Experiences of Crisis Management Training

Consumer Reflections

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Introduction

In many care settings, physical skills may be needed to keep people safe, and when this is the case, physical methods should be taught to a high standard and with clear guidelines around their use. These restrictive practices are designed to be used only when individuals in crisis are at risk of causing harm to themselves or others. At Studio 3, we believe in teaching physical interventions only on an individualised basis and after a Training Needs Analysis has been carried out.

When crisis management training is delivered and implemented appropriately, these practices can help ensure that safeguarding practices are upheld. When this training is not taught or implemented appropriately however, it can have the opposite effect and incite toxic cultures of restraint and seclusion.

Many training courses in crisis management, to this present day, unfortunately can convey quite mixed messages. Training providers do often teach staff de-escalation strategies, but they also may teach physical restraint techniques alongside this. Some training courses don't even provide any de-escalation strategies whatsoever. What message is this conveying to staff teams?

Experiencing Crisis Management Training as a Consumer

As workers in the care sector, we have a responsibility to take every precaution necessary to ensure the safety and uphold the well-being of ourselves and those we support. In order to keep our approach adaptive to our environment and the needs of those we support, learning from what does/does not work, we must engage in reflective practice. The case study below describes the experiences of 'Sarah,' a pseudonym representing accounts from a number of practitioners, which have been

pulled together to demonstrate some common real-life experiences of receiving crisis management within care settings.

Anonymised Case Study

The Work Environment

At Sarah's place of work, physical intervention training is required for all members of staff to help protect themselves and those they support in crisis situations. Though 'mandatory,' this training was held infrequently at set dates and times. As a result, many members of staff did not have any training for long periods of time (e.g., 6-8 months), Sarah included. When she would remind her manager of this, Sarah would be to blame for working on the floor without restraint training.

"I felt scared to work," she said. "Someone may get hurt if I don't intervene and someone may get hurt if I do." Sarah was worried that if she intervened incorrectly, as she hadn't had training, she may unintentionally cause harm. Evidence suggests that emotions can be contagious and cause mind and body arousal (Schachter and Singer, 1962). As people "tend to mimic the facial expressions, vocal expressions, postures, and instrumental behaviours of people around them", they can "'catch' others' emotions as a consequence" (Hatfield, Cacioppo, and Rapson, 1993). This phenomenon is known as emotional contagion.

Sarah's stress spread to her staff team which, in turn, was inevitably felt and adopted by those that they supported, too. This created a negative cycle of care where staff were now increasingly responsible for the behaviours they were managing. This is not good safeguarding practice nor does it create a sense of a 'home' environment. In practice, Sarah reported seeing staff utilise a 'zero tolerance approach' to managing behaviours that challenged. If a service user 'misbehaved', for example, that was often

enough for staff to go ‘hands-on.’ This is not person-centred or trauma-informed practice: it is abusive practice.

Contrasting with a ‘zero tolerance approach,’ which imposes punishments for people’s misbehaviour, a ‘Low Arousal Approach’ is a person-centred, non-confrontational method of managing behaviour which adopts a humanistic view of people. An underlying theme of the approach is the avoidance of using punishment in response to behaviours of concern. Low Arousal means tolerating behaviours that you may be inclined to want to change, and accepting that the first priority is often not the behaviour of concern itself, but the underlying causes such as stress and trauma. It also acknowledges that emotions and stress are transactional in nature, as previously addressed, and therefore emphasises the importance of appearing in a state of low arousal, even when we feel stressed or anxious. This will help lower arousal levels of others.

The Crisis Management Training

When Sarah finally received restraint training many months after starting, there was no teaching of de-escalation strategies. Sarah and her team were taught a wide range of restraint techniques over the span of two consecutive days. According to McDonnell (2022), intense training such as this can lead to forgetfulness:

“In many cases, even those who have received training in physical interventions are taught such a vast range of physical methods in such a short period that they forget these skills as soon as they leave the classroom.”

Confusingly, and dangerously, one of the restraint techniques that Sarah was taught how to use was a floor hold restraint technique that staff had been told not to use anymore as it was too dangerous. The training was also made ‘fun,’ perhaps to be

engaging, with many laughs throughout. This training was valid for one year, but many members of staff did not receive it, working for many months with expired training.

Reflecting on Sarah's Crisis Management Training

Good crisis management training is about ensuring that everyone is kept safe. When staff are untrained or wrongly trained, those who receive the support will more likely be victims of abusive practices. A BBC investigation in 2015 found that "Patients are being 'put at risk' because some healthcare assistants are working without proper training or supervision." Nearly 8 years later, the story is not over. The training provided to Sarah and her staff team, for example, was very unclear, with trainers even dismissing the relevance of elements of the programme they were teaching. Considering this, alongside many staff being permitted to work without this 'mandatory' training, the training was often ignored/not implemented.

Physical restraint techniques should only be used on a case-by-case basis, under clear guidelines, as a last resort to ensure that safeguarding practices are upheld. Any crisis management training programme that deviates away from this understanding moves further away from person-centred, compassionate care. In line with this understanding, Sarah's team should have been taught personalised de-escalation techniques for those she would be supporting and specific restraint techniques for specific individuals if absolutely necessary as a last resort to keep everyone safe. The primary goal of crisis management training should be 'arousal regulation,' for both staff and those they support. How will this be achieved if staff are only sufficiently supported and trained only to restrain?

What about teaching staff to check in with themselves? In McDonnell's (2019) book, *The Reflective Journey*, he focuses on how behaviour management starts with

those providing support. In his book, he provides reflective guides for practitioners to consider how their own thoughts and feelings may influence their own behaviours when managing the behaviour of others. Considering that emotional states are transactional in nature, we must be conscious of our own stress levels before supporting others to manage their stress levels. Good crisis management, therefore, involves good emotional coregulation, so an understanding of oneself is just as important as having an understanding of personalised de-escalation techniques. Both should supersede the importance of physical restraint.

Crisis management training being delivered in a ‘fun’ way represents a great lack of respect for the nature of what is being taught; how to physically restrain a vulnerable person. Though making training ‘fun’ may be a more engaging approach to keep trainees’ attention, it may also create a disconnect between the reality of implementing this training in practice. There is a stark contrast between ‘fun’ restraint training and using physical force to bring another person into submission.

To help mitigate such control and give power and dignity back to those she supports, it would be recommended that Sarah’s workplace considers implementing the Low Arousal Approach to crisis management. This would help ensure that there is space to address the sources of distress in those she supported as opposed to managing the behaviours that herself and her staff team were inciting in them.

Exercise for Readers

After reading through the reflections on poor crisis management training and what makes for good crisis management training, read the following exercise and consider how a ‘zero tolerance approach’ and a ‘Low Arousal Approach’ would influence outcomes:

You are supporting an individual who is around other service users and is becoming increasingly heightened and anxious. Though they have been encouraged to not swear around others, they are cursing often and explicitly. It is now beginning to cause significant distress to those around them. What do you do?

1. How would a 'zero tolerance approach' influence outcomes?

   In Sarah's workplace, care staff were not taught how to de-escalate situations, they were only taught to restrain. They were also not taught to look inward and check in on how they are feeling and consider how this may influence their management of such situations. This may result in a zero-tolerance approach whereby the individual will be restrained.

2. How would a 'Low Arousal Approach' influence outcomes?

   Adhering to the philosophies of the Low Arousal Approach and utilising de-escalation strategies, however, staff can provide more considered, person-centred care. Studies in psychology have identified that people tend to behave very differently when they have an audience. This tendency is called the 'audience effect (Hamilton & Lind, 2016):

   "In conditions where an audience effect arises, participants consider their own self-concept, consider how they appear to others, and consider how to communicate a favourable impression to others."

   To help the individual in the above example regulate their arousal levels and to prevent the situation from escalating into a crisis, staff would ideally escort the other service users away from the individual who is in a heightened state of arousal. The goal of de-escalation strategies is not to stop behaviours, but to regulate

arousal. Sometimes that means, as David Pitonyak says, 'Riding Out the Storm.' Perhaps the individual needs space or less stimulation. This can be considered on a case-by-case basis and should be tailored to each individual.

Conclusion

Good crisis management is an essential, core component of staff training which helps to ensure that safeguarding practices are upheld. The Low Arousal approach is Studio III's favoured evidenced-based approach to crisis management training.

Without effective crisis management training, the needs of those being supported are more likely to go unmet and cultures of social control can emerge. These staff cultures are not only more likely to elicit placement breakdowns, but they also increase the number of avoidable instances and dehumanise individuals by restraining them when they are struggling to regulate their emotions and/or behaviours.

References

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