Behaviour Support in Schools and Services Policy

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Scope
This policy applies to all NAS schools, young people and adult services that provide support for people where the NAS has a duty of care. This policy should be read in conjunction with other NAS policies including: safeguarding, Restrictive Physical Intervention (RPI) and bullying.

NOTE – This policy incorporates the policy Behaviour Support in Adult Services SO-0027. The policy does not apply to Northern Ireland. Please see separate policy SO-0029NI for Northern Ireland.

Purpose
The purpose of this document is to ensure a common understanding across NAS services regarding why people with autism behave in the ways that they do, taking into account the impact of having autism alongside an individual’s own life events and experiences. This in turn will inform both general strategies that can be effective for many of the people that we support, as well as detailing more individualised proactive
and reactive strategies and considering more complex behaviour that can challenge individuals and services.

**Introduction**

People with an autistic spectrum disorder (ASD) can see and experience the world in ways that are sometimes very different to the rest of the population. A consequence of this is that people with autism can behave in ways that are difference to what the majority of us might consider ‘normal’.

Our first concern when working with those people in our services who behave differently is to determine whether behaviours that staff may see as ‘inappropriate’ or different are dangerous for the person displaying the behaviour or to those around them, are illegal or significantly impede the individual’s access to normal community services and learning opportunities, or are a sign of distress. If this is not the case then our role rather than to change behaviour or alleviate the distress, is to raise awareness throughout the wider community, working as individuals and as an organisation to change attitudes towards people with autism whose behaviour may appear unusual or different.

**Legal context**

It is not possible to point to a single piece of legislation, in England & Wales, Scotland, or Northern Ireland, that covers all the law relating to the care of children, young people and adults. All relevant legislation is found in the reference section at the end of the policy.

**Challenging behaviour**

Some behaviours displayed by people who access our service may be described as ‘challenging’.

Challenging behaviour can be defined as:

‘...behaviour of such intensity, frequency or duration that the physical safety of the person concerned or other people is at serious risk, or the behaviour results in the person only having limited or no access to ordinary community facilities’

(Emerson, Eric (2001).

Behaviours that may challenge are frequently characterized as being aggressive or violent in nature. However, other behaviours that include the people we support’s non-participation in activities, withdrawal from interaction, repetitive routines or questioning can often challenge staff and services as much as the more obviously physically challenging behaviours.

**Factors affecting behaviour:**
A variety of factors may influence a person’s behaviour and underpin challenging behaviour. *Autism itself is not a cause of challenging behaviour. Rather the impact of having autism within this social world combined with other factors such as those highlighted below come together to create difficult behaviours.*

**Impact of Autism**

Autism is a lifelong developmental condition which results in ‘hard wired’ differences in the way that parts of the brain are structured. So people with autism are likely to perceive, interpret, process and experience the world in a different way.

All people with a diagnosis of autism have a dyad of impairments as set out in DSM-5 that affect each individual to a greater or lesser extent. The dyad of is made up of impairments in:

- **Social communication and Social Interaction**

People with autism do not develop a ‘Theory of Mind’ at the same time or to the same degree as the rest of the population. This means that it is difficult for a person with autism to understand that others have independent thoughts and thus different perspectives from their own. This can cause a variety of problems in terms of interacting with others as a person with autism will be at the very least delayed in their ability to understand others’ points of view, or struggle to realise that communication is necessary for others to understand and meet their needs. For example, a person with autism may feel thirsty and then become frustrated when a carer or member of staff does not help them to get a drink.

People with autism find it difficult to process and understand the social world. Social rules and conventions that the rest of us learn intuitively often need to be explicitly taught and even then may not be fully understood and applied. Many people with autism want social relationships, but most struggle to know how to interact, and experience high levels of anxiety in social situations. Some people with autism may find the social environment so confusing that they withdraw from social situations completely.

- **Restricted, repetitive patterns of behaviour, interests or activities**

People with autism have a difficulty with flexibility of thought. Some people with autism may find it very difficult to change the focus of their attention so may become stuck or obsessed with a particular item or topic of conversation. They are likely to find dealing with novel situations difficult due to difficulties with generalising skills and experiences learnt from other situations. Often people with autism can find change and transition problematic, e.g. transitioning from home to their school or day service, or changes to expected activities, so they rely on routines and predictable events to feel secure.

- **Sensory issues**
Many people with autism also experience differences in the way their sensory processing systems work. Some may be particularly (hyper) sensitive to noise so may hear, become upset or distracted by noise that the rest of us would hardly notice. Conversely others may be under (hypo) sensitive to touch so may need to exert extra pressure when touching objects or other people to receive the same sensory feedback.

Most people autism have issues with sensory processing and integration meaning that they may struggle to process and understand the information coming in from a variety of sensory modalities. They may struggle to filter out irrelevant information and to concentrate on what is necessary.

- **Additional stressors**

While we must always recognise a person’s autism is likely to pose the above challenges, people who have autism are just as likely to be affected by other factors which affect their mental health and emotional wellbeing as the rest of the population, and are sometimes at increased risk.

- **Life events and experiences**

Like the rest of us people with autism are affected by life events and experiences such as bereavement, moving house, puberty, family breakdown etc.

- **Illness and wellbeing**

Illness and pain can affect how a person behaves especially if unable to properly explain this pain to others.

People with autism may also suffer from low self-esteem, be bullied, excluded and lonely.

- **Stress**

People with autism often experience very high levels of stress. This is true for people with autism across the spectrum – those functioning at a lower level may experience stress and anxiety related to difficulties communicating and understanding the world around them; those functioning at a higher level may have more insight and awareness into their difficulties and differences in comparison with other people their own age, and those supporting them may overestimate their abilities and hence not always provide effective support.

High levels of stress can emphasise and increase those other difficulties described above.

**Positive Behaviour Support**

The NAS follows an ethos of Positive Behaviour Support (PBS)
• PBS seeks to discover the function and/or communicative intent behind behaviours through the use of good quality functional assessment (Incident forms, observations, ABC charts etc.).
• Interventions that teach functionally equivalent alternatives to difficult behaviours can then be planned.
• It is a non-aversive approach meaning that the focus is on positive reward and teaching new skills, rather than punishments and sanctions.
• There is a focus on determining antecedents to behaviour and then removing or minimizing effects.
• Teaching functional communication that is relevant and useful for the individual is paramount.
• PBS emphasises enhanced community presence, choice participation and a person centred approach to behaviours rather than solely focusing on behavioural change.
• Restrictive practises and physical interventions are kept to an absolute minimum.

General proactive strategies

Good general strategies that take into account the factors that influence the wellbeing and behaviour of people with autism are vitally important to reduce the likelihood, severity and frequency of behaviours that might become problematic for the person themselves, staff or the wider public.

A variety of autism specific strategies can be used that focus on the relative strengths of people with autism and aim to reduce anxiety. These should be adapted to meet individual needs. They include:

Clear visual supports. Use of clear, simple language. Structuring the environment in a way that is visually clear to the individual. Use of structure to help individuals understand what they are doing, how long they might be doing it for and what they will be doing next. This may include pictorial or written timetable, objects of reference or photographs, timers. Low arousal environments. Teaching new skills in a calm low arousal environment with these visual supports, before generalising to more ‘real life’ environments.
Specific interventions

Proactive

Proactive strategies use knowledge of an individual’s likes, dislikes, triggers and cues to behaviour to identify potentially difficult situations and prevent the behaviours occurring.

This would include: teaching coping strategies, stress management and relaxation techniques, changes to the environment, providing alternative ways to meet the same need the behaviour achieves (e.g. use of sensory items to chew on to negate need for biting), providing structured times for appropriate engagement in activity (E.g. banging on drum timetabled 3 times a day to negate need to bang on windows).

Reactive

Reactive strategies are used once a behaviour has occurred to manage the behaviour and deescalate the situation as quickly as possible.

Reactive strategies include:

De-escalation techniques: reducing demands, removing triggers, distracting and motivating, reducing sensory input (turning off lights, reducing noise and language).

On some occasions when there is no alternative and as a last resort it may be necessary to use a restrictive physical intervention (RPI) to keep the person displaying behaviours or those around them safe – see RPI policy.

Individual Support Plans (ISPs)

Every person with an ASC will have had different life experiences and have unique characteristics personalities and interests, as well as dislikes and potential sources of stress. Therefore each person who requires support from NAS services requires their own individual support plan.

The people we support will have, where appropriate, an Individual Support Plan (ISP) to assist in the management of their anxiety, distress and behaviour. We use the term ‘support’ as we recognise most behaviour results from unmet needs and therefore we focus on how we must provide support to meet those needs, not solely on the behaviour causing concern. The intention is for people to increasingly be responsible for managing their own behaviour. All ISPs should be written in line with the following principles:

- ISPs are drawn up by the staff who know the person well, with advice from other staff with responsibility for behaviour management. Where appropriate families should be consulted and contribute to these plans.
o All ISPs identify motivators (likes), causes/ antecedents/ triggers/ dislikes, and relevant sensory issues. General management strategies are given as well as specific proactive and reactive strategies for all frequent and/ or significant known behaviours. The ISP should be concise, clear and functional to ensure that consistency of behaviour management is achievable across different settings and with different staff.

o Each person’s ISP is reviewed as and when required according to individual need. The relevance and effectiveness of each ISP will be assessed at least annually and modifications made as necessary.

o Strategies used will be evidence based and data will be collected to ascertain the effectiveness or otherwise of strategies used.

o Within 48 hours of a placement starting an initial ISP should be put in place where required. This should be reviewed regularly during a baseline period and a final ISP in place by 12 weeks after the placement starting.

The long term aim will always be to try to empower the individual with autism to be aware of their own triggers and cues and to give them the skills to manage their own behaviours to the best of their ability. Where appropriate, it would be best practice to include a young person or adult in compiling their ISP. This can assist with the NAS’s overall aims to help people with autism to manage their own behaviour.

Sanctions

A sanction is a negative consequence applied to unacceptable behaviour, for example missing recreation time or a trip. The NAS promotes a non-aversive approach to behaviour management. Whilst people we support will experience natural consequences, we do not support the use of punishment.

Self-Injurious Behaviour

In NAS schools between 40% and 60% of the children and young people may at some time exhibit self-injurious behaviour of varying degrees of intensity. In a minority of these cases the tissue damage from any one incident is serious but for most the injuries are minor e.g. bites that do not break the skin or head tapping. However the cumulative effect of many instances of behaviours such as dropping to the floor on knees, eye poking or head banging could result in permanent tissue damage, particularly sensory impairment, so all instances of self injurious behaviour must be carefully noted.

The NAS recognises that self-injurious behaviour can be one of the most difficult behaviours to support as it can be resistant to change and emotionally draining for parents, carers and staff. Self-injurious behaviour should be supported using the same analytical, positive and low arousal approaches as any other behaviour that gives rise
to concern. The function of the behaviour should be ascertained if possible and the individual taught other, less damaging, ways to meet his or her needs.

The following points must be considered when devising an individual support plan for self-injurious behaviour:

- Health problems such as headache, stomach ache, tooth ache or generally feeling unwell can result in self injurious behaviour. Appropriate clinical investigations should be sought whenever behaviour changes or intensifies without there appearing to be a cause.

- Ritualistic, routine led behaviours are often connected with self-injurious behaviour. Physically intervening to stop self-injurious behaviour that is part of a routine is often counterproductive as the person being supported will try to complete the routine later, often when they are in a heightened state of anxiety resulting from the previous prevention.

- The use of head gear to reduce damage from head banging should only be used where there is no other strategy available as in some cases the wearing of head gear can result in the person banging harder to achieve the same effect or more frequent banging through stimulus response.

- Some people who display self-injurious behaviour also have a history of aggression towards staff and others, sometimes resulting in serious injury. Any direct staff intervention, including the use of a planned RPI, must be carefully assessed in these cases and the risk of greater injury to the person concerned or to staff associated with intervening balanced against the risk of not directly intervening.

**Strategy:**

- Good quality functional assessment based on incident data and any further recording should inform strategies that are adopted. These strategies should be in line with positive behaviour support principles.

- In the first instance staff have a duty of care to intervene to stop or reduce damage caused by these behaviours. However, sometimes the best support strategy to prevent increase in potential injury is to ensure that the individual is as safe and as comfortable as possible but make no direct intervention until the episode is over. This can result in shorter episodes with less likelihood that the self-injurious behaviour will escalate and result in more serious injury. Such supervision without direct intervention should be agreed with relevant external parties such as parents and the local authority.

- Pain relief and medical investigation should be considered in the presence of new self-injurious behaviours.
• Chewy tubes, apples, oranges or similar may be offered as safe alternatives to those who may bite themselves.

• Pillows or cushions may be used to reduce impact of head banging behaviours.

• People who display self-injurious behaviour’s often have lower levels of functional communication. Teaching meaningful communication skills at the appropriate level is a key strategy in trying to reduce self-injurious behaviour.

• Increased structure, extra sensory opportunities, teaching self-regulation and relaxation strategies, and physical exercise can all help reduce frequency and intensity of self injurious behaviour.

• Staff should try to respond in a calm neutral manner in the presence of SIB and reward and praise appropriate behaviours wherever possible.

• If possible staff should try to redirect the individual to a preferred activity that is incompatible with the self-injurious behaviour. E.g. squeezing a stress ball if engaged in hitting self.

• Self-stimulatory behaviours may have an inverse correlation with self-injurious behaviour, so a decrease in one is associated with an increase in the other. Therefore extra care should be taken when trying to change self-stimulatory behaviours and appropriate, safe alternatives should be taught.

• Where there is any evidence of tissue damage or there is persistent low intensity self-injurious behaviour, first aid for the damage or possible damage must be given.

• Care needs to be taken over the recording of self injurious behaviour to ensure that persistent low intensity self-injurious behaviour, which could lead to long-term damage, does not go unrecorded. Parents and carers should be informed of any significant incidents involving self-injurious behaviour with the individual’s consent, if this can be gained.

• Providing treatment, support and care for people who exhibit self-injurious behaviour is emotionally demanding. Not all staff are equally confident in managing self-injurious behaviour and some find it more distressing to observe than others.

• Management needs to ensure that the staff supporting people who exhibit more intense self-injurious behaviour have sufficient competence in their ability to fulfil their role.

• The NAS recognises that staff supporting people who show self-injurious behaviour are in a potentially vulnerable position; if the individual sustains serious
injury the quality of their care is likely to be questioned and the reputation of the
service may be harmed. Services must ensure that staff are appropriately trained,
supported and prepared to deal with challenging situations and at the very least
must make sure they are aware of and understand the ISP of each person for
whom they have responsibility.

- In an emergency, staff can only fall back on their professional experience, their
  training, their common-sense, the ‘best interest’ principle and their over-riding
duty of care to wherever possible prevent harm to a vulnerable person. Provided
staff act reasonably, proportionately and sensibly, their actions will be supported.
Any such emergency action must be carefully recorded on an incident form.

Training

Staff will receive initial training in Studio 3’s ‘Managing challenging behaviour’ three
day course and one day refresher sessions every 12 – 15 months.

Staff will receive SPELL training as part of their induction.

Where specific staff training needs for the support of individuals are identified, the
individual’s support staff will receive appropriate training either delivered internally by
Psychology, Speech and Language or Occupational Therapy teams or others with
relevant experience in autism and behaviour management; or additional training will
be sourced externally when the need arises.

Reporting recording and monitoring

- Challenging behaviours will be recorded using incident recording systems or other
data gathering methods to assist in monitoring behaviours, functional assessment,
and ascertaining the effectiveness or otherwise of behavioural interventions.

- Where behaviours are recorded routinely, data should be monitored regularly to
ascertain trends and patterns.

- Unexplained or sudden changes or increases in challenging or concerning
behaviours should always be investigated.

- Regular reports on the incident data for services should be made to the senior staff.

- All serious behavioural incidents should be reported to senior staff immediately.

- Results from behaviour recording or behavioural interventions should be shared
with parents and carers, where appropriate.

- Injuries or accidents arising from behavioural incidents must be recorded in
accordance with the relevant policies.
• Every use of a restrictive physical intervention (RPI) arising from a behavioural incident must be recorded in accordance with the RPI policy.

• In some cases an individual may display behaviours that staff are not able to manage with the skills they have been taught or within the environment the person is living or accessing. In this situation it is essential that a care review meeting is called with representation from the family, local authority and the NAS to review the support package and agree on future interventions.

• Self-injurious behaviour that is likely to result in serious permanent tissue damage should, in addition to taking the appropriate emergency action, be discussed at a full case conference with an agreed recommendation to the Head of Operations Adult Services or Head of Operations - Schools.

• Serious or persistent violence and extreme anti-social behaviour – e.g. serious injury or damage such as arson - should, in addition to contacting the police or other relevant agencies, be discussed at a full case conference with an agreed recommendation for further action passed to the Head of Operations - Adult Services or the Head of Operations - Schools.

Responsibilities

Trustees

• Ratification and review of the policy on the management of behaviour in services.

• Reviewing reports from the Responsible/Nominated Individual on the incidence of self-injurious behaviour (delegated to the Quality and Risk Committee).

Head of Operations - Adults/Schools

• Monitoring of implementation of this policy;

• Ensuring the allocation of internal and external resources, including clinical, to address the needs of children/young people, adults and staff with regard to the implications of more serious or prolonged behavioural challenges.

Service Managers

• Enforcing the implementation of this policy in their service;

• Ensuring that a comprehensive recording and reporting process relating to the management of behaviour is in place and is regularly reviewed.

• Ensuring that the behavioural support systems in place in the service are used competently through regular monitoring and training of staff.
• Ensuring that support teams develop risk assessments and individual behaviour support plans which detail behavioural support strategies.

• Ensuring plans are shared with the individual, using the method of communication most appropriate to them, parents/advocates, purchasers and other interested agencies, recognising the importance of consent in terms of the fundamental issues of respect and dignity.

• Ensuring that individual behaviour support plans are regularly reviewed and updated in the light of people’s development and progress.

• Ensuring that staff have access to advice and support from specialists in behaviour management where necessary. This can be from within services, such as psychology staff and behaviour coordinators, and through using external consultants.

• Ensuring that parents and carers are kept regularly consulted on their dependent’s response to his or her behaviour program and that any significant events are communicated promptly. Parents and carers should be made aware of serious behavioural matters without delay.

• Ensuring that training in the management of the behaviour of people with autism is provided for staff. Where specific training needs to help particular staff support people’s behaviour have been identified, ensuring that those staff have access to the advice, training and development opportunities appropriate to their needs.

• Providing regular information to their Area Manager and Head of Operations Adult Services or Head of Operations - Schools.

Staff

• To treat all people who use our services fairly, with respect and understanding while having regard for their rights and responsibilities.

• To work always in the best interests of the person, having high expectations of people’s behaviour and to strive to ensure that all people work to the best of their ability.

• To assist the people we support to manage and improve their behaviour as part of everyday activities. Helping people to manage their behaviour is just as much a team effort as managing all other aspects of their life.

• To thoroughly familiarise themselves with the current behaviour and person centred support plans for the people they support and consistently apply the strategies described.
• To satisfy themselves that they are clear on what they may and may not do in terms of behaviour support, and to seek clarification as necessary;

• To record and report behavioural incidents as required by the systems in the service.

• To contribute to the development of support plans.

• To report any changes they notice in the individual’s response to their ISP to the team supporting them.

• To use staff review, Support and Supervision, sessions to confirm their understanding of this policy and to seek further explanation or personal development as necessary

• To take part in training in behaviour support for people who have ASD.

• To support other staff in the team and demonstrate confidence in each other’s skills and abilities to support people.

• To provide appropriate models of behaviour for people they support at all times.

• Personal likes and dislikes and values to with regard culture, age, sex, religion, must not influence staff’s approaches.

• To seek help with managing behaviour when necessary; it is not a sign of failure to do this.

• To dress appropriately whilst at work and to adhere to service dress codes when asked.

• To wear clothing to help protect them when working with individuals in crisis as specified on individual Risk Assessments. This will be decided on a case by case basis, having regard to the dignity of the individual and the safety of the staff. Protective clothing shall be as neutral and non-stigmatizing as possible e.g. caps for tying hair back, discreet arm guards and shin guards etc.

• To make judgments in the light of this policy and to act within the service’s procedures on managing behaviour. However, as no policy or procedure can cover every eventuality, staff are expected to use their professional judgment and experience when supporting individuals. Staff will be supported when action in good faith follows from such judgments. The following judgments can reasonably be expected of staff:

  o Deciding on the best course of action to keep the people they are supporting, and staff, including themselves, safe.
o When deciding on the need for action, however rapidly, considering the risk of immediate danger to persons or property.

o Deciding on the appropriateness of intervention in keeping with the behavioural incident that gives rise to it

o Taking into account the age and competence of the individual in deciding on the degree of intervention necessary.

o Whether to intervene in an incident even if the member of staff has not signalled they need assistance.

• Senior staff are responsible for ensuring staff support systems are in place and are being used. This will include ensuring that post incident debriefing is offered to the staff involved. Debriefing will be offered on the day of the incident, the recipient can express a choice of who debriefs and the information will be kept confidential.

• Senior staff have a responsibility to demonstrate trust and confidence in the staff's ability to manage the people they are supporting. If shortcomings in such management are identified, senior staff have a responsibility to address these through Support and Supervision and Appraisal.

Staff are expected to implement the approaches and strategies they have been taught in training when supporting an individual who is displaying challenging behaviour.

Debriefing:

• It is essential that all services make good use of the systems in place for staff debriefing and support where they are working with people who show challenging behaviour, including self-injurious behaviours. All staff working with people who show high levels of self injurious behaviour should have regular supervision in which the emotional impact upon them can be discussed and understood (see Stress at Work policy HR-0024). Staff should be made aware of the 'First Assist Employee Assistance Programme (EAP)' the employee assistance scheme (0800 716 017).

• It is important for staff to recognise when they need more specialist clinical support in managing self-injurious behaviour, and how to access this. The commissioning authority should always be involved where there are serious incidents of self injurious behaviour which need further clinical input, and decisions should be made within the context of a multidisciplinary meeting including families wherever possible. Where appropriate, referrals should be made to other relevant services for additional support.
• Staff should also ensure the people we support have a meaningful debrief at their level of understanding after being part of or witnessing incidents. For some this may involve talking about what happened for others it may involve spending some calming time with favoured staff and/or activities.

Parents and Carers

To work collaboratively with the service so that the people being supported receive consistent messages about appropriate behaviours.

- To take part in a supportive dialogue with the service about the individual’s behaviour, each informing the other promptly if there are causes for concern or celebration.

- To be familiar with and support the strategies in the individual’s behaviour support plan, contributing to its development if possible through the ongoing consultation process.

- If parents or carers have concerns over the service’s management of their dependent’s behaviour to raise the matter with the service in the first instance. If the concerns remain and/or the issues cannot be resolved the complaints procedure can be used.

Complaints

Individuals using NAS services, their parents, friends or family have the right to offer comments and refer to the Complaints Procedure in the case of any disagreement in the management of behaviour. Please refer to the Compliments, Comments and Complaints Policy QS-0009 for further information.

Whistleblowing

Employees of the NAS have a duty to voice any concerns over care practice. Please refer to the Policy on Whistleblowing (HR-0002) for further information.

References

• Restrictive Physical Interventions Policy (RPI) SO-0039
• Whistleblowing Policy HR-0002
• Stress at Work policy HR-0024
• Compliments, Comments and Complaints Policy QS-0009
• SPELL
• Section 21 of the Education Act 2002 as amended by section 38 of the Education and Inspections Act 2006. www.legislation.gov.uk
• Sections 89 and 93 of the Education and Inspections Act 2006
• Section 550A of the Education Act 1996
• Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) 2013
• Our Health, Our Care, Our Say, Department of Health 2006
• Use of Reasonable Force – Guide for Head Teachers, Staff and Governing Bodies, 2012, Department for Education
• ‘National Minimum Standards for Residential Special Schools’ DoH 2002
• Rights, Risks and Limits to Freedom, Mental Welfare Commission for Scotland, 2006

Legal Context References

The relevant statutory legislation in England and Wales includes regarding adults are:

• The Care Standards Act 2000 (with the associated regulations and national minimum standards)
• The Mental Capacity Act 2005,
• The Human Rights Act, 1998
  In Scotland the legislation is covered by:
• Regulation of Care (Scotland) Act 2001
• The Adults with Incapacity (Scotland) Act 2000
• The Adult Support and Protection (Scotland) Act 2007
• Human Rights Act

The relevant statutory legislation in England and Wales regarding children and young people includes:

• The Education and Inspections Act 2006
• The Care Standards Act 2000 (with the associated regulations and national minimum standards),
  • the Mental Capacity Act 2005,
• The Mental Health Care and Treatment (Scotland) Act 2003
• The Children (Scotland) Act 1995
• The Human Rights Act, 1998.

The latter’s framework of respecting the right to dignity, respect and freedom underpins the NAS philosophy of care.

Schools must also comply with equalities legislation and the duty to promote the wellbeing of pupils.