The need to clearly distinguish and separate Physical Intervention training from Positive Behaviour Support training in the UK

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Introduction

There has been a long debate in the UK about whether restraint or Physical Intervention (PI) training and Positive Behaviour Support (PBS) training should be taught together or separately. In this document Bild set out a rationale for separation.

Context

PBS first developed in the United States (US) in the 1980s as a human rights-based alternative to aversive behaviour modification techniques (Horner et al 1990). In the US, PBS was, and still is, conceived as a prevention framework based on a public health model, focused on getting universal support right by understanding and meeting people's needs. In America PBS and Positive Behavioural Support Interventions and Supports (PBIS), its counterpart in education have never been associated with physical intervention training. A systematic review of all published definitions of PBS in the US and UK (MacDonald 2017) does not mention restraint or restraint training. The Handbook of Positive Behaviour Support (Sailor, Dunlop, Sugai and Horner 2009) has no content listings for Restraint or physical intervention.

In the UK PBS is recognised by many stakeholders as an evolving system of support that must be embedded across everyday practice, leadership, and organisational culture and not viewed or delivered as a single discreet intervention. (Bild 2026, Gore et al 2022) Its impact is seen in enhanced quality of life, meaningful engagement alongside a reduction in restrictive practices. PBS is an evidence-informed, human rights-based framework for supporting people to live meaningful, fulfilling, and inclusive lives. It does this by creating capable and supportive environments where people are understood and supported in ways that work for them.

PBS recognises that behaviour is a form of communication, shaped by a person's experiences, relationships, and environment. Behaviours of concern often indicate that something in the person's life is not working well for them. PBS looks beyond the behaviour of concern to understand and respond to the person's strengths, preferences, and needs by changing the environment and support provided.

Good PBS practice is constantly evolving and is co-developed with people, their families, and those who support them, valuing lived experience alongside professional knowledge and research evidence (Bild 2024).

At the heart of good PBS is a commitment to enhance the quality of life for the person and their circle of support. Rooted in human rights it recognises the harmful impact unnecessary restrictive practices can have on people's lives and actively works to reduce and avoid their use. Indeed, the success of PBS can and should be judged by the way it makes people feel (Bild 2026).

In contrast, there is very limited evidence that restraint leads to meaningful outcomes for the people being restrained, such as enhancements in quality of life and wellbeing (McDonnell et al, 2023). However, there is considerable evidence to support the view that restraint techniques are aversive, in other words, people subjected to them don't like them and often experience them as abusive, restrictive and traumatic (Griffith et al 2013, Hawkins et al 2005, Askew et al., 2020; Hui, 2017; Knowles et al., 2015, Chieze et al., 2019, Duxbury et al., 2019, Tomlin et al., 2020, Duffy et al., 2024). Restraint techniques are inherently dangerous. Significant physical and psychological injury to both care staff who use restraint and the people they are applied to have been well documented (Chieze et al., 2019, Duffy et al 2024 Lawrence et al.,2021, Duxbury et al., 2019,) and in some cases deaths have occurred (Duxbury et al., 2011,. Weiss et al., 1998).

Both Bild and the Restraint Reduction Network (RRN) acknowledge that very occasionally a person's distress can escalate and become harmful to themselves and others. In these situations, it is important that staff and other carers supporting the person know how to de-escalate the situation and use non aversive reactive strategies. Staff must be competent to restrain safely if, in that moment, it is the only

way to prevent immediate and clearly identified harm, rather than a perceived or speculative risk. Some people may need a separate risk management plan that outlines crisis responses and may contain a physical restraint technique or other restrictive practice. This should not be confused with a PBS plan which focuses on proactive environmental improvements to increase wellbeing.

Most people advocate that restraint should only be used as a last resort. However, this assertion becomes rhetorical in services where restraint is frequently used and little attention is paid to developing staff practice and PBS skills concerning proactive prevention. In this incapable environment restraint becomes the first resort in practice, despite the well-rehearsed, but empirically untrue assertion that it is always used only as a last resort. This is because staff do not know what else to do or think this is the appropriate thing that they should do.

Most physical intervention training is provided under a brand name by, private profit-making organisations (McDonnell et al. 2023). During the 1990's there was a growing acceptance within UK services that, for a small number of people responses which use some form of restraint were appropriate and unavoidable (Jefferson, 2009). At the same time, serious concerns were being raised around the misuse of restraints in services leading to injuries, deaths, and abusive institutional practices (Deveau & McDonnell, 2009). In response Bild published a Policy Framework (Harris, Allen, Cornick & Jefferson, 1996) which set out the core principles for organisational policy governing the use of physical interventions. This was followed by the development of a voluntary Code of Practice and the Physical Intervention Accreditation Scheme (PIAS) intended to improve quality in an otherwise unregulated commercial training market.

Some of the more ethically motivated PI training providers saw PBS as a route to educating people about alternative non aversive reactive strategies that could be used in high arousal situations to reduce the likelihood of harm and to emphasise the need for preventative approaches in general. While the motive was admirable the conflation of PBS and physical intervention training has been problematic and caused misunderstanding about the meaning and practice of PBS.

In the UK, PBS has been primarily, but not exclusively, focused on supporting people with learning disabilities and or autistic people. The State of the Nation report (Gore et al 2022) has elimination of aversive abusive and restrictive practices as one of its 12 components and does not consider Physical Intervention to be part of PBS. Rather. Gore et al argue that.

> "Those using a PBS framework work to eliminate use of aversive, restrictive and abusive practices to ensure the rights of people with learning disabilities and key people in their lives. Use of such practices is inconsistent with PBS due to their detrimental effect on quality of life, emotional wellbeing and relationships. Elimination of these practices means, firstly, that pain, shame or fear-inducing responses (i.e., those that cause physical, sensory or emotional pain, are dehumanizing, or violate people's basic rights) are never used as part of PBS, a founding and sustained commitment of the approach (Carr et al, 2002; Gore et al, 2013; Horner et al, 1990; LaVigna and Donnellan, 1986)".
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> Gore et al, 2022 page 18

The quality of therapeutic relationships are a major issue in the delivery of effective support and a key predictor of treatment outcome (Askew et al., 2020; Tingleff et al., 2019, Priebe & McCabe, 2008 Roche et al., 2014). It has long been recognised that good relationships between a care giver and the person lead to better outcomes. This rationale is reflected in the importance placed on relational working in good PBS (Bild 2024). Research consistently shows that restraint detrimentally effects therapeutic relationships (Duffy et al 2024, Knowles et al 2015, Duxbury 2019, Fish & Hatton, 2017). Indeed, in can be argued that the use of physical restraint in practice compounds the very problems in seeks to address rather than alleviate them (Duffy 2024, Bateman & Fonagy, 2006).

The argument for separation

Whilst we acknowledge that physical intervention providers have a rational motivation for adopting PBS as a means of introducing non-restrictive practices into restraint training, this has conflated and confused the understanding and practice of PBS. Restrictive interventions are incompatible with the key principles of PBS because, they

focus on management and control rather than support and collaboration. Some restraint trainers are clearly concerned about ethics and advocate that teaching 'good' restraint leads to its reduction (McDonnell 2023). However, PI training does not appear to reduce restraint, and there is some evidence that its use increases after PI training (McDonnell et al, 2023, Baker & Bissmire; 2000). McDonnell et al (2023) found that restraint training is very variable and generally poorly described and concluded that there was no robust evidence base for physical intervention training and currently physical intervention training is an 'unlicensed product'.

In the UK, and internationally, Restraint Reduction is based on 6 key evidence-based core strategies (RRN 2026; Hucksorn 2004)

Leadership - Both organisational leadership and practice leadership are needed

Involving people with lived experience - Using lived experience to inform reduction strategies at all levels

Data collection & analysis - Using evidence-based decision making and monitoring progress

Workforce Development - Staff are trained in preventative (rather than just reactive approaches) in line with the RRN training standards

Using prevention tools & strategies - Using evidence-based trauma informed and preventative approaches such as Safewards or PBS

Post-incident support & post incident review - providing emotional support after an incident and non-blaming opportunities to reflect and learn later on

Restraint training is not one of these strategies, as it does not fulfil the requirements of the third strategy to develop the workforce's knowledge and skills to understand and prevent crisis behaviour or the key competencies to support the view that restraint is used as a last resort.

Common misinterpretations in the field illustrate the problem. It is, unfortunately, quite common for staff who have received Physical Intervention training to incorrectly think that they have been trained in PBS (MacDonald 2017). Further some services simply relabel pre-existing behaviour management plans as PBS plans with no change in content, as a result they contain no recognisable PBS strategies that focus on prevention and well-being (Quinn 2025). But, of course, these restrictive interventions are labelled as PBS and become what people think PBS is. Critics of PBS include members of the neurodiverse community who have been subject to PBS plans often written by a restraint trainer (Quinn 2025). Unsurprisingly these plans have a focus on risk and safety and contain rationales and instructions for using restrictive interventions. In some cases, PBS has become a label for restraint techniques being used. 'I had to PBS him' is a phrase sometimes heard meaning 'I restrained him'.

We would argue that safety plans may in some cases be necessary and should adhere to the least restrictive principle. However, they are not the same as PBS plans that focus mainly on improving a person's quality of life, choice, relationships, inclusion and a person-centred capable environment. If both PBS proactive strategies and reactive behavioural management strategies are contained in the same document the difference between these should be clear and transparent with the greater emphasis and therefore the largest part of the plan always being PBS. In this case should be clear when a plan changes from the coproduced preventative strategies that are consistent with PBS to behaviour management techniques that means we take control for safety reasons.

This paper is not making judgements on the quality of preventative strategies taught during restraint training, but it is reasonable to assume it is variable and the main aims of restraint training are focused on managing crisis successfully. That staff are confused by being taught PBS and restraint techniques together, by the same people, as part of the same training event, should not surprise us. Combining them asks training participants to make a challenging psychological switch from a focus on prevention and improving quality of life to a focus on restraint. The teaching often changes from a classroom/workshop setting to a matted 'judo' arena and styles change in the process to learning by role playing physical restraint and breakaway 'moves' in a simulated environment. This is often the culmination of the training and

combined with the greater emphasis paid to it leaves many staff with the strong feeling their real job is to restrain not enable. Combining the training of PBS with PI limits the amount of time and focus on PBS and severely risks the breadth and quality of PBS training. This increases the likelihood that PBS is misinterpreted as another behaviour management process simply used in response to the escalation phase of the emotional arousal cycle.

There are many cases where service commissioners stipulate that "PBS training 'certified against the RRN Training Standards" is a condition of tender. When in fact, the RRN Training Standards relate specifically to training that includes a restrictive component and require that preventative strategies are taught before breakaway and physical restraint. The certification scheme does not accredit PBS itself, or any standalone preventative approach. At present there is no certification or accrediting body for PBS. Skills for Care operates a peer endorsement scheme for PBS training and has explicitly distinguished this from ACT certification of training against the RRN Training Standards (Skills for Care, Bild Act & RRN; 2024). Skills-for-Care-ACT-RRN-statement-July-2024-2.pdf

PBS training can be delivered in many different ways, and a blended combination of training techniques is best and is best embedded through onsite practice leadership. PBS training is increasingly being delivered in small manageable chunks, to increase effectiveness and in response to resources issues in the health and social care sector which prevent whole teams being released to attend training. PI training is different and often requires a specific 'gym' like venue and physical instruction, it is awkward and expensive to provide.

Good therapeutic relationships play a crucial role in determining the quality of care and support, PI teaches techniques that impair and can destroy therapeutic relationships to the extent that they are extremely difficult to repair or rebuild. The impact of PI training also inflates staffing numbers when more than one member of staff is required to administer them, which is often the case. Some recommended PI moves are complex which raise a whole series of issues concerning their effectiveness in practice, not least whether staff remember how to do them in the midst of a crisis. However, sometimes PI requirements may result in higher staffing ratios to provide

more staff for the purpose of restraint rather than support which is problematic as it further strengthens inappropriate and incapable service cultures that focus on restraint.

At times, the use of euphemisms for restraint such as 'positive handling' or 'therapeutic holds', implies a therapeutic intent or positive change for the person. This can conveniently mask the extent to which these practices are experienced as frightening, disempowering, and traumatic. The belief that restrictive practices are necessary for safety often persists even though they conflict with the core values of PBS. In the absence of psychological safety, staff are more likely to revert to familiar patterns of restrictions, shaped by underlying biases in risk. Staff may overestimate the risk associated with moving away from such practices, whilst underestimating the harm caused by restraint (Leadbetter, 2008). PBS helps people to understand the impact of the wider environment and to enable change and reduction over-time. The use of restrictive practices, including restraint should reduce overtime with effective PBS interventions which meet the person's needs. With the right support, there should not be a need for rolling, large-scale PI training year after year. History has shown us that restraints have the potential to accumulate, be relied on as routine practice, and in some cases, may become a permanent part of a person's support.

The differences between PBS and restraint and restrictive practices are summarised in table 1.

Table 1. The differences between PBS and Restraint

PBS	**RESTRAINT**
Primary focus is improving Quality of Life	Primary focus is immediate safety and restriction. Restraint does not improve quality of life in fact research shows it is physically and psychological harmful.
Key outcome is increased Quality of Life	Key outcome restriction and control

Done with	Done to
Non-aversive / no punishment	Aversive / can be punitive
Therapeutic and supportive	Not therapeutic
Staff role is to support and help	Staff role is to restrain, control and restrict
Relational; builds positive relationships	Can undermine trust and damage relationships
Focus on environmental improvement	Focus on environmental restriction
Concerned with understanding individual needs and adapting the environment to meet them	Concerned with immediate management of dangerous situations
Concerned with enabling participation, skill development and independence	Concerned with teaching approved restraint and breakaway techniques
Collaborative and consent-based	Taking control to maintain safety reinforcing the power imbalance
Focuses on prevention, reduction and elimination of restrictive practices	Focuses on responding to crisis situations

Conclusion

The conflation of PBS and PI is problematic and seems to be specific to the UK and Australia. PBS is incompatible with restraint and other aversive interventions and combining them in training events give confusing mixed messages. It makes no sense on theoretical, practical or economic grounds to conflate them. If both are needed, they should be taught separately. It is the lack of attention to training and implementing effective PBS preventative strategies that causes the reliance on restraint. Therefore, we should focus on PBS and non-aversive reactive strategies. It is notable that McDonnell et al 2023 found that very little research attention was paid to the impact of restraint training on supported people and even less regarding their views. It is important to listen to the voices of those people subjected to restraint and the views of staff who trained in it and are required to do it.

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