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Introduction

When social care workers must respond to behaviour which poses serious, imminent danger, the response can sometimes take the form of physical restraint. Physical restraint has long been the subject of serious concern in social care, as well as other areas, such as law enforcement and psychiatry. This chapter focuses on physical restraint in residential child care. It is one of the most complex and ethically fraught areas of practice, yet there is almost no dedicated literature that applies itself to the ethical dimensions of this practice in this field. The chapter starts with discussion of the context of practice in residential child care. A tentative explanation for and critique of the lack of ethically dedicated attention to the subject of physical restraint in residential child care is then provided, with an argument for the transformative potential of care ethics to develop related thinking and practice. The chapter goes on to draw from a large-scale, qualitative study of physical restraint in residential child care in Scotland. The study was funded by Save the Children, Scotland and included in-depth interviews with 41 care workers and 37 children and young people. Interviews were comprised of four, multi-level vignettes and a semi-structured interview schedule and averaged around 100 minutes for workers and 30 lawminutes for children and young people. Relevant findings are then examined and discussed through the lens of care ethics. While the contextual issues and findings discussed below are located specifically in Scotland, they have relevance to residential child care (and indeed other forms of care where physical restraint is used) in the United Kingdom and internationally.

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Context

In Scotland, residential child care is comprised of a range of provision that includes secure accommodation, residential schools for children with emotional and behavioural difficulties, children's homes, and homes that provide respite to families whose child or children are disabled. The vast majority of children and young people who are placed in residential care have experienced abuse, neglect and/or other trauma (Anglin, 2002, Ward, 2006b) and sometimes their related, underlying pain can manifest in behaviours that pose risk of serious harm to themselves and/or others. According to The National Task Force on Violence Against Social Care Workers (2000), practitioners who work with teenagers in residential care are one of the groups suffering the most violence of those working in social care, and it is children in their teenage years who are most represented in the residential child care population (The Scottish Government, 2013).

There are particular complexities in these settings that impact on practice and on the use of restraint specifically. They include: a continuing perception of residential child care as a last resort service (McPheat et al., 2007); the related practice of only placing children and young people with the most serious difficulties in residential care (Forrester, 2008); poor levels of workers' qualification given the complex demands of the work (Heron, 2006); and the 'dark shadow' cast by the 'unremitting

nature of the focus on institutional abuse' (Corby et al., 2001, p.181). As a result, care in residential child care is carried out in a context that, at best, is ambivalent towards it.

Residential child care is also affected by a wider social work context in which the central role of relationship has been significantly stifled by managerialism (Munro, 2011). The foundational principles of economy, efficiency and effectiveness (Audit Commission, 1993) upon which managerialism rests are derived from business models and are poorly suited to the context of helping professions (Meagher and Parton, 2004). They are based on 'an understanding of human behaviour that privileges cognition, rationality, and predictability and pays less attention to the emotional, irrational and unpredictable dimensions of human beings' (Ruch, 2011). Specific impacts of managerialism in residential child care include an increased focus on outcomes, many of which are nonsensical in that the 'outcomes' for children who come from a long history of deprivation, abuse and/or other trauma –a long history often due to the residential care being used as a last resort – are being measured against the general population rather than children of similar histories (Forrester, 2008). It is the reparative experiences of care, relationship and self that are central to the healing potential of residential child care, yet it can take a long time for these experiences to have an impact and when they do, they are often not particularly measurable. There may indeed be in inverse relationship between what is important and what is easily measurable (Scottish Council Foundation, 1999).

Another key impact of managerialism is the framing of care in technical-rational terms. This can be seen in the raft of policies, procedures and paperwork now central to a residential child care worker's task (Smith et al., 2013), as well as other technologies of care that include a variety of assessment tools and programmed interventions (Webb, 2006, Smith, 2009). Even care workers' reference to basic exchanges of touch have been found to use language of techniques derived from crisis intervention training packages (Steckley, 2012). Finally, managerialist emphasis on governing the actions of front-line workers (Meagher and Parton, 2004) can be seen in the erosion of authority of heads of residential homes and the diversion of decision-making power to external managers or health and safety personnel, many of whom have little understanding of the complexities and ambiguities of relationships in residential child care (Smith, 2009).

The reductivist and simplifying impulses behind managerialism (Moss and Petrie, 2002, Smith, 2009) are not conducive to the highly complex and demanding nature of residential child care work (Anglin, 2002, Ward, 2006a, Garfat, 2008, Stevens, 2008, Steckley and Smith, 2011). Situations leading up to and involving the practice of physical restraint are one of the strongest illustrations of this demanding complexity. For the purposes of this chapter, physical restraint is defined as 'an intervention in which workers hold a child to restrict his or her movement and [which] should only be used to prevent harm' (Davidson et al., 2005, p. viii). While there is a recent trend in some residential establishments towards calling restraints 'safe holds' (presumably based on the name of Scottish guidance), many restraints

are experienced as violence by young people and by care workers (Steckley and Kendrick, 2008b). Negative effects can be severe and long lasting, not only on young people but also on the workers who carry them out. These can include physical injury, demoralization, and trauma/re-traumatisation (Allen, 2008). Yet some efforts to avoid physical restraint, including the use of medication, seclusion or involvement of the police, have the potential to be even more damaging to young people and to their relationships with those who care for them (Steckley, 2009). Additionally, young people identify a need for physical restraint in situations of imminent or actual harm (Morgan, 2012, Paterson et al., 2003, Steckley and Kendrick, 2008c), and some young people have reported more positive effects of being restrained (Steckley, 2010, Steckley and Kendrick, 2008c).

Effective restraint reduction requires strong leadership and investment at almost all organisational levels, including staffing, training and development, unit culture, therapeutic approaches and, fundamentally, relationships (Fisher, 2003, Colton, 2004, Paterson et al., 2008). This has significant resource implications, as does the introduction of Snoezelen (Lancioni et al., 2002) or sensory rooms (Champagne and Stromberg, 2004) as alternatives to restraint. Such alternatives are becoming more prevalent in psychiatric settings or services for people with learning disabilities or dementia, but have yet to make an impact on the residential child care sector (see Freeman, 2011, for a North American exception).

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Ethics, residential child care and physical restraint

Despite ongoing concerns about the restraint of children and young people, there has been little written providing an analysis of the related ethical dimensions of practice (Cornwall, 2006 and, Wilkins, 2012 are two notable exceptions); still less has been theorised from an ethical or moral philosophical perspective. There are several possible reasons for this lack of attention. Residential child care has a relatively short history of research and scholarship compared with, for example, medicine, where more has been written about the ethics of physical restraint from a bio-medical perspective (see, for example, Gastmans and Milisen, 2006, Strumpf and Evans, 1991, Taxis, 2002). In social work, within which residential child care is professionally incorporated in the United Kingdom, the curricular requirement for dedicated ethics content on the honours degree has come about relatively recently (Department of Health, 2002, QAA, 2000). While some who work in residential child care have completed the honours degree in social work, most workers currently achieve lower levels of qualification (Scottish Institute of Residential Child Care, 2010) – ones which do not require dedicated ethics curricula.

Dominant approaches to ethical theorising draw on traditions that locate moral deliberation in the public realm and emphasise a moral agent who applies ethical principles in a detached, impartial, rational and universal manner (Tronto, 1993). These approaches do not lend themselves to the complexities of the relational practice of caring for children and young people in public/private fault line of public

care (Steckley and Smith, 2011). Consequentialist arguments, crudely applied, can be used to justify poor practices related to physical restraint. Universal principles of imminent danger and last resort (criteria applied in assessing the acceptability of restraint) are widely supported (Davidson et al., 2005, Day, 2000, Hart and Howell, 2004), but in practice are ambiguous. Interpretations of what constitutes imminent danger or last resort can vary greatly, both in general and in the moment. Predicting the consequences of one course of action over another is not wholly reliable under ideal circumstances; in the lead up to a physical restraint, with its complex, multiple variables and extreme emotional charge, these variances can be even more pronounced.

Rights based discourses, drawing on a deontological tradition, have a dominant influence on policy and practice in residential child care (Smith, 2009). Their development in Anglophone contexts has been predicated on the notion of contractual and/or legal mediation of relationships between individuals – individuals who are constructed as rational and autonomous (Dahlberg and Moss, 2005). Such an orientation can obscure the interdependent, affective and reciprocal nature of caring relationships, and undermine the centrality of trust within them (Held, 2006). 'Trust is a quality often missing from simplistic conceptions of rights, which can distort thinking into adversarial terms (e.g. workers' rights versus young people's rights or rights versus responsibilities), stripping out the context and complexity of relationships' (Steckley and Smith, 2011, p. 185).

The impacts of managerialism can make it difficult to hold onto the values and motivations that attract workers to social care in the first place (Moss and Petrie, 2002, Smith, 2009). Aronson and Smith (2010, 2011) describe social service managers' struggle to resist managerial practices that subvert their own professional values and the perceived precariousness of their 'valued selves' within their wider professional identity. Resistance, however, requires the perception that there is something that needs holding onto, and something to resist. The managerial tendency to reduce problems to technical and administrative issues obscures their ethical dimensions (Moss and Petrie, 2002). Ash (2010, p. 205) identifies this tendency in her study of elder abuse, arguing that 'the social and political context of the work of social workers and their managers mitigated their alertness, or attentiveness, to barely acceptable situations for older people'. Bauman (2006) names this tendency adiaphorization and argues that it leads to an ethical deskilling of workers by desensitizing their moral sensibilities and repressing their moral urges. There was similar evidence of ethical deskilling and obscuring in the study, which will be discussed in the next section.

Care ethics offers not only a critique of traditional ethical approaches and the managerialist paradigm, but a framework against which care can be meaningfully and ethically assessed. It is an *ethic* of care, not simply care, that is needed (Held, 2006). Its fundamental project of making relational realities explicit (Gilligan, 1982, 1993) is highly relevant to residential child care and the messy, complex work of cultivating close, caring relationships with children who have been relationally

harmed. Its attention to context, particulars and emotion (Held, 2006) make possible a meaningful engagement with the ambiguities of relational practice.

Care ethics provides a language that can enable discussions and debates that foreground and make sense of the ethical dimensions of practice (Barnes, 2012). Shifts in language can reshape beliefs (Vojak, 2009), and the transformative potential of care ethics' language resides in its resonance with workers' experience and its ability to reignite their values. Moreover, care ethics' call to action on institutional and structural levels (Tronto, 1993, Tronto, 2013) offer a means for envisaging residential child care within a wider care system, one where determinations of resources, training and professional standing are no longer dominated by managerialist conceptualisations.

Findings

The first-level content analysis yielded a more subtle and complex account of the phenomenon of physical restraint than previously reflected in the literature. Almost all respondents (workers, children and young people) indicated at some point in their interview that physical restraint was sometimes necessary and acceptable. They consistently connected its appropriate or acceptable use with issues of danger, destruction, risk, harm, safety or protection. There was also a dominant theme about the importance of attempting less intrusive interventions and that restraint should be used only as a last resort. So while there was a general consensus across

the majority of care workers and young people about the conditions under which restraint was seen as acceptable, further discussion exposed significant ambiguity about the degree and type of harm necessary to justify a restraint, the accuracy of assessments of the degree of harm and of imminence (especially under what was usually highly pressured and emotive conditions), and at what point other interventions should be abandoned and physical restraint should happen (again, this was the case for both workers and young people). From this, one can see the gross limitations of a technical-rational application of imminent harm and last resort, as well as the need for an ethical framework that engages with context, particulars and emotion.

All respondents recounted negative emotions and experiences of either being involved in a physical restraint or witnessing one (a very small number of respondents had only witnessed restraint). Some young people (around a third) also recounted positive experiences or effects of physical restraints, and some workers identified positive effects on young people. Experiences, both negative and almost all positive, were strongly linked to the perceived quality of the relationships amongst those involved – both before the restraint and subsequent to it. In other words and in contrast to dominant related discourses (Steckley and Kendrick, 2008a), some young people recounted feeling safe, cared for or protected in/by the restraint due to the safety and trust they felt for the workers involved; additionally, some young people stated they felt more trust in workers due to the way a situation (in which restraint was a part) was handled. Conversely, some young people

reported extremely negative experiences of restraint based on poor relationships with those doing the restraining, and damage to relationships as a result of unnecessary or excessively rough restraints.

From a care ethics perspective, the findings related to relationships make sense. The perceived quality of a relationship would clearly impact the degree to which a restraint is experienced as an act of care and protection, and the degree to which it was experienced as violence and coercion. Given the complex, ambiguous nature of situations involving restraint, it is often not a question of either/or: a heady and contradictory mix of powerful motivations and emotions can all be present in an incident involving restraint. Attending to relationship, prior to, during and following incidents involving restraint will strongly influence which motivations and emotions dominate the experience and the subsequent meaning made of that experience. From a care ethics perspective, this attending (or the absence of it) is an ethical issue.

In the semi-structured interview schedule, workers were asked what ethical considerations affected their use of restraint. Their responses had a very different quality than other questions in the interview; well over half of the respondents visibly struggled to answer the question and a third clearly stated that they did not understand the question. Their discussion became unclear, at times even incoherent, and their discomfort was palpable. The adaphorizing impact of managerialism offers a potential way of understanding these reactions; many

responses reflected an ethical deskilling, though the consistent, discernible emotional charge also present within their responses may belie a continued sensitisation to the ethical dimensions of physical restraint. It was as if there was an 'ethical stomach ache' related to this area of practice, but the words to articulate or make sense of it were lacking.

Well under a quarter of respondents did offer a clearer response to the question of ethical considerations. Their most frequently cited ethical consideration was related to whether the restraint was done for the right reasons and that it needed to be for the safety or protection of individuals involved. Misuse of power was most commonly commented on in terms of unethical use of restraint, though no respondent explicitly labelled it as such. Some stayed in clearly technical-rational territory, citing adherence to policy, procedure and risk assessments. Interestingly, no respondent made reference to their relationship with the child as an ethical consideration. Neither did any respondent speak of children's rights or a duty of care (current ethical lexicon applied to residential child care) in response to the question. Children's rights and a duty of care did appear on very few occasions elsewhere in interview, and it is interesting that these terms did not serve respondents when asked for their ethical considerations. It may well be that the language of duties and rights has not made its way more strongly into workers' thinking and language because the current managerialist context saps these concepts of their vitality in addressing more complex dimensions of practice.

Tacitly, most workers seemed aware that physical restraint is an ethically complex area of practice, and they raised significant, related concerns throughout their interviews. They discussed ambiguities of its practice, conveyed considerable ambivalence about its use and consistently expressed guilt, doubt and defeat for not being able to avoid it. At organisational levels, an over-reliance on technical-rational approaches appears to have obscured the ethical dimension of physical restraint. All of the establishments who participated in the study appeared to have policies and procedures in place related to physical restraint. A great deal of energy appears to have gone into training and refreshers, related paperwork (incident forms, debriefing forms) and requirements to inform families and social workers of occurrences of restraint (Steckley, 2010). There was, however, far less evidence of attention given to spaces for naming and making ethical sense of the complexities, ambiguities and anxieties related to the practice of restraint. For example, most workers described their experiences of debriefing (post restraint) as only happening 'in theory', inconsistently or superficially.

Discussion – physical restraint and care ethics?

Barnes (2012) argues that the development of ethical skills and sensibilities is required for care ethics potential to be realised, and this involves enabling processes and environments which foster workers' reflection on ethics. For this to be possible,

workers need to see ethics not as policy or politics happening 'out there', but as relevant here and now (Ash, 2010). The conceptual orientation and language of care ethics hold promise for making this relevance accessible and real. For example, when workers and young people discussed the impacts of restraint on their relationships and vice versa, the language of care ethics was strongly reflected. They spoke of trust, understanding, need, dialogue, context, relationships and care (Held, 2006, Noddings, 1984, Parton, 2003, Tronto, 1993, Gilligan, 1982, 1993). Yet care workers did not consider their relationship with the young person as an ethical consideration related to restraint.

Care ethics' attention to care receiving (Tronto, 1993) highlights the importance of including the views and experiences of young people in development of ethical skills and sensibilities of workers. Processes of naming and making sense amongst workers and young people are also served by the language of care ethics. Such processes contribute to the development of relationships that can hold episodes of imminent danger without recourse to physical restraint, or can provide the foundation for restraint to be experienced as an act of care if it does become necessary.

Restraint is portrayed as violence in much of the literature, and respondents' experiences reflect both violence and care. Held (2012, p. 121) asserts that 'even in the context of care, violence may occasionally be called for…The point of these uses of violence is to further the aims of care'. Held's quote offers a way in to

understanding how a young person can describe her experience of restraint as feeling cared for, but close attention to power (Tronto, 2010) is necessary to determine whether such a restraint furthered the aims of care or further distorted the young person's understanding of caring relationships. Moreover, the way that power is enacted at all levels within an organisation, and not just within the confines of an incident and the relationships within it, must be considered. If the aims of care are to promote compensatory and healing relationships, relational congruence is necessary across all levels of the organisation (Anglin, 2002).

Does this mean that violence has a legitimate place in residential child care practice? Certainly no respondent made such an explicit, bold statement. The aforementioned trend of calling a restraint a safe hold may indeed belie an underlying sense of the unacceptability of violence in the context of a caring institution, but it also has a euphemistic quality. Such distancing from the uncomfortable realities of physical restraint serves to repress related anxieties and inhibit processes of naming and making sense.

When workers enter a situation with a young person whose emotions and behaviours are escalating towards harm, and particularly at the point of initiating a restraint, it would be fair to say that they are demonstrating a willingness (albeit often an ambivalent and/or reluctant willingness) to potentially go to a violent place with that young person. In some cases, they may already be there. Is this the same thing as using violence to further the aims of care? It would be interesting to go

back and ask worker respondents whether they felt they had 'used violence'. It is clear from the data that some young people felt that violence had been used against them; conversely, others did not – even when the restraint itself could have been characterised, at the very least, as coercive if not violent.

The integrated ability to hold onto the aims of care, both in one's activity and disposition (Tronto, 1993), through an episode involving restraint is of great importance in how the element of violence is experienced. In order for the relationship to hold and withstand the eruption of violence, workers must be able to convey unwavering care throughout the process; there must be congruence between their affect, actions and communication of care and last resort. Such relationships exemplify the kind courage and emotional stamina that continues to be insufficiently noted and valued (Gilligan, 1982, 1993).

Conclusion

Physical restraint must be understood within the context of relationships. The relational, emotional, embedded realities of situations involving restraint are far better served by care ethics, which attends to their relevance and puts relationship at the centre of its consideration. To develop safe, ethical and developmentally rich environments, residential cultures must make space for, and effectively address related ambiguities and tensions, including those between care and control and the

impact of violence on care environments. This can be particularly difficult in such an ethically fraught area of practice, but for this reason it is all the more necessary. If residential child care is to truly attend to and meet the needs of children and young people who are in pain, then the relationships within this care must be able to hold the related complex, ambiguous, contentious dynamics and manifestations of that pain with ethical clarity. Care ethics offers a language and orientation that can facilitate such clarity and transform related practice.

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