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Physical Intervention: Policy into Practice

A report on the one day conference held at the Whitebrook Training Unit, Manchester on 22 July 1998

Pauline John

North West	NW
Training & Development Team	TDT

Working with local services in Cheshire, Greater Manchester, Lancashire, Merseyside and South Cumbria in moving towards better futures for people with learning disabilities.

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Special thanks to Alan Lewis, Lisa Jones and Phil Jones.

Contents

Introduction

This one day conference was run jointly between the North West Training and Development Team and Manchester Joint Learning Disability Service to look at current practice across the region in the field of physical intervention.

In 1993 the Regional Advisory Group for Learning Disability Services published a document *Physical Intervention: How we work with people who are considered at times to be in need of physical restraint*.

The report concerned situations where a carer makes a judgement that physical intervention is needed to avoid the person with a learning disability causing damage to themselves and others. The guidance was aimed at managers to ensure that staff were given the appropriate training, supervision and support required to work in these specific situations.

As part of that work an organisational audit schedule was devised and distributed to managers within the North West Region. This allowed services to ensure that important strategic issues of service design were in place and operational. The audit focused on aspects of policy and procedure and the process of monitoring and evaluating its impact. It also helped to ensure safeguards against potential abuse of physical intervention being used unnecessarily or inappropriately.

Prior to the one day conference, the North West Training and Development Team surveyed both Social Services and Community Health Trusts developments in policy and practice in the area of physical intervention with particular reference to the 1994 regional guidelines and this work was presented at the one day conference as part of the basis for exploring current practice and future developments.

Organisational audit and survey findings

All social services departments and health trusts in the region were asked to fill out an organisational survey based on the 1994 survey to consider how far practice had moved on and look at the key issues that may be emerging. The survey (Appendix 1), focused on five main areas that should be of concern to services:

- policy and procedure
- training
- staff support
- monitoring and safeguards
- accreditation of independent providers.

The number of returns totalled 24 out of a possible 42, which is equivalent to a 57% response rate. Three of the returns were a joint response which could technically take the return rate to 64%. The returns were broken down as follows:

- Joint replies = 3
- Social Services = 12
- Community Health Trusts = 9.

Generally, the overall results of the survey were very positive with many returns showing a high degree of awareness of the issues, with policy and procedures in place and staff who are being trained. On a cautionary note it may be that those organisations that completed and returned the survey were those with the greater commitment to having proper systems in place to support the work of front line staff within the organisation. The returns may, therefore, only be demonstrating 'good practice' rather than highlighting the need for improvement.

Policy and procedure

Five returns indicated there was no policy guidance on either responding to violence and aggression or physical intervention. Four returns had no policy on physical intervention policies that were available. Policies that were in place dated in the range of 1991 to 1998. Two were currently in the process of being developed with a target date November and December 1998 respectively.

All returns had systems for documenting incidents of violence and aggression even where policy did not exist. 17 of the 24 had senior managers responsible for monitoring. In two other organisations, a Health and Safety Officer and a member of the Additional Support Team were responsible for monitoring policy. Of these only ten produced regular reports to the senior team.

Training

Awareness training for staff on responding to violence and aggression was available in 19 services. Where physical intervention was to be used, 17 of the 24 had the following in place:

- specific training for the staff involved
- written plans on file
- regular multi disciplinary monitoring
- regular reviews.

Regular training was available in 15 of the 24 organisations who either ran their own internal training or bought in training. Training was secured from the following sources:

- Cardiff
- Calderstones
- Broadmoor Special Hospital
- Studio Three (Bath).

Staff support

A mechanism for staff support that is identifiable and known to all is available in 19 of the 24 organisations. However, only in eight of the services do line managers receive training in staff support.

Monitoring and safeguards

In six of the organisations there was monitoring and safeguards available that were external to the organisation.

Those stated were through the Registration and Inspection Units within local authorities and through the use of local advocacy services.

One service used the process of ‘reciprocal checks’ by another organisation, particularly in respect to their training.

This is clearly an area which needs to be further developed to ensure a greater sharing of ‘good practice’ as well as a check on the potential for poor practice.

Accreditation of independent providers

Of the 15 local authorities who submitted returns, five already had a process built in to their contracting procedures. One authority wanted to develop this as part of their policy guidance.

One authority was very specific that individual agencies were required to have a policy which is validated prior to a contract being agreed.

This is an interesting area of future development. Indeed, if independent agencies are required to have policies prior to contract, it would assume that all ‘in house’ provision should certainly have policies and procedures in place.

Policy development in Manchester

This paper was presented by Mark Burton, Head of Development and Clinical Service, Manchester Joint Service.

Aims

1. Describe the policy in use in Manchester.
2. Describe its assumptions.
3. Describe its evolution.

Evolution

Factors leading to the production of the policy in Manchester:

- issues arising in practice
- RAGLDS document
- NWTDT sponsored training
- formation of city wide Joint Service.

Why a policy?

It is important for organisations to understand the need for policy and its benefits.

- To define what is right and wrong.
- To protect service users and staff.
- To identify a decision making process.
- To get organisational ownership.
- To set up a monitoring framework.

What's in it?

- Introduction
  - the legal situation
  - other interventions
  - keeping the service user central.
- Practice guidelines for the use of physical intervention.
- Training
  - levels.
- Post-incident procedures.
- Staff issues.
- Documentation and audit.
- Management responsibilities.
- External organisations.
- Definitions.

This policy:

- outlines Manchester Joint Services specific philosophy and procedures for responding to aggression and violence.
- is informed by a review of best practice, current knowledge of safe, effective methods and of ways of avoiding the need for physical intervention wherever possible.
- does not substitute for the general 'violence at work' policies agreed by the signatory organisations.

Assumptions:

- aggression and violence always happen for a reason
- it is the responsibility of service providers to understand these causes as they affect individuals, and to devise ways of reducing their impact
- physical intervention will be a last resort.

The legal situation

The use of physical intervention may be construed in law as 'trespass to the person'.

Potential offences:

- assault
- battery
- false imprisonment.

A legal **defence** against the above offences:

A person may restrain someone who is doing or about to do, physical harm to themselves, or

another person or damage property. In all circumstances any restraint must be reasonable.

‘Reasonable’

- The force used is no more than is necessary to accomplish the particular aim
- the reaction of the case staff to the service user’s behaviour must be in proportion to the harm threatened.

What action is reasonable depends on:

- the scale of the threat to the service user and to others
- the other options available for reducing the threat
- the feasibility of carrying out the proposed actions
- the likelihood of its success
- the ability of the service user to give consent.

What is reasonable in the short term might not be reasonable in the long term as other (preventative or therapeutic) strategies become effective.

Other interventions

Since the mid 1980s a variety of non aversive interventions of known effectiveness has been available.

These should be used under the direction of appropriately trained staff and should be planned as indicated by proper assessment and analysis of behaviour and its causes.

Methods now available should reduce the need for reactive approaches such as physical intervention.

Sometimes medical treatment is indicated, for an underlying cause, (e.g., headache, sinus congestion, psychiatric disorders, or pre-menstrual tension).

Chemical restraint

In certain cases tranquillising medication, prescribed by a medical practitioner, is used as a ‘least worst’ short term expedient to reduce damage to the person or others.

Only a temporary measure:

- build up of tolerance to the drugs used
- possibility of various side effects
- uses of ‘chemical restraint’ should be audited as for physical intervention.

Keeping the service user central

Always asking why?

The key is to address service user’s interests.

Therefore emphasis on understanding service users, includes trying to interpret what they may be communicating through their behaviour in context.

Critical issues:

- the possibility of abuse
- the grouping of service users whose needs and behaviours conflict
- unmet need, including failure to detect illness
- environmental considerations (e.g., personal and physical space).

Responsibility to seek professional and managerial guidance about dilemmas in treatment and care.

Consultation

- Small internal consultation on an initial draft.
- Large consultation (86 organisations and individuals) on substantial draft.

Ratification

- Social Services Committee.
- Trust Board.

Implementation

- Briefings to relevant staff from our service and other service organisations.
- Establishment of Physical Intervention Advisory Group.
- Establishment of monitoring framework.

Workshop 1: Physical Intervention Advisory Group

This workshop was presented by Alan Lewis, Behavioural Therapist, and Phil Jones, Clinical Manager, Manchester Joint Service.

Physical Intervention Advisors Group (PIAG)

A group of trainers in Manchester who have specialised in this area have come together to provide advice on individualised, safe, ethical and structured responses to severely physically challenging behaviour. This group became known as the PIAG when the policy on responding to aggression and violence was introduced and now helps to ensure the policy is carried out by handling all referrals or enquiries regarding the use of physical intervention.

In the event of a referral being made, a referral will also be made to the local Community Learning Disability Team, to ensure a comprehensive assessment is made and to avoid physical intervention being considered or practised in isolation from other approaches.

Physical intervention can never be sanctioned as an initial response and the group stress it is only ever to be used as a last resort. Extensive evidence of the use of alternative approaches is required before physical intervention can be considered as an option. To date, the majority of referrals to the group have been resolved by working with staff teams to understand the behaviour (see below), and to devise preventative strategies to reduce the need to resort to physical intervention as a response to challenging behaviour.

Referrals 1997-1998 summary

Ten referrals (nine adults, one child).

Two required full physical intervention guidelines.

Membership

Associate Psychologist - a member of a Community Additional Support Team.

Behavioural Therapist - a member of a Community Additional Support Team.

Three RNLD Nurses - one community nurse, two clinical managers.

How the group functions

- Meetings every six weeks, to process/review referrals.
- Joint work with Community Learning Disability Team, Additional Support Teams.
- Staff training and advice.
- Audit and monitoring.
- Policy development.

What do we do?

- Offer advice and training to carers to provide safe methods of managing complex behaviour.
- Will only offer advice when an assessment of the behaviour and preventative measures are in place, except in extreme circumstances.
- Provide individualised intervention guidelines, produced following an assessment.
- Plan, evaluate and audit guidelines and interventions.
- Use the least intrusive and restrictive options.
- Aim to reduce the use of physical intervention where appropriate.

Intervention and three levels of training

Level I Awareness and understanding of aggression and violence.
Preventative methods.
Responding in a positive manner.
Confidence.

Level II Basic 'breakaway' techniques.
Awareness of the environment.
Risk assessment.

Level III Individualised packages.
Guidelines on safe practice.
Auditing and monitoring.

Initial assessment

- Who is involved?
- Reason for referral?
- Health status of the service user?
- Possible triggers?
- Description of behaviour?
- What are the alternatives to physical intervention?
- What are the current interventions?
- What recording methods are used?
- Has a behavioural assessment been done?
- What are your expectations of us?

Strengths	Weaknesses
Buys time to develop long term preventative approaches.	Not our full time role.
We provide a second opinion and widen the responsibility for developing reactive strategies.	Risk that responsibility for intervention design becomes exclusive to the group.
Helps to develop and inform on policy and monitors the use of physical intervention.	Persons may receive negative image because of being referred to us.
Our main approach is to avoid the use of physical intervention.	Most of our practice is in response to low level physical threat. If we need to respond to greater risks we would not be as well prepared.
Encourages the development of non physical intervention approaches and a better understanding of the causes of aggression.	Perception that the only response to aggression and violence is physical intervention.

Workshop 2: Key issues in policymaking

This workshop was presented by Mark Burton, Head of Development & Clinical Services, Manchester Joint Service and Pauline John, NWTDT.

Policies are tools that:

- identify responsibilities of both staff and the organisation
- provide guidance to staff
- clarify the aims of the organisation and the means by which it reaches them.

Policies versus procedures

Key things to consider before writing a policy:

- level, scope and specificity
- ownership
- implementation and review.

So you think you need a policy? Steps for producing a policy

1. Planning

Identify the need that the policy is intended to meet, for example:

- what would be the scope of the policy?
- who else thinks you need a policy?
- is there a person or group with lead responsibility for policy development?
- is there access to administrative support.

2. Writing the policy

Consider:

- workshop to map issues
- review of the field
- collective writing
- drafts - label each one clearly with version number.

3. Consultation

To decide on audience and process, consider:

- what is the purpose of the policy?
- who is involved?
- who will be affected?
- whose agreement would be necessary or desirable?

Possible stakeholders:

- other providers, statutory and independent
- personnel departments
- health authority
- registration and inspection
- service users and their organisations
- families of service users
- advocates
- carers
- education providers
- professional groups and advisers
- other agencies (housing, policy, probation)
- legal advisers
- contract managers.

4. Ratification

Who ratifies?

Depends on level and scope of policy. Who needs to own the policy, and take responsibility for its consequences? Do you need to write a social services committee report or NHS Trust board report?

5. Implementation and review

Decide what is needed and who should be involved:

- formal launch?

- briefing and training? Consider who you need to target? What about independent providers?
- new responsibilities for some?
- feedback on effectiveness?

Now:

- define a timetable for implementation
- agree frequency for monitoring and review date.

Workshop 3: Safeguards - what can go wrong?

This workshop was presented by Lisa Jones, Assistant Clinical Manager, Manchester Joint Service.

What can go wrong?

1. Training

- diluted to others
- misinterpretation
- not enough analysis/information
- may not be remembered
- used too much/too little
- physical intervention becomes first instead of last resort
- dehumanised (ethical implications).

2. Application

- forget approaches
- abuse of service user
- generalisation
- change approaches when people change behaviours
- accountability may be lacking
- private/independent sector - whose responsibility?

Present safeguards

- clear written guidelines
- signed procedures
- pictorial evidence
- briefing systems for managers and staff throughout the organisation
- good, regular training including service principles and seven accomplishments
- reciprocal checks by external organisation
- monitoring by senior managers who collate all information
- review policy and procedure and schedule a review date
- accreditation of training
- private/independent providers ‘sign up’ to policy, as part of the contracting process.

Other ideas

Limit training to specific need.

Training of specific staff teams.

Use observers from outside i.e., external checks.

Refresher training as necessary.

Sift out inappropriate referrals.

Workshop 4: Physical intervention in practice - the Calderstones model

This workshop was presented by Mark Mercer, Intervention Co-ordinator, Julie Allen and Fiona Tilley, Behaviour Therapists - Forensic Services and Jackie Scott, Behaviour Therapist - Challenging Behaviour Services, Calderstones NHS Trust.

The workshop was designed to provide brief information about the specialist service which Calderstones NHS Trust provides for people with learning and associated disabilities. Details of the physical intervention techniques that have been adopted by the Trust were also given, along with the reasons. A demonstration of some of the Trust approved physical intervention and breakaway techniques followed, with the emphasis on such intervention strategies being employed only as the last resort and never as a matter of course.

In 1985, a forensic service was developed at Calderstones. The Individual Planning Process came into operation focusing on people's strengths and needs with the intention of devising goals to meet identified needs.

In 1989, the Behavioural Approaches Course commenced at Manchester University - Hester Adrian Research Centre. Calderstones have always shown a keen interest in the course and have seconded over 20 staff to attend. Selected staff have returned equipped with skills to write training and behavioural programmes along with individual management guidelines to meet identified needs.

Aggression workshops were designed by Mick Stephens and started in 1991 giving staff insight into anger and aggression along with advice and guidance about how to manage difficult behaviour. There are currently three different aggression workshops, the first level taking place at Induction.

It was clear that the emphasis was changing from a broadly reactive, to a far more proactive service, and in the prevention of, rather than dealing with aggressive behaviours when they occurred.

At this time, Calderstones started to look at how other services dealt with aggression. It seemed, however, that the only services that provided any training for staff was in the prison service and in Special Hospitals where Control and Restraint was used. A group of senior managers looked into the suitability of Control and Restraint for our client group in 1991, but it was felt to be inappropriate.

1993 saw the formation of the Regional Advisory Group for Learning Disability Services and a sub group was formed to look specifically at physical intervention. This led to the production of the document *Physical Intervention: How we work with people who are considered at times to be in need of physical restraint.*

The following year, two members of the group, John Smith and Laura Golding from Communicare NHS Trust, became aware of a model used in Cardiff which seemed much more suitable to managing aggressive behaviours displayed by people with a learning disability whilst maintaining a therapeutic relationship. As a result, David Allen and Tony Doyle from Cardiff agreed to train selected practitioners from teams around the North West in these methods to a standard whereby they could teach others.

At Calderstones, it was agreed that the Behaviour Therapists should be trained to become trainers of other members of staff who were involved in the implementation of individual management guidelines. To become a physical intervention trainer, staff had to undergo a four day course with the main emphasis on practical techniques.

Training was focused on the individual, and guidelines were very specific around physical intervention methods as the very last resort. De-escalation techniques aimed at calming potentially aggressive situations were also detailed in the guidelines.

In 1995, anger management workshops were designed by the Consultant Clinical

Psychologist, Jeanette McDonagh, and Behaviour Therapist, Forensic Services, Mark Mercer, with the aim of educating referred clients in various aspects of anger and the effects that aggression can have on others. Through a combination of group discussions, short presentations and role plays, clients became aware of their automatic thoughts and were subsequently given the skills to challenge them and hopefully, replace them with more reasonable thoughts. Anger management maintenance groups commenced in 1997. It would appear that many of the clients have benefited from attending the course having made significant progress with regard to their behaviour and in managing their angry feelings in more appropriate ways.

A three day basic Behavioural Approaches course started for staff in 1995. The course involved many of the Behaviour Therapists, and staff subsequently became more involved in the assessment, planning, implementation and evaluation of training and incentive programmes, as well as management guidelines. These courses have proved to be extremely popular, and two further courses have since been planned and are presented on a regular basis.

In September 1997, the Trust appointed a Physical Intervention Co-ordinator, Mark Mercer. The main responsibilities and priorities of the post were:

- to monitor use of physical intervention through incident forms
- to establish a database of various details of incidents
- to organise and monitor staff training
- to offer advice to service managers about any areas of concern
- close involvement with the Health and Safety Committee.

The introduction of regular refresher courses for trainers was one of the first priorities and certain techniques have since been modified and adapted to meet the needs of various individuals. We are consistently seeking ways of improving our practice and are always open to new ideas and techniques which might be better than our own.

In February 1998, the Trust's Moving and Handling Advisor, Christine Holmes, was involved in our Train the Trainers course to assess the physical intervention and breakaway methods from her specialist point of view. Again, a few intervention techniques were changed to satisfy the moving and handling requirement and further reduce the risk of injuries - mainly back related.

At the moment, the Trust has 45 physical intervention and breakaway trainers, who are graded on a star system in relation to their experience and competence. One of the main requirements for them to maintain 'three star status' is for them to attend at least two refresher days and be involved in at least 20 hours training every year.

The training is monitored by the Mancunian Community Health NHS Trust, Joint Learning Disability Service as part of a reciprocal arrangement.

The aims and objectives of the Breakaway course at Calderstones are:

- all participants will demonstrate the Breakaway techniques which are Trust approved
- participants will be aware of the safety aspects of each Breakaway method
- participants will consider the need for breaking away from a certain situation by analysing the motive and intentions of the client.

A demonstration of the following breakaway techniques was given, however, participants who attended the seminar were advised not to practice the techniques without instruction and supervision from an experienced trainer:

- safe stance
- one handed wrist grab
- two handed wrist grab
- one handed clothes grab
- hair pulls.

The aims and objectives of the physical intervention course at Calderstones are:

- trainees will demonstrate competence in all the physical intervention techniques which are Trust approved
- trainees will have a knowledge of the courses which give an insight into anger and in ways of encouraging acceptable alternatives to aggression
- trainees will have a knowledge of the de-escalation process.

A demonstration of the following physical intervention techniques was given, and again, participants were advised not to practice the techniques without instruction and supervision from an experienced trainer:

- standing and holding restraint
- sitting restraint
- floor restraint.

Calderstones have found that the physical intervention and breakaway techniques they use seem to be the most effective and least aversive methods to manage people with learning disabilities who behave in an aggressive manner. The main issue raised during the workshop, however, regarded different services having access to the training. It was explained that there is still a great deal of staff training needed at Calderstones at the moment, and that there are little opportunities to train staff in other areas of the region. This situation may change in the future so that other services may have opportunities to access the training.

Appendix 1: Organisational survey

Name of Social Services Department: _____

Contact Person: _____

Tel No: _____

		Yes *(please tick)*	No
1.	Is there a departmental policy on Responding too Aggression and Violence? (Date introduced _____).	☐	☐
2.	Is there a policy on the use of physical intervention? (Date introduced _____).	☐	☐
3.	If yes, are all managers and care staff aware of the policy?	☐	☐
4.	Is a copy available at all relevant locations within the service?	☐	☐
5.	Is there a system for documenting incidents of aggression and violence?	☐	☐
6.	Is there a senior manager with responsibility for monitoring and evaluating the use of physical intervention in the service?	☐	☐
7.	Does the senior manager responsible produce regular reports of the frequency and level of physical intervention used?	☐	☐
8.	Is there a clear system for all incidents to be reported to the senior manager?	☐	☐
9.	Is awareness training on responding to violence and aggression available to all care staff?	☐	☐
10.	Are care staff working with specific service users given priority in training?	☐	☐
11.	Where physical intervention is likely to be used with a specific client, the following are in place:		
	• specific training for staff on appropriate physical interventions	☐	☐
	• a written plan available or service users file	☐	☐
	• regular monitoring of the use of physical intervention by a multi disciplinary team	☐	☐
	• multi disciplinary review at regular intervals	☐	☐
12.	Is there a mechanism for staff support that is identifiable and known by all care staff?	☐	☐
13.	Do line managers responsible for care staff who work with aggressive service users receive training in staff support?	☐	☐
14.	Is there a small number of staff and managers who receive more in-depth training in the use of physical intervention?	☐	☐
15.	Is their training subject to regular refresher training by outside specialists?	☐	☐

16. Do these staff then act as advisors to multi disciplinary staff who may be using physical intervention? ☐ ☐

17. Where do trainers get trained? (Please specify).

18. Is there any monitoring or safeguards available external to the organisation? ☐ ☐

19. Is there a process and accreditation for independent providers built into the contracting process in matters of physical intervention. E.g., are they required to 'sign up' to a policy? ☐ ☐

20. Is there any specific criteria used for users requiring physical intervention? If yes, please give outline. ☐ ☐

Do you have examples of good practice in your service you would like to share? Please describe.

Any other comments.

Please return to Pauline John, 55 Parsonage Road, Heaton Moor, Stockport SK4 4JW by 3 June 1998.

Appendix 2: Useful references

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