Physical intervention and COVID-19

By Brendan Loughnane

Guidelines for schools in relation to intervention, restraint and social distancing due to Covid-19.

This guidance is aimed at schools who adopt TEAM TEACH training as part of their practice but can be read in relation to other training packages that include physical interventions.

From June 1st schools were asked to consider the re-introduction of students, on a planned basis, into their buildings. This would involve many risks and challenges for school managers, other school staff, students and their parents/families.

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There is government guidance regarding the re-introduction of students to schools that includes safe distancing, personal hygiene, infection prevention and control procedures. (https://www.gov.uk/government/publications/actions-for-educational-and-childcare-settings-to-prepare-for-wider-opening-from-1-june-2020/opening-schools-for-more-children-and-young-people-initial-planning-framework-for-schools-in-england) .

There is also DfE guidance regarding SEND, in particular around risk-assessment and EHC plans. (https://www.gov.uk/government/publications/coronavirus-covid-19-send-risk-assessment-guidance/coronavirus-covid-19-send-risk-assessment-guidance).

It is obviously important for schools to familiarise with these guidelines and take into consideration when planning. I will be focusing specifically around the area of interactions with students that may include physical intervention and restraint.

Firstly we need to ascertain the risks. Ultimately, the key additional risk is that of contracting and/or spreading the Covid-19 virus. We already have guidance, policies and practices around physical intervention and restraint. These include the notions of:

- Only if/when necessary
- Use of minimal force
- Minimal amount of time
- Only if reasonable and proportionate
- All interventions to be in the best interest of the child
- Strategies to include prevention/avoidance and de-escalation as well as physical interventions.

These still apply and are important to remember and allude to. Just because there is an additional risk (Covid-19 in this case) it does not change the principles set out above. We still have to make decisions based on the 'rule of balance':

- What are the risks if I do?
- What are the risks if I don't?

In general terms we choose the safest and most effective option …… and this still applies.

So, what are the additional risks brought on by the threat of Covid-19? Well, actually, it is fairly straightforward and succinct:

- Student contracts the virus from staff
- Member of staff contracts the virus from a student

There is a danger that we catastrophise the situation (because of the potential of the virus) as opposed to the risk of basic infection through physical proximity. Whilst we will naturally be concerned about the ultimate dangers involved here we should be wary of panicking and becoming anxious about what we need to do. We need to assess the risks as thoroughly as possible and put practices in place that minimise its potential harm. As with most strategies, however, we cannot completely eliminate risk.

Firstly, we need to assess the existing health situation of students and staff to highlight the individual levels of risk. For this we need to refer to NHS guidance (https://www.nhs.uk/conditions/coronavirus-covid-19/). These assessments should help to make primary decisions in terms of whether a student is safer to be at school or at home and similarly if staff are safe to attend work or need to stay home based.

The next step is to consider these within a risk assessment of behaviour, intervention and outcomes.

For example:

- a student/member of staff who has underlying health symptoms as listed at higher risk from Covid-19
- a student who is identified as having issues around anxiety that manifests in dangerous, physical outbursts
- a student/member of staff who have family at home who are potentially vulnerable to the virus

These are just a few examples and certainly not an exhaustive list; individual schools need to assess their own community issues.

We need also to consider the potential risks of not supporting students with physical proximity, touch, guidance and/or restraint. There are children who can be more effectively calmed with the physical presence of an adult and the reassurance of touch is often the sensory input a child needs to remain or return to self-control. If such children do not receive this support their behaviour can escalate in relation to their anxiety and inability to self-control; this could be a greater risk to the child and others.

In considering these risks we need to think about and plan the environment we are operating in. The government guidance recommends outdoor learning and activities, as far as this is possible and realistic, as this reduces the risks of transference of infection. If indoors, we can minimise this risk with ventilation of rooms. This should be considered in terms of strategies regarding the management of challenging behaviours. We should identify safer places for children to be directed to (or taken to) to minimise negative stimulation and direct risks of virus transference.

Now we need to plan our intervention strategies in relation to the risk assessments.

The compilation of strategies should include the thoughts and views of the student, the parents/carers, the staff involved and any other outside agencies that might be involved (nothing new there). This is particularly important as the situation is new and unprecedented and will arouse anxieties in all involved. Clear communication, understanding and agreement is crucial. All agreed plans should be recorded and made available (both for clarity and to protect the school and those involved from potential enquiry and litigation).

Possible additional intervention strategies might include:

1. Non-physical

- identifying early signs of emotional triggers and, if necessary, intervening early to prevent escalation (maybe earlier than normal)
- distraction, support, re-assurance and clear guidance offered in a clear and understood manner
- reminders of agreed strategies in a manner that re-assures the student rather than exacerbates the situation
- 'time-out' and withdrawal that helps the student to stay calm and in control
- alternative place for the student to go (e.g. pop up tent, perimeter table, soft cushion area, another room)
- pointing out unacceptable behaviours and suggestion of better options
- clear instruction and guidance

- use of assertive voice (this needs to be utilised carefully and as a planned intervention … i.e. not from adult anger)
- eye contact to re-assure the child and to help with clear communication
- clear gestures and facial expressions to support communication and feelings
- 'virtual hugs': telling a child that you would normally give them a hug (if appropriate) or hold their hand, etc. but the situation prevents this. This is reinforced by simulating a hug on self and encouraging the child to do likewise.
  The above could be done with selected, emotional objects of support (e.g. a doll, teddy, cushion, blanket, etc.) anything that could partially replicate the sensory need for human physical support/control.
  This list is not exhaustive but hopefully will give some ideas.

2. Physical

- light touches for re-assurance (palm to back of shoulders or side of arms, hand on child's hand). Important that these should be considered (planned) interventions and appropriate to the individual child's needs/experiences.
- turning/re-directing a child. Most effective (and least intrusive) way of doing this is with an open palm, 'caring-C' shape (from Team-Teach), placed just above the child's elbow in a manner that prevents the child turning towards you. If staff use a straightened arm to do this you will have considerable physical resistance to a child's movements and so have a level of safety and control. This can be progressed to actually turning the child away from you with minimal additional force.
- at this point we are not looking to restrain (overpower) the child but to prevent any initial dangers from their actions.
- all of the above physical interventions should be aligned with verbal and non-verbal communication that aims to calm the situation down.
- if it is necessary to use more intrusive physical intervention including restraint then we need to consider the potential heightened dangers of Covid-19 transmission. This might include biting, spitting and close face to face proximity.
- to prevent biting and/or spitting at staff we might block the actions using the 'caring C' shaped hand as a support to the side of the child's face (taking care not to obstruct the eyes, ears, nose and mouth). The physical force used by staff here is just enough to prevent the child spitting/biting at the member of staff and not to move the child's face away. Again, this should be supported with calming words of re-assurance for the child or, if more appropriate, silence to avoid heightened stimulation (individual intervention plans should suggest which is best for the child you are with).
- to prevent potential contamination through face to face proximity staff should consider turning the child to face away. This can be effected with a 'Hip-hug' hold and/or a 'Half-shield' hold, maybe supported by a colleague for stability (see Team Teach guidance for holds). It is important that staff re-assure the child that these actions are to keep them safe.
- whilst the general government guidance says it is not recommending the use of PPE such as gloves, face-masks, etc., if a child is spitting and/or biting within a physical restraint it might be safer to

bring in a member of staff who IS more protected with such items (This needs to be balanced with the potential to exacerbate the anxiety of the child in doing this).
Again, these strategies are not comprehensive but hopefully can help staff to be as prepared as possible.

3. Post incident practices

- it will be vitally important for staff and student to debrief after any significant incident so that there is understanding, empathy, re-assurance and agreement about what has happened and why.
- allowing the child to explore and express their thoughts on what happened and how they felt is paramount to understanding the child and showing care and respect.
- exploring what happened will help inform preferred future interventions.
- the all-important relationship between child and staff will be at least maintained at the same level as before or better because of the shared experience. This will be determined by the quality of the debrief.
- all involved in any physical intervention need to practice safe and healthy hygiene afterwards. This includes thoroughly washing hands, faces and any other surface that might have been contaminated during the incident.
- all involved should be supported in relation to their emotional well-being with counselling from a trusted adult/colleague.
- when writing reports on incidents it is important that staff refer to making 'dynamic risk assessments' and clearly state the reasons for their decisions.
- senior leaders at schools should check accounts and record their views. This will act as support of staff in their actions, alleviating anxieties around having acted appropriately. It may also be the case that staff involved, in hindsight, could have chosen a better way to manage the situation. This does not necessarily mean the actions were wrong but reflection on practices is always a positive and professional way to learn.
- any revised strategies for future interventions, arising from a debrief of an incident, should be clearly recorded and communicated to all relevant people.

Additional support

The guidance above should be read in conjunction with all guidance given within Team Teach training. The physical interventions mentioned here are based within Team Teach training and should only apply to those schools/staff who have adopted this training.

If schools would like additional clarification and/or discussions around this guidance I am available (via Zoom social media in the first instance) to meet with you for this. It would also be possible to demonstrate the physical interventions suggested here via the video meetings. I can be contacted via admin@sebda.org

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