

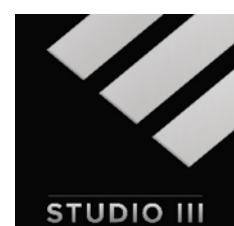


Understanding the Studio 3 Approach to Physical Interventions: Part 2 – Listening to Our Consumers

Written by Professor Andrew McDonnell

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Studio 3 Clinical Services and Training Systems



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Before I became a Clinical Psychologist, I worked in care settings, many of which were medicalised in nature. This was in the 1980s, when the battle for person-centred care was growing, particularly in NHS settings in the UK. When I became an assistant psychologist in a hospital for people with intellectual disabilities, I was very fortunate to be supervised by a psychologist called Rowena Kelleher, who encouraged myself and other assistants to spend time with and talk to clients. It was a profound experience listening to the life stories of individuals who in some cases had spent their entire adult lives in institutional settings. Many of these individuals have been victims of restraint, seclusion, and punitive sanctions of various kinds. I remember being amazed by the resilience of some of these individuals. A key lesson for me throughout my career has been that, unless we listen to our customers, our approach to managing crisis situations will be one-sided and inherently ineffective.

Staff and carer belief in the effectiveness of physical interventions is inextricably linked to their own experiences and belief systems. We can become trapped in a style of thinking that overly justifies the use of restraint because, in our experience, 'there is no alternative.' It can be extremely difficult to get people to change their minds, and understand that there are alternatives; that restraint and seclusion should only be used as a last resort (Deveau & McDonnell, 2009). Most importantly of all, to keep people safe even in crisis situations requires calm and mindful responses. The human rights and consumer views research in general has always been present in our work. Whilst we wish to keep all people safe in crisis situations, the people that we are supporting (whom I will call consumers) have a voice, and sometimes this is not listened to enough by practitioners.

Restraint and Seclusion: The Imbalance of Power

Whilst professionals often convince themselves that crisis management strategies are part of the process of keeping people safe from harm, there is another dimension to their use which can involve a power dynamic, whereby individuals attempt to over-control people. In my experience, many staff and carers are blissfully unaware that they are reinforcing a narrative that can lead to individuals becoming more rather than less distressed. In the case of Winterbourne View (Panorama, 2011), there were numerous examples of staff who used coercive methods to control the behaviour of the consumers as if they were 'naughty children' who needed to be taught a lesson. There is by definition an imbalance of power in the application of restraint, seclusion, and other restrictive practices. Fortunately, my colleagues and I at Studio 3 now work within a sector that does have more checks and controls than in the past. However, with regards to the views of our consumers, it is my honest view that individuals require greater independent advocacy if they are to lead flourishing lives. Professionals, staff, and families all need to be part of the conversation to challenge the use of any restrictive intervention as routine practice.

The Case for Social Validity

In my early work, I was strongly influenced by a researcher called Montrose Wolf. This was one of the first people, particularly in the 70s and early 80s, who talked about what he called the 'social validity' of behavioural interventions (Wolf, 1978). In my book, *'Managing Aggressive Behaviour in Care Settings: Understanding and Applying Low Arousal Approaches'* (2010), I identified that Wolf's work could be applied to crisis

management methods such as restraint and seclusion. This involves thinking about the social impact of methods on the person, the people around them, and society.

Consumer satisfaction is a major component of this. Wolf, in his 1978 article, really emphasised this point:

‘It seems to me that by giving the same status to social validity that we now give to objective measurement and its reliability, we will bring the consumer – that is, society – into our science.’

Wolf clearly understood that society in general is also a consumer. I appreciate that sometimes when a restraint has been implemented with an individual in a crisis situation, there are two consumers, not one (staff and client). Both may be traumatised by the process, but I do not believe that this is a 50/50 transaction. The people we support are often vulnerable, highly stressed, and struggling to make sense of a chaotic world. They often live - sometimes temporarily, sometimes permanently - in places where they have little control over their lives. My colleagues and I believe passionately that the people in receipt of restraint should have a say in their care.

Listening to People

Alexis Quinn has previously been a consumer of services. In her book ‘*Unbroken*,’ she described her experiences in the mental health system, where she was restrained 96 times (2018; pp. 53-4):

‘Someone would push an alarm on their belt. This started the high-pitched **doot-doot-doot-doot** sound. At least four people, maybe six, would come. Three from the ward I was on, three from other units in the hospital. This was a standard procedure. The

staff would immobilise me by taking over my movement in a standing, sitting or prone position, depending on where I was, what I was doing, and where was easiest for them. They would smash me onto the floor. One might hold my head down onto the floor. For the first two years it was always a face-down restraint. One would be on each arm, pressing them straight out like a starfish. They would lean in to my body. There was also one on each leg, and one just talking at me. This was how they controlled me, and by injection too – a chemical restraint.’

It is difficult to read this passage without feeling some distress. Too often, people justify such methods as the ‘only option.’ The reality is that, to change someone’s practices, people need to understand that restraint is not neutral.

My colleague Rebecca Fish at the University of Lancaster has excessively researched the experiences of women who have been restrained or secluded. In 2017, she published an article with Professor Chris Hatton, interviewing 16 women with intellectual disabilities on locked wards. The following is an unedited sequence that is difficult to read (Fish & Hatton, 2017: p. 797):

‘Researcher: What happens when you get restrained?

Louise: They just hold you down, and you can’t move...

Researcher: How does it feel?

Louise: Horrible, hate it. It makes me more angry.

Researcher: Does it not help you calm down?

Louise: No.’

In the opinion of the author, this study should be compulsory reading for healthcare professionals. The authors recommended, and I would agree with them, that a gender-sensitive analysis of the alternatives to restraint is urgently needed. We cannot

continue to justify such experiences which are traumatising to all parties concerned. Accounts such as these are not just a collection of interesting observations: they should be viewed as scientific data and used to inform practice.

Active Campaigning and the Neurodiversity Movement

I was once speaking to an eminent researcher who I will not name, who bitterly complained that research was becoming more difficult unless it contained a consumer's account or lived experience perspective. His point was that there was no 'pure academia' any more. I think I surprised him when I said, 'I agree there isn't; and about bloody time.' I pointed out that the growing neurodiversity movement in our work is not going to change, in fact it's going to grow. We cannot – or more appropriately have no right – to try and put the genie back in the bottle. Coproduction and collaboration from neurotypical and neurodivergent individuals is the way forward. Restrictive interventions is an obvious area that requires collaboration.

Increasingly over the years, I have become genuinely frustrated with the minimisation of the experiences of neurodiverse individuals around being restrained, restricted, and secluded. We need to continue to view individual accounts and experiences as data (McDonnell, 2022; pp. 108-9):

'It is not anti-scientific to include data from a whole range of sources, including individuals with lived experience of restraint and seclusion. We must be aware of the limits of research when it comes to changing practice. Restraint, seclusion and other restrictive practices are unpleasant and traumatising for all people concerned. We cannot wait for laboratory studies and field trials to drive the agenda: we have a duty to address human rights injustices within the industry.'

Achieving consensus in these sensitive matters is a challenge for all of us, not just within the neurodiverse community. If we are serious about eliminating restraint and seclusion, we have to change the narrative. It is my view that, as society changes, the challenging of out-dated practices such as restraint and seclusion will become more commonplace. Professionals and providers of supports and services not only have to start listening to people's accounts, no matter how emotional and unpleasant they are, but they must also channel their emotions into focusing on positive changes. I think the phrase that best fits this is, 'less talk, more action.'

Listening to People with Lived Experience: Consumers as Trainers

One of the most positive developments that I have witnessed in the crisis management industry is the increasing awareness that the views of our consumers about the use and abuse of restrictive practices has become increasingly more central. Alexis Quinn, who described her harrowing accounts of experiencing restraint in the mental health system in her book '*Unbroken*,' is today a Manager for the Restraint Reduction Network. The evidence base highlighting the negative experiences of consumers in the healthcare system continues to grow. It is imperative that we listen to the views of consumers, and include them in the conversation in order to eradicate restraint and seclusion. Of course, the counter-argument remains that we have to keep people safe, and sometimes this means using methods on an emergency basis. Whilst I do accept that there are extreme situations where there is a need for emergency responses, I also believe passionately that people with lived experience should be more actively involved in crisis management training, and informing which methods are acceptable and which are not. My own organisation has made attempts to be as inclusive as

possible. The more trainers who have walked the walk, the more impactful I believe our training will be.

Consumers, Quality Assurance, and Coproduction

Collaboration and coproduction have to be the way forward if we are to have meaningful dialogue in this field. If I am to declare my own bias, I have never viewed the views of consumers and staff about restraint as being equal. Often, the people we support are distressed and traumatised, and do not have people to advocate for them. To create a new way of thinking requires us to apply some weight to their account. I am more in favour of putting the opinions of consumers above those of staff when weighing up the need for restraint, seclusion and other restrictive practices.

Increasingly, collaboration and coproduction is becoming part of our approach. I have recently been involved with my colleagues at the Anna Freud Centre and AT-Autism who have collaborated to develop a National Autism Training Programme (NATP) which will aim to train staff in understanding the principles of autism. The training delivered on this programme is balanced between individuals with lived experience and professionals. My colleagues and I are involved with this programme delivering training on the Low Arousal Approach to managing behaviours. Programmes such as these are, I believe, the future, and they move us away from the 'professional versus other' paradigm.

Coproduction should also be part of training organisations' quality assurance processes. When thinking about the application of physical interventions and their quality control, the Studio 3 organisation is highly supportive of the goals of the RRN.

Increasingly, an approach to regulation is emerging which could arguably make the training of crisis management that includes physical interventions safer.

Studio 3 Learning Principles

1. When delivering training or supports, it is essential that supporters have to be exposed to consumer accounts of restraint, seclusion, and other restrictive practices.
2. Consumers of services accounts and experiences must be considered as data.
3. Involving consumers in the entire training and coaching process where true coproduction can occur should be at the core of training.
4. Traumatic accounts of peoples' negative learning will only change practice if they are followed up with collaborative action, which should include members of the neurodiverse community.

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