
As the last resort: *Reducing the use of restrictive physical interventions.*

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BACKGROUND

This research builds on work by Murphy et al (2001, 2003) on the impact of the British Institute of Learning Disabilities (BILD)/National Autistic Society (NAS) policy document (Physical Interventions A Policy Framework: Harris et. al. 1996) on the learning disability field. Their work also examined the use of Physical Intervention (PI) (and associated training) within services but was conducted before a training accreditation scheme was established by BILD in 2002 and Government policy was published in the same year.

The 1996 Policy Framework was commissioned by the Department of Health as a response to widespread professional and campaigner disquiet on the use of restrictive PI. Perhaps because of the commercial opportunities in providing training, accrediting this, and debating the nature of techniques taught, little attention appears to have been given to limiting the use of PI in the UK. The use of PI is associated with a culture viewed as aversive, restrictive and controlling. 'Progress without Punishment', (Donnellan et al, 1988) was an influential publication arguing against the prevalence of controlling and restrictive practices within services. More recently in the UK the BBC documentary McIntyre Undercover, (16 November 1999) showed how PI can become part of an abusive culture within services. More practically, debate has centred around particular methods of PI used in mental health and learning disability services, some being associated with deaths of patients or involving the use of pain to gain compliance. In 2004 the NHS National Patient Safety Agency responded to these concerns by prioritising physical restraint, as one of five safety issues affecting people with learning disabilities. In addition the National Institute for Clinical Excellence has recently 'provoked outrage' by failing to introduce a three minute limit on prone physical restraint as recommended by the enquiry into the death of David Bennett, following his being restrained face down on the floor for twenty five minutes in 1998 (Community Care 16 December 2004).

Against this background service users describing their experience of being restrained have voiced themes that were overwhelmingly negative with pain; anxiety and mental distress; anger; and the perception that the staff were experiencing anger, hatred and feelings of enjoyment during the interventions. Government policy (2002) on restrictive physical interventions, legal imperative and individual service provider policies will concur that the use of restrictive PI should be as the 'last resort', even in its use as a proactive, planned intervention in a person's best interest. If this is to be more than rhetoric then practical policies and actions to develop and reward alternative responses by staff should be available.

AIMS AND OBJECTIVES

This project, part of a wider PhD study, sought to:

- Examine the impact and adoption of the BILD Policy Framework and Government policy on PI use in learning disability services
- Examine service practice and attitudes to reducing restrictive PI as opposed to managing its use.

METHOD

A postal questionnaire survey was conducted in the South East of England covering three local government areas. Participation was invited from all the service providers for people with learning disabilities registered with CSCI and those directly managed by the NHS in two English counties and one London borough. 137 services responded, just over 25% of all providers.

The questionnaire comprised mostly closed questions; information sought covered: number of service users, challenging behaviours experienced, physical interventions employed, presence of PI policy, provision of PI training and whether services monitored the frequency and restrictiveness of PI use as part of quality assurance (QA) programmes or more generally. Services were also asked for their

opinions on whether they should be seeking to reduce PI use and how. Open response sections were applied to several of these questions.

The questionnaires addressed to the service or home manager were posted in September 2005 with a follow up in February 2006. Analysis of the data involved a mixture of descriptive and inferential procedures. Open response sections were analysed for themes raised.

OUTCOMES

Some of the main findings include:

- In general, the results show that most services providing for people who exhibit challenging behaviour have adopted much of the recent policy guidance. Most services employing PI do so within written policy frameworks, provide PI training and monitor the frequency and restrictiveness of PI use. However, a small proportion (approximately 15%), similar to that found in a survey conducted in 2000 and reported in Murphy et al (2003), do not have PI policies or provide PI training. This is cause for concern. Positive evidence from some provider organisations suggests they have adopted sophisticated organisational approaches to monitoring physical intervention use, partly with the aim of reducing its use.
- With regard to the four types (NHS, local authority, private, voluntary) of provider agencies surveyed, statistically significant results included:
 - NHS services were more likely to cater for high frequency self injury and more likely to use sitting restraint;
 - Only the NHS and private services reported using floor restraint;
 - Voluntary sector services were less likely than other sector services to use all forms of PI, except escorting with arms held;
 - Private providers were less likely to provide PI training than other service provider agencies.
- Monitoring of PI use and including this as part of quality assurance (QA) processes were explored by the survey. About a half of the services said that this was part of their QA programme. The proportion of services that said they generally monitored the frequency and restrictiveness of PIs used rose to around three quarters. Perhaps a surprising minority said they did not monitor these - 15% and 24% respectively.
- Forty nine services, 36% of the total, stated that their organisation should be seeking to reduce the use of PI. Some explained this simply in terms of the "rules" e.g. the urgings of recent policy directives. Other more expansive comments demonstrated a sophisticated appreciation of whole organisational approaches to monitoring and supporting this goal.

The report concludes that policy and practice should explicitly focus on reducing the use of restrictive physical interventions. In the long-term, this is likely to have greater impact upon quality of support for people with learning disabilities and challenging behaviour than being satisfied with the better management of such procedures. If "as the last resort" is to mean what it says then such statements must be accompanied by serious attempts to reduce both the frequency and restrictiveness of PI use.

Three core strategies are suggested that will need to be considered by services wishing to reduce their use of PI:

- Leadership and organisational change
- Data use to inform practice
- Specific restraint reduction strategies at service and individual service user level.

RESEARCH TEAM

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Full report at:

http://www.kent.ac.uk/tizard/research/research_projects/analysisreportrdpm07pdf.pdf

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