

# INFORMATION SHEET



## Physical Interventions for Challenging Behaviour

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### Introduction

One of the unfortunate characteristics of challenging behaviour is that it tends to be long-term; it may therefore be displayed by a person for many years. Even with the best intervention plans in place, there are likely to be times when behaviour is out of control, and when carers will need to intervene to prevent damage to the person concerned or to themselves. In the absence of well-thought out plans to manage out of control behaviours, the risks of injury for both parties are increased.

### What are reactive strategies?

Reactive strategies provide carers with clear plans for how to respond to challenging behaviours. As their name suggests, they are 'reactive' in the sense that they are brought into play once challenging behaviours become apparent. Their use will not result in any future change in the pattern of a person's behaviour; their goal is simply to help carers achieve rapid, safe, and effective control of out of control behaviours.

Because of these limitations, reactive strategies must never be used on their own, but should instead be employed alongside proactive, preventative plans for changing behaviour. The latter may include steps for reducing or avoiding known triggers for a person's behaviour, procedures for teaching skills which will help reduce a person's dependence on their challenging behaviour, and short-term behavioural or medication based strategies for more rapid change. LaVigna and colleagues (1989) provide an excellent summary of the place of reactive strategies in intervention plans.

The key to the effective use of reactive strategies is a detailed knowledge of the pattern of behaviour shown by a person. Despite the frequently held view that challenging behaviours occur 'out of the blue', most people show us signs that they are becoming agitated or distressed before they lose control. Learning to recognise these early signs is the basis for early intervention, and the earlier carers intervene, the more probable it is that serious behavioural outbursts can be avoided.

A good reactive plan should therefore follow a gradient approach, with the early signs of behavioural agitation being responded to with efforts to distract the person and defuse the situation; if this proves ineffective, the priority will change to thinking about the possible use of physical interventions to re-establish behavioural control.

## Physical Interventions

The term 'physical interventions' refers to 'any method of responding to challenging behaviour which involves some degree of direct physical force to limit or restrict movement or mobility' (Harris et al, 2008). Three broad categories of physical intervention may be identified:

- Direct physical contact between a carer and a person with challenging behaviour (e.g., self-protective 'breakaway' techniques for escaping from grabs and chokes or minimal restraint to briefly immobilise the person)
- The use of barriers, such as locked doors, to limit freedom of movement
- The use of materials or equipment to restrict or prevent movement (e.g., the use of arm splints to reduce self-injury)

## Use of Physical Interventions

As can be imagined, this is an emotive topic which generates numerous ethical and practical concerns. Many care agencies shy away from considering this issue - despite that fact that physical interventions will almost certainly be being used on an informal basis within any service supporting children or adults with severely challenging behaviour. Evidence (Emerson 2003) suggests that over 50% of people with intellectual disabilities and challenging behaviour are regularly exposed to restraint. Operating in a vacuum can be extremely dangerous, and agencies run the risk of failing to meet Health & Safety requirements if they do not train their staff adequately in this area.

In 1996 (revised 2008), the British Institute for Learning Disabilities produced a set of policy guidelines designed to help services improve their practice in this area. Some key principles are that:

- Restrictive physical interventions should only be used in the best interests of the person with learning disabilities
- They should only be used in conjunction with other strategies to help people learn to behave in non-challenging ways
- They should be individualised and subject to regular review
- They should employ minimal force and not cause pain

The second of these points is particularly crucial, as physical interventions can only be ethically delivered within an overall context of an individualised package of positive behavioural support (Allen et al., 2005). Please note though that there are 32 principles in all in the document - and they are all important!

The policy guidelines were followed-up with a Code of Practice for Trainers (2001; revised 2006) and an accreditation procedure for training organisations (2002). A list of organisations that have been accredited by BILD can be found on their website ([http://www.bild.org.uk/03behaviour\\_organisations.htm](http://www.bild.org.uk/03behaviour_organisations.htm)). BILD have also produced a series of downloadable leaflets on topics such as mechanical restraint and seclusion as well as a number of user friendly guides to physical intervention.

The Department of Health & the Department for Education & Skills issued their own guidance on restrictive physical interventions (DOH/DES, 2002). This guidance was prompted by a BBC MacIntyre Undercover programme, which highlighted the inappropriate use of physical interventions in a residential care home. The document usefully draws

attention to high- risk procedures, some of which have been associated with deaths of service users (Paterson et al., 2002). In response to these concerns, the Welsh Assembly Government (2005) has banned the use of prone (face down) restraint.

### **Legal Issues**

The law surrounding the use of physical interventions is also extremely complex. Christina Lyon and Alexandra Pimor (2004) have produced a major review of UK legislation concerning the use of restraint with children, young people and adults with learning disabilities and severe challenging behaviour.

### **Medication**

It should be noted that the most prevalent form of intervention within services is probably chemical, not physical. Many persons with learning disabilities and challenging behaviour will be subject to high rates of medication, the primary role of which is to act as a behavioural suppressant rather than a treatment in the conventional sense. While the use of medication is outside the scope of this information sheet, it is interesting to note that the use of chemical restraint has generally attracted less attention than physical restraint. Deb et al. (2006) have however produced some general guidelines for using medication to manage challenging behaviours (<http://www.ld-medication.bham.ac.uk>). Importantly, Tyrer et al. (2008) recently demonstrated that placebo medication was more effective than either risperidone or haloperidol in reducing rates of aggressive behaviour.

### **Research into Physical Interventions**

Given the highly intrusive nature of physical interventions, it is of grave concern that so little research exists in this area. Allen (2001) reviewed the available research and concluded that the evidence for the effectiveness of training in physical intervention skills was weak.

### **Further Reading**

Allen, D. (2001) **Training Carers in Physical Interventions. Research towards evidence-based practice.** Kidderminster: BILD.

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Department of Health & Department for Education & Skills (2002) **Guidance for Restrictive Physical Interventions. How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder.** London: DOH.

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Harris, J., Cornick, M., Jefferson, A. & Mills, R. (2008) **Physical Interventions. A Policy Framework**. Revised Edition. Kidderminster: BILD/ NAS.

LaVigna, G.W., Willis, T.J., & Donnellan, A.M. (1989) The role of positive programming in behavioural treatment. In Cipani, E. (Ed) **The Treatment of Severe Behaviour Disorders**. Washington; AAMR.

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