Understanding the Studio 3 Approach to Physical Interventions:

Part 1 - Terminology

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As a Clinical Psychologist and practitioner with expertise in crisis management for the last 35 years, my views on teaching physical intervention skills has radically changed. Many of the ideas myself and my colleagues at Studio 3 Training Systems share have been placed in the public domain in my recent book, 'Freedom from Restraint and Seclusion: The Studio 3 Approach' (McDonnell, 2022). In this series of articles, I want to focus more on my own personal reasons for continuing to campaign about the policies and practices in the crisis management training industry, and the teaching of physical intervention skills.

Understanding the Studio 3 Approach to Physical Interventions – Part 1: Terminology

The restraint industry or, more appropriately, the 'restraint industrial complex' (McDonnell, 2022), often obsesses about terminology. It is important that we understand that terminology can drive our thinking processes. In this article, I would like to focus on the use of terminology which, although well-intentioned, can sometimes make issues 'fuzzy.'

Physical Interventions: A Rose by Another Name

The use of the term 'physical interventions' has, particularly in the last two decades, become quite extensive. I have never liked it myself, even when I was a member of the working party on physical interventions chaired by BILD in the late 1990s. I remember the passionate arguments of people saying that words like 'restraint' and 'seclusion' were too negative. My concern at the time - and now - is that we were sanitising physical restraint. Don't get me wrong, language does influence thought,

and we have increasingly seen people correctly move away from negative terminology such as ‘mental deficiency’ and ‘aggressive behaviour.’ My concern is that calling something an intervention has too many positive connotations. In medicine, intervention is a synonym of treatment; when it comes to physically managing a vulnerable person, this is not the case.

In the crisis management industry, there has undoubtedly been significant progress in the area of regulating training through bodies such as the Restraint Reduction Network (RRN). However, there has been relatively little progress in regulating the use and types of physical interventions. Our use of terminology also greatly influences these processes. In 2000, in the BILD publication ‘*Ethical Approaches to Physical Interventions Vol. 2*’ (Allen, 2009) described a protocol where experts could agree on the merits and demerits of particular physical methods. It was my hope at the time, although somewhat misguided, that this would be the next stage in regulation. This process involved colleagues of mine (Alan Martin, David Leadbetter, and Brodie Paterson) forming an expert panel to discuss specific methods that were randomly selected (Martin et al., 2009). In another article, I will discuss specific physical methods, but the important point to know is that even agreeing on names for techniques and holds was difficult.

Restraint Terminology

Most readers will be aware that in the Studio 3 system we don’t teach prone or supine holds; we never have done, and we never will. It is still the case in 2023 that individuals and organisations do not want to talk about the merits and demerits of particular methods. At present, there is a consensus that when talking about physical restraint,

we have prone, supine, and seated holds as generally agreed categories. Interestingly, in the Studio 3 system, we have a walking hold called the Walkaround Method that does not fit into these categories at all.

Whilst there is a consensus about this terminology, it becomes problematic when talking about other, uncategorised techniques that involve people using physical interventions to escape from an individual or protect themselves. Most alarmingly, I have noticed that training organisations often adorn the word ‘restraint’ to make it sound better. Over the years I have heard prefixes such as ‘dignified’ and ‘peaceful,’ to name but a few. The reality is that immobilising someone against their will, be it on the ground or in a chair, is neither peaceful nor dignified. It is a traumatic process for all parties concerned.

Negative Language: Breakaways

When we talk about so-called ‘physical interventions,’ there is a category of methods for physically restraining or immobilising people. In addition, people are also taught skills to break free from grips, having their hair pulled, being strangled etc. When I first got involved in the industry in the 1980s, terminology for this was often colloquially referred to as ‘breakaways.’ From both a scientific and practical basis, this is a dreadful term which in my opinion should be banned. When people used to ask me as a Studio 3 trainer, ‘Do you teach breakaways?’ I would often feign dumbfounded ignorance to the terminology and remind them that, at the time, a breakaway was a commercially available chocolate biscuit. To this day, I still hear people use the term. I would prefer it if people used words like ‘physical disengagement.’ We have to change the language and the emphasis.

Why do people teach these skills on training courses? The answer for me is very simple. When we are trying to help people become more confident, teaching simple physical strategies is almost like a team-building approach on most courses I have seen. Unfortunately, we have ample practitioner evidence that people start to forget these skills as soon as they leave the training room. These days, I prefer trainers to 'break the ice' by focusing more on people's fears and concerns rather than on a few physical tricks that they may not remember.

I often say, 'People can only focus on learning one movement at a time.' If we add together the number of methods taught on a training programme, and then add to that the number of different potential movements, this formula suggests that a short training course that teaches physical interventions across 1-2 days realistically should mean the teaching of maybe 2 physical interventions in an entire day. This allows time for positive practice and rehearsal, which is the key to remembering any physical movement. Even with this simple syllabus, people will inevitably forget when they leave the classroom.

I remember attending a training course in the late 1980s where, in the space of two days, the 'instructors' taught 15 physical techniques. It is far better to teach only specific methods where there is a clear evidential need. If you are supporting an individual who, for complex reasons, pulls hair and has hurt individuals, then by all means teach key staff what to do in those circumstances. This is very different from teaching hundreds of thousands of people in healthcare and educational settings how to get out of having their hair pulled when they have very little chance of experiencing such a behaviour. The mantra I have always used and become more passionate about is, 'Teach fewer physical skills, but teach them to a high level, as people are more likely to remember them.'

Negative Language: Strangulation

Many training courses (including Studio 3) have a category of physical interventions that focus on protecting people from specific types of what can often be highly traumatising behaviours. In the learning disabilities field, the most common situations encountered by staff in my experience involve individuals having their hair pulled, being bitten and clients grabbing clothing. My colleagues and I try to discourage physical techniques being labelled in specific categories. One of the reasons for this is that it is relatively common to come across terminology that implies aggressive intent from the people we support. Some good examples of these include phrase differences.

You might use the expression, ‘hair pulling procedure,’ which has different connotations to ‘defence against hair pulling.’ There are so many examples where the language used to describe physical intervention methods can shape your thinking. In the Studio 3 system, we stopped teaching a class of methods called ‘strangulation’ 25 years ago. There were a number of reasons for this: firstly, it was such a rare experience for a staff member to be ‘strangled’ that we believed the teaching of this was unnecessary; secondly, the fear of being strangled evokes strong emotional reactions in all of us; thirdly, we believed that we needed to simplify our approach. Today, we will teach a method defined as ‘airway protection’ in instances where there is a clearly defined need for certain staff supporting an individual who may squeeze or hug you so tightly that they may restrict your airway (though this is still comparatively rare). The important point is, airway protection is a good descriptor of the method, as it is explicitly clear what the purpose is without negative emotional connotations.

Avoid Sanitising Terms

The flipside of this is that we must be careful that we do not use a term purely because it sounds nicer or less emotive. There is a balance between being specific in our descriptions, whilst at the same time trying to avoid negative connotations. I genuinely believe that the use of the term 'physical interventions' has moved the discussion away from specific methods and techniques, and created more generalisation and ambiguity. We exist within a legal system where terms such as physical restraint and seclusion are used because of their specificity. I was recently asked to write a report (outside of the UK) where an organisation's policy used the terms 'physical intervention' to cover all methods, including restraint and seclusion. It was interesting to me that in my role as an 'expert' I could not find any adequate descriptions of the methods used, particularly a three-person restraint hold.

It may be time to agree that nebulous terms such as 'physical interventions' have outlived their sell-by date. I believe as practitioners that talking about specific restrictive practices such as physical restraint, seclusion, sanctions, and PRN medication is less vague and more helpful to debates and discussions.

Studio 3 Best Practice

Whilst my colleagues and I do not wish to put ourselves forward as the authority in this field, there are some practices that we have adopted as an organisation that may be useful for other training and care organisations to consider when thinking about terminology.

1) Use terms that are specific, such as 'physical restraint' and 'seclusion,' rather than over using the term 'physical interventions.' All Studio 3 trainers and

practitioners are encouraged to use the term ‘restraint’ and ‘seclusion’ if that is what we are talking about – otherwise we are sanitising the process.

2) When describing physical methods, we need to think about how the terminology can be misconstrued, and imply that the people we are supporting are aggressive or violent in some way.
3) Do not use terms such as ‘breakaway,’ as they have particular associations with the more traditional training that used to permeate in the 80s and 90s - most notably systems that went by the names ‘control and restraint’
4) If you are a trainer/practitioner within your own organisation, encourage for written procedures to be routinely reviewed, ensuring the language adopted is positive but descriptively accurate wherever possible.
5) Accept that language does evolve, and that we must move away from terminology which focuses on simplistic distinctions, such as ‘victims’ and ‘perpetrators.’
6) Terms need to be clearly defined in organisational policies. The term ‘restrictive practices’ has become so overused in recent years that it lacks clarity and specificity. We may restrict someone’s liberty under a best interest principle, but there are some restrictive practices that are indefensible – these should not be categorised in the same way. In our case, at Studio 3 we do not support anything that could be construed as a punishment or a sanction.

It is my colleagues’ and I’s hope that we can continue to shed light on our approach, much of which is specified in my own recent book (McDonnell, 2022). In this series of articles, we wish to present meaningful debates and arguments to training organisations and providers to encourage open dialogue about an area which is, by its very definition, difficult to talk about and even considered taboo. My next article will

look at the ‘psuedo-martial arts’ underbelly of crisis management training, and how we must move away from the mindset that sees self-defence physical skills as appropriate in caring environments.

References

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