Response ID ANON-2PNB-RA61-C

Submitted to Statutory Guidance On The Reduction And Management Of Restrictive Practices In Educational Settings In Northern Ireland
Submitted on 2023-11-03 11:42:07

Introduction

1 Please select the box that best describes you:

If Other, please specify

If Other, please specify:

Professional body

2 If you are responding on behalf of an organisation please specify below. (Optional)

Organisation:
Royal College of Speech and Language Therapists

3 Name (optional)

Name :
Sue McBride

Children's Rights Centred

4 To what extent do you agree or disagree that the guidance is Children's Rights Centred?

Agree

Understanding Behaviours

5 To what extent do you agree or disagree that the guidance includes reference to understanding of behaviours and what they are communicating?

Disagree

Additional Comments (optional):

RCSLT NI feel that the draft guidance does not clearly reference the understanding of behaviours and how this is communicated. Whilst communication as a form of behaviour is mentioned, this is not expanded upon. It is imperative to acknowledge that many children and young people who have behavioural difficulties, including those with social, emotional and mental health needs will also have speech, language and communication needs (RCSLT, 2019). However, these needs often go unrecognised because the child or young person's behaviour can mask these needs. Speech and Language Therapists (SLTs) can assess and appropriately identify these needs and advise families and other professionals how to respond.

The following statistics highlight the link between behaviour and communication and show the size of this need:

- 81% of children with emotional and behavioural disorders (EBD) have significant unidentified communication needs.
- 57% of children with diagnosed language deficits are identified with EBD.
- In a study of pupils at risk of exclusion from school, two thirds were found to have SLCN.
- Excluded boys had significantly poorer expressive language skills than their peers who had not been excluded from school; many of their difficulties had not previously been identified.
- More than 60% of young people who are accessing youth justice services present with SLCN which are largely unrecognised.
- Children with persistent and severe conduct problems are about three times more likely to have low verbal ability than children with a low risk of conduct problems

Further information and the reference for above can be found here:
https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/rcslt-behaviour-a4-factsheet.pdf

The guidance recommends that children and young people should be listened to and and understood in order to meet their needs, however, it does not state how this will work with those who are non-speaking. We would strongly recommend that this is expanded with communication tools given as examples to support the children and young people's communicative intent. It is concerning to us that their is no mention of how behaviour that challenges can be a manifestation of physical ill health in those children and young people who have a learning disability.

There are approximately 355,000 children and young people in the UK who have a learning disability of which approximately 40,000 will display behaviour that challenges and other neurodevelopmental, physical and mental health comorbidities. (Absould et al., 2019). It is worrying to the RCSLT NI that there is no recognition that these children and young people with behaviour that challenges could be due to safeguarding concerns, given that these children are at a substantially higher risk for all forms of abuse, neglect and social disadvantage (Absould et al., 2019). We would strongly suggest that this is referenced as a possibility for any new or unexpected behaviour as a cause.

Given the aforementioned figures and that over 10% of children and young people in the UK have some form of long-term commination need which will impact their daily life (Norbury et al., 2016) we feel that the above is vital to acknowledge and set the scene of communication needs. We would welcome these additions to the guidance.

Restrictive Practices

6 To what extent do you agree or disagree that the guidance is clear on what restrictive practices should NEVER be used?

Disagree

Additional comments (optional):

As we have mentioned, behaviour is a form of communication. Often children are communicating an unmet need or simply communicating their distress in the only way they can. When attempts to de-escalate do not work, restrictive practices are sometimes used. The RCSLT NI is concerned regarding the lack of recognition that alternative methods of communication such as visuals, social stories, and communication passports have as they should be trialled as part of a prevention and de-escalation approach.

The RCSLT NI acknowledges that the guidance suggests that restrictive practices should only be used in crisis situations. The guidance however does not offer suggestions of alternative methods of allowing the child or young person to communicate, such as the use of visual aids if they are feeling overwhelmed and/or are unable to communicate effectively. This may reduce the need for any restrictive intervention. We would welcome an addition in the guidance to reflect alternative methods of allowing the child or young person to communicate their needs.

There is no mention of restrictive practice approval forms, which are in place in some health and social care trusts in NI. These are initiated and completed by our occupational therapy (OT) colleagues, however they will routinely ask speech and language therapists for their input on decision making e.g. whether we agree with the rationale outlined as to why a child requires a wheelchair and how that child will communicate that they want out of the chair. Also the child's ability to follow instructions/ level of comprehension will inform the OT for example, as to whether they can be taught danger awareness skills.

We would recommend that this is explored in further detail and incorporated into the final document.

Supportive Practices

7 To what extent do you agree or disagree that the guidance is clear on what supportive practices are and when these should be used?

Disagree

Additional comments (optional).:

The RCSLT NI was disappointed to see the lack of mention of Speech and Language Therapists (SLTs) and acknowledgement of their role within education and in supporting staff to manage and reduce the requirement for restrictive practices to be used.

The RCSLT NI would welcome the addition and recognition of SLTs as a supportive practice. This will allow for appropriate assessment and recommendations for the individual child or young person on their specific and individual communication/ and or eating, drinking and swallowing needs. These recommendations should form part of their daily communication and care plan needs and thus reduce the likelihood of any escalation of behaviour that challenges due to being unable to communicate their needs/intent.

Additionally, an essential supportive practice and possible restraint that may occur is regarding children and young people who have eating, drinking and swallowing needs (also known as dysphagia). Their SLT will have assessed their swallowing and provide individual recommendations that ensure that they are able to eat, drink and swallow safely. An example of how this may constitute a restrictive practice would be when a child or young person is required to stay upright after eating and drinking (possibly for around 20 minutes) and should they begin to lie down or express a desire to recline, staff may need to intervene to encourage them to remain upright.

We would strongly recommend that speech and language therapy input is added under supportive practice.

Understanding Behaviours of Concern and the Development of Behaviour Support Plans

8 To what extent do you agree or disagree that the guidance highlights the importance of understanding behaviours of concern and the development of behaviour support plans

Disagree

Additional comments (optional):

The RCSLT NI would welcome further expansion of understanding behaviours of concern and specific examples, as we feel that this is lacking in the document. This will allow for clarification and therefore a greater understanding for all involved in the care of the children and young people.

We are disappointed that the role of SLTs is not recognised in the development of behaviour support plans, as it would allow a greater focus on the child or young person's needs around how best to communicate effectively. In some HSCT regions, children and young people with speech and language therapy input will have a goal listed on their behaviour plan.

Our members have a significant role supporting staff and those around the child or young person to effectively communicate with the use of a variety of communication tools, including visuals, social stories, high-tech alternative augmentative communication and communication passports. Although the speech therapist may not be required to input into every child or young person with behavioural needs, a lot of these children will have communication needs that impact on their behaviours. The SLT can support staff to effectively communicate and reduce any use of or reliance on restrictive practices.

Last Resort Circumstances

9 To what extent do you agree or disagree that the guidance highlights the last resort circumstances when reasonable force can be used?

Disagree

Additional comments (optional):

The RCSLT NI welcome the recommendation that reasonable force should only be used as a last resort. We do feel however that the situations where this would be appropriate need to be expanded upon, with the use of more detailed case studies and examples.

We would welcome the addition of mandatory training for staff to safeguard both themselves and the child and young person. We know that our members are well placed to support and add to any essential training that is rolled out, given their expertise in communication.

We note that there is no mention in the guidance of any de-brief for those pupils who may have witnessed use of restrictive interventions. This will likely be an overwhelming experience to witness and in order to safeguard the wellbeing of all children and young people, there must be plans in place to acknowledge any harm that observing these scenarios will cause and provide appropriate support.

Pupils' Care Plans

10 To what extent do you agree or disagree that the guidance includes measures that ensure the recording of supportive practices in pupils' care plans?

Disagree

Additional comments (optional):

The RCSLT NI feel that this is largely unclear in the guidance. While supportive practices are mentioned, it is unclear what measures are taken to ensure that this is all recorded in the pupil's care plans. We would welcome more robust guidance in relation to care plans and who can/should contribute to these.

Our members have a vital role to play in supporting staff with care plans specifically around both communication and eating, drinking and swallowing needs for children and young people.

Planning and Training

11 To what extent do you agree or disagree that the guidance highlights planning and training that prevents escalation and addresses crisis situations if they arise?

Disagree

Additional comments (optional):

The RCSLT NI would welcome the addition of training resources which have been created by the SLT 'Children with Disabilities task and finish group'. There is a body of trainings to help staff in mainstream and special school (these were created for staff with no experience of children with LD and SEN) to access and allow for a greater understanding of a range of topics which impact communication. We believe that receiving specialist training in communication produced by specialist SLTs, will enable staff to be upskilled in communication techniques which are aimed at reducing any escalation of behaviours due to the child or young person struggling to communicate their needs.

The RCSLT NI recommend that other available supports to schools (including any training) include a referral pathway to speech and language therapy. This will allow the child or young person's communication needs, and or eating, drinking and swallowing needs to be appropriately assessed and if required, therapy support and/or advice can be put in place. This should allow for the addition or amendment to any care plans which are in place.

Alignment with Departments of Health and Justice

12 To what extent do you agree or disagree that the guidance details the legislative and policy context, provides clear definitions of restrictive practices and supportive practices, aligned as far as possible with those of the Departments of Health and Justice?

Agree

Additional comments (optional):

RCSLT NI agree that the guidance details the range of legislative and policy contexts with clear definitions of restrictive and supportive practices,

Roles and Responsibilities

13 To what extent do you agree or disagree that the guidance outlines the roles, responsibilities and accountabilities of school staff, health professionals, Principals, Board of Governors, the EducationAuthority, parents/carers, children and young people and the Department itself?

Disagree

Additional comments (optional):

The RCSLT NI feel that this section should be expanded upon and we would welcome an additional section which is dedicated to the above parties, clearly detailing their roles, responsibilities and accountabilities.

Speech and language therapists play a key role in supporting children and young people's communication and swallowing needs, and also supporting and building parents/carers/education staff's capacity in these areas. Once again, there is a clear lack of mention or recognition of their significant role in supporting staff to reduce restrictive interventions.

Mandatory Recording and Reporting

14 To what extent do you agree or disagree that the guidance provides for the mandatory recording and reporting of all incidents of physical restraint/reasonable force by educational settings?

Agree

Additional comments (optional):

The RCSLT NI agree that the guidance is clear on the mandatory recording and reporting. We would however, welcome the addition of a mandatory de-brief for all parties involved including the child or young person's parents or guardians. This will allow for any amendments/additions to be made for care/support plans and /or onward referrals to appropriate services as required, for example, speech and language therapy.

We also feel that it is appropriate that in the final document that there is reference to listening to the child or young person's voice. We would suggest that within any de-brief the child or young person is included and appropriate communication tools are used to illicit their views. This would allow for recommendations/procedures to be put in place to prevent the reoccurrence of any future restrictive practice.

We would also note that it is likely that some parents of children and young people who are neurodivergent or who have speech, language and communication needs, may have speech, language and communication needs themselves, and this should be taken into account. We would strongly suggest that this is reflected in the final guidance so parents and carers can receive effective, accessible communication in relation to their child or young person. Therefore, written and verbal advice must be user-friendly and easy-read versions are recommended.

Exemplars of Practices

15 To what extent do you agree or disagree that the guidance includes exemplars of positive, preventative and early intervention practices identified by the Education and Training Inspectorate?

Disagree

Additional comments (optional):

RCSLT NI feel that this could be made clearer in the guidance and reference appropriate bodies/examples of good practice.

We feel that the case studies used overall lacked rationale and we are unclear if the examples detailed were suggesting best practice or otherwise.

It is also important to highlight that there will also be children and young people within a mainstream school, that due to lengthy waiting lists, will not have received any assessment or have a firm diagnoses, despite having clear special education needs. The RCSLT NI are concerned that these children and young people's needs will be overlooked without any support being put in place. We would recommend that this is acknowledged in the final document.

We have listed 3 case studies below which we feel represent good practice and detail the importance of multi-disciplinary team work and would welcome this inclusion:

Case Study 1: The use of restrictive equipment

A 14 year old who attends special school and has diagnoses of a rare genetic syndrome, Severe Learning Difficulties (SLD), significant anxiety and eating, drinking and swallowing difficulties. This young person had historically used a wheelchair to maintain a safe upright position for eating, drinking and swallowing to reduce the risk of choking, which had been recommended jointly by SLT and OT through a restrictive practice risk assessment. They had been discharged from previous speech and language therapy input. This young person's physical skills had developed and he was now independently mobile and a re-referral was made to Speech and Language Therapy services to review his eating, drinking and swallowing and communication needs.

The young person was very anxious and found it extremely difficult to sit still and would often be up and down off his seat and trying to get out of the classroom. This meant his risk of choking was greatly increased.

A re-referral was made to speech and language therapy and a reassessment took place. The speech and language therapist (SLT) found that the young person had severe communication difficulties, limited understanding of verbal language and reduced communicative intent. The young person's motivation was limited; however, they were motivated by walking outside in the school grounds or going for a journey in the car. The young person would express this by pulling the staff member to the door.

The SLT arranged for a joint assessment with an occupational therapist (OT) to review the use of restrictive practice of the wheelchair for his eating, drinking and swallowing needs and to gain a wider understanding of his engagement within the classroom environment. They found that he was more than able to sit safely in a standard chair to eat at mealtimes rather than in the wheelchair when appropriate communication tools were used to allow the young person to understand. The SLT assessed that the use of objects of reference, in this case a plate to signify that it was time for dinner and, Makaton signs to reinforce that it was time to eat, drink and sit were required and alleviated the need for the use of restrictive practice in the wheelchair. However, the young person was still at significant risk of choking and therefore, if they got up off the seat, the plate was removed, as it was unsafe for them to have access to food when not seated. Positively, he is now able to remain seated for the duration of most mealtimes within the school environment with limited prompting from staff.

It is also noted that a lap table and belt, which are also classified as a restrictive practice, were trialled but deemed unsafe due to the young person being able to rock back and forth in the chair.

The speech and language therapist trained the school staff in how to use objects of reference, useful Makaton signs and explained how the young person was trying to communicate his intent, for example, when he stood up, he was trying to explain he would like something. The SLT not only assisted in removing the use of the wheelchair with her OT colleague but allowed him to engage in both circle time and the use of the sensory room, while fully mobile. The OT also implemented a sensory chair which the young person was allowed access to aid his need for sensory regulation and he can now sit in this for up to 45 minutes, which is progress.

The young person now no longer uses the wheelchair in school. Staff are fully trained in his communicative needs and have the skills, tools and resources to allow for open and effective communication. School staff have also had access to the intensive interaction training produced by the Children with Disabilities (CWD) SLT team which has allowed for a greater understanding and generalisation of communication skills with this young person.

The speech and language therapist also supported the family and assisted in ensuring that they were using the same approach at home, this consistency has allowed the young person to thrive and the use of any and all restrictive practices are non-existent.

Case Study 2: Communication friendly environment and strategies

A young child, aged 5 years, who had diagnoses of Autism Spectrum Disorder (ASD) and a significant speech sound disorder attends a mainstream placement with access to a full time classroom assistant.

The young child struggled with adjusting to the school routine. He was very difficult to understand in and out of context, and although he had a good level of receptive understanding, his speech sound disorder made it very difficult for him to express himself. This made him very frustrated, and he would physically lash out at his classroom assistant and peers, who became fearful of him and did not want to be in his company.

The young child was known to a speech and language therapist (SLT) who had assessed him and was supporting him with his speech sound difficulties and functional communication. The SLT liaised with school staff put in place several supportive measures for the child to access. This included a core vocabulary board which allowed him to express his need when he could not communicate this verbally. The SLT also introduced a first and then approach, alongside a choice board for a preferred activity when he had finished the classroom work. This positively aided both his understanding and communicative ability and reduced the physical behaviours as he understood what was happening and was able to communicate with staff more effectively.

The Autism Intervention Team and Occupational Therapist from the HSCT also gave advice regarding sensory regulation, using a visual schedule and a having a workstation in the classroom. This all added to the child's ability to self-regulate and participate in the school day.

The SLT worked alongside the teacher and his classmates to explain how the children could help the young child to participate, for example, in PE, he would be overwhelmed by the noise. The speech and language therapist explained that if the children could move about more quietly in PE and thereby reduce the sensory overload, this would help the child to take part. The classmates took this onboard, and the young child was able to participate in PE without any ear defenders for 10-15 minutes and he was able to use his core vocabulary board to express his wish to leave the room when he had enough.

The school staff also availed of the training on offer which allowed them to collectively look at promoting speech, language and communication needs in the classroom, and universal strategies which they implemented across the classroom environment for all the students. This has allowed any behaviours

that challenge to reduce dramatically, and the child is now fully included in the classroom and has been able to make friends.

Case Study 3 – MDT working to manage restrictive practices.

A 9-year-old child attends a local special school. He has a diagnosis of autism spectrum disorder and Severe Learning Disability. He gets over excited/over-stimulated which mum finds difficult to manage including when helping him transition safely outside of the home. This could be a typical long-term presentation given his rigid behaviour patterns and learning disability. Mum understandably finds it difficult to manage on her own without the use of equipment to meet keep him safe.

The occupational therapist (OT) recommended a wheelchair for longer distances and outdoor use. Mum had been using a privately purchased buggy although the child has now outgrown this, and a bigger buggy is not within service protocols considering child's age. The OT advised that they could consider a wheelchair as an alternative, less restrictive option to a buggy. The OT contacted SLT to discuss the need for evidence around the wheelchair in terms of a restrictive intervention. SLT and OT discussed the risk of the wheelchair being overused or not used for its intention and importantly, could the child communicate consistently to others when he wanted out of the chair? The OT then completed a Restrictive Practice Form which advocated for the provision of a wheelchair for the child for longer distances. A multi-disciplinary team approach was used in trust in which information from a range of professionals is required for the decision to be agreed upon (Restrictive Practice Panel). The child's paediatrician was also contacted to share in the decision making and they are still waiting for allocation of a social worker.

SLT assessment has determined that the child can routinely understand basic instructions at a one information carrying word level, but he is unable to consistently understand 2 word level instructions. The child communicates at home by pulling his parents to what he wants/ needs and he will tap their hand to indicate "no". The child can communicate his needs in class via a PECS book and responds well to a first/then board. His parents are keen to implement PECS and Makaton outside of the school environment but consistency across settings has been a barrier in the past.

SLT staff agreed to trial some individual therapy sessions to enable the child to signal to adults/ his parents that he would like to get out of his wheelchair using AAC (Combination of PECS and Makaton). This has to be an approach that child understands and that he can use across settings. Training for parents also arranged and to include other aids to facilitate with transition.

SLT and OT will continue to liaise with parents and class team to review suitability and ensure any restrictive practices remains minimal, evidenced and in the interests of the safety of the child.

Training and Resources

16 To what extent do you agree or disagree that the guidance includes details of training and resources available for educational settings, from the Education Authority, in relation to handling behaviours of concern?

Agree

Additional comments (optional):

The RCSLT NI welcome the list of training and resources available, however, we feel that it is missing the valuable input of training which has been created by Allied Health Professionals. We would suggest that this list is expanded to allow for the addition of relevant HSCT/SLT led trainings which are available free of charge to school staff.

This includes the Children with Disability training (as mentioned previously), RISE NI, Help Kids Talk and the individual HSCT training which is available to schools and families.

We are happy to assist in detailing the trainings available at your request and would strongly recommend these are added to allow education staff to access and signpost.

Informing Parents/Carers of Incidents

17 To what extent do you agree or disagree that the guidance outlines the requirement for educational settings to immediately inform parents/carers of any incident followed up with a formal report which should include measures to support the child and staff and prevent further incidents?

Disagree

Additional Comments (optional):

The RCSLT NI acknowledges that the guidance details that parents/carers are informed, however, it does not state the timeframe for this, or use the word 'immediately'. There is no mention of follow up by formal report within the guidance. We would welcome clear instructions and expectations on staff to inform families and the time frame for this within the final guidance.

Complaints Process

18 To what extent do you agree or disagree that the guidance outlines the complaints process and links to the Department's Safeguarding and Child Protection Guidance which includes advice on the escalation of safeguarding and child protection concerns?

Agree

Additional comments (optional):

RCSLT NI agree that this appropriately outlined in the guidance, however, do do feel that there should be an easy-read version for parents/carers to access. We would suggest that this is reviewed by the department and are happy to assist.

Whistleblowing Procedures

19 To what extent do you agree or disagree that the guidance outlines whistleblowing procedures?

Agree

Additional comments (optional):

RCSLT NI agree that this is appropriately outlined in the guidance.

Consultation

20 To what extent do you agree or disagree that the guidance was developed in consultation with schools, professional bodies, children and young people and parents/carers.

Agree

Additional comments (optional):

The RCSLT NI agree that the guidance was developed in collaboration with a range of relevant parties. We are however, disappointed that we, as a professional body, were not asked to participate. Given that speech and language therapists are experts in communication, our members could have assisted on the expansion of communication and it's impact on behaviour, provided case studies and supported the department of education with this guidance.

Please note we are happy to be contacted to assist with any amendments.

Measures to Ensure Mandatory Recording and Reporting of Restraint

21 To what extent do you agree or disagree that the guidance includes measures to ensure mandatory recording and reporting of restraint?

Agree

Additional comments (optional):

RCSLT NI agree that this made clear in the guidance document.

Additional Comments

22 Please provide any additional comments you may have.

Any other additional comments (optional) :

Thank you for the opportunity to provide feedback on this important consultation. The RCSLT NI would welcome the addition of our 'five good communication standards' to underpin this guidance. These standards reflect person-centred care, inclusion, accessibility and wellbeing and would increase the value of any service or document.

The five good communication standards:
Standard 1: There is a detailed description of how best to communicate with individuals.
Standard 2: Services demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services.
Standard 3: Staff value and use competently the best approaches to communication with each individual they support.
Standard 4: Services create opportunities, relationships and environments that make individuals want to communicate.
Standard 5: Individuals are supported to understand and express their needs in relation to their health and wellbeing.

We are happy to be contacted and would welcome the opportunity to support the Department of Education.

Additional Information

23 If you would prefer your response to remain confidential, please tick this box

Remain Confidential:
No