

CHAPTER 11

Hold On

Physical Restraint in Residential Child Care

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Introduction

The physical restraint of children and young people in residential child care is a highly contentious issue. Historically, evidence of the concerns of children and young people about physical restraint has appeared in the context of abuse in residential care (Hart and Howell 2004; Kendrick 1997). The death of Gareth Myatt following a physical restraint in a secure training centre in England brought to the fore concerns about restraint related fatalities which have been increasingly profiled in the USA (Milliken 1998; Nunno, Holden and Tollar 2006). On the other hand, residential staff frequently have to deal with violence, aggression and challenging behaviour (National Task Force on Violence Against Social Care Staff 2000).

Legislation related to physical restraint is very complex, involving general criminal law, health and safety regulations, human rights legislation, education law, social care regulations, and national standards (Hart and Howell 2004). In the UK, there have also been concerns about the lack of practice guidance, although in Scotland this has recently been addressed through the publication of *Holding Safely* (Davidson *et al.* 2005).

Although in other countries the use of mechanical and chemical restraints is widespread, in the UK almost all physical restraints are interventions ‘in which staff hold a child to restrict his or her movement...’ (Davidson *et al.* 2005, p.vii). This chapter draws together research on physical restraint that has informed a recent study that explores children, young people and staff member’s experiences of physical restraint in residential child care in Scotland. However, it must be acknowledged that, given the very serious nature of this area of residential work, there is a dearth of research and a need to develop a much better evidence base.

Restraint as abuse and restraint related injury and death

A recent consultation with looked after children in Scotland found that, although they understood the reason for physical restraint, they also identified much more negative experiences including: unwarranted restraints, excessive force, improper techniques, pain or injury, and feeling disliked (Paterson, Watson and Whiteford, 2003; see also Moss, Sharp and Fay 1990; Safe & Sound 1995; Who Cares? Scotland nd).

Unwarranted and excessive use of force in physically restraining young people has also been identified in inquiries into abuse (Kirkwood 1993; Waterhouse 2000).

Children and young people have suffered injury through physical restraint, although there is a concerning lack of information about the extent of injuries or comparison of different techniques (Stark 1996). Hart and Howell (2006) provide evidence that approximately one in seven of the injuries in one Young Offenders Institute were related to the use of physical restraint. One recent US study compared the frequency of injury during physical restraint using two different restraint systems – Professional Crisis Management (PCM) and Therapeutic Crisis Intervention (TCI) (Henderson *et al.* 2005). All restraint incidents in the programmes of one agency in the states of Pennsylvania and New York during 2003 were recorded and analysed. Two different systems were used in these two states. Children and adolescents experienced 5 critical injuries and 189 serious injuries in the 5580 PCM restraints, and 10 critical injuries and 85 serious injuries in the 1274 TCI restraints. Staff injuries occurred more frequently than injuries to children. ‘The TCI restraint method was associated with a higher frequency of injuries compared with the PCM method’ (Henderson *et al.* 2005, p.195)

Increasingly, concerns have mounted over the risk of death related to physical restraint. Deaths have been associated with physical restraint in areas of law enforcement (Leigh, Johnson and Ingram 1999), emergency medical services (Stratton *et al.* 2001), mental health services (Patterson *et al.* 2003; Mohr, Petti and Mohr 2003), health care (Rubin, Dube and Mitchell 1993), and learning disability services (Patterson *et al.* 2003). Restraint related deaths have also occurred in residential child care, with most reported cases in the United States. An investigative series published in the US newspaper, the Hartford Courant (Weiss 1998) brought this issue to public attention and prompted the Children’s Health Act of 2000; this act

requires state regulation of child management interventions and mandates certain conditions for the use of physical restraint (Jones and Timbers 2003). A recent US review of all known restraint-related fatalities in residential child care between 1993 and 2003 found that 38 children died during or following a physical restraint (Nunno *et al.* 2006). In those cases where information was available, the child's documented behaviours did not warrant a physical restraint in terms of danger to self or others. The study acknowledged that, due to limited information, it was unable to give an estimate of 'risk of death' related to type of restraint or position (Nunno *et al.* 2006, p.1324).

Until recently, there were no recorded cases of young people dying as a consequence of the use physical restraint in residential care in the UK. In April 2004, however, 15-year-old Gareth Myatt lost consciousness while being restrained by staff in a secure training centre in Coventry, England and died a short time later (Youth Justice Board, 2004). His death provided the impetus for an independent inquiry into the use of physical restraint, solitary confinement and forcible strip searching in secure residential establishments for children and young people (Carlile 2006). The inquiry found a lack of consistency in the use of physical restraint across the establishments investigated, and serious instances of misuse and abuse. Recommendations included curtailing the use of restraint as a punishment or to gain compliance, stopping the use of handcuffs and pain compliance, and giving high priority to reducing violence, resolving disputes and ensuring regular training.

Methods of behaviour management and physical restraint

There are a large number of behaviour management and training packages which involve the use of physical restraint, and these are used in a range of settings. Little information and limited research, however, is available on those systems used in residential child care. There are concerns regarding the combination of commercial interests with an area of practice that carries so much complexity and potential for misuse. There is also a lack of a regulatory framework and many hold concerns around the absence of a body to accredit these methods specifically for residential child care. This leaves establishments in the predicament of having to assess for themselves the suitability of the method and trainers they chose without the benefit of research evidence or objective criteria (Allen 2001). In the UK, the British Institute for Learning Disabilities (BILD) has attempted to address this issue by developing a directory of physical interventions training organisations, a code of practice and an accreditation scheme for those organisations that demonstrate compliance with this code (Harris 2002; BILD Website). Questions still remain, however, about the efficacy and comparative effectiveness of different behaviour management and training packages.

Training

A review of the training of carers in behaviour management strategies across different user groups identified a range of positive benefits. These included: an increase in staff knowledge and confidence; and a decrease in incidents of challenging behaviour, subsequent 'reactive strategies' and injuries (Allen 2001). Two studies undertaken in residential child care settings also found an increase in staff knowledge and confidence (Nunno, Holden and Leidy 2003; Perkins and Leadbetter 2002). Nunno *et al.* (2003) also noted a decrease in critical incidents. Killick and Allen (2005) studied

training in managing aggressive and harmful behaviour in an adolescent inpatient psychiatric unit. They found that staff confidence increased through training, though this was not maintained long term. An increase in knowledge, however, was maintained over time.

Bell and Stark's (1998) study assessing the competence of trainers and practitioners in their use of specific techniques for physical restraint found considerable variation among trainers in assessing the competence of trainees due to the complexity and speed of restraint techniques. Suggestions for improved acquisition and retention of skills included training only one technique at a time, allowing time for trainees to learn a technique to saturation level, maintaining regular refresher training, and regularly assessing the competence of trainers and practitioners. The importance of refresher training has been highlighted in other studies (CWLA 2004; Day 2000).

Currently, there are no studies comparing the different training approaches (Allen 2001), and 'little is known about the critical independent variables involved in the provision of effective training' (Kaye and Allen 2002, p.129). Additionally, training in behaviour management strategies must be located within a wider, ongoing training plan that is well grounded in an understanding of child development and enhances practitioners' capacity to manage and understand the impact of their own fear, anger and other anxieties on their interactions with young people (Braxton 1995). Training must also be contextualised in a much broader approach which addresses: leadership, training needs of managers, unit ethos, staff supervision, care planning, risk assessment, monitoring of incidents, trauma-sensitive care, de-escalation, post-incident de-briefing, and involvement of families (CWLA 2004; Nunno *et al.* 2003;

Paterson, Leadbetter and Miller, 2005). Such wider issues have been addressed in a small number of studies in residential child care.

Reducing restraint

Jones and Timbers (2003) examined the implementation of a comprehensive, systematic, skill-based model of care and treatment in two residential child care establishments. They found that not only incidents involving physical restraint rapidly and significantly declined, problem behaviour decreased as well (whether or not physical restraint was required). Rather than focussing on suppression or containment of harmful behaviour, as crisis intervention programmes must, the treatment model in this study is wider reaching. Its core elements include: selection and training of front line workers; round the clock availability of professional consultation; a treatment orientation that supports young people in acquiring skills and empowers them to make choices and exercise leadership; and consistent and ongoing evaluation of practice and performance. In addition to enabling and empowering young people as a primary aim, this treatment model also seeks to professionalise the care and treatment of troubled young people.

Colton (2004) developed an instrument aimed at assisting organisations to identify and assess their progress in addressing those factors which influence the reduction of the use of seclusion and restraint. He reviewed over eighty publications and Internet resources addressing the use and/or reduction of seclusion and restraint, and used a content analysis to identify common themes. The instrument, based on these themes and the elements that comprise them, was pre-tested by 20 reviewers and field tested in the United States in five behavioural health care facilities, one of which was a

residential treatment facility for children and young people. The nine key themes informing the instrument include: leadership; training/staff skills; staffing; physical environment; programmatic structure; responsive and timely treatment planning; processing after the event/debriefing; communication and consumer involvement; and systems evaluation and quality improvement.

The Child Welfare League of America's study (CWLA 2004) involved supporting and evaluating five residential child care establishments, or demonstration sites, over a three year period. During this period, each establishment implemented a model training programme and endeavoured to shift its own organisational culture, both toward the ultimate objective of reducing the use of restraint and seclusion. The sites had varying levels of success in reducing physical restraint. This was attributed to the sites' overriding focus on reducing the use of mechanical restraint (where applicable) and seclusion (used in all sites), and in some cases, the fact that sites had significantly reduced the use of physical restraints prior to the start of the study. While all sites were successful in reducing the use of seclusion, only one achieved a significant decrease in physical restraints. More usefully, the study identified several practices and strategies for reducing restraint and seclusion, which informed the Child Welfare League of America's related guidance document (Bullard, Fulmore and Johnson 2003). These resonate with (and were included in) the research by Colton (2004), and include: leadership; organisational culture, agency policies, procedures, and practices; staff training and professional development; treatment milieu; and continuous quality improvement.

As a result of the study, the Child Welfare League of America also makes four recommendations for the field of residential child care. First, establishments are strongly encouraged to use the tools available for supporting reduction efforts. On a more macro level, two recommendations involve the adoption of a single set of agreed definitions regarding restraint and seclusion, and the subsequent development of a national incidence data tracking system for monitoring their use. Perhaps most importantly, funding agents are compelled to ensure establishments have adequate funding to undertake efforts at reduction. Many successful agencies in the study acknowledged having to shift resources away from other areas, including personnel costs and training budgets, to achieve their targets (CWLA, 2004). As is becoming clear, reducing the use of physical restraint requires a comprehensive approach that addresses many, often interrelated, aspects of a residential child care establishment's functioning and practice, so to cut resources from other areas in order to enable efforts at reduction will likely undermine those very efforts.

The views of children, young people and staff

The experiences of children and young people related to physical restraint have not been thoroughly explored. We have seen that their concerns about restraint have been raised in relation to wider issues of abuse and negative practice. Little research, however, has focused on children's and young people's actual views of physical restraint.

Mohr, Mahon and Noone (1998) identified trauma as a key theme in a study of the memories and experiences of 19 previously hospitalised children. This trauma manifested in three forms: direct trauma, alienation from staff, and vicarious trauma.

Similarly, Day (2000) identified a wide range of negative emotions, including fear, vulnerability, embarrassment, powerlessness, and a feeling of being punished. His review, however, covered seclusion and mechanical restraint, as well as physical restraint.

In the UK, and narrowing the focus to residential child care, research and consultations have also identified the negative reactions of children and young people. Hayden (1997) explored the views of young people as part of a study of physical restraint in one social services department in England. The young people described feeling angry, frightened, frustrated and scared. None stated that they experienced the restraint as reassuring. Although based upon discussions with only four young people, other studies reflect these negative feelings.

This being said, the young people in these studies did indicate that sometimes young people might need to be restrained under certain circumstances, for example, peer violence or the destruction of the unit (Hayden 1997). They have demonstrated an understanding of the rationale for restraint, including its use as a last resort. Children and young people reported that staff need to be able to avoid problems building up to a dangerous level. They accepted that restraint is sometimes necessary, but only when someone is likely to get hurt or property is likely to get seriously damaged. They were clear that restraint should never involve pain and stressed the importance of staff training in how to restrain without hurting (Morgan 2005; Paterson *et al.* 2003).

Even less research has focussed on the views and experiences of staff related to physical restraint. While there is general consensus amongst staff as to the necessity

of physical restraint in certain circumstances and the principle of its use as a last resort, most also express anxiety, upset, fear and/or guilt surrounding its use (Bell 1997; Day 2000; Hayden 1997; Stone 2005). This research, however, does not appear to explore these experiences in any depth; given the complex, demanding and often dangerous nature of practice related to managing harmful or potentially harmful behaviour, this represents a significant gap in research, addressed to some extent by the study detailed below.

Experiences of physical restraint in residential child care in Scotland

This study aimed to explore the views and experiences of children, young people and staff members related to their experiences of restraint, and to give voice to these views to inform policy and practice (Steckley and Kendrick 2007; Steckley and Kendrick forthcoming). Thirty-seven children and young people and forty-one staff members participated in the research. They came from twenty residential establishments which included children's homes, residential schools and secure accommodation across the local authority, voluntary and private sectors. Semi-structured interview schedules and vignettes were used to assist participants to discuss their views and experiences in as much depth as they felt comfortable. Because of the sensitive nature of the research, careful attention was paid to ethics and the research integrated safeguards for protecting confidentiality, addressing potential disclosures of abuse, and protecting participants from undue distress.

Many of the findings in this study parallel the research that has explored the views of young people and staff. There was near unanimity regarding the necessity, in certain circumstances, of physical restraint and these circumstances were almost always

linked with issues of safety and harm. Most staff discussed the importance of using less invasive interventions to diffuse potentially unsafe situations, and only turning to physical restraint as a last resort. Young people were also aware of the concept of last resort and indicated an awareness and appreciation of staff members' other efforts to help them to calm down. Some young people, however, expressed frustration that staff members were too quick to use restraint, and concern about unnecessary, rough or painful restraint was a dominant theme across the young people's interviews.

Young people did not, however, describe a feeling of being punished as a result of being restrained, and on the few occasions when asked directly whether physical restraint is ever (or should ever) be used as punishment, all clearly stated 'no'.

Both young people and staff expressed ambivalence about the use of restraints, with some young people even directly contradicting themselves over the course of the interview.

Also similar to other findings were the myriad of negative emotions experienced by young people and staff. All of the young people who discussed their own experiences of being restrained described at least some of those experiences negatively. Negative emotions identified included sadness, frustration, embarrassment, regret, hate or aggression towards staff, hate or aggression towards themselves, and anger. Anger was the overriding and most readily identifiable emotion expressed. All of the emotions identified by staff related to their experiences of restraint were also negative, and they included anxiety, upset, sadness, fear, frustration, discomfort for the young person, worry, doubt, and guilt. A sense of guilt, failure or defeat over not being able to avoid the restraint was a dominant theme within staff discussions of their feelings related to restraint.

This study, however, also provided additional information about young people's experiences of physical restraint which diverged significantly from other studies. First, young people discussed their views about seeing another young person get restrained, and both positive and negative views were given. Secondly, a small minority of young people stated having no recollection of or feelings about being restrained, and thirdly, a significant minority of young people identified positive emotions linked to restraint. These included feeling glad that a restraint occurred because it helped to keep them safe or out of trouble, and feeling cared about. These positive experiences appeared to be clearly linked with young people's views about their relationships with staff members, another theme identified in this study and discussed below.

In regard to staff members' experiences of physical restraint, related dilemmas and complexities do not appear to be covered in any depth in the research literature. Those discussed by the participants in this study include: the ambiguity of the seemingly simple notion of last resort, the multitude of factors that need to be considered in assessing situations involving imminent harm (sometimes under extreme pressure and in a very short amount of time); the complexities and lack of clarity surrounding issues of absconding and property damage; the impact of gender on related practice; and, the potentially positive impacts of physical restraint as part of an overall caring response to imminently harmful behaviour.

The significance of relationships as the context within which young people and staff experience restraints, and the impact of restraints on their relationships are dominant

themes identified in the study. While a strong body of related theoretical and practice literature is developing (Bullard *et al.* 2003; Colton 2004; Fisher 2003; Garfat 2003), in terms of in-depth research, this has been a previously unexplored aspect of young people and staff members' experiences of physical restraint. Given the importance of relationship as a vehicle through which young people can develop, heal and change, its impact on physical restraint and vice versa bears closer scrutiny.

In analysing the data from this study, conceptual themes are being identified which may help to better understand and respond more effectively to the situations that potentially warrant physical restraint, as well as episodes of physical restraint once they do occur. One such theme involves the notion of containment, which has often been referred to as a primary task in residential child care (Sprince 2002; Ward 1995; Woodhead 1999). This can simply be a literal referral to practical aspects of care, the physical environment and limits on behaviour, with the extreme end of the latter being physical restraint. The concept also involves a more complex process involving the interplay of relationships, activities, and models of care coming together in a manner that safely absorbs and assists young people to develop the capacity to manage previously unbearable (or uncontainable) emotions. Physical restraint can also be located within this conceptual framework, and understanding the relationship between physical containment and therapeutic or relational containment, while difficult (Deacon 2004), might assist efforts to reduce its use.

The meaning young people and staff ascribe to physical restraint generally, and to their own experiences of physical restraint specifically, must have a strong impact on how restraint is used and experienced: its appropriateness, its effectiveness, the

intentions behind its use, and the outcomes of the event. This is evident throughout the themes identified in the study. Notably, Garfat (2004) has begun the process of researching and developing useful theoretical frameworks for becoming aware of and more consciously influencing the construction of meaning within residential child care settings (see Steckley and Smart 2006). Attending to the processes through which staff and young people make sense of restraint would enhance the effectiveness of residential establishments' attempts to address most, if not all, of the themes highlighted by Colton (2004) and the Child Welfare League of America (Bullard *et al.* 2003), increasing the likelihood of the reduction of the use of physical restraint.

Conclusion

One of the clear messages from the literature reviewed here is the seriousness and complexity of issues surrounding physical restraint, and the importance of understanding it within a much broader context. Simply viewing physical restraint as an issue residing with the behaviours of young people or the skills of staff does little to improve efforts to reduce or eliminate its use. Nor does it ensure that when it must be used, it is used properly and effectively. Research efforts aimed at improving practices related to physical restraint must be creative in addressing this multilayered complexity. They must also continue to take on board the views and experiences of those most directly affected, residential staff members and children and young people.

The study outlined above reveals a greater breadth and depth of views than before.

While many of its findings parallel previous studies, some are new. Children, young people and staff continue to have negative experiences of physical restraint, with misuse in varying forms an ongoing, serious concern. By the same token, findings

related to the potentially beneficial aspects of its use give insight into a better understanding of the complex phenomenon of physical restraint and how practice might be improved.

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