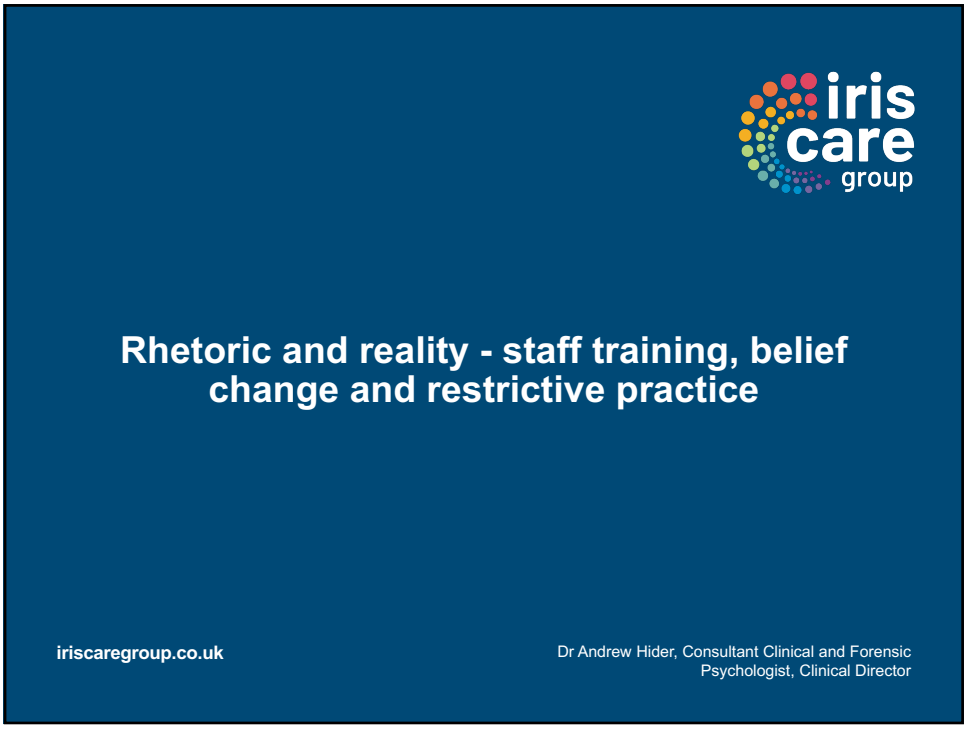
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Rhetoric and reality - staff training, belief change and restrictive practice
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Dr Andrew Hider, Consultant Clinical and Forensic Psychologist, Clinical Director

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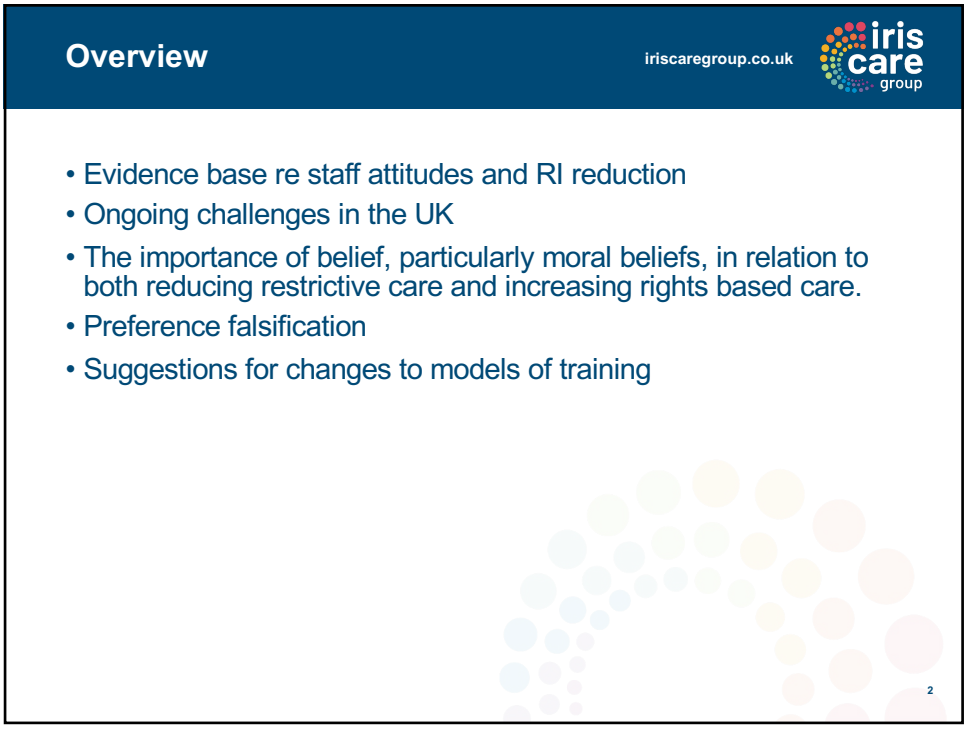
Overview
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• Evidence base re staff attitudes and RI reduction
• Ongoing challenges in the UK
• The importance of belief, particularly moral beliefs, in relation to both reducing restrictive care and increasing rights based care.
• Preference falsification
• Suggestions for changes to models of training
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## Evidence

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- Attribution and attitude research a large component of the CB literature (cf Emerson, Hastings. McGill 1994, Hastings 1997 etc)
- Heaton and Whittaker (2013):

  - *This study also found that nursing assistants were more likely to receive injuries as part of their job role with over 70% of the staff having received such injuries. Just over 31% of the total staff had been injured during the past month between 1 and 4 times. A positive attitude towards to the use of restraints was revealed, with 69% feeling that they were useful and 70% saying that they were important for the safety of others*

- Wong and Bressington (2022)

  - *Nurses' attitudes were marked by negative feelings and moral conflict towards the use of physical restraint. However, nurses applied physical restraint as an ordinary nursing intervention. Educational interventions and the leadership role may facilitate the change of current practice to a restraint-free environment.*

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## Evidence

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- Laukannen et al – integrative review – psychiatric inpatient settings:

- A total of 24 relevant papers published between 2002 and 2017 were selected for further analysis. These studies revealed variation in nursing staffs' attitudes towards the use of containment methods. The use of containment methods seems to be widely accepted and nurses reported rarely considering alternative measures. It appears that attitudes towards containment have continuously become more negative, although the change has not been very pronounced.

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## Evidence

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- Services that are compliant with training and PBS are not necessarily safe.
- Ongoing UK scandals re abusive care, overseen by qualified clinical staff.

Mandatory training for staff included safeguarding, fire safety, health and safety, positive behaviour support, Mental Health Act, Mental Capacity Act, first aid at work, emergency first aid at work and infection control, de-escalation techniques, conflict resolution and managing violence and aggression and the use of physical interventions. The service was meeting [redacted] 80% compliance rate for mandatory training. The service fell below 80% compliance for care certificate training, due to the amount of new staff that had recently started.

All of the care plans contained the patient voice and were personalised, holistic and recovery orientated. Care records we reviewed contained positive behavioural support plans which had been updated in the last three months. The

Staff had completed comprehensive mental health assessments for patients and developed care plans to meet the identified needs. These included 'Positive Behaviour Support' plans for the majority of the patients of the wards. We reviewed 58 'Positive Behaviour Support' plans, all were holistic, personalised and recovery orientated. Staff had updated care plans when necessary.

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## Why Should we be surprised?

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- Thesis
- Humans probably operate automatically on hard wired 'moral' circuits.
- Wynne et al 2017
- *Many scholars draw on evidence from evolutionary biology, behavioral economics, and infant research to argue that humans are "noble savages," endowed with indiscriminate kindness. We believe this is mistaken. While there is evidence for an early-emerging moral sense—even infants recognize and favor instances of fairness and kindness among third parties—altruistic behaviors are selective from the start. Babies and young children favor people who have been kind to them in the past and favor familiar individuals over strangers. They hold strong biases for in-group over out-group members and for themselves over others, and indeed are more unequivocally selfish than older children and adults. Much of what is most impressive about adult morality arises not through inborn capacities but through a fraught developmental process that involves exposure to culture and the exercise of rationality.*

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## Why should we be surprised?

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- What does this have to do with 'challenging behaviour' and reducing restrictive practice?
- Do we expect staff to demonstrate 'indiscriminate kindness' on the basis of ***knowledge of (clinical) theory (of the causes of challenging behaviour) alone***?
- Do we expect staff to accept that in the clinical setting, justice is absent (according to their innate perception of injustice – for example a colleague being severely assaulted)?
- Do we expect systems to automatically organise around a principle of ingroup (staff) benevolence towards an outgroup that is sometimes threatening to the safety of ingroup members?
- Do we support a space to allow for rationality to intervene on automatic moral judgements and 'moral' behaviour.

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## Preference Falsification

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- Kuran (1997) : "Private truths, public lies"
- Theory originating in economics
- Used by political parties to develop policy (eg people endorse wishes to pay more taxes in public surveys yet do not vote accordingly).

*"Preference falsification is the act of misrepresenting a preference under perceived public pressures. It involves the selection of a publicly expressed preference that differs from the underlying privately held preference (or simply, a public preference at odds with one's private preference)."*

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## Preference Falsification – Health and Social Care

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| System Beliefs and Values | • Private truth? |
| --- | --- |
| All behaviour has meaning and can be understood. | • There is no excuse for bad behaviour. Understanding is excusing |
| Restraint should be the last resort. | • If I think I'm (we're) going to get harmed I'm not going to let it happen. We're going to put them on the floor. Restraint works. |
| Developing a formulation is important as it helps us understand behaviour | • Nothing makes any difference. People need (negative) consequences to make them change |
| Good relationships and feeling safe make people less threatening | • Being weak when people are aggressive makes you vulnerable |

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## Preference Falsification

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Thesis

- It is probably reasonable to assume that when offering staff contextual / environmental, technical behavioural or psychological understanding of challenging behaviour and associated interventions aimed at least restrictive practices, at least a proportion of those staff will publicly endorse believing in such approaches while secretly believing that such approaches are inconsistent with their moral beliefs about how transgression should be dealt with.
- These staff, if they become "culture carriers", probably influence systems that become abusive and excessively restrictive.
- We might predict that some staff, even after such abuses are disclosed, retain their beliefs that their behaviour was just, in order to maintain their moral belief systems and preserve their sense of themselves as morally intact.

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## What to do?

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- Training, supervision and quality improvement around restraint reduction should always include information on human factors, rather than asserting that some things are 'right'.
- Expecting staff to simply believe rhetorical moral arguments presented in training / quality initiatives etc., is unreasonable.
- Psychological explanations are effortful. Simpler moral arguments about challenging behaviours are more accessible, particularly when under stress (see Kahneman, 2011) "It's just wrong, teach a lesson etc"
- Ignoring these impulses risks creating a huge gap between the 'work as imagined' (by system leaders) and the 'work as done' (by direct care staff).
- The technology that helps us understand is modern (social) cognitive neuroscience and traditional psychodynamics.

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## Main (1957) – Br Jnl Medical Psychology

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- "We know that if human needs are not satisfied, they tend to become more passionate, to be reinforced by aggression and then to deteriorate in maturity, with sadism invading the situation, together with concomitants of anxiety, guilt, depression and compulsive reparative wishes, until ultimate despair can ensue"

VOLUME XXX 1957 PART 3

THE AILMENT*

By T. F. MAIN

When a patient gets better it is a most reassuring event for his doctor or nurse. The nature of this reassurance could be examined at different levels, beginning with that of personal potency and ending perhaps with that of the creative as against the primitive sadistic wishes of the therapist; but without any such survey it might be granted that cured patients do great service to their attendants.

The best kind of patient for this purpose is one who from great suffering and danger of life or sanity responds quickly to a treatment that interests his doctor and thereafter remains completely well; but those who recover only slowly or incompletely are less satisfying. Only the most mature of therapists are able to encounter frustration of their hopes without some ambivalence towards the patient, and with patients who do not get better, or who even get worse in spite of long devoted care, major strain may arise. The patient's attendants are then pleased neither with him nor themselves and the quality of their concern for him alters accordingly, with consequences that can be severe both for patients and attendants.

We know that doctors and nurses undertake the work of alleviating suffering because of deep personal reasons, and that the practice of medicine like every human activity has abiding, unconscious determinants. We also know that if human needs are not satisfied, they tend to become more passionate, to be reinforced by aggression and then to deteriorate in maturity, with sadism invading the situation, together with its concomitants of anxiety, guilt, depression and compulsive reparative wishes, until ultimate despair can ensue. We need not be surprised if hopeless human suffering tends to create in ardent therapists something of the same gamut of feeling.

It is true that he who is concerned only with research and is less interested in therapeutic success than in making findings will not be frustrated by therapeutic failure: indeed, he may be elated at the opportunity for research it provides; but such workers are not the rule among therapists. In much of medicine it is not difficult to detect something of the reactions I have described, together with defences of varying usefulness against them. An omnipotent scorn of illness and death, the treatment of patients as instances of disease, the denial of feeling about prognosis, are devices some doctors use to reach at something of the detachment of a research worker, and which permit them to continue their work without too painful personal distress about the frustration of their therapeutic wishes. Refusal to accept therapeutic defeat can, however, lead to therapeutic mania, to subjecting the patient to what is significantly called 'heroic surgical attack', to a frenzy of treatments each carrying more danger for the patient than the last, often involving him in varying degrees of unconsciousness, near-death, pain, anxiety, mutilation or poisoning. Perhaps many of the desperate treatments in medicine can be justified by expediency, but history has an awkward habit of judging some as fashions, more helpful to the *amour propre* of the therapist than to the patient. The sufferer who frustrates a keen therapist by failing to improve is always in danger of meeting primitive human behaviour disguised as treatment.

I can give one minor instance of this. For a time I studied the use of sedatives in hospital practice, and discussed with nurses the events which led up to each act of sedation. It ultimately became clear to me and to them that no matter what the rationale was, a nurse would

* Address from the Chair, to the Medical Section, British Psychological Society, on 20 March 1957.



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## What to do?

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- Ensure training materials address the following:
- Ideas of natural justice
- Effortful nature of psychological / behavioural explanations and human tendency to dismiss them.
- Relationship between emotional arousal and regression to early (quick) thinking which taps basic moral preferences for justic

However, we know that as people, we are naturally inclined, when things go wrong, to explain why they went wrong by blaming things outside of our control, or other people. We do this naturally to protect our own feelings - because we don't want to feel bad.

It is important for us all to be able to question and learn from each other when we are trying to find the best way to support someone with challenging behaviour – we do this by being aware of this natural tendency to be defensive when we are challenged about the role we may have played in an incident and being open about how we feel when we are working with the people we look after.

This is why in LSH we expect everyone to take part in a **'learning debrief'** after each incident. Some people can find these challenging, but it is important to get used to questioning yourself and allowing yourself to be questioned. We are all here to challenge and improve our practice, and because we are not perfect, we will all make mistakes. We can only learn if we are open and honest about what we could have done differently in each incident. Sometimes, it is only by learning about what doesn't work or what makes things worse that we find the best way to support people.

| Exercise |
| --- |
| Think about a situation you have been in where you think you may have made the situation worse because of something you said or did?<br>How did you feel?<br><br>What have you learned about yourself and the service user from this experience? |

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## Human Factors

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- Currently undertaking evaluation of staff training workbook.
- Completed in private
- Reflected in supervision
- Permission to talk about feelings and beliefs
- Normalisation of 'regressed' beliefs when under stress.
- Maintenance of clear moral boundaries re: unacceptable and unethical behaviour
- Clarity re legal / regulatory consequences of non-compliance

In comparison, sometimes we can feel pushed in to a 'punitive' or 'dismissive' position - particularly when we are finding it hard to work with someone, or when we feel that whatever we do doesn't help.

When this happens, we may show the following behaviours:

- Negative comments and feelings about the service user.
- Dismissive of service user behaviour or reported distress.
- Failing to follow plans, or being cynical and hostile about plans that try to understand the reasons for the behaviour.
- Blaming the service user for all the problems that happen in the service.

This can lead to ***depersonalisation*** of service users. This means that we start seeing them as 'problems' rather than people with distressing experiences that need our care. We can become discouraged by our job and become less and less professionally concerned. When this becomes more severe, we can develop an extremely negative view of the service user. It can lead to us thinking that service users are deserving of their troubles. In turn, the care that is delivered can, without us meaning for it to be, become punitive or dismissing, or in extreme circumstances can be neglectful and abusive. Sometimes, whole teams can start working in this way, which causes severe harm to services users in their care.

More often, we find that some staff in a team can move toward the 'over attached' position and some to the 'dismissing' position. This can result in severe conflict in teams. Often, these problems are the underlying cause of challenging behaviour and placement breakdown (i.e. when a service user has to leave the service because they are not recovering).

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## Initial Feedback

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- "The exercises allowed me to reflect on previous situations and the impact I may have had on a SU in a situation, particularly in relation to power dynamics, in a way I've not done before."
- "The workbook helped me to consider how my emotions/biases may impact on my interactions and I have applied this to my role since reading it."

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## References

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- Emerson, E., Hastings, R.P. and McGill, P. (1994). Values, attitudes and service ideology. pp.209–231. doi:https://doi.org/10.1007/978-1-4899-2961-7_9.
- Hastings, R.P. (1997). Measuring staff perceptions of challenging behaviour: the Challenging Behaviour Attributions Scale (CHABA). *Journal of Intellectual Disability Research*, 41(6), pp.495–501. doi:https://doi.org/10.1111/j.1365-2788.1997.tb00742.x.
- Heaton, S. and Whitaker, S. (2012). The attitudes of trained and untrained staff in coping with challenging behaviour in secure and community settings. *International Journal of Developmental Disabilities*, 58(1), pp.40–47. doi:https://doi.org/10.1179/2047387711y.0000000006.
- Kahneman, D. (2011). *Thinking, Fast and Slow*. New York: Farrar, Straus and Giroux.
- Laukkanen, E., Vehviläinen-Julkunen, K., Louheranta, O. and Kuosmanen, L. (2019). Psychiatric nursing staffs' attitudes towards the use of containment methods in psychiatric inpatient care: An integrative review. *International Journal of Mental Health Nursing*, 28(2), pp.390–406. doi:https://doi.org/10.1111/inm.12574.
- Main, T.F. (1957). THE AILMENT*. *British Journal of Medical Psychology*, [online] 30(3), pp.129–145. doi:https://doi.org/10.1111/j.2044-8341.1957.tb01193.x.


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## References

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- Timur Kuran (1997). *Private truths, public lies : the social consequences of preference falsification*. Cambridge, Mass.: Harvard University Press.
- Wong, W.K. and Bressington, D.T. (2022). Nurses' attitudes towards the use of physical restraint in psychiatric care: A systematic review of qualitative and quantitative studies. *Journal of Psychiatric and Mental Health Nursing*. doi:https://doi.org/10.1111/jpm.12838.
- Wynn, K., Bloom, P., Jordan, A., Marshall, J. and Sheskin, M. (2017). Not Noble Savages After All: Limits to Early Altruism. *Current Directions in Psychological Science*, 27(1), pp.3–8. doi:https://doi.org/10.1177/0963721417734875.


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## Thank You

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Associated Information

Hider, A, Thomas, H & Price, V (2022). **Hard Yards' – the experience of delivering a six year restraint reduction programme**. *Bulletin of the FPID, Vol. 20, No. 2, August 2022* 69. Leicester : British Psychological Society


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