Restrictive Physical Intervention & Restraint Reduction Policy

(including prevention, de-escalation, reasonable force, restrictive intervention, recording, post-incident support and restraint reduction)

ABA Pathways

This policy is reviewed at least annually and sooner where there are statutory, regulatory, commissioning or operational changes.

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1. Aims and statement of intent

ABA Pathways is committed to reducing and, wherever possible, preventing the need for restrictive physical intervention. Our starting point is that behaviour is understood in context and that safe, capable environments, accessible communication, positive relationships, skill teaching and early support should reduce the circumstances in which physical restriction becomes necessary.

- Protect the dignity, safety, rights and wellbeing of children and young people and those supporting them.
- Use prevention, Positive Behaviour Support (PBS), functional assessment and capable environments to reduce foreseeable risk.
- Treat restrictive physical intervention as a safety response of last resort, never as punishment, coercion, a teaching method or a shortcut to compliance.
- Use only lawful, necessary, reasonable and proportionate intervention, for the minimum time and with the minimum restriction required.
- Continuously monitor physical and emotional safety during any intervention and stop or reduce restriction as soon as it is safe.
- Learn from every incident through accurate recording, post-incident support, review and changes to the Behaviour Support Plan (BSP), risk assessment, environment or staffing where indicated.
- Monitor restrictive practice data with an explicit aim of reducing frequency, duration, intensity and reliance on restraint over time.

2. Scope and legal framework

This policy applies across relevant ABA Pathways education, alternative provision, early years, respite, community, home-based and direct support services. ABA Pathways is not the statutory school for every child it supports; the precise legal power and statutory recording/reporting duty therefore depends on the setting, placement and commissioning arrangement.

This policy has regard, where applicable, to the current framework in England, including:

- Education and Inspections Act 2006, including sections 93 and 93A.
- Restrictive interventions, including the use of reasonable force, in schools (Department for Education, effective from 1 April 2026).
- Schools (Recording and Reporting of Seclusion and Restraint) (England) Regulations 2025.
- Equality Act 2010, including reasonable-adjustment duties.
- Children and Families Act 2014 and SEND Code of Practice: 0 to 25 years.
- Human Rights Act 1998.
- Children Act 1989 and Children Act 2004.
- Keeping Children Safe in Education 2026, where applicable.
- Working Together to Safeguard Children, as updated.
- Health and Safety at Work etc. Act 1974.
- Early Years Foundation Stage statutory framework, where applicable.

Where school statutory duties sit with a commissioning school, ABA Pathways will cooperate with the school and provide the information needed for it to discharge those duties. ABA Pathways will nevertheless apply equivalent transparent recording, review and restraint-reduction standards across its own services.

3. Definitions and terminology

3.1 Physical intervention

For this policy, physical intervention includes direct or indirect physical action used in response to risk. The training presentation used by ABA Pathways defines physical intervention as the use of direct or indirect force to limit another person's movement. Not all physical contact is restrictive: supportive presence, prompting, guiding or disengagement may be non-restrictive where there is no use of force to overcome a person's movement or resistance.

3.2 Restrictive physical intervention / restraint

Restrictive physical intervention means physical action that restricts a child or young person's movement, liberty or ability to act freely. It may include holding, physical containment or escorting where force is used. The level of restriction affects the level of justification required.

3.3 Reasonable force

Where the statutory school power applies, reasonable force means force that is necessary in the circumstances and proportionate to the risk being addressed. It is not possible to prescribe a fixed amount of force in advance; staff must justify why intervention was required and why the force used was no more than reasonably necessary.

3.4 Restraint reduction

Restraint reduction is the systematic process of preventing restrictive intervention and reducing its frequency, duration, intensity and impact through data, functional understanding, environmental change, skill development, staff support and individual planning.

4. Core principles

- Restrictive intervention is a last-resort safety measure.
- Prevention and de-escalation come before physical restriction wherever practicable.
- Any intervention must have a clear safety rationale and must not be punitive, retaliatory, humiliating or used for staff convenience.
- Staff must be prepared to explain what risk they perceived, what alternatives were attempted or considered, and why the intervention was necessary.
- The child's age, size, communication, SEND, physical and mental health, trauma history, sensory profile, medical conditions and known vulnerabilities must inform decisions.
- The environment, number of staff available, location, access to medical support and other situational risks must be considered dynamically.
- Restriction must be reduced or stopped as soon as the immediate risk no longer requires it.
- Every incident is an opportunity to improve prevention and reduce future restriction.

5. Roles and responsibilities

5.1 Directors and senior leads

- Maintain a clear organisational commitment to restraint reduction.
- Ensure staff training is appropriate to the children supported and the interventions staff may be expected to use.

- Ensure planned restrictive interventions are clinically/operationally justified, risk assessed and incorporated into the child's BSP.
- Review serious, unusual, repeated or high-risk interventions and escalate safeguarding or medical concerns appropriately.
- Monitor restrictive-practice data and ensure reduction actions are implemented.

5.2 Behaviour analysts/consultants and BSP leads

- Ensure assessment identifies setting events, triggers, functions, communication needs, early signs and proactive supports.
- Specify the least restrictive reactive strategies required for foreseeable risk.
- Ensure any planned physical intervention has clear indications, contraindications, monitoring requirements and a reduction plan.
- Review data following incidents and amend BSPs where evidence indicates a change is needed.

5.3 All staff and practitioners

- Follow the current BSP, risk assessment and training.
- Use proactive and de-escalation strategies early.
- Undertake dynamic risk assessment before and during intervention.
- Monitor the child continuously and communicate with colleagues.
- Stop or reduce intervention if risk changes or signs of medical distress emerge.
- Record and report incidents accurately and participate in post-incident review.

6. Prevention and restraint reduction

ABA Pathways' primary strategy is to reduce the conditions in which restrictive intervention becomes necessary. This aligns with the Behaviour Policy and BSP framework.

- Develop predictable, low-arousal and capable environments.
- Ensure children can communicate needs such as help, break, stop, finished, space, pain or sensory needs.
- Identify and reduce unnecessary triggers, waiting, ambiguity, excessive demands and avoidable sensory stress.
- Provide meaningful choice, preferred activities, reinforcement, regulation opportunities and positive relationships.
- Teach functional communication, coping, tolerance, independence and safety skills where these improve quality of life.
- Use early intervention, diversion, redirection, changes of adult, reduction of language/demand and access to space before escalation.
- Review staffing, routines, environments and expectations rather than locating the problem solely within the child.
- Set measurable restraint-reduction objectives when restrictive intervention has occurred repeatedly.

7. Behaviour Support Plans (BSPs), risk assessment and individual planning

This policy must be read alongside the ABA Pathways Behaviour Policy and the child's current BSP. The BSP is the operational document that translates assessment into individual prevention, teaching, reactive and reduction strategies.

Where restrictive intervention is foreseeable, the BSP and associated risk assessment should include:

- A person-centred description of the child, their strengths, communication, preferences and what matters to them.
- Clear observable descriptions of behaviour, early indicators and escalation patterns.
- Known setting events, triggers, health/medical factors and environmental influences.
- Functional hypotheses and the evidence supporting them.
- Proactive environmental, communication, sensory and relational strategies.
- Skills and functional communication to teach.
- Non-restrictive de-escalation and reactive strategies.
- The precise circumstances in which a planned restrictive intervention may be considered.
- Known contraindications, medical vulnerabilities and elevated-risk factors.
- How staff will monitor breathing, circulation, consciousness, distress and other signs of deterioration.
- How the intervention will be ended and recovery supported.
- Post-incident arrangements, data collection, review criteria and an explicit restraint-reduction plan.

Planned restriction must never appear in a BSP merely because it has been used historically. Its continued inclusion must be justified by current risk and evidence, with safer alternatives actively developed.

8. De-escalation and non-restrictive responses

- Remain calm and use non-threatening posture, tone and positioning.
- Reduce language and allow processing time.
- Offer familiar communication, choices and a clear route out of the situation.
- Reduce or pause non-essential demands.
- Remove bystanders or environmental hazards where possible.
- Use diversion, redirection, switching of staff or other agreed early interventions.
- Call for additional support early rather than waiting until risk has escalated.
- Where safe, withdraw and allow space rather than pursuing interaction.
- Attend to pain, illness, sensory distress, fear or safeguarding concerns that may be contributing.
- Use emergency services where the risk cannot be safely managed by the team.

9. When restrictive physical intervention may be used

Restrictive physical intervention may only be considered where there is an immediate or sufficiently serious risk that cannot be safely managed by less restrictive means and where the intervention is lawful within the particular setting and circumstances.

- To prevent or stop a child or another person from being harmed where the risk is significant and immediate.
- Where the statutory school power applies, in circumstances permitted by section 93 of the Education and Inspections Act 2006.
- In an emergency under wider legal principles where reasonable and necessary action is required to protect a person from imminent harm.
- Only for as long as the risk requiring restriction remains.

Physical intervention must not be used simply because a child refuses an instruction, does not complete work, is verbally challenging, is distressed without presenting an immediate safety risk, or because restriction is quicker or easier than de-escalation.

10. Decision-making: necessity, proportionality and least restriction

Before and during intervention, staff should use dynamic risk assessment. The training presentation emphasises that staff must be able to justify the use of force and explain why other methods could not safely resolve the situation.

- What is the immediate risk and who may be harmed?
- How serious and likely is the harm?
- What non-physical options have been tried, are available or are likely to work?
- Is withdrawal or environmental change possible?
- What individual medical, physical, communication or trauma factors increase risk?
- Do we have sufficient trained staff and a safe environment?
- What is the least restrictive intervention capable of managing the risk?
- Can force be reduced or stopped now?

11. Planned and emergency interventions

11.1 Planned intervention

Where assessment shows a foreseeable risk requiring a physical safety response, the intervention must be described within the BSP/risk assessment and delivered only by staff trained and assessed as competent in the relevant approach.

11.2 Emergency intervention

Unplanned circumstances may require immediate action to prevent serious harm. An emergency intervention outside the written plan must still be lawful, necessary, proportionate and as brief as possible. It must be recorded and reviewed promptly to determine whether the BSP, risk assessment, staffing, training, medical advice or environment needs to change.

Emergency use must not become an informal repeated strategy. Repetition is evidence that proactive planning requires review.

12. Prohibited and high-risk practices

ABA Pathways does not authorise restrictive intervention that deliberately causes pain, restricts breathing, uses the neck as a point of control, or is punitive, degrading or retaliatory.

- Any intervention that intentionally obstructs the airway, breathing or circulation.
- Pressure to the neck, throat, chest, abdomen or other vital areas as a means of control.
- Pain-compliance techniques.
- Deliberate use of restraint as punishment or to enforce compliance where there is no safety justification.
- Any technique for which the staff member has not been trained and assessed as competent, except the minimum emergency action reasonably necessary to avert imminent serious harm.
- Mechanical restraint unless there is a separate lawful, specialist, individually assessed and authorised basis for its use.

Ground restraint carries elevated risk and should be avoided wherever possible. The training material specifically identifies greater risk of serious harm or death in ground restraint, particularly where body position may impair breathing. ABA Pathways' approach is to prioritise standing, disengagement, environmental safety and release from restriction wherever this can safely manage the risk.

13. Medical and physical safety

Physical intervention carries an inherent risk of injury. Risk increases with factors including the method and position of restraint, duration, environment, number of staff, individual health vulnerabilities and access to medical attention.

Throughout any intervention, one staff member must maintain active oversight of the child's wellbeing. Staff must talk to and listen to the child where possible and continuously monitor breathing, circulation, responsiveness and distress.

The intervention must be reduced or stopped and urgent medical help sought where there are signs such as:

- Difficulty or unusual effort with breathing, complaints of being unable to breathe, or cyanosis/blueness around the lips.
- Vomiting, blocked airway or choking concern.
- Reduced consciousness, collapse, unusual passivity or non-responsiveness.
- Seizure.
- Signs of head, neck or spinal injury.
- Facial or neck swelling.
- Very high body temperature/hot skin, severe confusion or sudden marked deterioration.
- Suspected fracture, significant injury or any other medical emergency.

Known medical contraindications must be recorded in the BSP/risk assessment. Relevant factors may include cardiac or severe respiratory conditions, recent fractures or surgery, musculoskeletal problems, pregnancy, seizure risk and other child-specific vulnerabilities. Medical advice and child-specific training will be sought where required.

14. Team working during an intervention

Where more than one staff member is involved, roles should be clear. The training presentation emphasises lead-and-support working and the need for one person to take responsibility for monitoring the intervention and the wellbeing of those involved.

- Identify a lead communicator where practicable.
- One person should maintain oversight of the child's safety and signs of distress.
- Support staff should observe the wider environment, other people, hazards and the lead colleague's safety.
- Use clear, concise communication between staff and avoid contradictory instructions.
- Additional staff should not join an intervention unless their involvement is necessary for safety.
- Where a colleague has become part of the escalation, consider a planned change of adult ('switching') where safe.
- Team members must communicate immediately if they believe the intervention should be reduced or stopped.

15. Seclusion, withdrawal and environmental restriction

Seclusion is distinct from a child voluntarily choosing a quiet, low-arousal or safe space from which they are free to leave. ABA Pathways does not use seclusion as punishment, routine behaviour management or for staff convenience.

- If a child is prevented from leaving a space, this must be recognised as restrictive practice rather than described as an ordinary break or regulation opportunity.
- Any emergency restriction of a child's ability to leave must be necessary to manage immediate risk, used for the shortest possible time and subject to continuous appropriate supervision.
- Where school statutory duties apply, seclusion and relevant restraint incidents will be recorded and reported in accordance with the 2026 requirements.
- Repeated environmental restriction or seclusion will trigger senior review and an explicit reduction plan.

16. SEND, communication, trauma and reasonable adjustments

Children and young people supported by ABA Pathways may have significant communication, sensory, learning, medical or regulation needs. These factors can alter both the meaning of behaviour and the risks associated with physical intervention.

- Communication systems, including AAC, must remain accessible wherever safely possible.
- Staff should not interpret limited speech, delayed processing, sensory overload or distress as deliberate non-compliance.
- Reasonable adjustments should reduce avoidable escalation and disability-related disadvantage.
- Known trauma and adverse experiences must inform prevention, touch, proximity and post-incident support.
- The child's preferred communication method should be used to obtain their perspective after an incident.
- Assent, choice and self-advocacy should be promoted proactively; immediate safety may temporarily limit choice only where necessary and proportionate.

17. Training, competency and supervision

Planned restrictive intervention may only be used by staff who have received training appropriate to the intervention and have been assessed as competent. Training alone does not authorise an intervention: the legal and individual justification must still be present each time.

- Training will include prevention and de-escalation, not only physical skills.
- Staff must understand medical risks including positional/restraint asphyxia and signs of deterioration.
- Staff must know the individual BSP, risk assessment and contraindications before implementing planned techniques.
- Competence will be maintained through refreshers, supervision, practice review and incident learning.
- Staff should not improvise physical techniques because a planned technique is difficult to apply.
- Where staff confidence or competence is in doubt, this must be escalated before they are expected to implement a planned intervention.

18. Recording and reporting

All restrictive physical interventions will be recorded factually and promptly. Records should distinguish observed facts from interpretation and provide enough information to understand why intervention was used and whether it remained necessary.

- Date, time, location and people present.
- What was happening before the incident, including known setting events and triggers.
- Behaviour and immediate risk observed.
- De-escalation and non-restrictive strategies attempted or considered.
- The physical intervention used and why it was selected.
- Who was involved and their roles.
- Approximate duration and any significant changes during the intervention.
- How physical and emotional safety was monitored.
- Any injury, first aid, medical assessment or emergency-service involvement.
- How and when the intervention ended.
- The child's presentation and support after the incident.
- Notifications to parents/carers, commissioners, school or safeguarding leads as applicable.
- Any immediate changes required to the BSP, risk assessment, staffing or environment.

Where section 93A and the Schools (Recording and Reporting of Seclusion and Restraint) (England) Regulations 2025 apply, the responsible school must have procedures for the statutory recording and reporting duties. ABA Pathways will provide incident information promptly to enable the commissioning school to meet its responsibilities.

19. Post-incident support, debrief and learning

Post-incident activity has three purposes reflected in the training presentation: providing support, learning from what happened and sharing good practice.

- Attend first to physical safety, medical needs, emotional recovery and reconnection.
- Offer the child a chance to communicate their experience when they are ready, using their preferred communication method.
- Do not require an immediate verbal debrief from a distressed or exhausted child.
- Provide staff with appropriate debrief, supervision and wellbeing support.
- Review what happened, what worked, what could be changed and whether staff actions reduced or increased escalation.
- Identify whether further training, mentoring, medical advice or safeguarding action is needed.
- Share relevant learning with the team and update plans promptly.

20. Restraint reduction review and data monitoring

ABA Pathways will use data to ensure restrictive practice is reducing rather than becoming normalised.

- Monitor frequency, duration, type and context of restrictive interventions.
- Review antecedents, setting events, location, time, staffing, injuries and post-incident outcomes.
- Consider whether particular children or groups experience disproportionate restriction.
- Review whether BSP strategies were available and implemented as written.

- Identify recurring environmental or organisational contributors.
- Set actions to reduce restriction, with named responsibilities and review dates.
- Escalate repeated, increasing, unusually long or high-risk restraint for senior and clinical/behavioural review.
- Evidence reductions and improvements through BSP reviews and organisational quality assurance.

21. Safeguarding, allegations and complaints

Restrictive intervention does not sit outside safeguarding. Any concern that force was unnecessary, excessive, punitive, deliberately painful, unsafe, discriminatory or otherwise abusive must be managed under the Safeguarding and Child Protection Policy.

- Seek medical attention and preserve relevant evidence where injury or serious concern is present.
- Report allegations or low-level concerns about adults through the appropriate safeguarding route.
- Consult the LADO where the threshold for an allegation against a person working with children may be met.
- Children, parents/carers and staff must be able to raise concerns without fear of retaliation.
- Complaints will be considered alongside, but will not replace, safeguarding or disciplinary processes.

22. Parents, carers, commissioners and multi-disciplinary working

- Parents/carers should be involved in developing and reviewing BSPs and restraint-reduction strategies wherever appropriate.
- Commissioning schools/local authorities will receive information required by the placement and statutory framework.
- Relevant medical, OT, SALT, CAMHS or other professional advice will be incorporated where it materially affects risk or intervention.
- Where a parent/carer raises concern about an intervention, ABA Pathways will provide the factual record and explain the review process, subject to safeguarding and confidentiality requirements.
- Repeated restrictive intervention should prompt a multi-disciplinary review rather than simply repetition of the existing response.

23. Quality assurance and governance

- Directors will review restrictive-practice data and serious incidents at appropriate intervals.
- Audits will consider whether incidents were necessary, proportionate, correctly recorded and followed by reduction action.
- Training records and staff competency will be monitored.
- BSPs containing planned restrictive intervention will be reviewed when circumstances change and at appropriate scheduled intervals.
- Patterns suggesting unsafe practice, excessive restriction or ineffective prevention will result in immediate corrective action.
- This policy will be reviewed at least annually and sooner following significant legal/guidance changes, serious incidents or organisational learning.

24. Links with other policies and ABA Pathways BSPs

This policy should not be used in isolation. It operates directly alongside the ABA Pathways Behaviour Policy and individual Behaviour Support Plan format.

- Behaviour Policy - particularly assessment, BSPs, proactive support, responding to behaviour of concern, restrictive intervention, seclusion and post-incident review.
- Individual Behaviour Support Plans (BSPs) - the child-specific operational plan for proactive strategies, skills teaching, reactive responses, any planned restrictive intervention and restraint reduction.
- Safeguarding and Child Protection Policy.
- SEND Policy.
- Health and Safety Policy.
- Positive Handling / Intimate Care arrangements where applicable.
- Medication Administration Policy and individual healthcare plans.
- Equality, Diversity and Inclusion Policy.
- Risk assessments and individual emergency plans.

Appendix 1: Restrictive intervention decision framework

- 1. Identify the immediate risk: what harm is likely and to whom?
- 2. Use/consider prevention and de-escalation: communication, space, environmental change, reduced demand, redirection, change of adult, additional support.
- 3. Decide whether physical restriction is genuinely necessary now.
- 4. Select the least restrictive option capable of managing the risk.
- 5. Consider individual and environmental risk factors before and during intervention.
- 6. Maintain communication and active monitoring of wellbeing.
- 7. Reduce force/restriction as soon as the risk allows; stop immediately when no longer necessary or if a medical emergency develops.
- 8. Provide post-incident care, record accurately, notify as required and review how recurrence can be prevented.

Appendix 2: Minimum recording requirements

- Child/young person, date, time and location.
- Staff and others present.
- Antecedents, setting events and immediate risk.
- De-escalation/non-restrictive actions.
- Reason physical intervention was necessary.
- Technique/type of restriction and staff roles.
- Duration and monitoring.
- Child's communication and presentation during the incident.
- Any injury, first aid or medical response.
- How intervention ended.
- Post-incident support and child's perspective where available.
- Parent/carer, school/commissioner and safeguarding notifications.
- Review outcome and changes to BSP/risk assessment/restraint-reduction plan.

Appendix 3: Restraint reduction review checklist

- Has the frequency, duration or intensity of restriction increased or decreased?
- Are incidents clustering around particular times, activities, people, environments or demands?
- Are pain, health, sleep, sensory or communication factors adequately assessed?
- Does the child have an effective, accessible way to request help, stop, break, space or escape?
- Are proactive BSP strategies being implemented consistently?
- Can the environment or routine be changed to remove avoidable triggers?
- Are staffing levels, relationships, skill mix and training sufficient?
- Is any planned restrictive technique still necessary and the least restrictive option?
- Have the child's and family's perspectives been incorporated?
- What specific action will reduce the likelihood or restrictiveness of the next incident, who owns it and when will it be reviewed?