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Original Research Article

'*Don't take it home with you*': Views of secure care staff on debrief after restraint

Abbi Jackson

Abstract:

There is a dearth of research into debrief after restraint in secure and residential childcare. This research sought the views of care workers on debrief practice across three secure centres in Scotland, using a mixed methods qualitative approach. It was found that the definition of debrief varied across participating centres. Overall, staff highly valued managers checking their wellbeing after a restraint. Other themes were discussion around antecedents, what went well, decision making, care planning and what can be learned from the incident. Focus groups considered who instigates debrief, when it happens, and who leads it. Ultimately it was found that debrief discussion after a restraint sits in a framework of discussions rather than a stand-alone conversation. Furthermore, it was concluded that debrief is not the sole corelate to restraint reduction. This is also influenced by the young person's needs, relationships, risk assessment and care planning, quality of supervision, and not least, leadership and culture. There are implications for workforce psychological safety. Restraint reduction work is incomplete without listening to workers' voices. Application of theory is proposed to support workers' understanding, and a reflective tool drawn together for workers and managers to adapt and use in debrief after a restraint.

Introduction

This article examines debriefing practices in the context of restraint reduction, with a primary focus on post-restraint debrief processes, while recognising their interconnection with broader restraint practices. A condensed literature review is integrated here to contextualise the study for international readers, summarising key debates on restraint reduction, debriefing practices, and the policy framework in Scotland.

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In the UK there have been concerns for a considerable time about physically restraining children (Davidson et al., 2005). Staff may also be traumatised after restraint (Allen, 2008) and experience moral distress (Morley, 2019). Inquiries into poor practice within residential establishments have often highlighted possibilities of restraint slipping into abuse (Utting, 1997) and being generally dangerous to young people (Kent, 1997).

If children are restrained when there are other less restrictive options available, their rights are also breached under the United Nations Convention on the Rights of the Child (1989). However, young people themselves have advised that restraining them at the right time, in the right way (self-perceived), can be better than failing to restrain them (Steckley et al., 2023). Restraint may also be necessary to comply with common law duty of care or duties of safeguarding young people looked after under the Children (Scotland) Act 1995. The debate is very complex.

Furthermore, The Promise (2020) has clear expectations that Scotland strives to become a nation that does not restrain its children. For secure care, this parallels Standard 30 of 'Secure Care: Pathways and Standards', which states that children are only ever restrained when this is absolutely necessary to prevent harm; they are treated with respect, dignity and compassion and held in the least restrictive way, for the shortest time possible, and should be supported after a restraint (Scottish Government, 2020). Debriefing practice is a contributing factor in reducing restraint and going some way towards resolving this 'wicked problem' (Grint, 2007, p.19).

Following a comprehensive literature review it was concluded that there is a paucity of research into restraint reduction in secure care, and less specifically into debrief after an incident involving restraint in secure care. Guidance documents and literature recognise the clear function of debrief but locate it in general support and the structure and culture of the agency rather than as a stand-alone intervention. Colton (2004) is an important overall document on readiness for restraint reduction, mentioning debrief, while 'Holding Safely', Davidson (2005) remains a key guide, noting that debrief may occur in supervision, team meetings, and with outside consultants. Although Huckshorn (2005) has a valuable reflective section on debrief using root cause analysis within the six core strategies, there is overall a distinct lack of debrief tools available across existing research. However, Scotland is beginning to place greater focus on debrief after restraint (Social Value Lab, 2023). There was consensus across most of the literature that debrief should take place no longer than 72 hours after the incident, which resonates with the views of participants in the current research. The wider attitudes of staff as key agents in restraint reduction need to be fully heard and openly discussed to reduce restraint (The Promise, 2020). This article highlights some of these views in the specific context of debrief practice. For clarity, the terms used are outlined below.

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Term 1 – Children

Children are defined in Part 1 of the Children (Scotland) Act 1995 and the Children and Young People (Scotland Act 2014 97[1]) as people under the age of 18. This is also the definition of the United Nations Convention on the Rights of the Child (1989). For the purposes of this research, these children will be referred to as 'young people'.

Term 2 – Secure care

Secure care in Scotland is a,

> …form of highly regulated residential care for a very small number of children who are deemed to pose such significant risk to themselves, or to others, that for a particular time they require to be detained in the intensely controlled setting of secure care (Moodie & Gough, 2017).

Children and young people can be placed in secure or residential care by a children's hearing or a sheriff if they deem that at least one condition under s.83(6), 87(4) or 88(3) of the Children's Hearings (Scotland) Act 2011 is met. These conditions are, a) that the child has previously absconded and is likely to abscond again, and, if the child were to abscond, it is likely that the child's physical, mental or moral welfare would be at risk, (b) that the child is likely to engage in self-harming conduct, (c) that the child is likely to cause injury to another person. Other options for available care must be considered before making a secure order. It is likely that the majority of children in secure care in Scotland are there for reasons of welfare rather than primarily due to the harm they have caused to others (Gough, 2016). In 2022-2023 it was recorded that 53% of young people in secure care were placed there for less than three months (Gibson & Whitelaw, 2024).

Term 3 - Restraint

The working definition of physical restraint for this research is drawn from *Holding Safely: A Guide for Residential Childcare Practitioners and Managers about Physically Restraining Children and Young People* as '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). This does not include chemical or mechanical restraint. This aligns with the Human Rights Framework for Restraint (Equality and Human Rights Commission, 2019), which states that pain techniques must not be used on a child. It should be clarified that methods like holding a door to prevent a young person hurting someone, albeit restrictive, are not considered restraint for the purposes of this research.

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Term 4 – Residential care worker (also referred to as 'worker' or 'staff')

The term 'residential care worker' is used to describe the paid adult working directly with young people in secure care as this is the professional registration term used by the Scottish Social Services Council (SSSC). All participants in this study were registered with the SSSC and adhere to this Code of Practice (SSSC, 2016). These are the people who have relationships with the young people. All legislation and policy change impacts, with respect to decision making in care planning and managing ethical tensions, are filtered through the values and direct practice of these individuals. Therefore, it is critically important to listen to those who are closest to the young people.

Methods

An inductive research model was required, whereby concepts were generated from emergent data (Becker, Bryman, & Ferguson, 2012). An interpretivist approach was adopted, as it is this epistemology that previous qualitative researchers have found appropriate for generating meaning (Crotty, 1998). The researcher made a commitment to see through the eyes of participants but is solely responsible for the interpretation. Responsibility is taken for construction of themes, concepts and knowledge contributed. This is an attempt at what Braun and Clarke (2023) would consider reflexive thematic analysis and was achieved by sense checking material as it was emerging. Themes were validated with participants.

Recruitment

Non-probability purposive sampling was employed as this does not require complex sampling frames and can be used for exploratory studies (Campbell et al., 2016). Those currently employed in secure care were invited by senior managers to participate. No restrictions were placed on gender or length of time employed. Those who had moved on from employment in secure care were considered to hold valuable opinions but were outwith the scope.

Data collection method

A mixed methods approach was deployed, via an online questionnaire sent to care staff, and focus groups. Focus groups were chosen as they lend themselves to sharing experiences and show how the participants view the world (Bryman et al., 2012). A questionnaire was included so that participants could still contribute (Bryman et al., 2012) if they did not attend the focus groups.

Two online group session dates were initially offered per care centre. Two centres eventually participated, one with one group and one with two. Focus groups were recorded and transcribed using MS Teams software. Transcriptions were tidied on the same day as each group was held, aiming to ensure accuracy.

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Focus groups were facilitated by the researcher with the help of managers and staff in the centres.

Ethics

Ethical approval was granted by the University of Stirling and the secure care centres. Given the sensitive nature of restraint, participant wellbeing was safeguarded through consent processes, confidentiality, and signposting to support services.

To protect participants, the care centres were not mixed during the focus groups. This ensured good ethical practice in several ways. Firstly, having staff present from single settings only, meant that there was no conflict of interest due to the politics around competitive tendering processes in secure care in Scotland.

Secondly, staff who would have known young people who have moved between secure care settings were not placed in the position of judging workers who represent another establishment. It is likely that traumatised young people had behaved in ways the care setting could not manage prior to a move. If care services were in mixed focus groups, this would risk workers experiencing shame when discussing the sensitive topic of restraint, where they may hold beliefs that they 'failed' with a particular young person. Care staff must bring their whole selves to work, and they are deeply emotionally invested in the care of the young people. They cannot do the job effectively without investment. Keeping groups separate was an attempt to protect against negative impact on staff confidence.

Thirdly, good ethics were upheld by not placing staff in a position of mixed groups where they might form views of other workers during the meeting, or of the care settings they represent. This would not be based upon a full picture and could distort reputations or relationships between services.

Lastly, underpinning all the above, and possibly the most fundamental reason for separate groups, was that services use different accredited models of restraint and have different thresholds and cultures of care. Mixed groups would necessitate clarification of models, which would draw the focus away from key questions.

Participants were reminded that they could withdraw consent at any time and leave the group without having to give a reason. They were directed also to the questionnaire as another opportunity to share valuable input they may not have been comfortable sharing in front of peers.

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Other ethical issues

The ethical issue of researcher disclosure of practice involvement in one secure setting was attended to at the outset by full transparency within participant information. All material was anonymised including locations.

Data analysis

Thematic analysis was undertaken following Braun and Clarke's (2006) five step process. Data from the questionnaire was read, and emergent potential codes considered using a grounded theory approach (Glaser & Strauss, 1967). The data was read again, tentatively applying these codes, following which codes were grouped. The data was read and re-read from the focus groups and codes were assigned (Bruan & Clarke, 2006). A relatively simple data set emerged. Themes were identified from both sets of data to determine patterns and any sub-themes. Themes were reviewed, similar themes merged, and one theme with weaker evidence was removed (Nowell et al., 2017).

Through this analysis, attention was paid to potential bias due to the positionality of the researcher. Coding was carried out inductively without trying to fit data into a pre-existing coding frame or the researcher's pre-conceptions (Braun & Clarke, 2006). However, reflexive decisions had to be made for inclusion and exclusion of data for codes, what constituted a pattern or meaning, or what prevalence made each code or set theme-worthy (Braun & Clarke, 2006). It is noted that subjective judgements by the researcher about when a code became a theme align with Braun and Clarke's approach (2023), wherein they discourage procedures being prioritised over reflexivity and theoretical sensitivity. One limitation of thematic analysis is that single occurrences of valuable data can be overlooked. This would mean a new idea from an individual would be discounted using this method (Nowell et al., 2017). Therefore, a sense check was applied so relevant practice could be included in the analysis, and key points to develop a tool were noted.

Findings

It was challenging to achieve attendance at the focus groups. Workers need to prioritise the complex care needs of young people, such that releasing them from duties was difficult. Deeper still, residential care staff are exposed to hostile and conflicting perceptions from external sources that can attack their sense of themselves as worthy people (Cooper & Lees, 2015), and this research was asking them to share their personal and professional selves. Demands on time may have been cited as barriers to attendance, but underneath, it may have been possible that putting oneself in a position of saying something controversial was a risk many staff may not have been willing to take on a psychological (or financial) level. Themes around risk to staff are precisely one of the reasons this research is so critically important.

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Out of a possible 24 meeting options only three groups were facilitated, with 30 participants overall. Important topics were raised which the researcher experienced as passionate and committed conversations. The survey ran for 182 days and received 26 responses. One response was removed as it was completed by someone outside of the target sample.

Focus group findings

Group 1 comprised of senior care staff. This group fit the criteria of inclusion as they had a role in direct care. They talked of staff compliance with process and how they delivered debrief and managed the rest of the shift. They identified practice they considered good, including offering 'safe space' for staff to speak after an incident. The desired element of views from first level care staff was somewhat missing from this group.

Group 2 was facilitated with the help of a learning and development co-ordinator. They described the conversation model used with young people after restraint. This group noted that their centre was about to engage with the Reflection and Action Learning Forum (RALF), which trains facilitators in an action learning set model (Steckley et al., 2024). They also noted that there are ongoing discussions, meaning debrief is not a one-off event after incidents.

Group 3 utilised the opportunity as a reflective discussion, with the researcher sensing that there was learning happening amongst peers. They drew out the nervousness they felt with newly experienced hesitation around restraint decisions due to The Promise's (2020) drive to reduce restraint. The group deferred to the manager facilitating the MS Teams call, which meant that some key data could have been lost as to individual views. Interestingly this may mirror power dynamics in debrief in practice, and speaks to the need for psychological safety, as referred to below (Edmondson, 2018).

Coding

During coding, the number of times the code occurred did not necessarily reflect the time spent on that topic, nor quality of discussion. For example, the number of times relationships were discussed appears few, yet it is central to good quality practice. Emotional support as a theme was reasonably strong, yet it naturally occurs in a welfare check with staff, so the data may be lighter in this aspect than in reality. The theme around the welfare check was strong, so these aspects were grouped together. Reflective discussion was not considered by the researcher as a theme in itself, but rather as foundational to good debriefing practice.

The strongest themes were physical and emotional wellbeing check, followed by 'what is the learning?' and decision making (with emphasis on earlier intervention).

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Participants also talked about the function and value of debrief:

> …one restraint I had […] I was so upset but I had the debrief, yeah, absolutely. That day I wouldn't have been able to go home and sleep. That's the importance of it… (P1)

> … emotions are high, adrenaline's high, people can have personal opinions about how they felt […] I think it is only healthy that people have that, that safe space to say, do you know what? I'm not ok… (P2)

> …I don't think I've done a debrief that's not been useful… (P3)

Longer-term and wider reflection and learning was also noted to be happening, as mentioned by participants 4 and 5:

> …so, discussions are happening all the time and reflection of practice and how we are, you know, practicing, you know, doing our job really. So […] it's an ongoing thing. We're always learning and trying to get better. (P4)

> …To make sure you know the whole team around the child has that awareness. (P5)

Group 3 went on to spend some time on a discussion about who instigates a debrief.

One person believed '…the need for a debrief is measured by the people involved' (P6), although this was challenged by others who believed that staff might not come forward and ask for managers to lead a debrief for fear of how they may be perceived by others. This was suggested by P7:

> …(we) talked about it separately and actually, I didn't feel I could have went, actually can I get the whole team together? And I'm quite a confident person, but I don't know, I don't know. I needed that, but I almost felt dismissed that the conversation I was having about that was enough. (P7)

> …it might be easier if every single incident […] was just debriefed […] It takes it away from xxxx being like, oh, does anyone want a debrief [...] three or five people involved […] one person says 'no, I'm fine'. […] Those people that feel like they need one might feel a bit weak. (P7)

This indicates a preference for the six core strategies approach, which promotes that, '[a] formal rigorous event analysis will follow every incident of seclusion and restraint and will occur within the first 24-48 working hours post event' (Huckshorn, 2005). However, other participants perceived there may be threshold decisions for managers about when to debrief with staff.

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All three groups shared values around the need for restraint reduction, although practice models were the lens through which the research questions were viewed. One centre understood the debrief to be a discussion amongst adults. The other understood it as a conversation firstly with the staff and manager, and then as a life space interview (Redl, 1966) between the manager and the young person. Participants using this model noted that alternative behaviours would be discussed with the young person, advising that increased ownership leads to behaviour change.

Framework of debrief

A framework of debrief began to emerge. This began with a physical and emotional welfare check soon after the incident. Staff expected managers to lead on this. Staff also held impromptu peer-to-peer discussion relatively soon after the incident, and again after the shock had subsided. There was no time limit placed on these reflective conversations led by staff. There were also more organised reflective discussions about the incident, which staff expected managers or senior care staff to lead. Best practice timing was noted to be after a welfare check, but not so long after that staff felt uncared for. Discussion with managers and staff was undertaken whilst embedding changes to the care approach and could also happen without a more organised reflective discussion post-incident. Reflective discussion between staff, managers, and young people were noted. After some time had passed broader discussions with wider teams to share learning were undertaken.

The framework of debrief will be returned to below as it is embedded in wider practice factors.

Theme analysis

The themes arising were the physical and emotional wellbeing check, antecedents, decision making, what went well, and what the learning was. The check that people were 'okay' (Davidson, 2005) dominated, being mentioned in every focus group and every questionnaire response. One participant put the value of it succinctly:

> …I think it [check in after incident] is really important […] I've always appreciated that because it feels like [organisation] cares about me as well as, you know, us caring for others. (P9)

These comments resonate with the Department of Human Services Melbourne (1997), who acknowledge that debrief after incidents is necessary to minimise staff stress.

Decision making was threaded throughout all discussion and survey responses. The possibility for earlier intervention was explicitly mentioned in groups 1 and 2

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and alluded to in group 3, where it was stated that nervousness had crept in due to scrutiny around restraint reduction.

What went well was one of the weakest themes. Perhaps, in practice, this was combined with the previous discussions in the wellbeing check, or it may be that debriefs purposefully allocate time and energy to solution-focused discussion. There was moderate mention of restraint techniques, which may indicate that the debrief is less used to review physical skills and more heavily concentrated on problem solving.

All groups were clear that they were part of a learning culture, and participants seemed motivated to bring new learning into care planning. The needs of individual young people were deliberated, especially in group 2, where neurodiversity impacted their approach to debrief with a young person. This stood out from the other data as it directly related to the care approach.

The timing of the debrief, who it's instigated by, and who leads it were given critical focus by group 3, and a lesser focus by group 1. Group 2 mentioned that they discuss the incident as a team first before going to their manager. This may happen in the other groups, although practice norms cannot be assumed from such limited data.

There was no mention in the groups of wider matters affecting the young person's state of mind or analysis of transference and counter transference contributing to antecedents (Klein, 1952). There was no acknowledgement that some experiences of young people would test anyone's self-regulation and resilience in a generally volatile environment. This lack of depth may be due to understanding, or normalising, but also perhaps staff are experiencing subjective trauma themselves alongside vicarious trauma.

Discussion

The workforce can be considered the greatest asset to young people, and as such, there is a fundamental duty of care towards them as people first. This was strongly evident in the primary theme of the wellbeing check. Workers in residential childcare settings often experience limited autonomy and less respect compared to other human service professionals, despite engaging daily with young people who present serious behavioural challenges (Seti, 2008) and who can compromise workers' capacity for compassion satisfaction (Hughes & Baylin, 2016). Research into burnout among residential youth care workers indicates widespread emotional exhaustion, depersonalisation, and low levels of personal accomplishment (Decker et al., 2002; Lakin et al., 2008).

The importance of supportive structures following incidents cannot be overstated. Service commitment to debriefing as a learning opportunity contributes to the protection and wellbeing of everyone involved. However,

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inconsistencies emerged across services, with respect to both the clarity and flexibility of debriefing practices. While formal debriefs can offer containment and reflection, they are not consistently practiced or defined.

Staff relationships—both with young people and with each other—play a crucial role in shaping outcomes and supporting recovery. Positive staff-young person relationships are known to mitigate the effects of relational trauma and to reduce the likelihood of incidents driven by power struggles (Hughes & Baylin, 2016). Despite staff expressing a strong commitment to young people, this is not always perceived by the young people themselves, some of whom believe certain staff lack necessary skills (Gibson & Whitelaw, 2024). This disparity highlights the importance of staff understanding the deeper psychological functions of young people's behaviour. For instance, some young people may internalise the need for restraint as part of their identity (Schwartz et al., 2015), potentially jeopardising opportunities for relational repair. Skilful interpretation of behaviour—including psychodynamic, psychosocial, and systemic perspectives—can inform more therapeutic responses and reduce reliance on restraint (Kor et al., 2021).

Critical decisions about restraint must be made quickly, and the implications of those decisions can be profound. Timely, effective, therapeutic interventions tailored to the young person's needs are essential (Gerhardt, 2004).Failing to intervene appropriately and resorting to police involvement can be traumatising and may contribute to negative identity development for the young person (Goffman, 1963). Debriefing practices that allow space to explore these complexities in relationships can support more thoughtful, preventative strategies.

Equally important are the relationships between staff themselves, which underpin a culture of mutual support and wellbeing. Knowing and backing one another up was highly valued by research participants, aligning with Steckley’s (2010) findings. Burns and Emond (2023) argue for safe, continuous opportunities for staff to reflect on themselves and their colleagues in pursuit of a therapeutic environment. However, tensions can arise when staff hold divergent worldviews or values, particularly under stress. Navigating group dynamics and managing transference and countertransference (Klein, 1952) are daily challenges in residential care, especially in high-risk situations such as restraint. Emotional intelligence, frequently referenced by participants, is therefore critical in practice, including during debriefs.

Though a single organised debriefing event may be helpful, broader reflective practice must also address individual learning and support needs. Supervisioncan serve this function. Defined as a one-to-one discussion covering development needs and case reflection (Morrison, 2005), supervision can include reflection on staff behaviours during incidents and consideration of how these influenced outcomes. While participants did not mention supervision as a form of

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post-incident debriefing, the Reflection and Action Learning Forum (RALF), currently being rolled out in Scotland through The Promise funding (2023–24), was referenced. Supervision from external sources was not mentioned. This may mean it is not offered, or that it is not seen as an option by participants.

Debriefing practices were often inconsistently applied or unclear. One participant noted, 'I think it would be helpful to point out if a debrief is conducted full stop' (P10), reflecting previous findings by Steckley (2010), who argued that debriefs often happen 'in theory' or only when time allows. Some participants felt that the emotional impact of incidents on staff was overlooked. While discussions frequently centred around care plans, there was limited evidence that debriefs promoted the construction of meaning or epistemological containment. Theoretical frameworks were notably absent from participants' reflections, and while the study did not explicitly ask about theory use, its omission in discussion is notable.

The application of theory could enhance debriefs significantly. For example, understanding attachment and abandonment dynamics (Bowlby, 1979) could illuminate behavioural patterns. Similarly, recognising the role of shame (Brown, 2006) and power dynamics (French & Raven, 1959) could help staff reflect on triggers and improve future responses. Frameworks such as the power, threat, meaning framework (Johnstone & Boyle, 2018) may support a richer understanding of both staff and young people's experiences. Appreciating how trauma reenactments unfold in relationships (Hughes & Baylin, 2016) may also help reduce staff self-blame—particularly for those with a high internal locus of control (Rotter, 1966)—and support staff retention, which in turn stabilises the environment for young people (Schofield & Beek, 2015).

Tools like the Care Inspectorate's self-evaluation guide on restrictive practices (Care Inspectorate, n.d.) encourage services to reflect on how debriefing sessions influence culture, practice, and restraint reduction, yet still do not define 'debriefing' clearly. While this flexibility can empower services to tailor practices, it also creates ambiguity around expectations and accountability.

Leadership and organisational culture fundamentally shape the effectiveness of debriefing and broader support mechanisms. Lessons from Winterbourne View (Department of Health, 2012) underscore the shared responsibility of leaders and staff in cultivating positive care cultures. Residential childcare is recognised as a distressing and complex domain, often undertaken by under-supported staff (Furnivall, 2018), which makes structured debrief and care essential. Trauma-informed cultures, underpinned by leadership values of kindness, empathy, and mind-mindedness (Siegel, 2011), are critical. Participants in this study emphasised their appreciation for compassionate leadership (West, 2021), which is associated with improved staff wellbeing and care quality.

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Who initiates or leads debriefing was also a recurring theme. Group 3 echoed findings from the Department of Human Services Melbourne (1997), noting that when staff must request or independently access debriefing, morale is negatively affected. Visible, proactive leadership (Stirling et al., 2017) was clearly desired. However, opinions varied on whether debriefs should be manager-led or self-organised. Huckshorn (2005) advocates for debriefing as a formal, solution-focused meeting led by trained managers not involved in the incident, integrated into quality improvement. While participants recognised the value of reflective leadership, they also highlighted the potential for self-organised learning spaces (Dean, 2023; Stoll & Louis, 2007), where staff take collective responsibility for growth and accountability.

For such approaches to succeed, services must foster non-judgemental, open learning cultures. Open group climates, characterised by flexibility, support, and responsiveness (van der Helm et al., 2009), are more conducive to reflective practice than closed ones defined by coercion, mistrust, and inflexibility (van der Helm et al., 2011). Ultimately, psychological safety is essential for staff to engage in reflection, take risks, and grow (Smith, 2016; Smith & Fulcher, 2013). While some staff reported feeling safe during debriefs, such experiences are subjective and shaped by the power dynamics inherent in group settings. Tools such as reflective question guides (Appendix 1), used without the need for formal training, may help structure debriefs and support transparent, learning-oriented cultures (Johnson, 2021).

Limitations

The definition of debrief as a conversation between adults should have been more clearly identified and articulated to participants at the beginning of this research. Another limitation was that the research was undertaken by a single researcher. Although data was checked four or five times, it is acknowledged that no data set is ever perfect as coding is subjective and it themes are at best filtered and organised through the worldview of the researcher (Bryman et al., 2012).

A further limitation arose with respect to accessing participants. Undertaking focus groups in the way that best suited the services resulted in somewhat detached online facilitation. Related to this, the facilitation through the manager's MS Teams login (whereby they stayed in the meeting) did not allow for the full freedom of participation intended.

Conclusion

This research is a contribution to raising awareness of the function of debrief after a restraint, to support secure care staff who are practicing in high-risk environments where they are under significant scrutiny with respect to decision making. The weight of this responsibility and work context was acknowledged as

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sometimes feeling heavy for staff, but participants who engaged in the focus groups seemed committed to practice improvement. Caring relationships are where change is seen and felt with young people (Steckley, 2010). As experts by experience, participants noted they also need to feel cared for to be effective in their role. However, Burns and Emond (2023) believe that research on caring for staff is slow to emerge. Although there is no clear debriefing model across secure care in Scotland, it can be concluded there are a range of appropriate methods in operation. However, it is noted that this research is a very small-scale study, and the views of participants do not represent the views of their service nor those of secure care provision in Scotland.

Implications for practice

There needs to be a clear definition of debrief adopted. It would make sense for this to be defined across Scotland, and possibly to sit within a recognised framework of discussions which fulfil various purposes.

Services may reflect on a firmer policy around who should instigate, who should offer, and who should lead debriefs. This paper concludes that although staff felt cared for and cared about when managers undertook debriefs, there is also scope for staff teams to undertake these themselves. The tool in Appendix 1 may be a starting point. This tool intentionally assumes the definition of debrief as an adult-to-adult conversation, acknowledging there are intervention models already in use for life space interviews with young people.

It is not possible for staff to achieve an overnight reduction in restraint however good the practice is. This is likely because the young people who need the highest level of relational and emotional nourishment to recover from past experiences take time to change their survival behaviours (Hughes & Baylin, 2016). This should be considered alongside dignity for care staff who wrestle with moral distress (Brend, 2020; Morley, 2019) and experience complex accountability on a daily basis. Application of research and theory across practice in secure care may support deeper understanding.

Finally, the debrief cannot be the sole correlate to restraint reduction. Although it is clear that skilled judgement is required from managers and others to capitalise on naturally occurring moments to reflect, teach, and learn, skills improvement does not sit in isolation (Paterson et al., 2005). Restraint reduction must also be supported by a tightly woven context of positive culture, good leadership, supervision and relationships, risk assessment, and trauma sensitive care planning - in essence what Steckley (2010) refers to as multi-layered investment.

To lay down the core conditions for staff to feel able to reflect at the depth the tool can offer (Appendix 1), services should seek to increase the subjective experience of psychological safety (Edmondson, 2018). In this respect, the

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conclusion of this research aligns with that in Reimagining Secure Care (Gibson & Whitelaw, 2024), in that a 'trained, nurtured and valued workforce' is imperative for the future of secure care. It is also critically important to note that the debrief tool may be used (in whole or in part) after any incident and is not restricted to post-restraint situations. Routine use and reflection prior to action (Edwards, 2017) may positively impact psychological safety in terms of embedding a learning culture as well as increasing confidence in staff and managers around the function of the debrief.

Recommendations for further research

The views of managers and leaders were not included in this research. This was intentional, albeit could be considered a limitation of the study. Young people were similarly not included, who likewise will have key views on debrief after restraint. Further research on managers' views is recommended, in addition to research on young people's involvement with their own 'debrief' or life space interview (Redl, 1966), and their perceptions of their own future care. Alongside this, it is recommended that the impact of the use of theory in supervision and debrief in secure care is further explored.

Thanks

Sincere thanks are extended to all participants and those who made this research possible. This article is dedicated to secure care staff and managers in Scotland and beyond who come into work every day with an open mind and an open heart ready to care. It cannot be overstated how crucial the relationships they make are to young people and their communities. This small contribution to research is hoped to encourage policy makers to stop and hear the views of these adults who are closest to the young people day-to-day. Scotland will not be able to achieve the aims of The Promise without valuing them as key stakeholders.

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About the author

Abbi Jackson is a social worker who has worked across all sectors in social services for over 25 years. She has an interest in intervention with young people presenting as high risk, which has developed from fostering and secure/residential care work. She has authored two books to support practice in social work and residential care and is an experienced social work practice educator and business coach. She has set up businesses and charities and is currently an interim chief executive officer for a national charity.

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Appendix

Debriefing discussion tool (Jackson, 2025)

This series of reflective questions is designed to be used in children's residential and secure care to facilitate discussion in debrief after a restraint. They can also be adjusted for use after any incident. They do not need to be used in any specific order and not every question needs to be included in every debrief. It is intended that residential childcare workers and their supervisors and managers decide which questions are useful. The model can be freely adapted by individual services who may wish to add other relevant questions.

This tool is intended to be used in adult debriefing discussions either before or after a conversation with a young person about the restraint. It is intended to be used alongside the direct practice with the young person which values their own subjective views.

Understanding young people:

1. What insight would the young person have about their own restraint?
2. What function does the young person's behaviour serve for them?
3. Where is this young person experiencing shame?
4. Where can we offer choice to this young person?
5. Where can we change our language to reduce risk?
6. What theories can help us understand the antecedents?
7. What strengths does this young person have?
8. Where do we need to be more curious about this young person?
9. Where could we experiment with something new to support the young person?

Working together as adults:

10. What decisions during the shift need to be discussed and clarified?
11. Where did it help that our views aligned?
12. What do we need to know and discuss about each other's triggers?
13. Where is power helpful and unhelpful?
14. How do we manage shame and psychological vulnerability in ourselves here?
15. What can we do to help staff feel safe?
16. How can we support each other?
17. Where do we need more training or different training?

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Understanding our relationships with young people:

18. What is blocking our individual relationship with this young person?
19. What counter transference is happening?
20. What boundaries are we recognising?
21. What theories can help us understand the relational dynamics?
22. Where is power helpful and unhelpful?
23. What can we do to help this young person feel safe?

Wider questions:

24. What organisational issues have affected the antecedent to the incident?
25. What suggestions for organisational change do we have?
26. What do we need to do to support the group of young people?

To conclude:

27. What questions need to be revisited to round off this reflective discussion?
28. What specific measurable achievable realistic and timebound (SMART) actions can be taken forward?
29. Who will do what?
30. Who can we ask for further help?

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