
- The use of person-centered approaches
- Reflection and reflective practices

6.2 Factors that Influence Behaviour:

- Their socio-economic background
- Education and formative development
- Behavioural phenotype - aspects of a child's behaviour that can be attributed to the presence of a specific genetic or biological anomaly or condition e.g. Autism, ADHD, dyslexia.
- Physical or mental health
- Trauma
- Physical impairment
- Peer group pressure
- Communication difficulties
- The environment
- Drugs or medication
- Alcohol or substance misuse





6.3 Common functions of behaviour are:

- Escape / avoidance
- Social Attention
- Access to tangibles/activities/people
- Sensory needs

Functions of behaviour are analysed using ABC charts (Antecedent, Behaviour, Consequence) after a child has shown an unknown behaviour or repetitive behaviours. The function of the behaviour is identified and then a replacement strategy is selected, with strategies on how to teach the child whilst they are regulated on a daily basis. These strategies are recorded and monitored on their replacement skills document.

6.4 Identifying Causes and Triggers

There are two types of triggers to be aware of when planning to prevent challenging or hazardous behaviour: Slow and fast triggers.

6.4 Slow triggers are setting events.

They are prior events or conditions, either external or internal, which influence the probability of the individual presenting challenging behaviour. These events have often happened in the past and are different to the triggers that are observed just prior to a display of hazardous or challenging behaviour. The slow triggers do not typically cause the challenging behaviour, but their presence makes it more likely for the behaviour to emerge.

These can include:

- Past experiences or previous traumas such as abuse
- ACE's
- Life events such as bereavement
- Phenotype behaviour
- Long-term physical and mental health issues
- Sleeping patterns
- Hunger
- Breakdown in relationships
- Illness

6.4 Fast triggers are the events that happen directly before challenging or hazardous behaviour.

They describe the influencing factors that provide the catalyst or trigger to the change in behaviour and are referred to as the antecedent. These can trigger the child to go into a stress response of "fight, flight, freeze, fawn and flop."

These can include:

- Fear or phobias
- Difficulty communicating





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- Being restricted
- Perceived loss of control
- Transitions
- Change in routine
- An activity ending unexpectedly
- An injury
- A perceived injustice
- Loss of a game
- Interactions with peers/staff
- Access to activity / tangible / person
- Being provoked
- Sensory concern

7. Developing Person-Centered Positive Behavioural Support Plan & Restraint Reduction Strategy (PIP)

Each child at Little Acorn's has a personalised Person-Centered Positive Behavioural Support Plan & Restraint Reduction Strategy (PIP). These are written in collaboration with parents/carers and where appropriate with the child to ensure they are the most effective and relevant strategies to support the child. This collaborative approach ensures that interventions are person-centered and respectful of the child's rights and needs.

7.1 Primary strategies – understanding of the child to support them to be regulated:

- Trauma informed care
- Phenotype behaviours
- Likes / dislikes
- Communication and learning style
- Functions of behaviour
- Slow and fast triggers with preventative strategies
- Positive behaviour support

7.2 Secondary strategies – recognising changes in behaviour and responding to them effectively to prevent behaviour escalating.

Secondary Strategies focus on the child's early behavioural signs (physical, emotional, communicative, etc.), which can indicate an increase in behavioural disturbance. When we notice a change in a young person's mood or behaviour, our response is key to the management of that situation. Listed within the PIP are ways in which we can engage with and de-escalate the child.

Signs of a change in behaviour:

- Changes in their body language
- Agitation
- Red, flushed faced





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- Sweaty
- Fixed eye contact
- Making strange/loud/repetitive noises
- Head banging
- Refusal to cooperate or communicate

7.3 Escalation Phases and Prevention Strategies

Within the PIP there are 3 levels of escalation with individualised prevention strategies that have been successful at de-escalating that child.

Level 1: first signs of a change in mood/behaviour

Level 2: next phase of escalation should the response to level 1 fail

Level 3: next phase of escalation should the response to level 2 fail

7.4 Preventative strategies used at Little Acorn's:

For more details on each of these de-escalation strategies please see Appendix 1:

1. Interrupting the Behaviour Chain
2. Structuring
3. Restructuring
4. Active listening
5. Redirect–Reward
6. Delayed Co-operation
7. Distraction
8. Diversion
9. Hurdle Help
10. Directing/Directive Statement
11. Teaching
12. Humour
13. Injection of Affection/Praise (Hypodermic Affection)
15. Prompting/Signaling
16. Proximity/Touch Control
17. Boundary Setting
18. Permitting
19. Re-grouping
20. Bouncing
21. Removal of Person/Audience





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22. Reflection Time

23. Leave Option

24. Stimulus Change

25. Consequences

26. Rewards

27. Silence

Calming toolkit

Each child has a visual calming toolkit in their learning area. These are adult and child identified strategies that support the child's regulation. Calming toolkit's are to be non-verbal, visual, accessible so the child can access them when dysregulated. These are reviewed after every incident and is part of the reflection process.

Emotional check in's

A non-verbal way for children to show how they are feeling throughout the day. This supports the child to co-regulate with an adult and to work towards self-regulation.

photo	I feel	I might	I can
5	Furious	Punch people Break things Unkind words	Walk away Change of adult Calm talking by adult
4	Cross	Swear Kick things Run off	Change of adult Safe space to calm Do a job
3	Stressed	Rude tone of voice Walk out of class Refuse strategies Fast breathing	Talk to an adult of my choice Break in lobby / stage Breathe into a paper bag
2	Bored/Sad	Rude tone Cry Unkind to myself	Talk to an adult of my choice MP3 player Sunny
1	Calm	Making jokes Chatting Complete learning	Join in with the class

When a child indicates that they are not feeling happy or calm, an adult will support them in finding a calming strategy from their calming toolkit to support their regulation.

Little Acorn's promote 3 check in's each day to support children to regulate themselves:

- o Check in – first thing in the morning
- o Check up – in the middle of the day
- o Check out – at the end of the day

Therapy

Each child accesses individual therapy to support their emotional regulation, to understand their own emotions and to process traumatic events they have experienced.

7.5 Tertiary strategies – strategies to use when all the secondary preventive strategies have not been successful.

All Little Acorns staff are trained by PRICE. PRICE Principles:

- **De-escalation Techniques:** Staff are trained in PRICE's methods for recognizing early signs of distress and using non-confrontational techniques to prevent escalation (see Appendix 1).
- **Non-Restrictive and Restrictive Interventions:** Physical intervention is used only as a last resort to prevent imminent harm and is always conducted in line with PRICE guidelines.
- **Post-Incident Support:** After any incident, staff and students will participate in a debrief to process the event, restore safety, and identify lessons learned.





A tertiary strategy will only be used when it is necessary, proportionate and for the minimal amount of time to ensure the safety of the child or others.

These strategies can be separated into two categories: non-restrictive interventions and restrictive interventions.

Non-restrictive Intervention:

- De-escalation
- Diversion
- Distraction
- Strategic capitulation

Restrictive Intervention - *"Any intervention used to limit a person's liberty"* (Royal College of Nursing; 2006):

- Verbal, e.g. "you can't have it"
- Physical, e.g. holding someone preventing free movement
- Environmental, e.g. seclusion, blocking a doorway, removing from outdoor space

The specific physical interventions that have been agreed by school and home for the child will be listed in the level 3 preventative strategies. These are approved by parents/carers, class teams, SLT and PRICE. Only the agreed restrictive interventions can be used during a behaviour incident. Photos of the correct physical restraints trained by PRICE are included in the PIP.

Where after a physical intervention there is any concern over the health or wellbeing of the Child or a staff member, NHS direct must be called as a minimum procedure. Where advised to seek further medical advice from a GP or from the Accident and Emergency Department of William Harvey Hospital this must be completed immediately. A child who is complaining of injury must be given the opportunity for medical assistance via the above routes.

Where a Child complains of not being able to breath during a restraint the restraint must be released immediately. Children are susceptible to 'positional asphyxia' during restraint situations, this may not be obvious during a restraint. The Child may still be able to shout and talk, asphyxia can take effect sometime after a restraint has concluded. Therefore it is vital that any complaint of shortness of breath is heeded and immediate action to resolve the situation is implemented. Where shortness of breath has led to altered behaviours and perceptions, blueing of the lips, face or extremities, lack of coordination or other concerning side effect medical assistance must be sought immediately through the above routes, or with a call to 999 for the provision of an ambulance.

7.6 Least restrictive approach





By following the 3 levels of escalation preventative strategies we ensure that we always take the least restrictive approach:

- All other options were explored and failed, or the alternatives were deemed to be unsuitable for the level of risk presented
- The minimum amount of force was used for the minimum amount of time
- The response was professionally and legally defensible

8. Other documents which support the child's Person-Centered Positive Behavioural Support Plan & Restraint Reduction Strategy (PIP):

8.1 Risk assessments

Every child at Little Acorn's has an individualised risk assessment.

When determining risk, we factor in all of the information we have about the child, including any physical limitations or medical diagnoses they may have. We also consider professional advice and examples of lived experience to highlight risks that may be presented during the use of restrictive interventions.

They all include:

- The nature of the hazard and the potential for harm
- The factors that increase the likelihood of staff exposure to the hazard
- The measures necessary to eliminate, reduce, or manage the hazard

8.2 Replacement skills

Functional assessment of behaviour. Identifying the function of a behaviour using an ABC (antecedent, behaviour, consequence) chart, in order to teach replacement skills to support the child to learn appropriate, safe behaviours. These are included in children's Pupil Profiles.

8.3 Pen portraits

The primary strategies to understand and support the child remaining regulated, for practical use in the classroom. Important information that adults need to know about the child.

8.4 Behaviour support plans

The 3 level escalation phases with preventative strategies, colour coded on 1 side of A4 for practical use in the classroom.

8.5 Personalised Learning Plans (PLP)

Each child has 6 areas of targets per term to work on, which align with their Education Health and Care Plans. Each child has targets linked to their behaviour to develop over the term.

8.6 Pupil Profiles





Each child has a pupil profile folder displayed in class containing the most important information for each child. These include their most up to date:

- Pen portrait
- Behaviour support plan
- Replacement skills
- PLP

8.7 Reflective conversations

Children to engage in a reflective conversation with an adult to identify:

- What happened?
- How did you feel?
- Who was affected?
- How can you make it right?
- What can you do differently next time?

Reflective conversations happen 24 hours after a behaviour incident and the 'alternative strategies' identified by the child to be included in PIP, pupil profiles and replacement skills.

9. Managing Challenging and Hazardous Behaviour

9.1 PIP's

To follow the child's PIP and work through the 3 levels of escalation preventative strategies to always use the least restrictive intervention possible.

9.2 Replacement skills

To teach replacement skills identified by the function behaviour on their ABC charts, when the child is regulated and on a consistent daily basis.

9.3 Risk assessments

To always follow the child's risk assessment to ensure that everyone is safe at all times.

9.4 Pupil profiles

Most relevant and up to date information on the child to support every adult in preventing challenging behaviour.

9.5 Clear rules and boundaries

To have clear rules and expectation, that are discussed and followed by everyone. To have predictable responses to behaviour so the child feels safe.

9.6 Effective communication

The following are ways of ensuring more effective communication:





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- Keep an open mind. Question why there is misunderstanding or frustration
- Communicate at an appropriate eye level
- Ensure a “low arousal” approach, moderate eye contact, volume, touch, and proximity. Remember, the child may have difficulty understanding abstract concepts, time and negatives
- Use minimal language - Use of visuals to offer appropriate choices
- If needed, speak slowly, clearly and calmly using simple direct words and phrases. Give the child time to process the message
- Be clear in expectations and suitable choices
- Clarify any points and check their understanding; repeat or re-phrase if necessary
- Use keywords, visuals, objects, schedules, Makaton, pictures, tapes, videos or any other aids that may help
- The child may agree with you because it is easier; ensure they are given an opportunity to express their real needs
- Maintain a non-judgmental approach and don't make assumptions; challenging behaviour always happens for a reason; believe a positive outcome is possible and accept that sometimes our best efforts may fail through no fault of our own

9.7 Regulate yourself first

It is crucial that staff try to appear calm when under pressure and remain in control of our own responses. Despite how we might be feeling we should try to appear composed and assertive. We should try to look confident as if we are capable of dealing with the situation. We should control our voice and use measured tones, which should help to de-escalate the situation:

Composed

Assertive

Look confident

Measured tones

The child displaying challenging or hazardous behaviour may attempt to justify an escalation of their behaviour if they can provoke a negative or angry response from adults. It is essential that staff maintain a positive approach and attitude, as this will influence our thoughts and behaviour, which in turn will influence the attitude and behaviour of the child.

9.8 Change of face

It is vital to recognize who is the best adult to de-escalate the child in that moment.

Code phrases to support change of face:

- *“There is a phone call for you in the office.”* – When another member of staff recognizes a change of face will be more effective than the current strategy.





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- “I need to make a phone call in the office.” – When the member of staff recognizes they are not helping the situation, are feeling tired or are not regulated themselves.

9.9 Team work

- To always offer support to each other with managing hazardous or challenging behaviour
- To alert SLT of a hazardous behaviour using the walkie-talkie
- Where possible to have second adult “eyes on” an escalating behaviour to provide support, advice, change of face or witness
- To address changes in behaviour quickly and effectively using child’s preventative strategies
- To communicate effectively to support de-escalation
- To accurately use restrictive interventions as trained by PRICE

9.10 Emotional check in’s

A non-verbal way for children to show how they are feeling throughout the day. This supports the child to co-regulate with an adult and to work towards self-regulation.

When a child indicates that they are not feeling happy or calm, an adult will support them in finding a calming strategy from their calming toolkit to support their regulation.

Little Acorn’s promote 3 check in’s each day to support children to regulate themselves:

- Check in – first thing in the morning
- Check up – in the middle of the day
- Check out – at the end of the day

9.11 Calming toolkit

Adult and child identified strategies that support the child’s regulation. Calming toolkit to be non-verbal, visual, accessible so the child is able to access them when dysregulated.

9.12 Safe spaces

Designated calm zones and safe spaces identified for each child when they need space and time to regulate. An area identified in class and in the outdoor space. The aim of these spaces are for the child to use these independently when they are beginning to feel dysregulated.

10 Post Incident Procedures

10.1 Post incident support

After the child has had a behaviour incident, the post incident support is planned for in their PIP.

This includes:





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- Child's recovery phase – what is observed after the incident
- Post incident strategies - how can adults support the child after the event
- Bridging activities – activities to support getting back to learning

Support for all those involved is a priority, not just medically, in terms of any injuries, but also the psychological impact.

10.2 Debriefs with staff

Following an incident, we conduct a de-brief with all staff involved which allows us to carry out a review and to apply what we have learnt to better support the child in times of distress. Staff complete a staff reflection when a restrictive intervention lasts longer than 15 minutes or there are multiple restrictive interventions per day. This is a supportive process to ensure that the child and everyone involved is supported in the best possible way.

10.3 Recording the behaviour incident

After a behaviour incident, adults need to record the facts clearly, accurately and concisely within 24 hours, so that any occurrence of challenging behaviour can be looked at with a view to utilizing other strategies that are non-restrictive.

The information in these reports include:

- The antecedent to the incident
- What was each person doing? E.g., managing the left arm with a support hold whilst talking to the person in an attempt to de-escalate
- What primary, secondary and tertiary prevention strategies were used?
- Why was a restrictive intervention necessary?
- How did the child respond to the engagement of physical intervention? E.g., did they struggle, relax, or become verbally aggressive?
- How long did the intervention last
- What was said during the restriction? Exact wording is used
- Any recordable injuries

10.4 Reflective conversations

Children to engage in a reflective conversation with an adult to identify:

- What happened?
- How did you feel?
- Who was affected?
- How can you make it right?
- What can you do differently next time?

Reflective conversations happen within 24 hours after a behaviour incident. These conversations need to be timed carefully, when they have returned to their baseline behaviour and are receptive. If this is attempted too soon, this can often trigger a further escalation in behaviour.





Any 'alternative strategies' identified by the child during the reflection to be included in PIP, pupil profiles and replacement skills. These conversations are recorded and added to the behaviour incident.

10.5 Informing parents and carers

Post incident parents and carers will be informed of any behaviour incidents and any restrictive interventions will be shared with them.

10.6 Review of child's support plans

Class teams will debrief and review the following documents after a behaviour incident / physical intervention and during weekly class meetings:

- PIP
- Pupil profiles
- Risk assessment
- Behaviour support plan
- Replacement skills

When there has been a new, unusual or serious behaviour incident or physical intervention the class team will do an in-depth analysis into it, creating an ABC (Antecedent, Behaviour, Consequence to identify the function of the behaviour) form and come up with replacement strategy to actively teach the required skill, when the child is regulated.

10.7 Behavior Analysis

Senior leadership have a physical intervention reduction plan, which is reviewed regularly with the board of governors.

Senior leadership track physical intervention weekly to find trends which are shared with the staff team in bi-weekly meetings, this informs our physical restraint reduction plan.

11. Training of staff

Little Acorns School ensures that all staff receive continuous professional development and training to be able to understand the needs of children and young people at Little Acorns and how to support individual needs. Staff will also receive daily information and updates around children and young people with strategies to support the management of behaviour and support children and young people in their care.

As part of the professional support, all staff will have regular training on:

- De-escalation skills
- Communication skills
- Trauma informed practices
- Active and Proactive approaches to support behaviour





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- Physical intervention training (PRICE, annually)
- Any specific training around individual needs i.e. the use of strategy to learn cards, quiet space, sensory circuits.

This may include shared CPD from other colleagues or on courses from external agencies.

12. Monitoring this policy

This behaviour policy will be reviewed and agreed by the Headteacher and advisory board annually or more frequently, if needed, to address findings from the regular monitoring of the behaviour data (as per section 10). This will be overseen by the Executive Headteacher as part of the governance process.





Appendix 1- De-escalation & Defusion: De-escalation Strategies

The quality of relationships is central to the ability of supporting a person's distress, frustration and anger. The nature and quality of relationships will impact and influence the success of all of the de-escalation strategies suggested here.

1. Interrupting the Behaviour Chain: Some individuals may have relatively well-established patterns of behaviour which may tend to follow predictable patterns of escalation. If we are aware of these it may be possible to plan for and implement specific interventions for specific points in the incident with the intention of preventing further escalation. By developing good knowledge of the people we support it may be possible to assess an incident at a given point and to have the ability available to consider, from the agreed plans, which strategy might be the most effective one to employ at that point. This may be described more as an approach than a specific 'strategy' in its own right but will help us when completing IBSP's etc.

2. Structuring: establishing consistent, predictable and reliable routines and structures may be highly reassuring for individuals. These structures have to take account of individual needs and we need to balance the need for them to be robust and stand up to 'testing' whilst ensuring they do not become overly rigid and inflexible. If the structure is fragile this conveys a message of 'out of control', which may escalate challenging behaviour. Sam's (11) foster parents have said they can't watch the film Deadpool as it has a 15 certificate and they're refusing to go to bed until this 'stupid rule' changes – can/ should the usual routine be flexed to accommodate this? David's bedtime is 10pm. The World Cup Final has gone to penalties and won't be finished until 10.15 – can/ should his usual routine be "flexed" to accommodate this?

3. Restructuring: It should be acknowledged that our settings are dynamic, and the needs of individuals and services are constantly changing. On a day-to-day basis restructuring may be seen as dealing with these dynamics and the fluid quality of relationships as in the examples above but more long term the strategy involves ensuring that the routines and structures in place are appropriate to the individuals currently accessing services/ in the home/ class. Through effective recording and data analysis it may be possible to identify any 'hot spots' that are related to the structures and routines of the setting – in line with our principles we should use this information and reflective practice to change cultures where necessary – if we're asked why we do something a certain way the answer shouldn't be as simple as 'That's just how we've always done it...'

4. Active listening: Active listening is a way of listening that keeps you engaged with another in a positive way. It is the process of listening attentively (concentrate fully on what is being said. Listen with all your senses and give your full attention to the speaker. Interest can be conveyed to the person you are supporting by using both verbal and non-verbal messages such as maintaining eye contact, nodding your head and smiling, agreeing and encouraging them to continue), paraphrasing and reflecting back (e.g. you might say. "In other words, what you are saying is that you're frustrated" or "I'm hearing that you're frustrated about this situation." Summarising or mirroring what the person has said helps them feel validated and understood) and withholding judgment and advice (respond so that the person can trust they won't be shamed, criticized, blamed, or otherwise negatively received). To understand the importance of this, ask yourself if you've ever been engaged in a conversation when you wondered if the other person was listening to what you were





saying. You wonder if your message is getting across, or if it's even worthwhile continuing to speak or if it feels like "talking to a brick wall" and it's something you want to avoid.

5. Redirect-Reward: This strategy is most likely to be successful in the earlier stages of an incident – in particular when levels of arousal have not escalated to such a point that the individual is unable to communicate rationally or with reason – essentially whilst they are still in the upstairs brain.

Redirection may be achieved by changing the activity or environment, suggest something that you know will be more enjoyable. This suggestion may be presented in a questioning style e.g., "Would you like to walk with me to the office to take this folder back" as opposed to "You need to come with me now" – this avoids the message sounding like an 'order' or issue of control. It may be helpful to then 'reward' the individual for accepting the redirection in order to reinforce the strategy e.g. "Well done for coming with me, you made a really good choice"

6. Delayed Co-operation: Some individuals may require a period of 'take up time' following a request or demand. Providing this time may give them the opportunity to consider a response other than "no". For example, after refusing to get up and get ready for school being told "O.K. Have a minute to wake up and stretch, I'll come back again in a few minutes" may be more effective than persisting and getting drawn into a win-lose type scenario. This strategy also allows other strategies to be considered – for example a different member of staff/ carer going back may defuse the situation and give the individual the option to now co-operate without feeling like they have "lost-face".

7. Distraction: Similar to redirection – some individuals may benefit from a shift of focus away from a trigger, stressor or interaction. This may be as simple as pointing out something in the environment – "Have you ever noticed how the branch of that tree looks like a cat..." This strategy is not designed to disregard or minimize the significance of the underlying issue or need being communicated but to allow the opportunity for the individual to shift back into "upstairs brain" functioning.

8. Diversion: may be effective as a primary prevention strategy – when we can predict a potential triggering event before the individual becomes aware of it, it may be possible to divert away from the event/ situation. E.g., when seeing a dog (the trigger) approaching on the opposite side of the road we may divert the individual's attention to something in a shop window or turn to walk in another direction.

9. Hurdle Help: The person may become distressed by tasks or situations being too complex and/ or overwhelming. Hurdle help is a technique to reduce the complexity of the situation and to help the individual get started. For example, the teacher/ TA could do a small piece of the task at hand and break the rest down into smaller, more manageable steps or timeframes and make it less overwhelming, or rather than "Get ready for bed", carers could break this down into individual tasks – have a bath, put pyjamas on, have a drink, brush your teeth, read a story, settle to sleep only giving the next instruction when the previous task is completed.

10. Directing/Directive Statement: as stress increases, rationale for decisions decreases, which may necessitate provision of direct guidance. This can be a useful technique when a person is demonstrating difficulty in controlling their own behaviour and safety is becoming a concern; it may help bring a sense of control and order. Directive statements may be particularly effective with individuals who respond well to clear, specific requests. However, basic principles of respect, dignity and care should always be held in mind when giving directive statements.

11. Teaching: help people we support learn from experience, use every day experiences and situations as an opportunity for growth and learning. New ways of coping are often best learned





through experience and process. We should hold in mind that some of the people we support may have had limited experience of completing a task or facing certain situations and it is not helpful to

make assumptions based on any factors other than those directly related to the individual. e.g., “Come on, you’re twelve, you should know how to tie your shoes by now...”

12. Humour: an injection of humour can often release the tension out of a situation, divert attention or provide the person with an escape route. As with all strategies, this is not always appropriate. Humour may be less likely to work with high levels of anger and aggression where an individual may feel their distress is not being taken seriously, they are being mocked or perhaps that the staff/ carer is anxious and, therefore, not able to offer the level of support and containment required. Humour such as sarcasm (which may be at the expense of the individual) is also unlikely to de-escalate as arousal levels increase.

13. Injection of Affection/Praise (Hypodermic Affection): used as a primary strategy this may be an effective method for increasing self-esteem. Generally, people respond better to positive regard, praise and messages as to what they do well and can achieve as opposed to negatives. It may be helpful to hold onto the 1:10 principle. For every negative/ critical message we should aim to provide ten positive or affirming messages. As a secondary prevention strategy, individuals may benefit from expressions of genuine affection for, or appreciation of them or their skills/ positive qualities. This strategy supports the development and maintenance of caring, nurturing relationships and may reduce incidents of challenging behaviour from occurring or reduce the intensity and duration of them. **14. Past Strengths Appeal:** Focus centres on how well the person has dealt with similar situations in the past, particularly drawing out the positives as to how they managed their behaviour. This strategy also provides opportunities for the hypodermic praise discussed above as carers can affirm the positive attributes of the individual.

15. Prompting/Signaling: this strategy may include establishing verbal and non-verbal forms of communication to assist us in supporting individuals who may be becoming, or are, dysregulated. The signal technique lets the person know that they, their responses and/ or actions have been noticed. For example, a teacher who is delivering information to a class may nod towards a pupil who has raised their hand to indicate they have been noticed, even if their query cannot be addressed immediately. In the context of good relationships, this approach can be used to signal approval (e.g., a smile) or to indicate that a behaviour (communication!) has been noticed. When used in this context prompting/ signalling may avoid escalation as it can be done discreetly (e.g., through a “look” or facial expression) and avoid highlighting a behaviour to other service users/ children.

16. Proximity/Touch Control: with some people we support whose backgrounds are well known and with whom there is a strong relationship this can be a highly effective approach. It can be supportive to respond to negative behaviours through non-threatening approaches, such as sitting beside them, showing genuine concern. Proximity is about reducing or extending personal space and conveying a message of support and care through body language. Being close to a person who is struggling to stay in control can be a calmer. In some situations, and again with extensive knowledge, touch control can be effective. We must remember that touch may mean different things to an individual based on many factors – their experiences, their cultural background, the relationship with the other person etc. Extra caution is advised as individuals become more aroused/ dysregulated as their response to touch may change throughout the Stages of an Incident. For example, consider the likely different responses if a parent was to gently rub a child’s knee if they had bumped into a door frame as opposed to rubbing the same child’s knee if they had fallen and cut their knee badly!





17. Boundary Setting: it may be generally accepted that people require appropriate, clear, consistent and secure boundaries to facilitate their development.

It is important to hold in mind that the purpose of boundaries should be to support and keep people safe and not to control or restrict them from making appropriate choices. Boundaries may be tested – as discussed in structuring (above) it is important that boundaries are consistent and understood but also not overly-rigid or restrictive. There may be some which are non-negotiable, especially if they are concerned with

safety e.g. you have to wear your seat belt in the car, but others may need to be negotiated to suit the changing needs of individuals e.g. should we enforce the ‘no food and drink in the car’ rule if we’ve been stuck in traffic for 2 hours in 30 degree heat? Boundary setting needs to be fair, achievable and negotiated and not seen as an alternative to working to establish positive relationships.

18. Permitting: allowing the behaviour to take place. Giving permission for potentially disruptive activity often reduces the attraction of it. If no one is in danger and no damage is likely, it may be better to give permission for the behaviour to take place. This may combine with other strategies such as redirection/ diversion – e.g. if the challenging behaviour is someone singing loudly while others are trying to watch TV, rather than just attempting to stop the behaviour, we could get the karaoke machine out in another room. As with all strategies, it is important that we link them accurately to the function – in this example the function may be around attention (securing staff/ peer engagement), sensory (the noise), tangibles (the karaoke machine) or avoidant (not wanting to watch TV) so the combination of permitting/ redirection may actually meet any of these functions!

19. Re-grouping: This strategy may be employed on an individual or wider/ whole group basis. For individuals the opportunity to ‘re-group’ may be very beneficial to halt an escalation in behaviour and enable them to either access support to benefit from co-regulation or spend time on their own if they have developed effective self-regulation strategies. For groups, the strategy operates in a similar way, enabling the members of the group/ class or people affected by a situation to ‘take a breath’.

It may enable staff/ carers to communicate with one another and formulate a plan for what they may do next. This strategy may be particularly effective in group settings where staff/ carers may be dealing with a number of concurrent incidents. In these situations, feeling isolated or alone can make it increasingly difficult for staff/carers to remain thoughtful and responsive.

20. Bouncing: keeping dynamics fluid so that high levels of challenging behaviour do not have time to emerge. Essentially, we may be positively maintaining an individual at a state of slight arousal from baseline without allowing it to ever reach crisis. Bouncing may be achieved by continually moving the individual from one environment or activity to another, a kind of continuous restructuring. This strategy can require high levels of energy and enthusiasm (go swimming, then to the park for a picnic, then for a bike ride, then to the cinema, then home just in time for bed!) from staff/ carers and is not usually an effective long-term strategy but may help manage a day/ period full of potential ‘hotspots’.

21. Removal of Person/Audience: ideally this should be by request and agreement and may be most successful at lower levels of arousal. Creating space for a person, changing the level of stimulation, changing the environment or removing the trigger can be achieved by moving the person. This may include some form of touch control or escorting techniques where these would be justified and reasonable. Alternatively, it may be possible to remove any audience, either by request or using some of the strategies listed here (e.g., redirection, directing, prompting etc.)





Behaviour is often supported by an audience or through the fear of losing face. The removal of an audience changes the environment, offers an “escape route” and creates space for individuals to co/ self-regulate.

22. Reflection Time: time away to regain control in an area in which a person can think and reduce anxiety. This may be done alone or with support. This strategy may be helpful when employed in the ‘recovery phase’ of an incident to prevent further escalation/ crisis points. If individuals have just experienced high levels of arousal staff/ carers should remain alert to the likelihood of further escalation and, for example, consider availability of exits and additional staff support.

23. Leave Option: even when relationships are the focus of our work there may be times when we are ‘the wrong person at the wrong time’. If staff/ carers are acting as a trigger or have become the focus of aggression or violence consideration may be given to changing the person supporting. This strategy is reliant on open, honest relationships and for staff/ carers to remain able to reflect ‘in practice’ on their own role in an incident or at least to listen to the voice of a ‘critical friend’ who may have a different perspective on a situation. Whilst perseverance and resilience are important qualities, it is equally appropriate to acknowledge when we have stopped being effective de-escalators and may actually be contributing to increasing levels of dysregulation.

24. Stimulus Change: do something unusual or unexpected – this could be singing a song, make a noise, pull a face. This strategy is possibly most effective early on in an incident or for low level behaviours. We also need to consider the level of development and understanding of the individuals involved – this strategy may not be appropriate where the ‘shock factor’ or confusion caused would increase the levels of distress/ dysregulation.

25. Consequences: may be used as a means of re-enforcing boundaries or making reparation. Utilising sanctions which are fair, proportionate, consistent, achievable and legal may have a place in some settings. For example, if someone has thrown eggs at the minibus it may be appropriate to expect them help to clean it. If using sanctions, they must be considered within the ethical framework of the organization and its approach (e.g., PBS, Trauma Informed etc.) and in the context of the experiences of the individuals involved. A punitive, sanctions led culture with no other strategies available is unlikely to be effective, supportive or helpful. Again, it’s worth reminding ourselves that behaviour is a communication of unmet need – punishing someone for not having the ability to communicate their needs in socially valid ways may be quite unfair! Similarly, ‘natural consequences’ may have a place in some settings but the decision to expose individuals to these has to be carefully considered. If the natural consequence is harmful, stigmatising or otherwise aversive it should be avoided. Accepting natural consequences requires a degree of understanding and development which some individuals may not have yet achieved so their use will be ineffective and unhelpful.

26. Rewards: Rewards may include the use of relational interactions, positive regard and praise as discussed in “hypodermic affection” above but may also refer to more tangible rewards. Rewards may be effective as a means of re-enforcing and encouraging positive behaviour patterns. Rewards may be used as a short term means to cementing new patterns of behaviour, but it is important the person does not become reliant on a form of reward that is not realistic and sustainable or may not be replicated in other settings.

27. Silence: the person we support can feel companionship or comforted by someone being there. When working in the field of learning disabilities this can be useful in giving people time to take information in, comprehend what has been said and formulate a response.

28. Strategic Capitulation: Strategic capitulation may be an effective strategy if you know that the source of the person’s increasing agitation is because they are trying to access a specific reinforcer or





to avoid a particular trigger in order to get a specific need met. e.g., During shift-planning it's been decided that James will support Stan (9) with his bedtime routine tonight. When Stan is told he becomes verbally abusive, calling James rude names and saying he doesn't want to be settled to bed by him, he wants Sam (his keyworker) By capitulating and allowing Stan to be settled by his keyworker have we reinforced that shouting and being rude gets his needs met? Or Will it be possible for Sam to engage in some work around bedtimes, why it feels so important for Stan to be settled by him, what barriers there may be in Stan and James' relationship, look at the structure in the home and consider why the children aren't involved in the shift planning, get James to reassure Stan that he (James) is really pleased Stan's got such a good relationship with Sam and that he'd really like to get to that point in their relationship sometime?

29. DO NOTHING!! (be present) This strategy should not be confused with "giving up" or reaching a point of despair and feeling "what's the point, nothing works!". sometimes pausing to take a breath and essentially "stopping intervening" may be the best, most helpful strategy. In reality, by 'doing nothing' we are actually 'doing something'. If we're faced with a situation/ scenario where it's unclear what might be the most helpful response, there may be a tendency to just start implementing interventions with little thought – they're likely to be the ones from nearer the top of our toolbox and these might not always be the appropriate tool for the job. When we begin reacting chaotically or with unhelpful interventions, we are likely to add to and continue individuals' distress and dysregulation. Flipping a common phrase onto its head may be helpful here – "Don't just do something, stand there!"

