"Challenging behaviour" is a term used to describe behaviour that interferes with an individual’s or carer’s daily life. Common examples of challenging behaviour are aggression, self-injurious behaviour, property destruction, oppositional behaviour, stereotyped behaviours, socially inappropriate behaviour, and withdrawn behaviour.

The term ‘challenging behaviour’ is used as a way to label the behaviours as challenging, rather than label the person as the problem. Challenging behaviour affects many people in the community, and is not an inevitable result of developmental disability. The development of challenging behaviour is less likely when people with a developmental disability are taught pro-social behaviour from an early age and are provided with environments that eliminate the necessity to behave in problematic ways. While a clinician’s attention may be focused on the behaviour it is also important to maintain an appreciation of the positive aspects of the individual with the disability.

Challenging behaviour may seriously affect a person’s health and quality of life. Some examples are listed here.

- Self-injurious behaviour (including ingestion or inhalation of foreign bodies) can result in blindness, bowel perforation, infection, haemorrhaging, brain damage and even death.
- Oppositional behaviour may result in dietary deficiencies, weight loss, gross obesity and heart failure.
- Accidental injury is a common medical problem in people with aggressive behaviour.
- Lack of social skills can lead to loneliness and depression.

Influences on behaviour

Determining the underlying cause of behaviour using a biopsychosocial perspective is an important starting point in devising appropriate behaviour management strategies. Influences on behaviour include the following:

**Medical Influences**

- Unrecognised Pain or Discomfort
- Background Medical Conditions
- Medication
- Substance Abuse
- Epilepsy
- Syndrome Specific Conditions and Behavioural Phenotypes

**Psychiatric Influences**
People with intellectual disabilities have a much higher prevalence of psychopathology (in the order of 40%) than the general population. Communication and cognitive difficulties may confound the presentation.

**Challenging Behaviour Commonly Associated with Psychiatric Disorders**
- Depression may present as withdrawn behaviour, irritability, and aggression directed at people trying to motivate the person. Depression is common in people with developmental disability and is often missed.
- Manic depression may present as absconding, boisterousness and disinhibition.
- Psychosis may be indicated by aggression that has no clear precipitating factors and is associated with bizarre behaviours suggestive of hallucinations or paranoia.

**Be Aware**
- Consider if there is a family history of psychiatric disorders such as schizophrenia or mood disorders, as these can be inherited.
- Avoid the assumption that severe aggressive behaviour indicates a psychiatric disorder.

**Environmental (Social and Physical) Influences**
- Living and Working Environment
- Significant Life Events
- Communication Issues
- Life Stages

Behaviour serves a function or purpose for the person. Challenging behaviours are maintained if the person is successful in altering their internal or external environment through their behaviour.

**Common functions of behaviour include:**
- gaining social attention
- escape or avoidance of demands
- gaining access to preferred activities or objects
- sensory feedback (e.g. hand flapping, eye poking)
- pursuit of power and control over own life
- reduction of arousal and anxiety

**ASSESSMENT, INVESTIGATIONS, TREATMENT AND REFERRAL**
- It is important to describe in observable terms what constitutes a behavioural episode and to establish the historical background to the behaviour
- Be aware of all possible influences on behaviour.
• The medical practitioner can often investigate environmental (social and physical) influences, and offer advice and guidance (that does not involve medication) to the individual, family and carers.

• Parliament has legislation that covers the use of restrictive, aversive, or intrusive interventions with people with a developmental disability. It is important to be familiar with these requirements before proceeding with pharmaceutical or behavioural interventions.

• In general, medication should only be used where there is a clear advantage to the patient and where there is no other practical alternative to induce a desired behaviour change. Behavioural strategies can be effectively used to intervene with most challenging behaviour. Where the cause is clearly environmental or social, medication should only be used to compliment applied behavioural strategies, not as an alternative.

• Applied Behaviour Analysis (ABA) addresses the relevant environmental factors (social and physical) of challenging behaviour. ABA is the most effective intervention for challenging behaviour, and is a useful component of management even when medical or psychiatric causes are present.

**Intervention for challenging behaviour should aim to:**

Improve the person’s behaviour in the home and in the community. Enhance the carers’ capacity to support the person. A comprehensive functional assessment will include:

• a full description of the challenging behaviour
• a description of the escalating sequences of interaction between the person and others:
  • What triggers the behaviour?
  • How do others respond to the behaviour?
  • Is the response of others strengthening or maintaining the behaviour?
• the environmental features (e.g. persons, places, activities) relevant to the occurrence of challenging behaviour
• the medical/physiological factors associated with challenging behaviours
• educational or skill factors, e.g. communication skill deficits
• potential functions of challenging behaviours and maintaining re-enforcers
• personal re-enforcers e.g. events, activities, objects

This information about the function of behaviour and its maintaining variables leads to the design of a behaviour intervention plan.

When **working with the families/carers** of the person with a developmental disability it is important to consider the following:

• Collaboration with carers
• The ecology of the family or residential system
• Strengthening and empowering carers
Identify the positive aspects the person
Stresses within the family or residential system.

Checklist for Assessment of Challenging Behaviour
- Ensured safety of client and others
- Observed and described behaviour
- Collated relevant past history

Consider:
- psychiatric diagnosis
- communication difficulties
- physical/medical cause
- epilepsy

Review:
- Environmental issues
- Effect of psycho-active substances
- Developmental stage
- What else is happening?

THE ASSESSMENT OF NEEDS FOR CLIENTS TO MANAGE THEIR BEHAVIOUR

It is important to ensure agreement is reached with team members on the worker's role in the assessment process. Because of the nature of behaviour, special care must be taken not to encourage individuals to display adverse behaviour for the purposes of either enabling the worker to intervene to gather their evidence or for them to demonstrate any newly developed skills.

All relevant information on the client and their needs is obtained from other members of the care team.

All individuals involved are informed of the nature of the assessment and their role within it in a way which encourages their understanding and cooperation.

The appropriate assessment methods and approaches which have been agreed with the care team are used correctly.

The assessment is conducted in a way which is likely to be conducive to a successful outcome, values the individual as an individual, enables them to participate actively and optimises the likelihood of their full involvement.
During the assessment, the individual's behaviour is continuously monitored for signs of change and concern.

All interventions appropriate to the individual are made when there is a need to help them manage their behaviour.

Short term support is sought from an appropriate person where there are any difficulties with the assessment.

Realistic suggestions as to how the individual's needs may best be met, the different goals along the way and the role of the worker in this are offered to the team.

Records of the planning process are complete, legible, accurate and structured in a way which allows others to use them easily.

The goals of the therapeutic programme are agreed with the individual and a contract made.

EVALUATION AND REVIEW OF THERAPEUTIC PROGRAMMES TO ENABLE INDIVIDUALS TO MANAGE THEIR BEHAVIOUR

The progress which individuals have made towards agreed goals is identified and discussed with individuals and the other workers involved. Contingency action to help the individual manage their behaviour will involve such strategies as: talking through the problem, adopting a different approach, changing positions, taking appropriate steps to physically intervene. The term 'family' includes partners where these exist.

The effects which any short-term behaviour management interventions have had on the achievement of the longer-term goals of the therapeutic programmes are identified.

Individuals are given the appropriate support to contribute personally to the evaluation.

The reasons for activities achieving or failing to achieve their agreed aims are discussed and agreed with the other workers and the individuals involved.

Ways in which the programme could be modified and their feasibility are explored with other members of the team.

Agreements on any modifications to therapeutic programmes are reached with all involved.
Records are made of agreements reached and the implications for future work with the individual and are shared with all those who need to know

Where the worker needs more information and support on how to implement changes in their interactions with individuals, appropriate team members are consulted for advice

**CONTRIBUTE TO THE EVALUATION AND REVIEW OF THERAPEUTIC PROGRAMMES TO ENABLE INDIVIDUALS TO MANAGE THEIR BEHAVIOUR**

The progress which individuals have made towards agreed goals is identified and discussed with individuals and the other workers involved. Evaluation of the effectiveness of the therapeutic programme should take place on an ongoing basis. The more formal review of the effectiveness of therapeutic programmes will take place less often or may take place when evaluation suggests that this is necessary.

The effects which any short-term behaviour management interventions have had on the achievement of the longer-term goals of the therapeutic programmes are identified

Individuals are given the appropriate support to contribute personally to the evaluation. 'Appropriate support' in performance criterion might be in relation to enabling the individual to evaluate: the factors which have promoted the management of their behaviour; the factors which have made it difficult for the individual to manage their behaviour; the extent to which the programme has met its agreed purposes and goals.

The reasons for activities achieving or failing to achieve their agreed aims are discussed and agreed with the other workers and the individuals involved. Reasons for activities not achieving their agreed aims may be due to: the activities being inappropriate; unsuitable resources; inadequate resources; the goals being inappropriate for the individuals concerned.

Ways in which the programme could be modified and their feasibility are explored with other members of the team. The programme may be modified in relation to: the behaviour of the worker; the environment in which the programme is undertaken; how the individual prepares; the support structures which the individual can use; modification of the activities and the goals.

Agreements on any modifications to therapeutic programmes are reached with all involved

Records are made of agreements reached and the implications for future work with the individual and are shared with all those who need to know
Where the worker needs more information and support on how to implement changes in their interactions with individuals, appropriate team members are consulted for advice. Contingency action to help the individual manage their behaviour will involve such strategies as: talking through the problem, adopting a different approach, changing positions, taking appropriate steps to physically intervene. The term 'family' includes partners where these exist.

**RE-ITERATION**

"Challenging behaviour" is a term used to describe behaviour that interferes with an individual's or carer's daily life. Common examples of challenging behaviour are aggression, self-injurious behaviour, property destruction, oppositional behaviour, stereotyped behaviours, socially inappropriate behaviour, and withdrawn behaviour.

The term 'challenging behaviour' is used as a way to label the behaviours as challenging, rather than label the person as the problem. Challenging behaviour affects many people in the community, and is not an inevitable result of disability are taught pro-social behaviour from an early age and are provided with environments that eliminate the necessity to behave in problematic ways. While a clinician's attention may be focused on the behaviour it is also important to maintain an appreciation of the positive aspects of the individual with the disability.

Challenging behaviour may seriously affect a person’s health and quality of life.

**Some examples are listed here.**

- Self-injurious behaviour (including ingestion or inhalation of foreign bodies) can result in blindness, bowel perforation, infection, haemorrhaging, brain damage and even death.
  - Oppositional behaviour may result in dietary deficiencies, weight loss, gross obesity and heart failure.
  - Accidental injury is a common medical problem in people with aggressive behaviour.
  - Lack of social skills can lead to loneliness and depression.

**Influences on behaviour**

Determining the underlying cause of behaviour using a biopsychosocial perspective is an important starting point in devising appropriate behaviour management strategies. Influences on behaviour include the following:

**Medical Influences**
- Unrecognised Pain or Discomfort
- Background Medical Conditions
Psychiatric Influences
People with intellectual disabilities have a much higher prevalence of psychopathology (in the order of 40%) than the general population. Communication and cognitive difficulties may confound the presentation.

Challenging Behaviour Commonly Associated with Psychiatric Disorders
- Depression may present as withdrawn behaviour, irritability, and aggression directed at people trying to motivate the person. Depression is common in people with developmental disability and is often missed.
- Manic depression may present as absconding, boisterousness and disinhibition.
- Psychosis may be indicated by aggression that has no clear precipitating factors and is associated with bizarre behaviours suggestive of hallucinations or paranoia.

Be Aware
- Consider if there is a family history of psychiatric disorders such as schizophrenia or mood disorders, as these can be inherited.
- Avoid the assumption that severe aggressive behaviour indicates a psychiatric disorder.

Environmental (Social and Physical) Influences
- Living and Working Environment
- Significant Life Events
- Communication Issues
- Life Stages

Behaviour serves a function or purpose for the person. Challenging behaviours are maintained if the person is successful in altering their internal or external environment through their behaviour.

Common functions of behaviour include:
- gaining social attention disability are taught pro-social behaviour from an early age and are provided with environments that eliminate the necessity to behave in problematic ways. While a clinician's attention may be focused on the behaviour it is also important to maintain an appreciation of the positive aspects of the individual with the disability.

Challenging behaviour may seriously affect a person's health and quality of life.

Some examples are listed here.
- Self-injurious behaviour (including ingestion or inhalation of foreign bodies) can result in blindness, bowel perforation, infection, haemorrhaging, brain damage and even death.
• Oppositional behaviour may result in dietary deficiencies, weight loss, gross obesity and heart failure.
• Accidental injury is a common medical problem in people with aggressive behaviour.
• Lack of social skills can lead to loneliness and depression.

Influences on behaviour
Determining the underlying cause of behaviour using a biopsychosocial perspective is an important starting point in devising appropriate behaviour management strategies. Influences on behaviour include the following:

Medical Influences
- Unrecognised Pain or Discomfort
- Background Medical Conditions
- Medication
- Substance Abuse
- Epilepsy
- Syndrome Specific Conditions and Behavioural Phenotypes

Psychiatric Influences
People with intellectual disabilities have a much higher prevalence of psychopathology (in the order of 40%) than the general population. Communication and cognitive difficulties may confound the presentation.

Challenging Behaviour Commonly Associated with Psychiatric Disorders
- Depression may present as withdrawn behaviour, irritability, and aggression directed at people trying to motivate the person. Depression is common in people with developmental disability and is often missed.
- Manic depression may present as absconding, boisterousness and disinhibition.
- Psychosis may be indicated by aggression that has no clear precipitating factors and is associated with bizarre behaviours suggestive of hallucinations or paranoia.

Be Aware
- Consider if there is a family history of psychiatric disorders such as schizophrenia or mood disorders, as these can be inherited.
- Avoid the assumption that severe aggressive behaviour indicates a psychiatric disorder.

Environmental (Social and Physical) Influences
- Living and Working Environment
- Significant Life Events
- Communication Issues
- Life Stages
Behaviour serves a function or purpose for the person. Challenging behaviours are maintained if the person is successful in altering their internal or external environment through their behaviour.

*Common functions of behaviour include:*
  - gaining social attention
  - Observed and described behaviour
  - Collated relevant past history

*Consider:*
  - psychiatric diagnosis
  - communication difficulties
  - physical/medical cause
  - epilepsy

*Review:*
  - Environmental issues
  - Effect of psycho-active substances
  - Developmental stage
  - What else is happening?

**WORKING WITH CHALLENGING BEHAVIOUR POLICY**

**Who does this policy apply to?**

All staff, contractors and volunteers working with clients

Note: Volunteers should not be involved in a personal intervention situation unless directly supervised by a staff member and there is no other option available at the time.

**THE POLICY**

- Risk assessments should be carried out on all individuals who are deemed at risk of violent/aggressive behaviour
- Staff should take all necessary steps to avoid a situation arising
- Personal intervention should be used as a last resort and staff must ensure they do not use any form of physical force that could be construed as assault. Staff who do not conform to this policy may be subject to disciplinary action or criminal prosecution
- Personal intervention should not be used at any point as a means of punishment
- Staff may use personal intervention only where an individual is going to directly harm or significantly injure themselves or other people
- In no circumstances should staff put themselves or others at risk of personal harm or serious injury
- All incidents must be reported
• Challenging Behaviour training, which includes personal intervention, is available for all staff working with individuals

**Why we have this policy**

Meadow Court realises that with the client group it works with, there may be a situation when personal intervention is the only option available to keep Individuals and staff safe. This policy outlines the procedures and good practice for dealing with challenging behaviour and situations where personal intervention may be necessary.

**Responsibility**

The most senior member of staff present at the time of the problem should be responsible for any personal intervention being carried out, although they may not actually carry it out themselves, for example, if they are of a smaller stature or are ensuring the safety of the group.

**Reasons for challenging behaviour**

There is an underlying cause for all behaviour, this also counts for behaviours seen to be difficult, violent or Aggressive. It is therefore useful to try and work out what the individual is trying to achieve or what need they are trying to realise and see if this can be achieved in a more productive way.

**Preventing a Situation**

Staff should take all necessary steps to avoid a situation arising. Challenging Behaviour training to support this is available.

Risk assessments should be carried out on all Individuals who are deemed at risk of violent behaviour.

Where possible, information should be shared by the individual’s referral agency including their awareness of any ‘triggers’ that a individual may have. This information should be passed onto all staff that may work with the individual, in line with Meadow Court’s Confidentiality Policy.

**Preventative Techniques**

The following preventative techniques are for use when a individual becomes increasingly agitated: Ignore the inappropriate behaviour. Focus the individual on the task at hand or distract them from the source of agitation with another task.
Redirect or remind the individual with verbal reassurance and cues
Talk to the individual and set expectations, thus giving them a choice on how to respond to the situation

Acknowledge the situation and try to get the individual to express their feelings verbally not physically
Remove the source of the agitation, or the individual, to a more neutral environment. This can be done by moving the whole group or the individual but take care not to leave a staff member alone with an individual

There are situations where inappropriate behaviour cannot be ignored, such as violence or destruction of Property

The reactions of a staff member can have a large impact in these situations. Staff should therefore try to appear calm, even though they may feel quite the contrary

In attempting to defuse the situation, the use of touch should be considered carefully. An attempt to calm by laying a hand gently on the individual's shoulder, for instance, may lead to escalation of the behaviour

Body language can be a clear indicator of an individual becoming distressed or heading into a situation which could lead to personal intervention

**Employing personal intervention – This should only be carried out as a last resort when all other options are exhausted**

Are staff, Individuals or members of the public in immediate danger? Yes No
If yes – Call 999 Remove all other Individuals to a safe and secure location

**Is the individual an epileptic or pregnant? Yes No**

Individuals known to be suffering from epilepsy must not receive any form of personal intervention. If during personal intervention, an individual begins to have an epileptic fit any sort of physical intervention should cease. If personal intervention is unavoidable for pregnant women, extra care must be taken to ensure the minimum amount of force is used.

**Is personal intervention to prevent an individual taking drugs or alcohol? Yes No**

Personal intervention can only be used as a last resort if drugs are being used to cause deliberate self-harm, harm to others or if the individual under the influence of drugs behaves in a way that
requires an appropriate level of physical response from staff. In situations involving drugs, the assistance of the Police should be seriously considered. As many staff as available should be used to reduce risk to staff and to reduce where possible any injury to the individual. As soon as the situation is under control, report the incident to line manager. Relevant incident forms to be filled in. The Head of Programmes / Head of Operations has the discretion to decide if the individual is allowed back onto the programme. One-to– Ones to be carried out with the individual, in some cases this may be better on another day

Personal intervention is any form of physical contact with a individual to manage, control or direct their movement or actions.

Employing personal intervention

This should only be carried out as a last resort by staff when all other options are exhausted
In no circumstances should staff put themselves at risk of personal harm or serious injury. On no account should members of staff attempt to overcome a large and violent individual merely to re-establish control. If this sort of incident occurs, staff efforts should be directed towards the protection of themselves and other young people. If circumstance permit, it may be advisable to contact the Police.

Personal intervention guidance

Most individuals will respond positively if spoken to in a quiet and soothing manner, to encourage the speedy return of calm and self-control. In some cases this may not be possible
If personal intervention is necessary, it should be used with thoughtful consideration for their self-respect, dignity, privacy, cultural values and any special needs (e.g. physical illnesses or disability that the individual may have)
Personal intervention should be ceased if the contact appears to be arousing any sexual expectations or feelings
Personal intervention is not to be used purely to force compliance when there is no immediate risk to people or property
Staff should be careful where they touch or hold young people. For instance, they should be careful not to hold a individual in such a way that it involves contact with breasts or genitals
It is important to listen to what the individual is saying during personal intervention and use judgement to adjust any touch or hold if the individual complains of pain
Where possible, personal intervention should be conducted by a staff member of the same sex, this may not be possible in some situations

Maintaining a physical presence to control behaviour
By staying with an individual who may be heading towards a challenging or violent situation, a situation can be stopped from developing.

By their very presence, staff should be able to positively influence the individual's behaviour, through the use of a look, gesture or quiet word.

A staff member can devote themselves exclusively to one individual, in liaison with other staff present. Where possible, use constructive activity/discussion rather than just "shadowing".

In using physical presence the following factors must be considered:

- The technique should not be persisted with if the individual physically resists.
- If challenged, staff should be prepared to explain to the individual what is being done and why.
- The conscious use of physical presence for control purposes can be oppressive if extended over long periods, and this should be borne in mind.

Oppressive physical methods may also reactivate previous negative experiences for the individual, possibly resulting in a violent reaction. Such methods should not be used.

Maintaining a physical presence to stop an individual running away:

Physical presence can also be used when an individual is running away and is more advisable than resorting to personal intervention unless the individual is placing themselves in immediate danger of significant injury.

In the event that an individual is "running away", a staff member should maintain a presence.

The staff member should allow the individual to move far enough away from the others involved allowing them sufficient privacy to regain their composure.

Remaining staff should ensure they are within shouting/signalling distance and ready to assist if required.

Unless this assistance is requested, they should make every effort to calm the remaining young people and prevent them from attempting to follow, or communicate with, the individual concerned.

If the member of staff cannot keep pace with the individual, or is no longer in a position to request support from colleagues, they should stop attempting to maintain a physical presence.

At this point the senior member of staff should inform their line manager and Police of the missing individual.

The Incident Management Plan should then be implemented.

Recording the Incident:

At the earliest opportunity, the most senior staff member must inform their line manager and complete the appropriate forms in line with the Accident and Incident Reporting Policy.

The incident form should include how personal intervention was used, if relevant, and for how long.

Any incident resulting in: an injury to any party that requires professional medical attention, the assistance of Police or other emergency service, must be regarded as "major".

Following an Incident:
Following the use of personal intervention the individual should have the opportunity to recuperate and have
time alone if appropriate. However, an interview should take place as soon as possible. The more
time between the incident and the interview the less effective it becomes
The aim of the interview should be:

- To return the individual to an emotional level at which they can function appropriately
- To use the loss of control and the subsequent personal intervention to clarify the underlying causes that led to the incident in the first place
- To develop a strategy for change with the individual that will lead to better self-control

If required, staff should refer to the Exclusion Policy
Where deemed necessary, staff should run a debriefing session with other young people who observed the incident
The Manager should ensure that any incidents of personal intervention are discussed at a staff debriefing meeting. This should enable a constructive review of how the incident was managed, provide support to the staff involved and initiate appropriate follow-up with the individual/referral agency involved

Definitions

Presence is a form of control using no contact, such as standing in front of a individual or obstructing a doorway to negotiate with a individual; but allowing the individual the freedom to leave if they wish.
Includes minimum contact in order to lead, guide, usher or block an individual; applied in a manner which permits the individual quite a lot of freedom and mobility. This form of physical intervention is promoted amongst Meadow Court staff.
Holding is any measure or technique that involves the individual being held firmly by one person, so long as the individual retains a degree of mobility and can leave if determined enough.
Assault includes throwing missiles, pulling hair, smacking etc. The exception to this is where physical contact is used to prevent an immediate danger

RESTRICTIVE PHYSICAL INTERVENTIONS

This guidance has been prepared in the context of The Human Rights Act (1998)

It is based on the presumption that every adult is entitled to:
- respect for his/her private life;
- the right not to be subjected to inhuman or degrading treatment;
- the right to liberty and security; and
- the right not to be discriminated against in his/her enjoyment of those rights.
The Human Rights Act 1998 sets out important principles regarding protection of individuals from abuse by state organisations or people working for those institutions. Implementation of this guidance will help to ensure that practice within services is consistent with this Act. It is a criminal offence to use physical force, or to threaten to use force (for example, by raising a fist or issuing a verbal threat), unless the circumstances give rise to a 'lawful excuse' or justification for the use of force. Similarly, it is an offence to lock an adult in a room without recourse to the law (even if they are not aware that they locked in) except in an emergency when for example the use of a locked room as a temporary measure while seeking assistance would provide legal justification. Use of physical intervention may also give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the person concerned.

Under health and safety legislation, employers are responsible for the health safety and welfare of employees and the health and safety of persons not in employment, including service users and visitors. This requires employers to assess risks to both employees and service users arising from work activities, including the use of physical interventions. Employers should also establish and monitor safe systems of work and ensure that employees are adequately trained. Employers should also ensure that all employees, including agency staff, have access to appropriate information about adults they are working with.

**RISK ASSESSMENT**

When the use of a restrictive physical intervention is sanctioned, it is important that appropriate steps are taken to minimise the risk to both staff and service users. Among the main risks to service users are that a physical intervention could:

- be used unnecessarily, that is when other less intrusive methods could achieve the desired outcome;
- cause injury;
- cause pain, distress or psychological trauma;
- become routine, rather than exceptional methods of management;
- increase the risk of abuse;
- undermine the dignity of the staff or service users or otherwise humiliate or degrade those involved;
- create distrust and undermine personal relationships.

The main risks to staff include the following:

- as a result of applying a physical intervention they suffer injury;
- as a result of applying a physical intervention they experience distress or psychological trauma;
- the legal justification for the use of a physical intervention is challenged in the courts;
- disciplinary action.

The main risks of not intervening include:

- staff may be in breach of the duty of care
service users, staff or other people will be injured or abused;
serious damage to property will occur;
the possibility of litigation in respect of these matters.

Whenever it is foreseeable that a service user might require a restrictive physical intervention, a risk assessment should be carried out which identifies the benefits and risks associated with the application of different intervention techniques with the person. Where the use of self-harm prevention devices is indicated, staff should be fully trained in their usage.

Where incidents are foreseeable, service users should only be exposed to restrictive physical intervention techniques which are described in their individual records/Positive Handling Plans following a risk assessment.

All services should be designed to promote independence, choice and inclusion and to establish an environment that enables service users maximum opportunity for personal growth and emotional wellbeing.

Wherever possible, restrictive physical interventions should be used in a way that is sensitive to, and respects the cultural expectations of, service users and their attitudes towards physical contact. Restrictive physical interventions should always be designed to achieve outcomes that reflect the best interests of the adult whose behaviour is of immediate concern and others affected by the behaviour requiring intervention. The decision to use a restrictive physical intervention must take account of the circumstances and be based upon an assessment of the risks associated with the intervention compared with the risks of not employing a restrictive physical intervention. A restrictive physical intervention must also only employ a reasonable amount of force – that is the minimum force needed to avert injury or damage to property, or (in schools) to prevent a breakdown of discipline – applied for the shortest period of time. Any restrictive physical Intervention should avoid contact that might be mis-interpreted as sexual.

Restrictive physical interventions involve the use of force to control a person’s behaviour and can be employed using bodily contact, mechanical devices or changes to the person’s environment. The use of force is associated with increased risks regarding the safety of service users and staff and inevitably affects personal freedom and choice. For these reasons this guidance is specifically concerned with the use of restrictive physical interventions. Restrictive physical interventions can be employed to achieve a number of different outcomes:

- to break away or disengage from dangerous or harmful physical contact initiated by a service user;
- to separate the person from a ‘trigger’, for example, removing one pupil who responds to another with physical aggression;
- to protect a service user from a dangerous situation – for example, the hazards of a busy road.

It is helpful to distinguish between:
planned intervention, in which staff employ, where necessary, pre-arranged strategies and methods which are based upon a risk assessment and recorded in care plans;

emergency or unplanned use of force which occurs in response to unforeseen events.

The scale and nature of any physical intervention must be proportionate to both the behaviour of the individual to be controlled, and the nature of the harm they might cause. These judgements have to be made at the time, taking due account of all the circumstances, including any known history of other events involving the individual to be controlled. The minimum necessary force should be used, and the techniques deployed should be those with which the staff involved are familiar and able to use safely and are described in the service user’s support plan. Where possible, there should be careful planning of responses to individual adults known to be at risk of self-harm, or of harming others.

The use of force is likely to be legally defensible when it is required to prevent:

- self-harming;
- injury to service-users or staff;
- damage to property;
- an offence being committed;

The use of force to restrict movement or mobility or to break away from dangerous or harmful physical contact initiated by a service user will involve different levels of risk. Good practice must always be concerned with assessing and minimising risk to service users, staff and others and pre-planning responses, where possible. Examples of physical intervention that might generally be considered low risk include:

- members of staff taking reasonable measures to hold a service user to prevent him or her from hitting someone;
- a specially designed “arm cuff” to prevent someone self-injuring (see para 7.4);
- accompanying a person who dislikes physical contact to a separate room where they can be alone

**Elevated levels of risk are associated with:**

- the use of clothing or belts to restrict movement;
- holding someone who is lying on the floor or forcing them onto the floor;
- any procedure which restricts breathing or impedes the airways;
- seclusion, where an adult or is forced to spend time alone in a room against their will;
- extending or flexing the joints or putting pressure on the joints;
- pressure on the neck chest abdomen or groin areas.

Planned physical intervention strategies should be:

- agreed in advance by a multidisciplinary or school team working in consultation with the service user, his or her carers or advocates and, in the case of a , those with parental responsibility;
• described in writing and incorporated into other documentation which sets out a broader strategy for addressing the service user’s behavioural difficulties;
• implemented under the supervision of an identified member of staff who has undertaken appropriate training provided by an organisation accredited by BILD;
• recorded in writing so that the method of physical intervention and the circumstances when it was employed can be monitored and, if necessary, investigated.

Where planned physical intervention strategies are in place, they should be one component of a broader approach to behaviour management, treatment or therapy.

Unplanned or emergency intervention may be necessary when a service user behaves in an unexpected way. In such circumstances, members of staff retain their duty of care to the service user and any response must be proportionate to the circumstances. Staff should use the minimum force necessary to prevent injury and maintain safety, consistent with appropriate training they have received.

To the extent that seclusion (where an adult is forced to spend time alone against their will) involves restricting a person’s freedom of movement, it should also be considered a form of physical intervention. The use of seclusion for people detained under the Mental Health Act (1983; under review) is set out in the Code of Practice published in 1999.

The right to liberty and personal freedom is enshrined Article 5 of the Human Rights Act 1998 and is protected by the criminal and civil law. For these reasons the use of seclusion outside the Mental Health Act should only be considered in exceptional circumstances and should always be proportional to the risk presented by the service user.

In care settings, if seclusion is required other than in an emergency (for periods of longer than a few minutes or more frequently than once a week) then staff should seek advice regarding the use of statutory powers under mental health legislation.

Planned physical interventions should only be used as part of a holistic strategy when the risks of employing an intervention are judged to be lower than the risks of not doing so.
Any physical intervention should employ the minimum reasonable force to prevent injury or serious damage to property, to avert an offence being committed.

Records of incidents involving particular users sometimes show that there are set patterns to their behaviour which, if unchecked, will lead to it becoming dangerous or exceptionally disruptive. In these circumstances, it might be necessary to use restrictive physical interventions at an early stage.

**PREVENTION**

The use of restrictive physical interventions should be minimised by the adoption of primary and secondary preventative strategies.
• Primary prevention is achieved by:
• ensuring that the number of staff deployed and their level of competence corresponds
to the needs of service users and the likelihood that physical interventions will be
needed. Staff should not be are left in vulnerable positions;
• helping service users to avoid situations which are known to provoke violent or
aggressive behaviour, for example, settings where there are few options for
individualised activities;
• care plans or, for school pupils, Positive Handling Plans, which are responsive to
individual needs and include current information on risk assessment;
• creating opportunities for service users to engage in meaningful activities which
include opportunities for choice and a sense of achievement;
• developing staff expertise in working with service users who present challenging
behaviours;
• talking to service users, their families and advocates about the way in which they prefer
to be managed when they pose a significant risk to themselves or others. Some service
users prefer withdrawal to a quiet area to an intervention which involves bodily contact.
• Secondary prevention involves recognising the early stages of a behavioural sequence
that is likely to develop into violence or aggression and employing ‘defusion’ techniques
to avert any further escalation.

Where there is clear documented evidence that particular sequences of behaviour rapidly escalate
into serious violence, the use of a restrictive physical intervention at an early stage in the
sequence may, potentially, be justified if it is clear that:
• primary prevention has not been effective;
• the risks associated with not using a restrictive physical intervention are greater than
the risks of using a restrictive physical intervention; and
• other appropriate methods, which do not involve restrictive physical interventions, have
been tried without success.

For health and care settings: If it is foreseeable that an adult will require some form of restrictive
physical intervention, for each service user, there must be a written protocol which includes:
• a description of behaviour sequences and settings which may require a physical
intervention response;
• the results of an assessment to determine any contra indications for use of physical
interventions;
• a risk assessment which balances the risk of using a restrictive physical intervention
against the risk of not using a physical intervention;
• a record of the views of those with parental responsibility in the case of family members in
the case of adults;
• a system of recording behaviours and the use of restrictive physical interventions using an
incident book with numbered and dated pages
• previous methods which have been tried without success;
• a description of the specific physical intervention techniques which are sanctioned, the dates on which they will be reviewed;
• a description of staff who are judged competent to use these methods with this person
• the ways in which this approach will be reviewed, the frequency of review meetings and members of the review team.
• An up-to-date copy of this protocol must be included in the person’s individual care plan.

The use of a restrictive physical intervention, whether planned or unplanned (emergency) should always be recorded as quickly as practicable (and in any event within 24 hours of the incident) by the person(s) involved in the incident in a book with numbered pages. The written record should indicate:
• the names of the staff and service users involved;
• the reason for using a physical intervention (rather than another strategy);
• the type of physical intervention employed;
• the date and the duration of the physical intervention;
• whether the service user or anyone else experienced injury or distress and, if they did, what action was taken.

The views of the service user(s) involved in the incident should also be recorded. The contents of the incident book should be reviewed on a half-termly basis and appropriate action taken.

Recording will be used for a number of different purposes:
• compliance with statutory requirements;
• monitoring of service users’ welfare;
• monitoring staff performance and identifying training needs or outcomes;
• contributing to service audit and evaluation;
• updating medical records.

Services need to ensure that recording methods are in place to meet each of these requirements.

POST MANAGEMENT REVIEW

Following an incident in which restrictive physical interventions are employed, both staff and service users should be given separate opportunities to talk about what happened in a calm and safe environment. Interviews should only take place when those involved have recovered their composure. Post incident interviews should be designed to discover exactly what happened and the effects on the participants. They should not be used to apportion blame or to punish those involved. If there is any reason to suspect that a service user or a member of staff has experienced injury or severe distress following the use of a physical intervention, they should receive prompt medical attention.
To help protect the interests of service users who are exposed to restrictive physical interventions it is good practice to involve, wherever possible, family carers and independent advocates in planning, monitoring and reviewing how and when they are used.

TRAINING

All staff require induction training before being required to work with people who present challenging behaviours. Staff who are expected to employ restrictive physical interventions will require additional, more specialised training. The nature and extent of the training will depend upon the characteristics of the people who may require a physical intervention, the behaviours they present and the responsibilities of individual members of staff.

Staff should normally only use methods of restrictive physical intervention for which they have received training. Specific techniques should be closely matched to the characteristics of individual service users and there should be a record of which staff are permitted to use different techniques. It is not appropriate for staff to modify the techniques they have been taught.

The Department of Health and the Department for Education and Skills are working with BILD, and in collaboration with other agencies, to establish an accreditation scheme for those offering training on physical interventions for learning disability and education services. It is envisaged that accreditation within this scheme will provide an important indication of the quality of training available from different trainers and training organisation.