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ORIGINAL ARTICLE

As the last resort: reducing the use of restrictive physical interventions using organisational approaches

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Accessible summary

- People living in a home should not be restrained unless they are really hurting themselves or somebody else.
- People living in a home should be helped to manage their own behaviour without being restrained.

Summary

The development of restrictive physical interventions (RPI) to manage challenging behaviours based upon control and restraint during the 1980s and 1990s led to widespread professional disquiet and campaigning to improve the policies, training and application of physical techniques. This included the promotion of a value base within which physical techniques should be used. This value base may be summarised as any use of physical interventions must be in the person's best interests, 'least restrictive' and used as the last resort following preventive strategies. The last resort principle *implies* that services should be able to demonstrate support plans to prevent or reduce the frequency and/or restrictiveness of PI used in individual cases. This paper proposes that adopting explicit policies and practice to reduce restrictive PI is likely to be more effective in improving quality of support as opposed to solely managing PI use. Discussion of current policy and practice is followed by discussion of organisations' roles in relation to RPI reduction, with international comparisons.

Keywords *Challenging behaviour, intellectual disabilities, prevention, restrictive physical intervention*

Introduction

During the 1990s concern about the use of restrictive physical interventions (RPI) for people with learning disabilities (and other groups e.g. people with mental health problems, prisoners and children) living in institutional/residential care increased. These concerns focussed on associated deaths, injuries, the infliction of pain to enforce compliance and the role of RPI as part of restrictive and abusive institutional environments. This led in 1996 to Government commissioning of the British Institute of Learning Disabilities (BILD) and the National Autistic Society to produce a policy framework (Harris *et al.*, 1996) to guide this area of practice. Subsequent Government policy on RPI (Department for Education and Skills and Department of Health 2002), legal imperative and individual service provider policies concur that the use of PI should be as the 'last resort' to prevent harm to people, even when used 'proactively'. If this is to be more than rhetoric then practical policies and actions to develop and reward

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alternative non-restrictive responses by staff should be developed. Reducing RPI use can apply to both frequency and/or restrictiveness.

Current policy and practice: direction and dilemmas

Whilst little is known about what might be the 'right' levels of RPI use, it is known that RPI is used commonly in response to challenging behaviour and often associated with other restrictive responses to challenging behaviours, including seclusion, multi and frequent 'as required' psychotropic medication use (Emerson *et al*., 2000; Harris, 2002; McGill *et al*., 2008, In Press). Moreover, the series of actions and reactions surrounding RPI use is associated with injury/harm to the participants, staff and service users. Injury, both physical (Spreat *et al*., 1986; Hill & Spreat 1987; Harris *et al*., 1996) and/or emotional (Sequeira & Halstead, 2001; Murphy *et al*., 1996) may be experienced. In the latter two studies service users described their experience of being subject to RPI. Themes that emerged were overwhelmingly negative, with pain, anxiety and mental distress, anger, and the perception that the staff were experiencing anger, hatred and feelings of enjoyment during the interventions. Two subsequent papers have examined the responses of staff and service users to the same RPI event. Staff involved experienced similar negative, emotions and thoughts (Hawkins *et al*., 2005; Fish & Culshaw, 2005). In the latter study, conducted in a medium secure unit, staff reported feeling upset and guilty following the use of restraint and that this use was always as the 'last resort'. However, from the client perspective this was not the case. McIntyre Undercover (November 1999) showed graphically how the use of RPI can become part of abusive and restrictive care environments.

Our knowledge about the safety of specific restraint methods is limited, although some types are thought to pose increased risk e.g. prone restraint (Leadbetter, 2002). This has not stopped the exponents of various techniques (often the training organisations offering these) from vigorously promoting some and criticising others. The Millfields Charter proposes 'banning' prone restraint (McDonnell, 2007). In addition to others opposing this (Paterson, 2007; Leadbetter, 2007) a recent analysis of injury related to restraint position showed only a weak association between increased *staff* (our italics) injury and prone restraint (Lancaster *et al.* 2008). To date no specific assessment tool exists which compares the risks or effectiveness of different physical interventions.

In addition to the effectiveness of interventions Wolf (1978) proposed that social validity is an important factor. The views of consumers and users of RPI are a critical element. Consumer views of restraint have been examined (Cunningham *et al*., 2002) using video footage of three forms of restraint, two floor and one sitting restraint. The clear preference of staff and service users was for sitting restraint, showing increased social validity of reducing PI restrictiveness.

Staff training in PI has been widely adopted in the UK (Deveau & McGill, 2007; Murphy *et al*., 2003). However, research into the efficacy of staff training in physical interventions is in its relative infancy (Allen, 2001). A recent review identified only 47 studies with twelve studies that appeared to meet the minimum requirements of experimental control (McDonnell *et al*., 2008). The limited literature contains many paradoxical results. Some studies have reported reductions in physical interventions usage after training (Allen *et al*., 1997), others have reported increases in physical interventions usage after training (Baker & Bissmire, 2000). Rates of assaults also show some decreases (Infantino & Musingo, 1985) and increases (Rice *et al*., 1985). In Switzerland a relatively recent randomised control trial of training that used physical interventions, reported few positive outcomes (Needham *et al*., 2005). Staff training can increase staff confidence (Allen *et al*., 1997) although other studies do not report such effects (Hurlebaus, 1994; Hurlebaus and Link 1997). Training that increases confidence may well be popular in the marketplace (Harris, 2002); however, the direct effects of such training are still poorly understood. In summary, physical intervention training represents an approach to managing staff behaviour, based on a limited evidence base. The focus in the UK upon staff training and the safety/effectiveness of various RPI techniques has accompanied, in our view, a lack of focus upon wider organisational influences and upon 'restraint reduction'.

Organisational factors

With very few exceptions the UK research and practice literature has focussed upon managing the implementation of PI in services (Sturmey *et al*., 2005). This focus upon staff training and policy implementation in respect of immediate staff – service user interaction diminishes the role of leadership and organisational processes.

Early studies in institutional settings in the UK demonstrated that the effectiveness of interventions is not the main determinant of staff performance on the implementation and delivery of behavioural programmes (Woods and Cullen 1983, Moores and Grant, 1976). Woods and Cullen (1983) in a seminal study examined three behaviour programmes conducted by staff in an institutional setting. At follow-up, the most successful programme (room management) had been discontinued by staff and the least successful programme (toilet training) was still being maintained. Staff behaviour and performance are influenced by many factors, apart from official espoused principles and staff monitoring and training. Wider organisational factors,

notably organisational culture and leadership have received comparatively little attention (Sturmey & Palen McGlynn, 2002). A recent small scale study in the UK reported that better service quality outcomes for people with a learning disability were associated with services having a more positive organisational culture. Quality outcomes were assessed by a staff survey on service user lifestyles, based upon the 'five service accomplishments'. Lifestyles were scored higher for the unit with significantly lower scores on three 'negatively influential cultural styles: oppositional, competitive and perfectionist' (Gillett and Stenfert Kroese 2003). Leadership has frequently been identified as an important factor in successful organisations. In the USA, Baker & Feil (2000) surveyed 44 agencies in the state of Oregon which supported people with challenges, the authors compared six variables to assess the major influences between them (organisational stability, administrative leadership, staff structures, staff training, measurement systems and behaviour systems). Regression analysis demonstrated that administrative leadership, not staff training, predicted staff structures, measurement and behaviour systems.

Some evidence of organisational leadership and staff performance being directed towards RPI reduction is indicated in Table 1 of Deveau & McGill's (Deveau & McGill, 2007) large scale postal survey of learning disability service providers in the south east of England. This survey, in part a follow-up of Murphy *et al.* (2003), focussed on attitudes and practice to reducing the use of restrictive PI. The questions regarding RPI reduction asked whether services monitored the frequency and restrictiveness of PI use and for opinions on whether they should be seeking to reduce RPI use and how.

Although respondents experienced some uncertainty regarding their service's inclusion of PI use as part of QA programmes, three quarters monitored the frequency of use and two-thirds the restrictiveness of PI used within their services. Forty-nine services, 36% of the total, stated that their organisation should be seeking to reduce the use of PI. Some very brief comments explained their views in terms of the 'rules' – in this case recent policy directives. A few more expansive comments demonstrated an appreciation of whole organisational approaches to monitoring and supporting this goal. For example:

'I have worked within the service for 8 years and have seen, in that time, the introduction of three different physical intervention training providers. Encouragingly, each of these providers employed less intrusive/aversive techniques with pain compliance now completely removed from all training offered. We have not employed a PI in more than 6 months.' (NHS, R55, p.22).

'Appointed PI manager to collate all information and feedback to senior staff, working within BILD guidelines, attending regional meetings of PI managers addressing key topics, … working with service users drawing up care plans for PI.' (private, R21, p.22).

Whilst rhetoric about offering leadership and intervention in organisational and staff cultures is commonplace, practices aimed at changing these appear limited; based upon the evidence.

Table 1 Overall monitoring of PI and inclusion in QA programmes, frequency (%)

Question	Total response	Yes	No	Don't know
PI use part of QA	67	33 (49.3)	20 (29.9)	14 (20.9)
Frequency of PI use monitored	65	51 (78.5)	10 (15.4)	4 (6.2)
Level of restrictiveness monitored	63	41 (66.1)	15 (24.2)	7 (11.3)

PI, physical interventions.

Developing organisational practices that reduce physical intervention usage

'When people are given a power of last resort it quickly becomes the power of first resort' (Stone, 2004)

In the UK, examples of individual services or organisations focussing upon RPI reduction have been reported. For example, extensively evaluated and reported systematic approaches to reducing RPI over several years is summarised in Allen *et al.* (2002). Interventions they report include, focussing staff training on understanding aggression and prevention, reducing the number of PI techniques taught, and monitoring the frequency and techniques of PI employed. Among outcomes reported was the reduction of behavioural incidents, use of physical restraint (62%) and injuries to staff and service users (75% and 72% respectively). These interventions didn't focus specifically upon organisational approaches.

Other countries appear to feature wider and more focussed approaches to the principle and practice of reducing RPI. For example, Norway has implemented legal instruments regulating the use of 'coercive' procedures for people with intellectual disabilities. The authors report 'coercive interventions have decreased substantially over the last few years' (p. 32) for people with learning disabilities (Roed & Syse, 2002). In the USA, publication of 'Deadly Restraint' (Weiss, 1998) and legal action based upon the 'Constitution' and its Bill of Rights has led to different state action for several institutionalised groups of people focussed firmly on reducing restraint use. For example, for children (Jones & Timbers, 2003) in psychiatric services (Jonikas *et al.*, 2004) and in learning disability services (Sturmey & Palen McGlynn, 2002) reductions in restraint use appear to have been achieved. Sturmey & Palen

McGlynn (2002) reported on one service where interventions utilised a variety of 'organisational behaviour management' approaches; of 22 high RPI use clients, all but two achieved circa 90% restraint reductions. Two clients experienced increased RPI use.

Aside from legal structures and formal government policy initiatives, various typologies prescribing/guiding organisational approaches have been proposed. These emanate mainly from the USA and concern various 'cared for' populations, e.g. cared for children, adults with mental health problems and people with learning disabilities. For example, in 1999 the National Association of State Mental Health Program Directors called for the reduction and elimination of restraint and seclusion. A curriculum for organisational approaches, was developed in 2004, the Six Core Strategies. The Six Core Strategies are: (i) leadership and organisational change; (ii) use of data to inform practice; (iii) workforce development; (iv) use of seclusion/restraint prevention tools; (v) consumer roles in inpatient settings; and (vi) debriefing (see Stefan 2006). In children's services, a Child Welfare League of America project was renamed in 2003, Best Practices in Behavior Support and Intervention: Preventing and Reducing the Use of restraint and Seclusion (Child Welfare League of America, 2004). Also in children's services, Colton (2004) developed a comprehensive self evaluation checklist to assist organisations to achieve restraint reduction. This includes guidance on assessing the readiness of organisations' to achieve this; through stages starting with 'inaction' through 'espoused action' to 'sustained action and maintainance'. In the UK, Deveau & McGill (2007) proposed that organisations seeking to reduce RPI should attend to three core strategies:

- Leadership and organisational change i.e. the top leaders in organisations should expect to receive information on the levels of PI used in services and with individuals and regard these as key quality indicators.
- Data use to inform practice. The importance of visual information feedback to staff teams as part of total quality systems is described in LaVigna *et al.* (1994).
- Restraint reduction strategies at service and individual service user level.

In the UK, the apparent lack of political interest and leadership in reducing the use of restrictive approaches to challenging behaviour is surprising. The strongest central government policy leadership offered in the 'Guidance' (Department for Education and Skills and Department of Health 2002) relies upon services employing the prevention principle to drive practice towards achieving this. The guidance gives a 'key implementation task' for providers, commissioners, professionals, care staff and training organisations; that of 'establishing a system to monitor trends over time both with respect to the use of physical interventions with individual service users and to identify overall trends in the use of physical interventions within an organisation.' (Department for Education and Skills and Department of Health 2002, 14.1). The lack of an explicit direction or expectation to reduce restrictive PI use is unhelpful. Reliance upon the 'last resort' principle has the major drawback that it is an easily voiced rhetorical device and very difficult to observe or challenge. This lack of central direction or legal imperative has left individual organisations and services to develop practices and policies; or not. Two examples of organisations seeking change are: BILD has augmented its commitment to PI training by promoting the first UK conference presentation (first author) on reducing RPI (in 2006). Subsequently, three conferences planned for 2009 are devoted to this topic. An action research project in residential children's services is examining the effectiveness of post-restraint use meetings looking at alternative staff responses to reducing RPI; preliminary results are very encouraging (personal communication).

The impact of regulation and inspection upon the use of RPI is largely unstudied. Furthermore, despite emphasising quality of life issues within inspections some evidence shows that CSCI inspector ratings do not correlate with a variety of research measures of 'process and outcome' for service users (Beadle-Brown *et al.*, 2005). Anecdotal evidence leads to the view that individual inspectors vary greatly in their knowledge of and inclination to influence practice in this area.

Whilst we would not advocate explicit and general 'target' setting for restraint reduction we would recommend that inspectors, commissioners and service providers develop questions and enquiries that encourage all to examine practice and seek to reduce restrictive interventions. It may be that enquiries focussed differently from an approach commencing 'Does your home have a PI policy? Is it reviewed and dated?' to an approach which focuses upon a service's practice, (for example, 'Have you used floor or sitting restraint within the last year? If yes, has this use increased for the service user and have you tried to reduce this?') could lead to greater focus upon quality of life and lead to better illumination of support practice for people exhibiting challenging behaviour. As a minimum, services should be developing and implementing individualised restraint reduction programmes.

These studies begin to demonstrate practices through which RPI can be reduced and the principle of last resort use become reality for people with learning disabilities who exhibit challenging behaviour.

Conclusions

This paper has reviewed approaches to reduction of RPI usage. Debates about the training and effectiveness of different PI techniques, is perhaps a diversion from the organisational factors that would lead to improvements in

support for people whose behaviour challenges. The paucity of hard research data needs to be considered along with the qualitative data emerging from an increasing number of studies that report the impact of physical interventions on consumers and users. The impact of organisational factors such as the role of leadership, management and the monitoring of physical interventions usage appear to have substantial merit. As 'the last resort'? We believe that making such a statement a reality will require changes in the expectations and focus of many different agencies and professionals. The minimum needed now is for services to develop, and commissioners/inspectors to expect and monitor RPI reduction programmes for individuals and across services.

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