Brief Report

Physical Interventions for People with Intellectual Disabilities: Initial Survey of Training and Evaluation of a Policy Framework

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Background. Physical interventions for people who have intellectual disabilities are sometimes necessary, even though they are known to present dangers to both service users and staff. The present report concerns an initial study of training in physical interventions amongst a group of senior staff and their views on a recent policy framework on physical interventions developed by the British Institute of Learning Disabilities (BILD) and National Autistic Society (NAS).

Method. The participants in this initial study included those who had attended conferences on the policy and those who had purchased the policy document. 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. The participants came from a variety of services and were relatively well qualified and senior because of the way the sample was derived. They mostly had some training in physical intervention methods, although the type of training varied somewhat with their employing organization. Most participants were very positive about the BILD and NAS policy framework, and about two-thirds of the participants said that their services had, or were developing, a written policy on physical interventions.

Conclusions. This group of staff, many of whom were trained in physical interventions, rated the BILD and NAS policy framework as very helpful. There remained a clear need for guidance with respect to the advantages and disadvantages of the many available methods, and an evidence base on which to judge the effectiveness of different methods of physical interventions.

Introduction

Physical interventions or restraint procedures are sometimes employed in community care services, and in specialist health services for people with intellectual disabilities (IDs), mental health needs or the elderly, usually in order to prevent children or adults from harming themselves or others through self-harm or aggression. Harris (1996) noted that such procedures were normally justified as being ‘in the best interests’ of the service users, but it is known that injuries to service users sometimes result, especially when the restraint is ‘unplanned’ (Spreat et al. 1986). Indeed, some service users have died as a result of such procedures being inappropriately applied, as in the cases of Michael
Martin, who had mental health needs (Ritchie 1985), and Zoe Fairley, a young woman with IDs, who suffocated and died when restrained face down for 50 min (Community Care 1997).

As Lyon (1994) has commented, restraining or physically intervening with people against their will can be an offence in the UK: such interventions could be construed as false imprisonment, battery or assault against the service user. However, there are defences against such charges, including the common law right to protect oneself from harm, ‘lawful correction’, prevention of breach of the peace and possibly also the common law power to detain the ‘insane’ (Lyon 1994). If a service user is engaged in dangerous behaviour, staff have a duty of care to the service user and colleagues in their care, and therefore, they cannot simply stand by.

When physical intervention procedures are used, staff are often acutely aware of the difficult balance that needs to be struck between the protection of service users and their disempowerment. Staff are also aware of the fact that they may be in need of protection themselves at times. For example, Hill & Spreat (1987) reported that there were 256 restraint-related injuries to 465 staff in a residential facility for people with IDs in the USA over a period of 12 months. In the recent National Health Service (NHS) Executive survey of various types of health service in the UK, it was estimated that, on average, seven violent incidents per month were recorded, for every 1000 staff members in NHS trusts, nurses being the most common targets, and mental health and learning disability services being the riskiest areas (NHSE 1998).

Nevertheless, the policy framework for the use of physical interventions has been slow to develop. Until the early 1980s, staff in UK mental health and ID services developed ‘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 ID services were offered training in ‘control and restraint’ (C&R), a method of physical intervention originally developed in the prison service which was adopted in the NHS partly as a result of the recommendations of the 1985 Ritchie report (Wright 1999). Since then, a number of other methods of management of violence have been developed, 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. All of these methods have linked training courses, which have been marketed to the day and residential services that might employ them. However, service providers 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, the British Institute of Learning Disabilities (BILD) and the National Autistic Society (NAS) drew together a team of advisors to construct a policy framework for the use of physical interventions for people with IDs, Physical Interventions: A Policy Framework (Harris et al. 1996). They defined physical interventions as actions or procedures which were designed to limit or suppress movement or mobility (Harris 1996), and they 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 concerned to establish 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. The present initial study was conducted in this context.
Subjects and methods

Participants

In 1996 and 1997, BILD and NAS held three conferences in UK (in 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 the present study 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 the present study (later studies included geographical samples and samples of staff from particular types of services, but these will not be included here).

Measures

Two questionnaires were designed in order to investigate participants’ views of the BILD and NAS policy document, their training in methods of physical interventions, their use of these methods in their workplace, 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. In the present paper, only results from the first questionnaire, which sought the following information, will be described (copies may be obtained from the first author, G.M.):

- 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 IDs;
- details of the type of service in which the participants worked;
- participants’ own training in methods of physical intervention;
- their services’ use of methods of physical intervention (i.e. the method approved by the service, if any);
- participants’ attendance at one of the BILD and NAS conferences, and their view of its usefulness to their work (on a five-point rating scale);
- participants’ views of the document Physical Interventions: A Policy Framework overall and section by section (on five-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 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; and
- whether they would be prepared to complete a second questionnaire regarding physical interventions.

Procedure

The British Institute of Learning Disabilities provided the researchers with a list of the 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. Where no response was received to the initial request, a reminder letter was sent. If there was still no response, a second copy of the 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 the Statistical Package for the Social Sciences (SPSS), Version 9.

**Results**

The names and addresses of 371 participants were 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 IDs). Out of the remaining 337 individuals, 115 completed questionnaires were returned (a 34% response rate), and Table 1 shows their mean age, years of work in ID services, gender, ethnic origin and professional qualifications. The respondents were relatively well-qualified, and were employed in a variety of different types of services, including schools, residential homes, day services and peripatetic teams (see Table 2).

**Table 1** Participant characteristics ($n=115$)*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years) ($n=109$)</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>43.3</td>
</tr>
<tr>
<td>Range</td>
<td>30–65</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>6.74</td>
</tr>
<tr>
<td>Time worked in intellectual disability services (years) ($n=114$):</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>17.5</td>
</tr>
<tr>
<td>Range</td>
<td>3–31</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>6.01</td>
</tr>
<tr>
<td>Gender (%) ($n=115$)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>53</td>
</tr>
<tr>
<td>Female</td>
<td>62</td>
</tr>
<tr>
<td>Ethnic origin</td>
<td>(%) ($n=115$)</td>
</tr>
<tr>
<td>White</td>
<td>91</td>
</tr>
<tr>
<td>Irish</td>
<td>5</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1</td>
</tr>
<tr>
<td>Black British</td>
<td>2</td>
</tr>
<tr>
<td>Mauritian</td>
<td>1</td>
</tr>
<tr>
<td>Professional qualifications (%) ($n=114$):</td>
<td></td>
</tr>
<tr>
<td>Nursing (RMN/RNMH)</td>
<td>32</td>
</tr>
<tr>
<td>Social work</td>
<td>11</td>
</tr>
<tr>
<td>Clinical Psychology</td>
<td>7</td>
</tr>
<tr>
<td>Teaching</td>
<td>38</td>
</tr>
<tr>
<td>Other (e.g. relevant degree, diploma or Master of Arts)</td>
<td>10</td>
</tr>
</tbody>
</table>

*In some cases (most noticeably when asked their age), participants declined to reply, and therefore, the numbers vary for each question, as indicated.

| Only categories for which there were entries are listed here. |
There are a number of different methods or ‘brands’ of physical intervention training (see Table 3). Many will include some training in breakaway skills and de-escalation skills, and most participants had been trained in these aspects (70 and 67%, respectively), with most services approving their use (50 and 57%, respectively).

It appeared that the ‘market leaders’, in terms of the methods (or ‘brands’) of physical intervention in which participants were trained, were some type of C&R (including Care and Responsibility, Dignified Control and Restraint, and General Services Control and Restraint) and SCIP. These were also the most commonly used methods in services.

Some people had been trained in several methods of physical intervention: 24% had been trained in two, 10% had been trained in three, and 7% had been trained in four or more methods. In some cases, respondents reported that their service had approved

Table 2 Service characteristics (n = 115)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Percentage of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector worked in (n = 115)</td>
<td></td>
</tr>
<tr>
<td>National Health Service trust</td>
<td>30</td>
</tr>
<tr>
<td>Local education authority</td>
<td>26</td>
</tr>
<tr>
<td>Social services department</td>
<td>15</td>
</tr>
<tr>
<td>Voluntary or ‘not for profit’ organization</td>
<td>14</td>
</tr>
<tr>
<td>Other private organization</td>
<td>10</td>
</tr>
<tr>
<td>Other (e.g. higher education or independent consultancy)</td>
<td>6</td>
</tr>
<tr>
<td>Care role on an everyday basis (n = 115)</td>
<td></td>
</tr>
<tr>
<td>Residential home (e.g. care worker or manager)</td>
<td>15</td>
</tr>
<tr>
<td>Day service (e.g. instructor or manager)</td>
<td>4</td>
</tr>
<tr>
<td>Educational setting (e.g. school or further education college)</td>
<td>28</td>
</tr>
<tr>
<td>Peripatetic (e.g. CTLD)</td>
<td>25</td>
</tr>
<tr>
<td>Care manager</td>
<td>2</td>
</tr>
<tr>
<td>Management (no day-to-day contact with SU)</td>
<td>16</td>
</tr>
<tr>
<td>Other (e.g. training or inspection)</td>
<td>11</td>
</tr>
</tbody>
</table>

CTLD, community team for people with learning disabilities. SUs, service users.

Table 3 Training in physical intervention methods (n = 115)

<table>
<thead>
<tr>
<th>Method</th>
<th>Trained in this method</th>
<th>In services using this method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control and restraint</td>
<td>45</td>
<td>30</td>
</tr>
<tr>
<td>Care and responsibility</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>Strategies for crisis intervention and prevention (SCIP)</td>
<td>37</td>
<td>31</td>
</tr>
<tr>
<td>STUDIO-III</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Non-aversive psychological and physical interventions (NAPPI)</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Protection of Rights in Care Environments (PRICE)</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Preventing and responding to aggressive behaviour (Welsh centre method)</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Natural therapeutic holding/options method</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Timian training</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Crisis aggression limitation and management (CALM)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other methods</td>
<td>17</td>
<td>14</td>
</tr>
</tbody>
</table>

several methods of physical intervention (9% of respondents said that their service had approved three or more).

It was noticeable that staff in certain settings appeared more likely to have been trained in or to use particular techniques; for example, 22 out of 34 staff (65%) employed in NHS trusts used breakaway techniques in their services, whereas only seven out of 30 staff (23%) employed in Local Education Authorities (LEAs) did so ($\chi = 11.0$, d.f. = 1, $P < 0.001$). Five out of 34 (15%) NHS trust staff used SCIP in their settings, whereas 11 out of 30 (37%) LEA staff did so ($\chi = 4.1$, d.f. = 1, $P < 0.05$). Furthermore, fewer NHS trust staff than LEA staff [nine out of 34 (26%) and 13 out of 30 (43%), respectively] were trained in SCIP, but this was not statistically significant. With respect to C&R, 16 out of 34 staff (47%) employed in NHS trusts had been trained in C&R, whereas only 10 out of 30 (33%) staff in LEAs had been (again this was not statistically significant). Similarly, several LEA and social services departments ($n = 4$) employed PRICE, but no NHS trusts did so, while several NHS trusts employed the Welsh centre method ($n = 4$), but no LEAs or social services departments did so. These differences seemed to largely reflect the settings within which the methods had first been developed and deployed, rather than any logical differences between methods and the needs of service users in the different settings.

Overall, 71% of respondents said that they either already had a written policy on physical interventions in their organization, or that their organization had drafted one and was actively adjusting it. The remainder had no written policy. Those staff whose organizations had a written policy or were developing one were more likely to be trained in at least one method of physical intervention, and were more likely to be using one named method than staff in organizations without a written policy ($\chi = 9.02$, d.f. = 1, $P < 0.01$; and $\chi = 7.7$, d.f. = 1, $P < 0.01$, respectively).

The majority of participants (76%) had attended one of the three BILD and NAS conferences on physical interventions in 1996–1997 (the remaining 24% had received a copy of the policy framework, but had not attended a conference). Out of those attending the conferences, the vast majority rated the conference as ‘extremely useful’ (17%), ‘very useful’ (52%) or ‘quite useful’ (26%) to their work, only 4.7% rating the conferences as ‘a little useful’ or ‘not at all useful’ to their work. Eighty-eight per cent of all participants said that they had read the BILD and NAS document, Physical Interventions: A Policy Framework, or at least partly read it (a further 8%), and only 3% said that they had not read it at all. The participants mostly found the document ‘very easy’ (52%) or ‘extremely easy’ (31%) to understand (only 18% rated it as ‘quite easy’ to understand and no one rated it as harder than this). The majority of participants were overwhelmingly positive about the usefulness of the policy framework document to their work (including the various different sections of it; see Fig. 1 and Table 4).

The participants noted up to seven different strengths of the policy framework, with most people noting one (26%), two (8%) or three (23%) strengths (24% noted no particular strengths). The strengths mentioned included the broad overall perspective, the fact that it was useful for policy development, the summaries provided, the ‘good’ and ‘bad’ practice examples, and the action points. Respondents were generally extremely positive in their comments and some examples are given below (the figures in brackets indicate respondent ID numbers):

‘The document is a landmark and should be required reading for all . . . . The DfEE should be distributing it free of charge to all schools where physical interventions
are an unfortunate fact of life. Similarly (for) Health and Social Services’ (R32). ‘Excellent for reference and reminding [us] of all the key issues relating to such a complex area. We’ve used it for the basis of our current policy development ... Always on my desk’ (R41).

The whole document lends itself to an organization wanting to logically and sensitively work through issues and arrive at positive useful policy/practice position’ (R35).

‘(It) raises issues that matter. For too long, there has been a culture that has not “challenged” the status quo’ (R26).

‘As you can see from our policies, copies enclosed, the document was fantastic! I couldn’t have done my work without it’ (R70).

‘The entire framework is very informative, user friendly and accessible to all staff’ (R94).

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**Figure 1** Participants’ responses to the question, ‘How useful was the document to your work?’

**Table 4** Ratings of the usefulness of the different sections of the policy framework document \((n = 115)\)

<table>
<thead>
<tr>
<th>Section</th>
<th>‘Not at all’ or ‘a little’ useful</th>
<th>Quite useful</th>
<th>Very useful</th>
<th>Extremely useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guidance on law ((n = 101))</td>
<td>4</td>
<td>32</td>
<td>44</td>
<td>21</td>
</tr>
<tr>
<td>Guidance on values ((n = 99))</td>
<td>3</td>
<td>32</td>
<td>54</td>
<td>11</td>
</tr>
<tr>
<td>Guidance on prevention of challenging behaviour ((n = 99))</td>
<td>11</td>
<td>38</td>
<td>42</td>
<td>8</td>
</tr>
<tr>
<td>Guidance on promoting best interests ((n = 100))</td>
<td>4</td>
<td>33</td>
<td>46</td>
<td>17</td>
</tr>
<tr>
<td>Guidance on risk assessment ((n = 101))</td>
<td>6</td>
<td>33</td>
<td>46</td>
<td>16</td>
</tr>
<tr>
<td>Guidance on risk minimization ((n = 99))</td>
<td>7</td>
<td>34</td>
<td>41</td>
<td>17</td>
</tr>
<tr>
<td>Guidance on management responsibility ((n = 99))</td>
<td>4</td>
<td>30</td>
<td>47</td>
<td>19</td>
</tr>
<tr>
<td>Guidance on employer responsibility ((n = 99))</td>
<td>5</td>
<td>40</td>
<td>40</td>
<td>15</td>
</tr>
<tr>
<td>Guidance on staff training ((n = 99))</td>
<td>16</td>
<td>29</td>
<td>37</td>
<td>17</td>
</tr>
</tbody>
</table>
Participants also commented on weaknesses in the policy framework, with most people noting either no weaknesses (53%), one (23%) or two (11%) weaknesses. For example, one person said, ‘I don’t think there are any weaknesses’ (R26). Others simply wrote, ‘None.’ Out of those who did note weaknesses, it was very rare for these to be direct criticisms. Some respondents did consider that the framework was somewhat idealistic (n = 4), but only one person was thoroughly negative, saying that, ‘It seemed to me that BILD has very tunnel vision. It advocates SCIP which I know doesn’t work with adults that are violent’ (R14). In fact, BILD does not ‘advocate’ any particular technique, of course, and this was an aspect of the policy framework that drew some criticisms (see below).

Under ‘weaknesses’, the plea was most often for more guidance: on law, including Scots law (n = 9), on risk assessment (n = 5) and how to consult with service users and/or parents on physical interventions (n = 5), on Health and Safety requirements and/or employer responsibility (n = 4), on setting events or triggers (n = 3), on debriefing and/or staff counselling (n = 3), on the role of medication as a form of physical intervention (n = 1), and on how to deal with physical interventions in public (n = 1). Some respondents also asked for abbreviated versions of the framework for all staff to read (n = 3). However, by far the most common comment related to the need for guidance on training techniques (n = 16). These were variously phrased, for example:

‘It is not prescriptive of what you can actually do . . . . More guidance could be given regarding the confusion between the various types of training available and the legal status they hold if something goes wrong, i.e. if trained people then become trainers and disseminate information to others, what level of expertise is recognized as . . . sufficient?’ (R19).

‘It doesn’t describe what is available. Some of the techniques available aren’t appropriate to certain people/services . . . . An organization may commit to one technique for everything where this isn’t the right thing to do’ (R28).

‘The real problem is which training to use – there seems to be no independent evaluation available of the different types, which to my knowledge are very different. Also what is the legal position in relation to different techniques/types of training?’ (R44).

‘[The] policy framework document does not look at the various alternatives available for restraining individuals – an evaluation of the various models to look at their efficacy from a research evidence point of view would be useful’ (R46).

‘There is no reference to specific acceptable or unacceptable interventions. There is a need to give more specific guidelines which could enhance the national standards already established for RCNI and ENB’ (R73).

One respondent also identified a possible reason for the proliferation of methods, in the absence of any national coordination or control: the commercial motive, since most training is provided by independent agencies. She said:

‘How do you deal with the “hard sell” of people running physical interventions? They all seem to want to put the others down, rather than look at service and client needs’ (R28).

When asked what they thought their organization needed to do to improve the safety and well-being of service users and staff in relation to physical interventions, most participants named at least one (26%), two (28%) or three (14%) tasks, although 24% did
not make suggestions for tasks. By far the most common tasks named were to do more staff training on physical interventions (55 respondents), and to develop or improve the organization’s own policy documents on physical interventions (23 respondents). Some respondents took a broad and constructive view and commented that they felt they needed to improve the service quality generally because of the impact that this would have on the use of physical interventions ($n = 2$). For example, one deputy head teacher said that she would like:

‘To further extend and develop the facilities available to pupils in the hope of reducing anxiety and providing enough variety of enjoyable activities to lower the rate of incidents. To establish a variety of safe places where students can go to calm or relax at stressful times. To further improve our approaches to communication, social understanding, curriculum delivery, physical exertion, so pupils have less need to become anxious’ (R9).

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 suggested one (39%), two (20%) or three (7%) actions, while 30% made no comment. A number of respondents asked that BILD act as an information centre and network promoter (seven respondents). Several people remarked that, since the BILD and NAS framework had been published, a number of other initiatives had begun which needed to be covered in future editions of the framework: the Royal College of Nursing Institute and the English Nursing Board had validated courses in physical interventions; the Mental Health Act revised codes of practice (1999) included a section on physical interventions (page 93); and the 1997 Education Act (Care and Control), Section 550 A, Circular 10/98, gave guidance for LEAs on the use of physical interventions.

However, the most frequently proposed actions for BILD were to provide low-cost training (24 respondents), to mandate training (three respondents) and/or to provide advice on approved training courses (15 respondents). There were also suggestions that BILD could identify how training could be monitored for quality and efficiency. Two people seemed to sum up many respondents’ concerns, asking BILD for:

‘Clarification regarding the various approaches to physical intervention – some core shared content and uniformity relating to interventions used, their legal acceptability and all the preventative approaches. Why do we have so many different systems? It is confusing to parents and staff . . .’ (R9).

‘If practice is to be challenged, there must be agreed standards for trainers, including a directory of physical skills. Currently, the whole area of physical skills training is a mess, with all sorts of weird and/or potentially dangerous practices being taught by a variety of trainers’ (R71).

**Discussion**

The present initial study had a number of disadvantages which need to be taken into account in interpreting the results. First, the sample chosen was an opportunity sample of staff who had attended relevant conferences or purchased the policy document. This group were selected because they would all have had some exposure to the BILD and NAS policy document under investigation. This was certainly not a representative sample of all staff working in ID services. Rather, it consisted of people who were
probably already interested in physical interventions and were relatively senior managers, as Table 1 confirmed. Secondly, with regard to methodology, the resources available meant that the study involved postal questionnaires. While the response rate was better than is normal for postal questionnaires (which typically attain a 20–30% response rate; Hayes 2000), it is still not possible to know the extent to which those who responded were representative of the total sample. However, these data are presented as a first picture of the extent of staff training in physical interventions in a sample of ID services and of staff opinions of a policy framework for physical interventions. Such studies are extremely rare.

From the present sample of staff, who came from a variety of ID services, including educational, residential, day and peripatetic services, it appeared that most had had some training in physical intervention techniques. However, the sample is likely to have been strongly biased towards senior staff and those with special interests in physical interventions (see above) since they were recruited through conference attendee and policy document purchaser lists. It appeared that there were a large number of different methods of physical intervention being taught within the present sample, with no clear rationale for why some were taught in some settings and not in others. It is likely that there were historical, geographical and marketing reasons for the differing rates of use found; it is unlikely that the rates reflect the effectiveness of different methods since these have not been evaluated.

Overall, staff very much welcomed the BILD and NAS policy framework document, and in general, they seemed to want more guidance on a number of areas. Many staff voiced concerns about the plethora of methods of physical interventions available, and the lack of information and research into their relative efficacy.

Ideally, physical interventions should only be used within a framework of planned programmes of positive behavioural support, as Allen et al. (1997) 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, in press), and from time to time, cases come to light where physical interventions or restraint appear to have been used in an abusive manner. For example, a recent BBC documentary on some group homes in Kent (MacIntyre Undercover 16th November 1999) claimed to show abusive physical restraint of the residents in a community-based home. It is likely that this kind of practice represents the tip of the iceberg and it is clear that there is a long way to go in improving practice in the use of physical interventions. Further research will examine the extent to which the sample of participants in the present study was typical of those working in ID services in terms of their training and their attitudes to physical interventions.

Acknowledgments

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Correspondence

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