
Physical Interventions with People with Intellectual Disabilities: Staff Training and Policy Frameworks

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Background Physical intervention or restraint with people who have intellectual disabilities is sometimes necessary, even though it is known to present dangers to both staff and service users (some service users have died as a result of restraint).

Aims This study aims to investigate the extent to which staff in intellectual disability services were trained in the use of physical interventions or restraint. Their views of a recent policy framework on physical interventions were also sought.

Methods There were three groups of participants: (i) group 1 included staff who had attended conferences on the Policy Framework (the conference sample); (ii) group 2 included staff from two geographical areas (the geographical sample); (iii) group 3 included staff in specialist assessment and treatment services (the SpAT sample). All participants were sent a questionnaire asking them about their training in (and use of) physical intervention methods and their opinions on the policy document.

Results There were at least 12 different types of training recorded, including a number of varieties of Control and Restraint (C&R). By no means did all the senior staff did have training in physical intervention methods. The degree of training varied with the sample and the type of training varied with the employing organization. Most participants in group 1 were very positive about the BILD & NAS Policy Framework but few staff in groups 2 and 3 had read the document. About two-thirds of the participants said their services had (or were developing) a written policy on physical interventions.

Conclusions There remained a clear need for further training in physical interventions and evidence on which the effectiveness of different methods of physical interventions could be judged.

Keywords: challenging behaviour, intellectual disability, physical intervention, staff training

Introduction

In the recent NHS Executive survey of various parts of the health service in the UK, it was estimated that, on average, seven violent incidents occurred for every 1000 staff members employed in NHS Trusts each year. Nurses were the most common targets, and mental health and intellectual disability services were the riskiest areas (NHSE 1998).

In intellectual disability services, when faced with violent assaults, staff may have to resort to physical interventions with service users, usually in order to prevent children or adults from harming themselves (or others) through their self-injurious behaviour or aggression. Harris (1996) noted that such procedures were normally justified as 'in the best interests' of the service users.

Nevertheless, it is known that both staff and service users are at risk when physical interventions are employed. In relation to staff, Hill & Spreat (1987), for example, reported that over a period of 1 year, there were 256 restraint-related injuries to 465 staff in a residential facility for people with intellectual disabilities in the USA. Moreover, it has been demonstrated that injuries to service users are particularly common when the restraint is 'unplanned' (Spreat *et al.* 1986). Indeed, some service users have died as a result of such procedures being inappropriately applied (Department of Health & Social Security 1985; Community Care 1997). In addition, some cases have come to light where physical interventions or restraint appear to have been used in an abusive manner (such as in a recent BBC documentary on some group

homes in Kent, MacIntyre Undercover, 16 November, 1999).

Nevertheless, the policy framework for the use of physical interventions has been slow to develop in the UK, with staff in mental health and intellectual disability services developing 'management of violence' policies as best they could, in a rather haphazard way. From the mid-1980s onwards, many NHS staff (and some local authority staff) in mental health and intellectual disability services were offered training in 'Control and Restraint' (C&R). C&R is a method of physical intervention, which was originally developed in the prison service and which was adopted in the NHS, partly as a result of the recommendations of the 1985 Ritchie report (Wright 1999). In intellectual disability services, a number of other methods of management of violence have been developed since the advent of C&R, including Strategies for Crisis Intervention and Prevention (SCIP), Non-Aversive Psychological and Physical Interventions (NAPPI), Protection of Rights in Care Environments (PRICE) and Studio III, as well as newer versions of C&R (British Institute of Learning Disabilities 2002). All of these methods have linked training courses, which have been marketed to the day and residential services that might employ them. Service providers, however, have shown a growing concern about both the lack of a national framework for such physical interventions and the considerable arguments they see between proponents of the different methods.

As a result, with funding by the Department of Health, the British Institute of Learning Disabilities (BILD) and the National Autistic Society (NAS) drew up a policy framework for the use of physical interventions with people with intellectual disabilities (Harris *et al.* 1996). They defined physical interventions and provided guidance on the law, values, prevention of violence, best interests, risk assessment, minimizing risks, managers' and employers' responsibilities and staff training. Subsequently, BILD and NAS were interested in establishing the extent to which their policy document was affecting practice in services and they requested an independent evaluation of the impact of the policy document.

This study was conducted in this context with funds provided by the Department of Health. The aims were to investigate the extent and types of training in physical interventions amongst staff working with children and adults with intellectual disabilities, and to examine staffs' views of the BILD and NAS Policy Framework document. The study involved three groups of participants (see below). Some of the results for group 1 have already been published in a brief report (Murphy *et al.* 2001) but those are included here where comparisons across the groups

are of interest. Results for groups 2 and 3 have not appeared elsewhere.

Method

Participants

Group 1: In 1996 and 1997, BILD and NAS held three conferences in the UK (London, Manchester and Birmingham) at which the policy framework (Harris *et al.* 1996) was presented and delegates received copies of the policy document. The participants in group 1 included all of the delegates to these conferences. In addition, BILD held the names and addresses of some of those who had subsequently purchased a copy of the policy document, and these were also included in group 1.

Group 2: In order to examine the degree to which the BILD policy framework was reaching all intellectual disability services, two geographical samples were taken, and all intellectual disability services in those areas were contacted. The areas chosen were two boroughs in SE London, served by one NHS Trust (the total population of the two boroughs together amounted to approximately 435 000) and a rural county in the SE UK (total population 499 000). Educational, day, residential and peripatetic services for children and adults with intellectual disabilities were all included in this sample.

Group 3: It could be argued that the intellectual disability services most likely to be in need of comprehensive information about physical interventions and training in physical interventions are those providing specialist assessment and treatment. The third group therefore consisted of services offering short-term specialist assessment and treatment for people with intellectual disabilities in the UK.

These three groups are referred to (in Tables 1–6 and Figures 1 and 2) as group 1 (conf), group 2 (geog) and group 3 (SpAT) for clarity.

Measures

Two questionnaires were designed to investigate participants' own training (and that of their staff team) in methods of physical interventions, their use of these methods in their workplace, their views of the BILD/NAS policy document, their workplace policies on physical interventions, their own attitudes to physical interventions and some details of their use of the procedures with some service users. The two questionnaires were used with all three groups of participants (see Procedure below). There were very small changes of wording in a few places for the

Table 1 Participants' characteristics

Variable	Group 1 (conf) (n = 115)	Group 2 (geog) (n = 165)	Group 3 (SpAT) (n = 61)
Age (years)			
Mean	43.3	44.3	40.6
Range	30–65	22–72	29–54
SD	6.7	10.2	6.1
Years worked in intellectual disabilities			
Mean	17.5	13.9	16.9
Range	3–31	1–39	2–32
SD	6.0	7.3	7.0
Gender			
Male	53 (46%)	59 (36%)	25 (41%)
Female	62 (54%)	106 (64%)	36 (59%)
Ethnic origin ¹ (%)			
White	91	92	85
Irish	5	1	3
Black Caribbean	1	0	0
Black British	2	0	2
Black Other	1	1	5
Others	0	6	5
Professional qualifications (%)			
Nursing (RMN/RNMH)	32	16	71
Social work	11	8	2
Clin Psychology	7	1	5
Teaching	38	25	10
Other	10	22	12
None	1	29	0

¹Only categories for which there were entries are listed here.

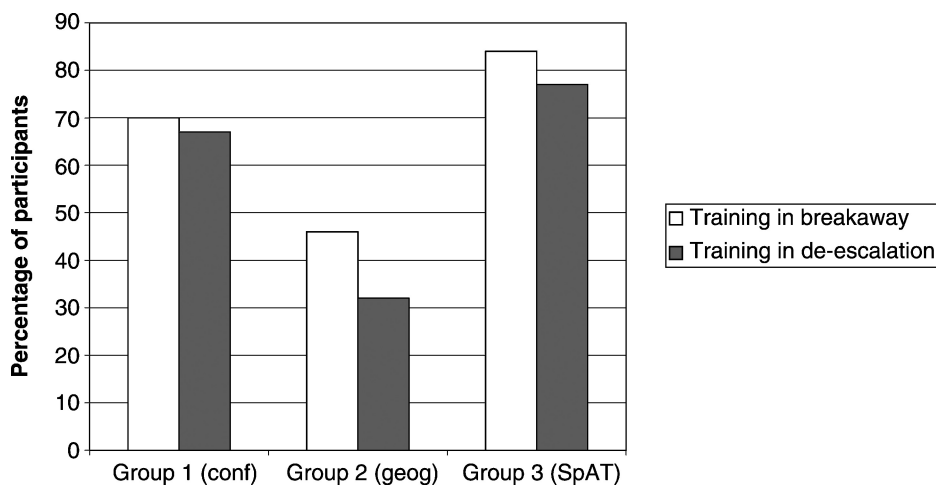


Figure 1 Percentage of participants with training in breakaway and de-escalation skills in the three groups.

Table 2 Service characteristics

	Group 1 (<i>conf</i>) participants (n = 115) (%)	Group 2 (<i>geog</i>) participants (n = 165) (%)	Group 3 (<i>SpAT</i>) participants (n = 61) (%)
Sector worked in			
NHS Trust	30	5	57
Local Education Authority	26	11	0
Social Services Department	15	18	2
Voluntary or non-profit organization	14	26	10
Private hospital	0	0	13
Other private organization	10	36	18
Other (e.g. HE; indep. consultancy)	6	4	0
Care role on an everyday basis			
Residential home (care worker, manager, etc.)	15	69	43
Day service (e.g. instructor, manager)	4	9	3
Educational (school, FE college)	28	13	13
Peripatetic (e.g. CTLD)	25	2	5
Care manager	2	0	0
Management (no contact with service users)	16	6	8
Others (e.g. service managers with contact with service users, training, inspection)	11	1	28

Table 3 Comparison of participants' own training in physical interventions¹

Method	Group 1 (<i>conf</i>) (n = 115)	Group 2 (<i>geog</i>) (n = 165)	Group 3 (<i>SpAT</i>) (n = 61)
Control and Restraint	45	33	66
Care and responsibility	16	16	20
Strategies for Crisis Intervention and Prevention (SCIP)	37	32	20
STUDIO-III	6	1	7
Non-aversive Psychological & Physical Interventions (NAPPI)	11	10	7
Protection of Rights in Care Environments (PRICE)	5	6	3
Preventing and responding to aggressive behaviour (Welsh centre method)	5	7	3
Natural Therapeutic Holding/Options method	5	2	0
Timian training	3	1	0
Crisis Aggression Limitation and Management (CALM)	1	4	0
Other methods (e.g. Team Teach; in-house methods)	17	10	13
None	19	39	13

¹Percentage of participants trained in each method.

different groups (e.g. to explain the references to BILD/NAS conferences and the policy document for groups 2 and 3). The largest difference was the inclusion of an extra page for group 3 participants, in order to obtain details about their service, so as to ensure that it was a specialist assessment and treatment service.

The first questionnaire, which provided definitions of terms on the front page and then 23 questions thereafter, sought the following information¹:

¹Copies may be obtained from the first author.

- Name, age, gender, job title, workplace and ethnic background of the participant
- Professional qualifications and years of work in services for people with autism and/or learning disabilities
- Details of the type of service participants worked in
- Participants' own training in methods of physical intervention
- Their services' use of methods of physical intervention
- Participants' attendance at one of the BILD and NAS conferences and their view of its usefulness to their work (on a 5-point rating scale)

Table 4 Comparison of methods of physical interventions used in participants' own services

Method	Group 1 (conf) (n = 115) (%)	Group 2 (geog) (n = 165) (%)	Group 3 (SpAT) (n = 61) (%)
Control & Restraint	30	7	60
Care & responsibility	10	8	18
Strategies for Crisis Intervention and Prevention (SCIP)	31	22	22
STUDIO-III	2	0	2
Non-aversive Psychological & Physical Interventions NAPPI	6	4	10
Protection of Rights in Care Environments (PRICE)	4	4	5
Preventing and responding to aggressive behaviour (Welsh Centre method)	4	4	5
Natural Therapeutic Holding/Options method	4	1	0
Timian training	2	0	0
Crisis Aggression Limitation and Management (CALM)	1	3	0
Other methods (e.g. Team Teach; in-house methods)	14	7	15

Table 5 Ratings of the readability and usefulness of the Policy Framework document

Group	'Not at all' or 'a little' (%)	Quite (%)	Very (%)	Extremely (%)
Group 1: readability (n = 103)	0	18	52	31
Group 2: readability (n = 15)	7	40	40	13
Group 3: readability (n = 22)	0	14	59	27
Group 1: usefulness (n = 102)	7	30	41	22
Group 2: usefulness (n = 15)	14	40	33	13
Group 3: usefulness (n = 22)	9	32	27	32

Table 6 Ratings of the usefulness of the different sections of the Policy Framework document

Section	'Not at all' or 'a little' (%)	Quite (%)	Very (%)	Extremely (%)
Guidance on law (n = 136)	7	35	40	18
Guidance on values (n = 134)	6	30	53	11
Guidance on prevention of challenging behaviour (n = 135)	12	40	38	10
Guidance on promoting best interests (n = 135)	7	31	44	18
Guidance on risk assessment (n = 137)	8	32	46	14
Guidance on risk minimization (n = 134)	10	31	43	16
Guidance on management responsibility (n = 134)	8	30	45	17
Guidance on employer responsibility (n = 134)	10	40	35	15
Guidance on staff training (n = 134)	16	33	36	15

- Participants' views of the document 'Physical Interventions: A Policy Framework', overall and section by section (on 5-point rating scales)
- Participants' views of the strengths and weaknesses of the policy document (free response section)
- Their views on what additional guidance was required, in terms of further principles, more depth and/or new issues (free response sections)
- Their view of what their own organization needed to do to promote the safety and well-being of

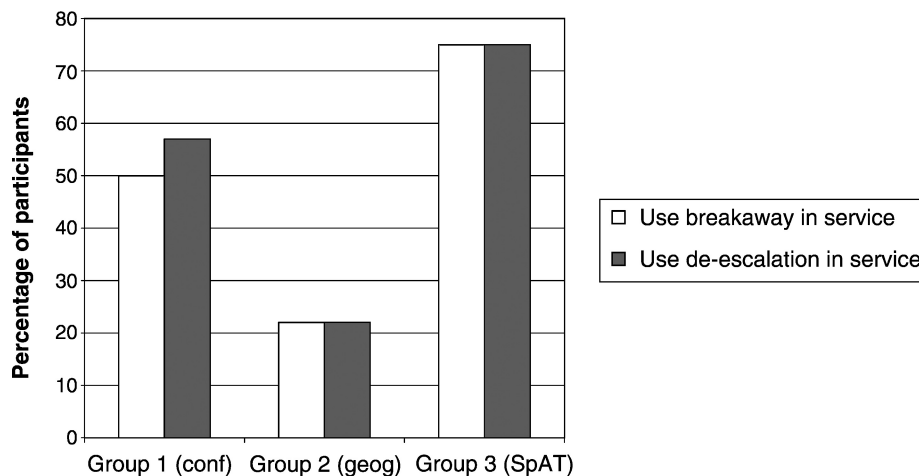


Figure 2 Percentage of participants using breakaway and de-escalation skills in their services in the three groups.

service users (and staff) exposed to physical interventions

- Their view of what BILD and other such organizations needed to do to promote the safety and well-being of service users (and staff) exposed to physical interventions
- Whether their service had a written policy on the use of physical interventions
- Whether they would be prepared to complete a second questionnaire regarding physical interventions.

The second questionnaire sought to explore further participants' attitudes to and use of physical interventions in their services. It will be the subject of a later paper.

Procedure

Group 1 (conf): BILD provided the researchers with a list of names and addresses of the relevant participants. All these participants were mailed a copy of the first questionnaire with an explanatory covering letter requesting their participation in the research.

Group 2 (geog): Service managers in boroughs and the rural county were asked for details of all intellectual disability services in their areas, including schools, day centres, supported employment schemes, residential housing of various kinds, hospital and nursing home provision and community learning disability teams (CLDTs). All of these services were mailed a copy of the first questionnaire with an explanatory covering letter requesting their participation in the research.

Group 3 (SpAT): There appeared to be no central list of specialist assessment and treatment services and, as a result, requests were made of local commissioning agen-

cies to provide addresses of such services in their areas. A list was also compiled of services already known about from other works. Those services on the final combined list were mailed a copy of the first questionnaire with an explanatory covering letter requesting their participation in the research.

In all three groups, where no response was received after about one month to the initial request for completion of the first questionnaire, a reminder letter was sent. If there was still no response, another copy of the first questionnaire and covering letter were sent. If this also produced no response, the participant was coded as having made 'no response'.

All those questionnaires that were completed and returned were coded, entered onto the computer and analysed, using Statistical Package for the Social Sciences (SPSS, version 9.0), using parametric and non-parametric statistical analyses as appropriate (a criterion of $P < 0.01$ was used, in view of the number of analyses involved). The 'free response' sections of the questionnaire were coded according to the themes raised.

A number of participants were sent questionnaires in more than one sample. For example, they may have attended one of the conferences (sample 1) but also worked as managers of specialist assessment and treatment services (sample 3).

Results

Response rates

In group 1 (the conferences sample), there were 371 participants' names and addresses provided by BILD. In 34

cases, the questionnaires were returned to the research office, marked 'unknown' (probably a reflection of the mobility of staff in services for people with intellectual disabilities). Of the remaining 337, there were 115 completed first questionnaires returned (a 34% response rate). In group 2 (the geographical sample), 423 first questionnaires were mailed to participants. After reminders, 165 were returned in all (a 39% response rate overall). In group 3 (the specialist assessment and treatment sample), a total of 132 first questionnaires were mailed and 61 returned, after all reminders (a 46% response rate). These response rates are higher than those typically obtained through postal questionnaires (Hayes 2000).

There was some potential overlap between samples: three participants who returned questionnaires in group 2 reported that they had attended conferences (and thus had been mailed a questionnaire in group 1). However, none of them had returned questionnaires in group 1. Similarly, four participants who returned questionnaires in group 3 reported that they had attended conferences (and thus had been mailed a questionnaire in group 1). However, only one of them had returned a questionnaire in group 1. Finally, there appeared to be no overlap in returned questionnaires between groups 2 and 3 (i.e. no one returned questionnaires in both samples).

Participant characteristics

Table 1 shows the mean age, years of work in intellectual disability services, gender, ethnic origin and professional qualifications for all participants who responded to the questionnaire. Group 3 participants were slightly younger than group 1 and significantly younger than group 2 participants ($t = 2.49, P < 0.02$ and $t = 3.23, P < 0.01$, respectively), while groups 1 and 2 did not differ in age. The respondents generally had considerable experience of working in intellectual disability services but participants in group 2 were less experienced than those in either group 1 or 3 ($t = 4.46, P < 0.001$ and $t = 2.76, P < 0.01$, respectively). The staff in all groups were relatively well-qualified (on the whole it was more senior staff who were completing the questionnaire). Group 2 participants were more often unqualified in comparison to either group 1 or 3 participants ($\chi^2 = 40.23, P < 0.001$ and $\chi^2 = 21.62, P < 0.001$, respectively).

In all samples, staff were employed in a variety of different types of services, including schools, residential homes, day services and peripatetic teams (see Table 2). Samples differed somewhat in the proportions of these services, with group 2 having proportionately more residential homes staff and group 3, not surprisingly, having more staff employed in NHS Trusts and private hospitals.

Participants' own training in and use of physical interventions

Many methods or 'brands' of physical intervention training include at least some training in breakaway skills and de-escalation skills. Most participants in groups 1 and 3 had been trained in these aspects, though fewer than half of group 2 had had such training (see Figure 1). Groups 1 and 3 did not differ significantly in the extent to which they were trained in these techniques. There were significant differences, however, between group 2 and the other groups: group 2 participants were significantly less trained in breakaway than groups 1 and 3 ($\chi^2 = 15.17, P < 0.001$ and $\chi^2 = 25.5, P < 0.001$, respectively) and they were also less trained in de-escalation skills than groups 1 and 3 ($\chi^2 = 33.06, P < 0.001$ and $\chi^2 = 36.44, P < 0.001$, respectively).

These figures were to some extent mirrored in the degree to which breakaway and de-escalation techniques were actually used in participants' services (see Figure 2). Group 3 used breakaway and de-escalation techniques significantly more than group 1 ($\chi^2 = 9.83, P < 0.01$ and $\chi^2 = 5.77, P < 0.02$, respectively) and group 2 ($\chi^2 = 52.51, P < 0.001$ and $\chi^2 = 54.01, P < 0.001$, respectively). Likewise, group 1 used these techniques significantly more than group 2 ($\chi^2 = 23.72, P < 0.001$ and $\chi^2 = 35.39, P < 0.001$).

Participants themselves were trained in a variety of different methods or 'brands' of physical intervention training (see Table 3). It appeared that the 'market leaders', in terms of the methods (or 'brands') of physical intervention in which participants were trained, were either a type of Control and Restraint (including Care and Responsibility, Dignified Control and Restraint, General Services Control and Restraint) or SCIP, and this was true for all three samples (see Table 3). These methods were also the most commonly used methods in services, for all three samples (see Table 4). Nevertheless, there were some significant differences between the groups in the extent to which one method was favoured over another, particularly with respect to C&R. Significantly more participants in group 3 were trained in this method than in group 2 ($\chi^2 = 18.99, P < 0.01$) and significantly more participants in group 3 used the method in their service than in group 1 or 2 ($\chi^2 = 15.22, P < 0.001$ and $\chi^2 = 72.25, P < 0.001$, respectively). Moreover, significantly more participants in group 1 used the method in their services than in group 2 ($\chi^2 = 26.11, P < 0.001$). There were no other significant differences between groups in terms of the types of methods employed (using a χ^2 , with $P = 0.01$ cut-off). However, the groups did differ in whether they had training in any specific method at all (excluding training in breakaway

and de-escalation skills): 81% of group 1, 61% of group 2 and 87% of group 3 had training in at least one specific method. Groups 1 and 3 did not differ significantly in this; groups 1 and 2 did ($\chi^2 = 12.31, P < 0.001$) and so did groups 2 and 3 ($\chi^2 = 13.52, P < 0.001$).

Some people had been trained in several methods of physical intervention: in group 1, 24% of participants had been trained in two methods, 17% had been trained in three or more methods. Likewise, in group 2, 21% were trained in two methods, 14% in three or more; while in group 3, 16% had been trained in two methods, 14% in three or more. In some cases, respondents reported that their service had approved several methods of physical intervention (for example, 9% of respondents in sample 1 said their service had approved three or more).

It was noticeable, across groups, that staff in certain settings appeared more likely to have been trained in or to use particular techniques: for instance, 76% of health service (NHS²) staff, 51% of education authority (Local Education Authority, LEA) staff and 57% of other staff were trained in breakaway techniques ($\chi^2 = 10.99, P < 0.01$) and more NHS staff (76%) than LEA staff (55%) or other staff (42%) were trained in de-escalation skills ($\chi^2 = 23.51, P < 0.001$). Likewise, more NHS staff were trained in C&R (58%) than other staff ($\chi^2 = 11.03, P < 0.01$) and LEA staff seemed to be more often trained in SCIP (43%) than were NHS (22%) or other staff (33%), though this latter difference was not significant.

Similarly, more NHS staff used breakaway techniques in their services (61%) than did LEA staff (38%) or other staff (34%) ($\chi^2 = 18.44, P < 0.001$) and more NHS staff used de-escalation skills in their services (65%) than did LEA staff (42%) or other staff (34%) ($\chi^2 = 22.99, P < 0.001$). This also held for the use of C&R methods in services: 40% of NHS staff, 28% of LEA staff and 18% of other staff used this method of physical intervention in their services ($\chi^2 = 16.22, P < 0.001$). Finally, 'other techniques' (mainly in-house methods) were significantly more often employed by NHS staff (22%) than LEA staff (11%) or other staff (5%) ($\chi^2 = 18.6, P < 0.001$).

Policies on physical interventions and the BILD/NAS policy document

Most participants said they had a written policy on the use of physical interventions: 71% of respondents from group 1; 58% from group 2 and 80% from group 3 said that they either already had a written policy on physical interven-

tions in their organization or their organization was drafting one (these group differences were significant, $\chi^2 = 8.92, P = 0.003$). The remainder of each group had no written policy.

Those staff whose organizations had a written policy, or were developing one (66% overall) were more likely to have been trained in at least one method of physical intervention and their services were more likely to be using one named method of physical intervention than staff in organizations without a written policy ($\chi^2 = 14.21, P < 0.001$ and 14.30, $P < 0.001$, respectively).

Group 1 were specifically selected as people who had attended the BILD/NAS conferences on physical interventions (76%) or who had purchased the policy document (24%). Far fewer of the other groups had been to the training conferences (2% of group 2 and 7% of group 3). Of those attending the conferences, the vast majority rated the conference as 'extremely useful' (18%), 'very useful' (50%) or 'quite useful' (25%) to their work, only 4% rating the conferences as 'a little useful' or 'not at all useful' to their work.

Almost all of the participants in group 1 (97%) said they had read or partly read the BILD/NAS policy framework document, whereas fewer of group 3 had done so (39%) and only 13% of group 2 had done so ($\chi^2 = 170.8, P < 0.001$). Participants mostly found the document 'extremely easy' (28%) or 'very easy' (51%) to understand (19% rated it as 'quite easy' to understand and only 1% rated it as harder than this). Group 2 seemed to find the document somewhat more difficult to understand than the other two groups (see Table 5) but this was not statistically significant.

The majority of participants were overwhelmingly positive about the usefulness of the Policy Framework document to their work, with 22% rating it as extremely useful, 40% rating it as very useful, 35% rating it as quite useful (and only 7% rating it as less than this). The various sections were also highly rated (see Table 6). The groups did not differ significantly on any of these aspects of the policy framework.

Participants in all of the groups noted various strengths of the Policy Framework, including the broad overall perspective, the fact that it was useful for staff training and policy development, the fact that summaries were provided for each section, the 'good' and 'bad' practice examples and the action points. Respondents were generally extremely positive in their comments (examples of comments from participants in group 1 are given in Murphy *et al.* 2001).

Participants were also asked to comment on any weakness in the policy framework. Most participants noted no weaknesses. Of those who did comment on weaknesses, it

²For simplicity, here private hospital services and staff are included under 'NHS'.

was very rare for these to be direct criticisms. Most often, the plea was for more guidance (see Murphy *et al.* 2001; for details of the comments from group 1). By far, the most common other comment, however, related to the need for guidance on training techniques, with many participants clearly feeling that there were far too many alternative 'brands' of physical intervention available, with no guidance on which 'brand' was suitable for their organization or for particular service users. A number of participants commented on the lack of any evidence base for choosing between different 'brands' of physical intervention (see Allen 2001; for a review of the small amount of evidence available).

When asked what they thought their organization needed to improve the safety and well-being of service users and staff in relation to physical interventions, most participants suggested that their organization needs more staff training on physical interventions (including training to improve de-escalation skills amongst their staff) and develop or improve the organization's own policy documents on physical interventions.

When asked what they thought BILD and other similar organizations should do to improve the safety and well-being of service users and staff in relation to physical interventions, most participants again suggested staff training. There were also calls for BILD to act as a networking service and an information resource (for example, providing policy up-dates and advice on training courses). A number of participants also called for BILD to consider accrediting training courses and to conduct research on the most effective types of physical intervention methods.

Discussion

The results of this study need to be viewed with some caution: the resources available meant that the study involved postal questionnaires. While the response rate was better than normal for postal questionnaires (which typically attain a 20–30% response rate, Hayes 2000); nevertheless, it is not possible to know the extent to which those who responded were representative of the total group. However, these data are presented as an initial snapshot of the extent of staff training in physical interventions in a sample of intellectual disability services, and of staff opinions of a policy framework for physical interventions. Such studies are extremely rare.

It appeared that the staff who responded to the questionnaire were relatively experienced and well qualified, particularly in groups 1 and 3. It is likely therefore that, if anything, the results overstate the degree of training in

physical interventions that is typical in their organizations. Nevertheless, it does seem from these results that by no means all staff in intellectual disability services are trained in the simple physical interventions of breakaway and de-escalation skills. Nor do all staff have any specific training in a particular method or 'brand' of physical interventions, even when they work in a specialist assessment and treatment service, where it is known that physical interventions are likely to be commonly employed because of the frequency of challenging behaviour (Emerson *et al.* 2000; Adams & Allen 2001).

There appear to be a large number of different types of physical interventions training available. There seem to be at least three varieties that are based on C&R (interestingly the proponents of the various types of C&R were often annoyed that their particular 'brand' had not been sufficiently prominent or differentiated in the survey). These varieties of C&R and SCIP appear to be 'market leaders' in intellectual disability services and it seems that C&R is particularly popular in NHS and specialist assessment and treatment services. However, whether this is because C&R is actually more effective or whether this is merely historical accident is not known.

It seems that about one-third of organizations (across all three groups in this study) do not have written policies for the use of physical interventions. This is particularly worrying in the case of specialist assessment and treatment services (of whom 20% do not have written policies), as it is highly likely that they are using physical interventions fairly regularly. No attempt was made in this study to ask participants about the contents of their policy documents, to see what they could remember of them, as the methodology was not suitable for this purpose. It is interesting to note, however, that where researchers in other studies have asked staff about the content of policy documents concerning abuse, remarkably few staff could provide much detail on the content (Brown *et al.* 1994), suggesting that even when policies are drawn up, they are sometimes destined to remain on a shelf gathering dust.

Overall, staff who had read the BILD/NAS Policy Framework document very much welcomed it. They mostly rated it as highly readable and very useful. In general, they seemed to want more guidance on a number of areas and often voiced concerns about the plethora of methods of physical interventions available and the lack of information and research into their relative efficacy. Worryingly, though, very large numbers of participants in groups 2 and 3 seemed to be unaware of the existence of the policy framework document (less than one-sixth of group 2 and a little over one-third of group 3 had read or even partly read the document). Of course, this would be immaterial if there

were numerous other guides around but, at the time of the survey, there were very few (apart from one by Lyon 1994 on the use of physical interventions with children).

Since the BILD/NAS framework was published, a number of other related publications have appeared, including the Royal College of Nursing (1999, 2000) and the Royal College of Psychiatrists (1998) guides on physical interventions; the Mental Health Act revised codes of practice (Department of Health and The Welsh Office 1999) and the 1997 Education Act (care and control), section 550 A, circular 10/98, which gave guidance for LEAs on the use of physical interventions. In addition, the DfEE and the Departments of Health and Social Services are actively drafting codes of practice for physical interventions. None of these government guides, however, tackles the issue of whether particular methods or 'brands' of intervention are preferable to others, even though there are often strong views amongst practitioners on such matters [for example, on the use of prone restraint and the likelihood of pain, particularly in C&R (Stirling 2001)].

Ideally, physical interventions should only be used within a framework of planned programmes of positive behavioural support, as Allen *et al.* (1997) and Stirling (2001) have commented. However, it is well known that behavioural support programmes employing such frameworks (Donnellan *et al.* 1988; Carr *et al.* 1994) are by no means universally available in services in the UK (Emerson *et al.* 2000). It is likely that poor practice and, at times, abusive practice will continue to occur for some time, as it seems that we still have a long way to go in improving practice in the use of physical interventions.

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