University of Strathclyde Glasgow

An Appreciative Inquiry into Holding in Residential Child Care:

Pilot Report

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Contents:

Introduction

While there have long been serious concerns about the physical restraint of children in residential child care – including restraint related deaths, traumatisation or re-traumatisation for all involved and abuses of children's rights (Steckley, 2018) – recently it appears that Scotland may be at a watershed moment in addressing this practice. In 2020, after listening to over 5,500 voices of those with experience of receiving or giving care in Scotland's care system, the report of the Independent Care Review asserted, "Scotland must strive to become a nation that does not restrain its children" (p. 85). Restraint reduction has become a more significant focus in residential child care.

This pilot study set out to identify and explore key factors in reducing or eliminating physical restraint, as well as in the successful holding, both metaphoric and literal, of children and young people in distress. It adopted an Appreciative Inquiry approach in two residential child care service sites in Scotland. It was funded by the School of Social Work and Social Policy in the University of Strathclyde, was approved by the University of Strathclyde's Ethics Committee, and was carried out by Laura Steckley, Lee Hollins, Sarah Deeley and Michael Bettencourt.

Our working definition of physical restraint, drawn from Holding Safely: A Guide for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People, was: 'an intervention in which staff hold a child to restrict his or her movement and [which] should only be used to prevent harm' (Davidson et al., 2005, p. viii).

We were interested in finding out about:

- **When a physical restraint is averted, what enabled that to happen;**
- **Preventative measures that have rendered physical restraint unnecessary or less necessary;**
- **Any other restraint reduction measures effectively being taken;**
- **Any practices identified as effective in the lead up to, during and/or after a child has been physically restrained;**
- **And wider influences on the effective reduction of physical restraint.**

This report will tell you some of what we found out, but first, it will explain a bit more about the study's design – the what and why of what we did.

What We Did and Why

In identifying its research priorities, members of the Scottish Physical Restraint Action Group (SPRAG)* repeatedly referred to how little (if any) information is being collected about what is working well in residential child care in relation to physical restraint – particularly those occasions when care workers and children manage to avert a physical restraint.

The Care Inspectorate requires clear documentation and the collection of data to keep track of physical restraints that do occur, but a similar mechanism does not exist for when they are successfully averted. The pilot was developed to address this gap in our knowledge and serve as the foundation for a larger study.

* For more information about SPRAG, please see A Final Note at the end of this report.

What is Appreciative Inquiry?

Appreciative Inquiry is a strength-based approach that looks to identify what works well, or what contributes to resilience, wisdom and energy in an organisation. It is often used in organisations when they are seeking to implement some form of 'change' that requires individuals to come together to work effectively (Cooperrider & Whitney, 2005, p. 282). It can also be used to shine a light on those practices that work well but are not always visible or validated. Appreciative Inquiry is increasingly being used by organisations themselves as an alternative to bringing in outsiders to scrutinise business operations.

Why Did We Choose Appreciative Inquiry?

Instead of focusing on a problem, which is a traditional approach to research, Appreciative Inquiry offers an opportunity to learn from positive incidents, and to then develop the solutions that can help workers and organisations to improve. This does not mean avoiding the negative challenges related to the focus of inquiry – a perception at the core of some criticisms of Appreciative Inquiry (Hung et al., 2018) – but that an appreciative inquiry approach can help organisations (or in this case, the residential child care sector) strengthen its capacity to 'face up to and address' existing problems (Jones & Masika, 2021).

What Is Involved in an Appreciative Inquiry approach?

There are five 'steps' in the Appreciative Inquiry process:

1. Define: What is our desired outcome?

2. Discovery: What are our strengths?

3. Dream: What would work well in the future?

4. Design: How can we make it happen?

5. Deploy: What actions do we need to take?

All of the steps are intertwined and lead towards positive action. This pilot study focused on steps 2 & 3 as it sought to discover what was working in order to begin to reach for a future where restraint was reduced if not eliminated.

Who We Listened To

In order to find out about what is working, we interviewed care and education workers*, adults with care experience*, and family members, individually, in pairs and in groups. We worked with two residential child care services:

- **Service A:**
  Interviews all focused on a long, challenging, successful process of working with a profoundly learning-disabled young person in a way that reduced her distressed behaviours and reduced the use of physical restraints;
- **Service B:**
  Dyadic (2-person) interviews with an adult with care experience and a care worker of their choosing discussed, looking back, their experiences and views of physical restraint.

The following table outlines all of the interviews and focus groups:

DATA COLLECTION EVENT	SERVICE	PARTICIPANTS
Individual Interview	A	Care and Education Worker [n=1]
Focus Group Interview	A	Care and Education Worker [n=3]
Focus Group Interview	A	Care and Education Worker [n=4] Family [n=2]
Dyadic Interview	B	Care Worker [n=1] Adult with Care Experience [n=1]
Dyadic Interview	B	Care Worker [n=1] Adult with Care Experience [n=1]
Dyadic Interview	B	Care Worker [n=1] Adult with Care Experience [n=1]
Dyadic Interview	B	Care Worker [n=1] Adult with Care Experience [n=1]

What We Did with What They Said

We listened closely and repeatedly to what our study participants had to say. To do this (and with their permission), we recorded all of the interviews and had them professionally transcribed. We also used software to support our analysis of the transcripts to identify themes and relationships between those themes across all of the interviews. In order to protect the identities of study participants, pseudonyms have been used throughout.

** Different terms are used to refer to care staff (and in the case of Service A, care and education workers). For the purposes of this report, we decided on the general term 'care worker' as this seemed to be the closes fit to the caring relationships described by participants, but also the skilful work they were doing. We noticed that 'staff' was a term often used as well, and as we reflect on the impact our language has on the way we think, feel and interact, it feels like more thought and conversation is to be had about this. Similarly, we considered several terms to refer to the adults with care experience who participated in the study and at the end of the day, we chose this term based on the strength of feeling/ argument of one of the participants.*

What We Found Out

The findings we offer here reflect the more dominant themes we identified across all of the interviews. While it is early in the life of what we hope will be a larger study, we think there is value in sharing these findings now given the sense of urgency we all share in addressing physical restraint in practice. We chose to include frequent quotes, some of which are long, to let the participants' words vivify the report. We suspect much of what we found will not come as a surprise, but we hope that the following will refresh what you already know, offer a different way of looking at it or deepen your knowledge further.

The Relationship as a Restraint-Reduction Resource

Adults with care experience, family members, and care workers spoke of the value of good relationships in every interview [n=7]. This is by far our largest and most dominant theme. Participants' descriptions revealed that individual relationships can be transformative and that those relationships were wide and varied. Our analysis provides a deeper look into the *doing* of relationships that makes the difference.

Attunement and empathy

Across all of the interviews, participants spoke of the importance of care workers being attuned and empathetic to what young people were experiencing when they were distressed. Understanding 'where that was coming from' (Stevie) enabled care workers to feel less anxious or threatened by young people's behaviour. Fear, pain, rage, overwhelm,

shame, and a breakdown in the ability to cope were all mentioned, along with what young people might experience at a sensory level (i.e. sensory overload), and importantly, not ascribing negative characteristics to the young person:

> She's not acting up or she's not being overly dramatic [...] I think if people are really understanding that she's feeling sick to her stomach and she actually feels like great harm is going to come of her because of this thing. Of course that's going to change how you respond.
>
> *(Susan, Care Worker)*

Something as subtle as a look that conveys understanding can have the power to avert a situation ripe for escalation, as described by one adult with care experience recounting a situation in which another young person was provoking her:

> I was quite young, so my anger always got the better of me. I think when Deidre gave me - whenever Deidre gives me a look, I just know that I'm all right. I know that it's fine, that I don't need to - I'm defending myself where I don't need to defend myself, because I've got somebody there to keep me safe instead of me trying to defend the situation.
>
> *(Angela, Adult with Care Experience)*

Care workers also linked attunement and empathy to their ability to identify what the young person needed during difficult moments: to feel safe, loved, understood, but also to have a sense of control over their lives and space to express painful emotions. Understanding young people's needs in a given moment informed longer-term strategies as well, including ways to support young people's ability to identify their own emotions and needs, and to exercise agency in their lives.

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Care-full Communication

The communication of empathy, care and support during moments of distress appeared to be a key factor in averting physical restraint:

> It would depend sometimes who was on shift, and the relationship that was there, and they obviously know how to speak to me, they know what was good for me, like maybe talking, or do you want to go out, get a wee bite to eat, or something like that. Just to take my mind off or prevent the situation whichever was going to happen that day
>
> *(Maggie, Adult with Care Experience)*

Conveying love, whether in difficult moments or more generally, was also deemed important in the majority of interviews:

> When I first had been restrained, I think I was about 13. That was a long, long time ago. It was obviously a lot different than what it is now. I think it was a bit more rigid if that - it was like the side cuddle. You don't say 'love you'. It was quite different back then, but I think as the acceptance of the staff being able to show love for the child and say that they love them, I think that was a turning point for me in terms of - somebody's coming in and out of your life and you just think one day I could snap and I don't know if you love me. Nine times out of 10, that's what it was. For me it was like I didn't know if I was loved. Being hugged - because I knew when I was younger that being hugged is a - it's a form of - well, you care about somebody when you hug them. You don't just hug random strangers. I don't know if you do, but I don't hug random strangers.
>
> *(Angela, Adult with Care Experience)*

It wasn't only the care workers' skilful, loving communication that was considered important. Young people developing the ability to express their distress, as well as their affection, intentions, and desires, were all connected to a reduction in types of situations that sometimes led to physical restraint:

To me that was preventing what was going to happen, because I knew in my head that I wanted to go mad, but just letting them know, and for them to kind of backtrack it a wee bit for me, and turn it round and that prevented that actually happening that day.

(Maggie, Adult with Care Experience)

So from going from three years ago from not being able to show anybody love to now being able to have a visit from mum, and when mum leaving say, 'I love you'. That's remarkable. She wouldn't have had that skill never mind the need for the feeling of that before. Now that's a beautiful transformation. Because for her to show her mum that she loved her, before she would have grabbed onto her hair, pulled it, and not wanted her to leave the immediate vicinity.

(Sean, Care Worker)

Trust

Trust was referred to in all interviews [n=7] and can be described as a feeling of confidence or security brought about in one person by another who cares (Thagard, 2018). It is enacted through meaningful forms of attention or action.

Trust also takes time.

She could talk to us about feeling the way she felt [...but] she felt she didn't have enough trust to tell us in the beginning [...]when they've only been in a short time, and they don't trust you yet, it can be really frustrating and hard [...] you are really giving them your all, and they don't accept it, and that's okay, because they don't know how to.

(Christine, Care Worker in interview with Maggie)

I'm quite a private person when it comes to things like that [...] I was so deep most of the time, as I say, it did take me loads of time to trust somebody. But when that trust was there, I would share things that was on my chest. Even things that I'd been through in my past with family and stuff like that as well

(Maggie, Adult with Care Experience)

Trust and attunement appear to go together:

The presence of somebody that you knew and I think trusted was really, really reassuring at that point [... it got] to the point where he'd calm down sufficiently and you were able to engage.

(Stevie, Care Worker)

/Yeah

(Martin, Adult with Care Experience).

/or cared for the most had the most ability to help. Then other times they were people that you were most

(Stevie)/

Most mad at.

(Martin)

/angry with and stuff like that

(Stevie).

As they finish each other's sentences several years after the period they are talking about, this exchange appears to reflect a continuing attunement between Martin and Stevie. It is also a reminder that the development of trust does not simply mean the elimination of difficulties between people. Indeed, it may create space for young people to learn how to work through relationship difficulties.

Relationships Between Adults

Relationships between the adults involved in the care of young people also came up in participants' discussions. In 3 of the 7 interviews, the relationships inside the team around the child were discussed as a valuable resource. One focus group discussed how a lengthy restraint had been averted. Their discussion reflected a synergy of relationships, characterised by trust and attunement and possibly sensed by the young person, coming together to make this possible:

If it had been people that had turned up that didn't know Katie, then they wouldn't have had/

(Diane, Care Worker)

/the same outcome

(Heather, Care Worker)

No, because it wouldn't have the same trust within the staff team. They wouldn't have known whether Heather really meant 'It's okay to let her go', or whether she was going to come after a certain staff member or what to do next if actually Heather let go and she wasn't calm. Whereas because it was all familiar staff to Katie, there was a trust within us as well, within each other, that we knew what Katie needed and Katie knew what [pause] we were predictable for Katie. She knew what we were going to do. I don't know about you guys, but I don't think – I wouldn't have felt as comfortable if it had been people from [another team].

(Diane, Care Worker)

That then leads to confidence building and the staff team understanding and know the parents and grandparents back us up. We can shoot for the skies here, we could be more aspirational, we can take risks, the positive risks.

(Sean, Care Worker)

In 4 interviews, reference was made to the value of relationships with individuals outside of the immediate team, including educational and healthcare staff as well as psychologists, social workers, and family members. In one focus group, these relationships appeared to support participants' confidence to explore and innovate in their practice:

> Actually, I wouldn't be confident enough to say to the class let's try this if I didn't have the support of the house team to do that [... and] when we had to phone and say an incident had occurred and something had happened, she [Katie's social worker] would never say to us, 'Why on earth did that happen?' Because she had trust in us that we risk assessed it and we were doing it for Katie.
>
> *(Diane, Care Worker)*

In a different focus group, the relationships between Katie's mother, grandmother, and the care team were identified as significant.

> Through that whole process they were supportive of the staff team and that makes it easier, then, to be brave in your engagement with Katie. Okay, if I go in for a cuddle and this goes wrong, and Katie ends up in a hold, are the parents going to be devastated or angry, or are they going to understand we were trying to do that because it was in her best interests? That then leads to confidence building and the staff team understanding and know the parents and grandparents back us up. We can shoot for the skies here, we could be more aspirational, we can take risks, the positive risks.
>
> *(Sean, Care Worker)*

Physical Restraint Can Be Necessary

Participants were not directly asked whether or not they believed physical restraint to sometimes be necessary. Its necessity in certain circumstances was nevertheless discussed in 6 out of the 7 interviews.

The people working with Katie described a six-year process that developed from what sounded like physical restraints done to stop harm but done *to* her, into physically restraining interventions done *with* her:

> So I was able to just be part of that atmosphere and just say, you know, 'Katie, Susan's just here to help'. I just held on to her arm. Because actually sometimes Katie does respond nicely to having that kind of level of comfort. Rather than [pause] I mean it is a physical intervention but I wouldn't have seen it as a big restraint [...] It was almost I was doing the job of, she wouldn't be able to pull her hair because my hand was underneath there to stop it [...] Within three minutes or so Katie then was able to take Tracy's hair out of her mouth and then at that point I had kind of stepped away and said oh well done Katie. [...] what Katie does is she knows what she needs and what she needs is time by herself. So Katie, through the time of being with us, has learned that if she says 'bye, bye' she can go to her place. [...] So by this point Katie was saying 'bye, bye, bye, bye, bye' and we said that's fine, let's go.
>
> ***(Susan, Care Worker)***

In a different focus group, a member of Katie's care team indicated a similar process of coming to understand the needs Katie was communicating through her harmful behaviour (to be reassured, to feel safe, to interrupt unmanageable sensory experiences) and how to meet those needs. This, in turn, caused a reduction in those behaviours:

> That was a lot more therapeutic for her. It was a lot less traumatic for me because I wasn't getting scratched or bitten. A colleague that I was working with wasn't getting her hair pulled. So the whole journey then became something she understood. So the more often that I did that, the more often she expected it and so her hands then began to reach out rather than have this anxiety-based need to grab on so violently.
>
> ***(Sean, Care Worker)***

In a dyadic interview, one of the participants spoke regretfully of not being restrained:

> I was careless back when I was younger. I didn't say no. I was always do before think. I think they were the kind of moments where I wished staff would have stopped me physically before I got myself into a lot of trouble [...] I wished that the staff would have noticed sooner and just pinned me down, because it [the thing that happened] was a big regret in my life.
>
> ***(Dylan, Adult with Care Experience)***

Restraint Meant Different Things to Different People

While there was a great deal of agreement around what had worked well in relation to physical restraint, underlying differences of meaning were revealed across all of the interviews. Both care workers and adults with care experience spoke of different types of physical intervention during situations of serious, imminent harm. Some of these descriptions met the definition of physical restraint used in this report, some did not, and in some cases, it was unclear.

In one focus group, a member of the care and education team responded to an opening question about averting restraint with the view that the child they were discussing had never been restrained while in their service. This led to a discussion among the focus group participants about the regular forms of physical holding they used to escape hair pulls, severe pinching (i.e. pinching that broke the skin) and biting. Many of these interventions involved holding the child's hands and arms, or physically moving the child. It appeared that the focus group participant's definition of physical restraint was based on specific holds from their service's training package, and because these other forms of holding did not constitute the specific holds from training, she had not considered them forms of physical restraint (whereas others had).

All of the dyadic interviews involved discussion of hugs or cuddles in relation to physical restraint. A hug was referred to as preventing a restraint:

> ... but the staff member that I had a grip of, she gave me a cuddle. She just - surprisingly because I was really, really angry. Sorry, where did you go? I was really, really angry. She just took it upon herself to just wrap her arms round me and then it was just like a relief.
>
> *(Angela, Adult with Care Experience)*

as a form of restraint:

> so that's when they try to put hands on. It was like I said earlier. It's more like a bear hug than an actual restraint, what they used to do with me.
>
> *(Martin, Adult with Care Experience)*

or even as a motivation that gets mixed up in the lead up to or during a restraint:

> But that's what it felt like. She was in - it wasn't long that she'd moved in. It was really alien, it was really upsetting for any kids to get brought into care, so that was probably just Maggie's way of saying, I don't want to be here, but I know you're going to keep me safe.
>
> *(Christine, Care worker)*
>
> Aye, I remember after that, I was just like, I actually needed that, because it meant that I was speaking about it everything that was on my mind and stuff, that I was holding in for quite a while. Because it was just obviously things about - like maybe feeling unsafe, because I was struggling with all these relationships and trust everybody. I felt like I couldn't say that in words, so it was just meaning that I was kicking off, and then I was getting that hug, and I was like, well, Christine

does really care for me, she does love me and she can give me a hug, and I can feel safe around her at that point.

(Maggie, Adult with Care Experience)

As indicated above, the relationships between young people and intervening adults profoundly influence how restraint and the avoidance of restraint was experienced, but also, as this finding suggests, whether or not a physically restraining intervention is experienced as a restraint. In one of the four dyadic interviews, the adult with care experience spoke movingly of the closeness and trust he had with his care worker, stating he had not been physically restrained by him (or anyone at that particular residential house). The care worker, however, indicated he remembered restraining him. In the ensuing discussion, it became clear that it was not a matter of events remembered by the care worker and not the young person, but a differing meaning attached to those events. This appeared to be due, in part, to the closeness of their relationship, and possibly due, in other part, to what being restrained meant. The messy realities of responding to young people when they are in distress, and perhaps the inadequacy of the technical language offered by training packages, also appeared to feature in their discussion:

I would struggle to try and separate my training language from what I would think, because there's something about like you're trained and so it's all part of holding safely. Then there's levels of restraint or at what point does a hug become - a comfort hold become a restraint? What we talk about a lot is that the training that you get never, ever, ever plays out the way that life plays out.

(Billy, Care Worker)

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Reflections Going Forward

By using focus groups and dyadic interviews, participants in the study were able to draw on their relationships while providing us with information. We think that resulted in richer data than we would have otherwise collected. We hope to replicate these methods in the larger study, while also offering more individual methods too (i.e. individual interviews and research diaries) so that we can benefit from both.

While the importance of relationships in averting, reducing or eliminating physical restraints is not an unexpected finding, the pilot has enabled us to begin to 'look under the bonnet' at how they work and what they need to go well. Relationships also appear to influence perceptions around the necessity and meaning of restraint, exposing different or even contradictory understandings that may impact on participants' experiences of giving and receiving care – especially in more difficult moments. We need to better understand meanings and experiences, for example, of a child's experience of not being restrained in a situation of serious imminent harm, and how he makes sense of that. An Appreciative Inquiry approach appears a strong fit for these explorations.

Messages for Practice

1. Explore and Make Meaning Together about What Restraint Means:

An important ingredient in reducing or eliminating physical restraints is clarity about the difference between physical intervention and physical restraint. This should include thinking together about the different ways children and young people's actions are 'restrained' in non-physical ways (e.g. restrictive interventions that don't involve a physical component), as well as non-restrictive ways we intervene (e.g. caring touch that helps a child calm down). External restraints are an integral part of the process of developing healthy self-restraint. They are much more likely to support that process when adults are clear and thoughtful about their use. Children and young people should be included in developmentally appropriate ways of thinking together about boundaries and limits – their necessity, how they are exercised and maintained. Making sense together of what a physical restraint means should happen within these wider considerations. Leaders and managers should support these processes of reflection in explicit and tangible ways.

2. Always Consider Physical Restraint in the Context of Relationships:

The overriding message across all of the findings is that the relationships between the adult(s) and the young person, and the relationships between the adults round about the young person, all have a powerful influence on whether being physically restrained is averted. These relationships also powerfully influence how the young person experiences physical restraint when it does happen. Any tendency to focus on physical restraint without a simultaneously robust consideration of relationships – how they are supported, what gets in their way, what is needed to overcome related obstacles – must be avoided. As services track the overall numbers of physical restraint, they should simultaneously attend to members' experiences of relationships within the service.

3. Attend to the Other Ways of Holding:

Loving relationships are the central way adults hold children in residential child care, and professionally supportive relationships 'hold the hands of those who hold the hand of the child' (Independent Care Review, 2020, p. 20). Yet participants told us that the development of attuned, trusting, mutually caring relationships takes time – sometimes a long time. And sometimes this process cannot be rushed. What happens in the time it can take to build trust and figure out how to meet a child's unique and sometimes highly complex needs is an important key in unlocking the puzzle of reducing or eliminating the need for physical restraint for that child. For example, Katie's family and care workers told us about a tent that became an important way of holding when she needed to feel held but could not tolerate the presence of other people. This was identified as a big turning point for Katie, but it took time and the development of attuned relationships to get to the point of figuring that out.

References:

Cooperrider, D., & Whitney, D. (2005). Appreciative inquiry: A positive revolution in change San Francisco: Berrett-Koehler.

Hung, L., Phinney, A., Chaudhury, H., Rodney, P., Tabamo, J., & Bohl, D. (2018). Appreciative inquiry: Bridging research and practice in a hospital setting. International Journal of Qualitative Methods, 17(1), 1-10. doi:10.1177/1609406918769444

Independent Care Review. (2020). The Promise. Retrieved from https://www.carereview.scot/wp-content/uploads/2020/02/The-Promise.pdf

Jones, J., & Masika, R. (2021). Appreciative inquiry as a developmental research approach for higher education pedagogy: Space for the shadow. Higher Education Research & Development, 40(2), 279-292. doi:10.1080/07294360.2020.1750571

Thagard, P. (2018). What is trust? Psychology Today. Retrieved from https://www.psychologytoday.com/gb/blog/hot-thought/201810/what-is-trust

A final note

We would like to thank the members of SPRAG, some of whom are represented in the logos below, for identifying the need to collect data on what is working and for supporting this study. SPRAG is member-led group of over 70 organisations and individuals working towards the common vision of:

> *bringing about more effective, empathic, loving ways of holding children, young people and the adults who care for them in residential child care – in relationally rich environments, populated by adults who are properly equipped with requisite skills, knowledge and ways of being with children in the way that children need.*
>
> *[SPRAG] will work towards making coercive forms of holding less or even unnecessary and, when children are restrained, ensuring that it is carried out relationally and with care. (SPRAG's Vision Statement)*

We would also like to thank both services for enabling us to carry out the research in their settings, and our most heartfelt thanks goes to the people who shared their experiences, views and feelings about what is such a difficult subject.

Laura, Lee, Sarah and Michael