

Regional Advisory Group for Learning Disabilities Services

Physical Intervention

How we work with people who are considered
at times to be in need of physical restraint

Preface

This report concerns situations where a carer makes the judgement that physical intervention is needed to avoid a person with learning disabilities causing damage to themselves and to others.

The guidance is for managers to ensure that staff are given appropriate training, supervision and support. The report should not be read in isolation but be seen in the context of other policies, procedures and training.

The North Western Training & Development Team will shortly be undertaking a survey of managers around Greater Manchester and Lancashire, based on the Organisation Audit Schedule (pages 8 & 9 of the report).

Staff training in physical intervention is currently being looked at by the sub group that put together this report. Guidance on training will be issued in due course.

Tom McLean
Chair

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Introduction

Within both community and hospital based services for people with learning disabilities, there has been growing concern about the use of physical restraint as an intervention option available to direct carers when responding to behaviours deemed physically threatening and/or assaultive.

This document specifically addresses the issues relating to the use of physical intervention with people who have a learning disability. Self injurious behaviour has purposely not been addressed in the document and requires separate attention in its own right. The document is intended to be read and used within the context of other regional documentation, including policies and guidelines for good practice relating to learning disability services.

The terms *physical intervention* and *physical restraint* are widely used inter-changeably. For the purposes of this document the Sub-Group prefer to use the term physical intervention which we feel more aptly describes the potential for a whole range along a continuum of graduated responses from manual guidance through breakaway to full physical control. The term physical restraint will be used when referring to the need for a much higher level of physical intervention.

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

- **Assault** An assault is an attempt or offer to apply unlawful force to the person of another.
- **False imprisonment** This is the infliction of unauthorised bodily restraint without lawful justification.

However, there are in law a number of circumstances under which a carer has the legal common law right to restrain a person who is doing or about to do, physical harm to himself, to another person or to property. But it is likely

that all circumstances are subject to the same requirements of reasonableness¹:

Reasonableness means:

- that the force used is no more than is necessary to accomplish the object for which it is allowed
- the reaction (of the care staff to the client's behaviour) must be in proportion to the harm threatened.

There is an inherent need for managers to be aware of the potential legal implications of using physical restraint.

In response to these concerns the Regional Advisory Group for Learning Disability Services (RAGLDS) commissioned a Sub-Group (see Appendix 5 for membership) with the following terms of reference:

1. To review the current literature on physical interventions.
2. To identify the organisational and practitioner issues of concern about physical interventions.
3. To ensure consultation and collaboration is maintained with relevant stakeholders, in order that their respective comments and advice influence the on-going work of the group. Examples of such links including:
 - Outreach or additional support teams.
 - Direct carers, including parents.
 - Purchasers in Health and Social Services.
 - Education departments.
 - Managers in Health and Social Services
 - Voluntary organisations.

¹ See Hoggett, B., 1990, *Mental Health Law* 3rd Edition, Sweet & Maxwell.

- Other interested individuals and organisations.
4. To identify guidelines for good practice in the use of physical interventions.
 5. To consider the training opportunities which should be developed including:
 - guidelines for training staff
 - guidance on appropriate training models
 - the piloting of a proposed training model.
 6. To produce an organisational audit schedule to enable services to determine effective response mechanisms to the use of physical interventions.
 7. To ensure the guidelines for good practice and audit schedule are disseminated as widely as possible to appropriate individuals and organisations across Greater Manchester and Lancashire.
 8. To consider any other relevant matters which emerge during the work of the group.

Organisational and Practitioner Issues of Concern

In order to solicit this information, the Sub-Group arranged for two, one day workshops.

Participants included practitioners, senior managers and members of the Regional Advisory Group. Nearly all districts within Greater Manchester and Lancashire were represented. In addition, there was representation from Royal Albert, Calderstones, and Outreach, a voluntary organisation in Prestwich.

The issues of concern identified in these two workshops are written up in detail in Appendix 1. Many common themes were identified across districts. Similar issues arose from both workshops.

These concerns are testament to some of the organisational inadequacies in our services. It has been the intention of the Sub-Group to focus on these concerns, within the guidelines for good practice, the recommendations made on training and the content criteria for the Audit Schedule.

Summary of Issues of Concern

- **Staffing issues**
e.g. recruitment issues, need for support networks, gender and skill mix.
- **Training**
e.g. lack of appropriate training models in physical intervention available, need for prevention as the fundamental objective.
- **Management responsibility**
e.g. need for policies and guidelines, need for acknowledgement, ownership and accountability of physical intervention issues from senior managers.
- **Documentation**
e.g. importance of recording incidents, need for incidents to be monitored.
- **Organisational ownership**
e.g. health and safety issues, the risk of restraint becoming the norm.
- **Service users**
e.g. need for service users' concerns to be listened to, medication sometimes used as a form of restraint.

The reasons for the maintenance of these issues (barriers to change) were also identified and are included in Appendix 1.

Guidelines for Good Practice

Key Principles

1. Prevention must be the fundamental objective. Physical intervention is a reactive initiative. The pursuit of more pro-active intervention should always be the preferred option.
2. Physical restraint should, wherever possible, be avoided.
3. Physical restraint should only be used as a last resort and **never** as a matter of course.
4. The use of pain to ensure compliance from the person being restrained e.g. by the use of wrist or arm locks **cannot** be sanctioned as acceptable practice.
5. Attempting to defuse potentially assaultive behaviour is a sequential process. There is a need to work from the premise of early intervention responses to avoid escalation of the aggressive behaviour.
6. Physical intervention should be sanctioned only when other less invasive initiatives have been deemed ineffectual and there is a reasoned judgement from the direct carers that assaultive behaviour (or other behaviour likely to cause serious harm to themselves or others) is likely to ensue.
7. Preventing the aggressive or violent behaviour from erupting by the manipulation of its antecedents and setting conditions, should be the preferred response strategy.
8. Unless the client is actually engaged in, or deemed by the carers as about to engage in, an activity or behaviour which could cause physical injury to themselves or others, it may be more prudent not to intervene with physical restraint. A subjective judgement may have to be made where significant property damage is taking place, this may in certain circumstances prompt the use of physical intervention.
9. Restraint techniques should not be viewed in isolation from existing therapeutic interventional skills. Effective restraint technique is only one means of helping to minimise the risk of injury to all involved in a violent incident.²
10. Physical restraint should be used in an emergency where there seems to be a real possibility that significant harm would occur if intervention is withheld. Any initial attempt to restrain aggressive behaviour should, as far as the situation will allow, be non-physical³:
 - assistance should be sought by call system or verbally
 - one member of the team should assume control of the incident
 - the client should be approached where possible and agreement sought to stop the behaviour, or to comply with a request
 - where possible staff should give the client an explanation of the consequences of him or her refusing to desist
 - other clients or people not involved in the use of restraint should be asked, or guided, to leave the area quietly.
11. Where non-physical methods have failed, or the incident is of such significance to warrant immediate action, a decision may have to be made to intervene physically. In doing so the following rules should be borne in mind²:
 - make a visual check for weapons including items which could be used as such
 - the person responsible for coordinating intervention should nominate staff

² Royal College of Nursing, 1992 *Seclusion, Control & Restraint*.

³ Department of Health, 1991, *Code of Practice, Mental Health Act 1983*, HMSO.

members to assist and allocate each a specific task

- having a large number of staff grabbing at people can be counter productive; fewer but well briefed staff are likely to be more effective
 - aim at restraining arms and legs from behind if possible, seek to immobilise swiftly and safely
 - continue to explain, as appropriate, the reason for action and enlist support from client for voluntary control as soon as possible
 - avoid neck holds
 - avoid excess weight being placed on any area, but particularly stomach and neck
 - do not slap, kick or punch.
12. Other considerations when using physical restraint are worthy of note:
- there must be no application of pressure on airways
 - in exceptional circumstances, if there are attempts at biting, the hair may be held firmly and the head held still
 - if limbs are to be held they should be held at major joints, to avoid dislocations
 - genital area should be avoided
 - deliberately inflicting pain cannot be sanctioned as an acceptable response.
13. The use of force in any physical restraint must be **reasonable in the circumstances**. This judgement will invariably lie with the carers directly involved.
14. Physical restraint should always be the minimum necessary to contain the harm that needs to be prevented.
15. The use of physical restraint as an intervention should always be viewed as a reactive short term strategy only. It is essentially a symptomatic response to prevent harm. There is a need to pursue more proactive, comprehensive management

strategies that attempt to take account of the functional nature of the aggression e.g. 'What is the person trying to communicate?' - 'I am frightened, bored, under pressure, unwell' etc.

16. When making the decision whether or not to intervene using physical restraint, it is important to assess the physical capability required for the restraint. If it is felt the carers do not have the physical capacity to contain the situation safely then the restraint should not be attempted. Likewise if the client is using or has ready access to weapons it may be more prudent to leave the situation to summon external support (e.g. line managers, the police).
17. Where personal removal from the situation is not a viable option, care staff have the right to take appropriate measures to defend themselves. The use of reasonable force sufficient to stop the assault and/or prevent injury to self or others continues to apply.
18. Clients should not be asked to assist in any physical restraint. However, it may in some circumstances be appropriate to ask them to seek assistance, providing their physical safety is not put at risk by undertaking such an action.
19. Any physical restraint means forcible control of one human being by another. Such action must be conducted in a manner that is professionally accountable and as far as possible maintains the dignity of the person concerned.
20. The use of mechanical restraints cannot be sanctioned.

Documentation

1. Service agencies should have written policy guidelines on responding to aggression and violence which are available in the workplace. This information should be disseminated and easily accessible to direct carers for reference.
2. Service agencies should have clear written policies on the use of physical interventions.

This documentation should again be readily available to direct carers.

3. There should be a clearly identifiable form for recording incidents where physical restraint has been actioned. This information may be recorded within an incident report documenting a violent episode (see Appendix 2).
4. All incidents recorded should involve a through-put mechanism whereby the line manager and senior service manager have counter-signed the incident form and made, or agreed, written recommendations.
5. Where physical restraint is deemed to be a possible intervention for an individual client, this should be designed by multi-disciplinary participation, and written up as part of the individual's care plan or IPP.

Any care plan or IPP which includes physical intervention should be subject to regular monitoring and evaluation by the multi-disciplinary team. A written record of these regular reviews should be maintained within the client's case file.

A copy of the individual restraint strategy and subsequent multi-disciplinary reviews of this should be forwarded to the service manager for information.

6. All violent incidents or where physical restraint has been used as an intervention should be communicated verbally by the direct carers involved, to the respective line management as soon as reasonably practicable (in some circumstances e.g. out of normal office hours or at weekends etc., this may involve the use of an out of hours on call system).

The date and time this information was communicated to the line management by the direct carer should be recorded on the incident form.

Training

1. The need for care staff to be appropriately trained is essential if they are to respond to

behaviours that may require physical intervention in a sensitive, humane and non-aggressive manner.

2. There is a need for all staff to receive some basic awareness training on responding to aggression and violence⁴.
3. Some staff work in settings where they need training in breakaway skills in addition to general awareness training in responding to aggression and violence. This skill based component of the training should be facilitated by an appropriately experienced, skilled practitioner.
4. It is not desirable for all care staff working in services to receive physical restraint training. It is more appropriate to identify target groups of care staff who are working directly with a client(s), who may require to be physically restrained on occasions as part of a continuum of agreed interventions.
5. Training needs to be in keeping with the current service values and philosophy established within the north western region. Staff need to have attended values workshops before physical intervention training.
6. It is advisable for each district to ensure that there is a small number of suitably experienced staff, who have received regular refresher training on physical intervention skills and issues. These staff could be available to act as trainers and advisors to other groups of staff who are in the process of constructing, implementing, monitoring and evaluating an individually focused physical intervention strategy.
7. It is important that managers encourage direct care staff to feel confident about asking for support in situations where they feel vulnerable. Care staff also need to feel supported when expressing their concerns about the practice of others.

⁴ Smith J & Golding L, 1993, *Responding to Aggression and Violence Resource Training Pack*, Blackburn, Hyndburn & Ribbles Valley Health Authority.

8. *The Health and Safety at Work Act 1974* makes reference to employers' responsibilities to ensure, as far as is reasonably practicable, the health, safety and welfare at work of all employees. This includes the provision of such information, instruction, training and supervision specific to their work situation. Employees are in turn expected to avail themselves of these opportunities.

Management Responsibilities

1. Within the senior management structure of the service, there should be a nominated officer responsible for the collation of all incident reports involving aggression and violence and physical restraint. This officer should also have responsibility for disseminating a periodic report or review of the overall local situation.
2. As part of training for line managers, there should be some focus on responding to the needs of assaulted carers and debriefing situations where aggression and violence and/or physical restraint has occurred. Other aspects of such a training focus should include some emphasis on:
 - monitoring and evaluation of incidents
 - supervision responsibilities
 - awareness of other support services accessible (see Appendix 3 for further information).
3. It is the responsibility of managers to ensure that information about staff support mechanisms is disseminated and available to direct carers⁵. These mechanisms may typically include:
 - line management support and advice
 - organisational support available e.g. personal, financial, legal
 - counselling support, via in-house or external sources e.g. professional organisation services (RCN CHAT).
4. It is essential that managers ensure regular structured supervision sessions are planned and take place for direct care staff, particularly those care staff who are working with clients whose behaviour is described as difficult to manage. The model advocated by the National Institute for Social Work⁶ may be worthy of consideration (see Appendix 4).
5. It is the responsibility of senior managers to respond to situations where physical interventions are having to be implemented. This may require an assessment of risks, reviewing e.g.:
 - human resources
 - skill mix
 - levels of expertise and experience
 - training needs
 - staff support mechanisms available and/or required
 - suitability of physical care environment

⁵ e.g. *Care Call* is a counselling network in Greater Manchester.

⁶ See Lancashire County Council, 1991, *Management Guide for First Line Managers*, LCC.

Organisational Audit Schedule

An Organisational Audit Schedule allows for services to ensure the important strategic components of service design are in place and operational. An example of such a schedule is outlined below and on page 9.

These measures will serve to ensure that where physical intervention is used, the whole process can be closely monitored and evaluated.

The advantage of using such a schedule allows for services to demonstrate as part of their service specification that an appropriate quality assurance mechanism is in place and operational.

As the purchaser provider relationship becomes more specific about qualitative issues, such an audit requirement may become essential.

The use of an Organisational Audit Schedule would also be invaluable in terms of safeguarding against the potential abuse of using physical intervention unnecessarily or inappropriately.

Audit criteria	Current service response level	Action required to achieve criterion
1. There is a departmental policy on <i>Responding to Aggression and Violence</i> . This is readily available and disseminated to all relevant locations.		
2. There is a departmental policy on <i>The Use of Physical Intervention</i> . This document has been disseminated through line management. All care staff are aware of the contents of the policy document. A copy of the policy is available at all relevant locations.		
3. There is a documentation system for recording incidents of aggression and violence or where physical restraint has been used. This system has the line management and senior management signatures and recommendations.		
4. There is a nominated senior manager with the responsibility for monitoring and evaluating the use of physical intervention within the service. This nominated senior manager will produce a periodic report (3-6 monthly), outlining the frequency of use, locations, service, proactive response etc. This report will in turn be disseminated to the Head of Services (e.g. Service Manager), and to the respective line managers for their information.		
5. There is a clearly identifiable mechanism for all incident reports to be forwarded to the senior manager with co-ordination responsibilities (as well as the respective line manager).		

6. Awareness training on responding to aggression and violence is available via the training department, and is accessed by all care staff.		
7. Care staff working with clients who have a known history of aggressive or assaultive behaviour are identified as a priority target group for training.		
8. Breakaway techniques are incorporated into awareness training on responding to aggression and violence for selected staff.		
9. Where physical intervention is likely to be used with an identified client:		
- specific training has been given to the direct carers on the appropriate physical interventions		
- this information has been written up and a copy retained on the client's case file		
- use of physical intervention is monitored and evaluated by the multi-disciplinary team		
- multi-disciplinary review of the physical intervention takes place regularly and is minuted.		
10. A mechanism for staff support is clearly identified and disseminated (including the involvement of line managers concerning their de-briefing role and the options for more neutral counselling support). Care staff are aware of these support mechanisms.		
11. Line managers, responsible for supporting direct carers working with clients who may be aggressive or assaultive, receive training on how to support such staff groups.		
12. There is a small number of care staff and line managers who have received more in-depth training in the use of physical interventions:		
- their training is subject to regular refresher training by outside specialists		
- these staff are available to act as advisors to multi-disciplinary groups of staff who may be using physical interventions.		

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Appendix 1

Organisational and Practitioner Issues of Concern

Staffing Issues

- Direct care workers are often young, inexperienced and untrained.
- Confidence often lacking and staff ill prepared.
- Recruitment issues and selection of staff - potentially in antagonism to equal opportunities policies because more subjective criteria may need to be considered.
- New staff need a probation period and improved induction training.
- Issue of gender and skill mix. For some, the ideal perceived stereotype may be a preferred option e.g. male, 6 ft, 15 stone.
- Scape goating and victim blaming after a violent episode has occurred e.g. staff blamed due to ineffectual management.
- Need for comprehensive support networks, often a void at present -includes post-incident and peer support.
- Effect of work on personal life and relationships due to pressure, trauma etc.
- Staff often feel vulnerable in implementing physical intervention strategies. There are also issues about staff managing their own feelings of aggression etc.
- Staff turnover due to pressure of work.
- Staff more isolated now than in the past due to changes in community orientated care provision.
- Staff feel they have to cope on their own.
- Finance restrictions are a predominating factor, on occasions leading to a compromised, less responsive service.

Training

- Prevention is the fundamental objective. It is difficult to measure the effectiveness of preventative initiatives.
- Favoured approach involves interventions tailored to meet the needs of the individual. Strategies should include proactive and reactive initiatives and reviewed regularly.
- Graduated levels of response required according to levels of aggressive behaviour displayed.
- Need for training in the possible functional nature of aggressive and violent behaviour occurs. What does it mean?
- How should training in physical intervention be delivered? Should it be part of general training or targeted to specific staff groups?
- Training must come after policy development and resource commitment. Training should follow, not lead.
- There are no 'quick fix' training solutions.
- Lack of appropriate training available.
- Training carried out generally by practitioners. Minimal investment in paid training officers.

Management Responsibility

- Need for policy and guidelines. There is a lack of these at present with pragmatic value.
- Need for acknowledgement, ownership and accountability of these issues from senior management.
- Need to target and train managers for change to take place.
- How can we increase managers' awareness of these issues to enable action to take place?

- Awareness of staff welfare issues needed.
- Need for post-incident support for staff service users. Need to address the reality of situations and acknowledge climate of fear and insecurity. Need to equip managers with appropriate response skills.
- Need for managers to enable staff to explore their feelings of fear, aggression etc.
- Service managers' responses are often variable due to their being protected by others and buffered from the practical situation.
- Incidents are often denied by staff due to their fear of being seen as not being good enough. Need for staff to feel valued by managers and listened to.
- Services need to be flexible e.g. staff may need to be redeployed to recuperate from the pressures of working with a difficult client.
- Restraint can be seen as a short term strategy to 'buy' time ('+') or a quick fix solution ('-').
- Need to recognise the role of bad service design in contributing to challenging behaviour. Problem of round pegs in square holes.
- There are very few severely challenging clients but they have huge impact (e.g. cost, trauma etc.) if their needs are not addressed.
- Health and safety issues - employer and employee responsibilities and liabilities.
- Need to safeguard the initiative of keeping people with challenging behaviour within existing services rather than creating segregated services.
- Difficulties in constructing a sufficiently safe and supportive learning environment for staff on responding to aggression and violence.
- Risk of restraint becoming the norm or the only intervention response pursued if poorly managed and monitored.

Documentation

- Incidents need to be reviewed, monitored and evaluated.
- Need for good documentation.
- Good report writing of incidents is an essential requirement.
- Important to document incidents where restraint has not occurred -demonstration of proactive initiatives/positive stories.
- Lack of co-ordination re: analysis of recorded incidents - who should do this?

Organisational Ownership

- Physical restraint is necessary for a minority of individuals. Risk therefore of having general policies and of over-reaction to individual circumstances. Too much emphasis on restraint issues can lead to creating an unrealistically negative picture.
- Physical restraint should not involve pain.
- Risk of avoidance due to the complexity and danger of the issues.
- Need to manage risks.
- Need for service to recognise the intensity and complexity of direct carer work.
- Concern about legal and ethical issues re: physical intervention. This seems poorly addressed in services.
- Advocacy - who advocates on behalf of the client?
- High quality services are more likely to result in a reduction in challenging behaviour.
- Problem of inadequate service provision for dealing with isolated and infrequent but very violent incidents. The community is not currently able to deal with such flash points.
- There may be a need for a centralised resource e.g. half way houses.
- Psychiatry services are frequently difficult to access for this client group - clinical restraint is often used.

- Purchaser - provider split - a predominating 'cost' focus - who pays? Health or Social Services purchasers.
- Who should be the provider? Health? Social Services? Joint?
- Expensive packages of care should not become political pawns of Health and Social Services purchasers.
- There are no guarantees of success. There will inevitably be some perceived 'failures'. This should not set a negative precedent for service response.
- What is the criteria for success? (100% cure or less?)

Service Users

- Lack of opportunities causing problems (e.g. boredom).
- Counselling or listening ear needed for service users' perspective.
- Communicating frustrations through challenging behaviour?
- Medication is sometimes used as a form of restraint.
- Self expression sometimes restricted due to nature of challenging behaviours.
- Service users are frequently not given the opportunity to make meaningful choices.
- Do service users who are victims of assaults etc. get adequate post-incident support?
- Could service users be involved in staff training?
- Often clients will need secure boundaries and opportunities to express emotions e.g., anger and loss.
- Clients will have perceptions and expectations from previous experiences.

Barriers to change

The reasons for the maintenance of the above issues of concern were identified as follows:-

- Lack of identified competent trainers.

- Concern over the potential negative consequences of giving physical intervention issues high profile e.g. increasing negative image of service users.
- Service's fear of bad publicity.
- Lack of adequate reporting mechanisms - communication often poor.
- The potential for abuse and misuse of physical intervention.
- The possible implications for the service of legitimising physical intervention.
- A fear of physical intervention being seen as a final measure.
- The individual nature of service users - complex issues and needs.
- The referral of service users out of districts due to lack of appropriate local services.
- Managers and services 'passing the buck'. Who's responsible?
- Inadequate management.
- A desire for a quick fix solution.
- A fear that discussion of these issues equates with approval.
- Other more pleasant priorities.
- This is a time consuming process.
- Bureaucracy.
- Everyone is waiting for someone else to address this issue.
- Complex issue - no guidelines or policies.
- Tolerance in services of aggressive and violent behaviour.
- Physical intervention is a taboo subject.
- Avoidance occurs due to the complexity of these issues.

Appendix 2
Report of Violent Episode or Untoward Occurrence
to Staff or Other Persons

Staff/other person's name (victim): _____

Assailant's name: _____

Ward/site/locality of incident (detail): _____

Address (victim): _____

Address (assailant): _____

Date and time of incident: _____

Type of incident (please tick)

- A. Verbal assault
- B. Verbal threat of assault to person or others
- C. Actual violence to inanimate object
- D. Actual violence to persons
- E. Violence to self
- F. Weapon involved (please state): _____

Give a factual account of the incident, including any possible precipitating factors, assailant's behaviour prior to violent incident and how the incident was actually dealt with. (If additional information is necessary please write on a separate sheet of paper and staple to this form).

Injuries sustained to self, assailant or others (details and names):

Action taken after the incident: (e.g., first aid treatment and action to prevent re-occurrence)

Has the incident been reported to others:

Senior staff (name): _____

GP (name): _____

Occupational health/H.S.E.: _____

Others (name): _____

Witnesses:

Name: _____

Address: _____

Form completed by:

Name: _____

Grade: _____

Date: _____

Senior Manager signature: _____ date

Further action taken including victim support and post incident evaluation:

This form should be completed and handed to the Senior Manager within two working days of the incident taking place, before being forwarded to the Unit General Manager

Unit General Manager signature: _____ date

Appendix 3(a)

Short Term Consequences of Assault for Staff

1. The crisis phase:
 - lasts up to 90 minutes after the assault as adrenaline dissipates
 - is followed by a gradual reduction in tension
 - can lead to increasing physical and mental exhaustion.
2. Post-crisis depression:
 - means that assault is often seen as dehumanising and degrading
 - can be associated with loss of confidence in ability to handle any client or patient
 - can be associated with a loss of sense of vocation or professional identity
 - can include sleeplessness
 - can include a pervading sense of hopelessness.
3. Medium-term effects can include:
 - over-estimation of the likelihood of subsequent violence
 - disproportionate fear of clients or patients with a violent record, or of situations where violence is likely
 - wariness of new situations and new people
 - decreased likelihood of confronting people
 - apprehension when people approach from behind.

Rowett, C., & Breakwell, G., 1992, *Managing Violence at Work*, NFER, Nelson.

Appendix 3(b)

Long Term Consequences of Assault for Staff

Normally explained in terms of Post-Traumatic Stress Disorder.

Main Symptoms

1. The experience of the stressful event which can be diagnosed as the basis of the problem.
2. Re-experiencing the traumatic situation by:
 - recurrent painful and intrusive recollections
 - repeated dreams and nightmares
 - a dissociative state (very rare) when the victim relives the event.
3. Numbing of responses to or involvement with the external world by:
 - feeling detached
 - being unable to enjoy things which were previously pleasurable
 - being unable to feel close to others emotionally or sexually.
4. Other symptoms, of which at least two were not present before the trauma:
 - being hyper-alert or having an exaggerated startle response
 - sleep disturbance
 - sense of guilt
 - memory impairment and/or difficulty in concentrating
 - avoiding situations which may lead to recall of the event
 - having a recurrence of symptoms when exposed to events which resemble or symbolise the original trauma.

Other Possible Symptoms

1. Suicidal thoughts.
2. Hyper-sensitive to all reported crime.
3. Sense of failure.
4. Difficulty in holding normal conversation.
5. Significant deterioration both physically and psychologically when cases involved criminal and/or compensatory proceedings.
6. Deterioration around the anniversary of the incident.

Wider Impact

1. On relationships - especially family and colleagues.
2. On work - reduced caseload, sickness absence, change of location.

Rowett, C., & Breakwell, G., 1992, *Managing Violence at Work*, NFER, Nelson.

Appendix 4

A Model of Supervision⁷

Objectives	1. Maintaining Unit Operation	2. Clarifying Staff Role and Responsibilities	3. Creating a Climate for Practice	4. Helping People Cope with Stress	5. Assisting Professional Development
	<p>Planning</p> <ul style="list-style-type: none"> developing a unit's objectives setting team objectives determining priorities <p>Monitoring</p> <ul style="list-style-type: none"> ensuring that agreed policies are being carried out checking that tasks are being done to the standards required <p>Review and Evaluation</p> <ul style="list-style-type: none"> conducting regular reviews of agency policy and practice ensuring that team members regularly review and evaluate their work 	<ul style="list-style-type: none"> ensuring that team members are clear about their job content, responsibilities and limits of their discretion and authority ensuring that team members are aware of what each other's job is about clarifying role and task boundaries within the team ensuring that tasks are distributed equitably ensuring that workloads are within team members capabilities ensuring that the volume of work can be coped with 	<ul style="list-style-type: none"> involving team members in all major decisions and policy development developing efficient methods of communication ensuring that team members have opportunities to share and reflect on their experiences promoting good working relationships; seeing that conflicts in the team are tackled and crises averted or worked through 	<ul style="list-style-type: none"> remaining sensitive to potential crises in the team being prepared to intervene when team members are under stress providing opportunities for stresses and anxieties to be communicated 	<ul style="list-style-type: none"> enabling new team members to learn about the policies, objectives and working practices of the agency in general, and unit in particular helping team members develop their knowledge and skills to meet their particular learning needs and those of the unit helping team members evaluate their progress helping team members develop their career plans

⁷ Lancashire County Council, 1991, Management Guide for First Line Managers, Fig. 3 National Institute for Social Work - Model of Supervision, LCC.

Appendix 5 Sub-Group Membership

Alan Coates	Principal Officer, Stockport Social Services and North Western Training and Development Team member
Olive Carroll	Purchasing Manager, Lancashire Social Services
Wilson Dickinson	Parent, member of Trafford Community Health Council, and member of Regional Association of CHCs
Chris Gathercole	North Western Training and Development Team member
Laura Golding	Clinical Psychologist, Outreach Support Team, Blackburn
John Smith	Convenor of Sub-Group. Team Leader, Outreach Support Team, Blackburn
Mick Stephens	Training Coordinator, Chestnut Drive, Calderstones NHS Trust
Paul Sutton	Director, Outreach, Prestwich
Chris Tomlinson	Team Leader, Extra Support Team, Preston

Appendix 6

Guidelines for Disseminating Physical Intervention Training

1. Prior to staff receiving any training in physical intervention techniques it is vital that:
 - a) Values training has been undertaken.
 - b) Staff have some experience of working with people who have learning disabilities.
 - c) Staff have received some basic awareness training on responding to aggression and violence, e.g., as outlined in the RAGLDS *Physical Intervention*.
2. Staff have been identified who are deemed suitable by their managers to receive such training.
3. The option for staff to withdraw from such training (or for managers to withdraw them) should be available.
4. Prior to providing such training, services should ensure that the important strategic components of service design are in place and operational. See Organisational Audit Schedule pages 8/9.
5. Staff who are working in situations where there is the potential for aggressive or assaultive behaviour to occur should receive appropriately targeted training.

Level I	Basic awareness training on responding to aggression and violence.
Level II	Training in breakaway skills.
Level III	Client focused training in physical restraint techniques.

 - All levels of training should be facilitated by an appropriately experienced and skilled practitioner.
 - Level III needs to be targeted at groups of care staff who are working directly with a client(s), who may require to be physically restrained on occasions as part of a continuum of agreed interventions (both reactive and proactive).
 - It may be that only level I or II are necessary to meet the training need.
6. Level III training - essentially client focused will form part of that person's individual care plan.
7. In line with current practice these care plans must have multidisciplinary involvement and be subject to regular multidisciplinary monitoring and evaluation.
8. A written record of the care plan and regular reviews should be maintained within the client's case file.
9. Any training proposed should be underpinned by the following key principles:
 - Prevention must be the fundamental objective.
 - Physical intervention is a reactive initiative - the pursuit of more proactive intervention should always be the preferred option.
 - Physical restraint should whenever possible be avoided.
 - Physical restraint should only be used as a last resort and never as a matter of course.
10. Within the context of the training the legal perspective should be clearly considered, in particular:
 - The notion of physical restraint being construed as an assault.

- The possibility of injuries being sustained by participants during physical intervention training.
 - The possibility of injuries being sustained by staff or clients as a result of the use of techniques advocated by the training.
 - The responsibility and liability issues that arise.
 - The potential implications for the use of physical interventions from the Mental Health Act and Code of Practice.
 - The implications concerning health and safety at work legislation.
11. Regular refresher time for trainers in physical intervention techniques should be made available.
 12. Regular training practice opportunities for staff who are trained in breakaway techniques and restraint practices should be made available.
 13. All trainers of physical intervention techniques will need to be fully conversant with all appropriate physical interventions. By contrast, direct care staff who need level III training may typically only need to know one or a small number of physical interventions, specific to their particular client(s).