

The Reality of Physical Restraint: An Online Survey for Adoptive Parents

“A Cry for Help”

Findings presented by Lee Hollins PGCert Health Research, BSc (Hons) Physiotherapy

INTRODUCTION

Violence is a very human reality. It's a phenomenon that has long been explored, often with research focusing on specific causal dynamics (e.g. violence towards nurses, taking place in pubs and clubs or within the intimate partner context). Alongside this exploration has been a drive to develop measures aimed at preventing its occurrence, along with those designed to ameliorate its impact. This latter category includes a range of proactive and reactive interventions, referred to as 'physical restraint' techniques. Due to various high profile deaths, work is also ongoing to better understand the risks as they undeniably exist when such techniques are applied (Paterson *et al*, 2003, Duxbury *et al*, 2011). One particular type of violence however that to date has been little researched is 'Child to Parent Violence'. Thorley and Coates (2017) recently surveyed 263 individuals including birth parents, guardians, kinship carers and foster carers. It was adoptive parents however who indicated they had been exposed to the highest level of violence¹. In fact adoptive parents faced more than all the other categories combined with 84.8% (n=224) indicating they had been exposed. Child to Parent violence within the adoption context is a real concern, and parents rightly want solutions. In the first report of its kind 'Beyond the Adoption Order: Challenges, Intervention and Adoption Disruption' (Selwyn *et al*, 2014) it was estimated that the proportion of adoptions disrupting post order was between 2% and 9%, with violence to parents and siblings being cited as the main reason for children leaving the adoptive home prematurely (80%). Even less research has been conducted into the reality of any physical restraint, employed by parents to manage their son or daughters violent behaviour. The subject can be extremely difficult for adoptive parents to talk about. But it is one that needs discussing if it is to be fully understood and effective solutions considered. This document presents the findings from a recent informal scoping exercise that sought to explore the subject.

METHOD AND ANALYSIS

In order to better understand the lived reality of restraint for adoptive parents, an online survey was launched in February 2017. It was disseminated through social media by blog sites with a personal and professional interest in supporting adoptive parents struggling with their child's challenging behaviour; 'The Open Nest' and 'Holes In The Wall'.

In total there were 86 respondents. Two were subsequently excluded from formal analysis. One was a duplicate return and the second did not meet the entry criteria. All respondents were completely anonymous.

The survey contained 16 items in total which included dichotomous and multiple choice questions, rating scales as well as open questions providing opportunity for qualification/clarification. There were two parts to the survey, the first gathering general information about the child's age, behaviour presented and parents knowledge of responses available (respondents, n=84). The second part related specifically to the parents experience of applying some form of physical restraint (n=66).

The definition of restraint* provided was: *'Physical Restraint' and/ or the act of restraining a child can should be taken as meaning "An intervention in which Parents hold a child to restrict his or her movement in order to prevent harm" (based on the definition in: 'Holding Safely', The Scottish Institute for Residential Child Care 2005).*

An informal manual coding process was undertaken with the verbatim answers provided first being reviewed, then assigned an initial code, before being organised into what became sub-categories. The repetition of key words, phrases or references to unifying topics/subjects were sought. Review and revision continued until a point

¹ Child on Parent Violence within the exploratory exercise survey questionnaire was defined as *'Any harmful act by a child, whether physical, psychological or financial, which is intended to gain power and control over a parent or carer'*

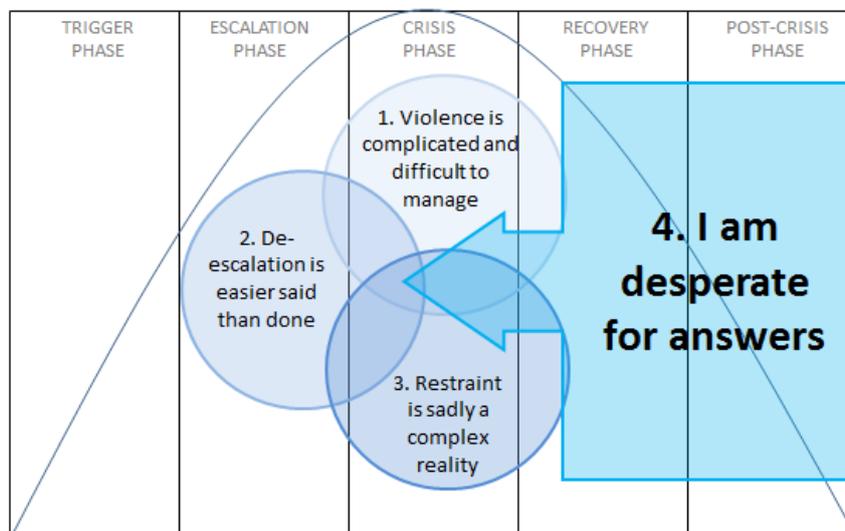
of analytical saturation was reached and four main themes emerged. Whilst the themes emerged from the raw data, the prior understanding of the area by the researcher helped inform the process of organisation. This is where a researcher’s insight and understanding of the subject can be valuable, however one must guard against making pre-judgements and over-sensitivity to pre-conceived notions. It was important to validate the findings. In line with Creswell and Miller (2000) the strategies used to do so were a ‘peer review’ and an ‘external audit’.

The table below illustrates the stages as they were undertaken during the analysis. A number of references were made by individual respondents to the various ways in which violence was aggravated, or complicated, by the presence or use of some ‘extra’ feature. These included everyday household objects such as pieces of furniture (n=29), the exploitation of the physical environment e.g. the use of stairs or a door (n=19) and also other named items (or unspecified objects) which were ready to hand to be used as weapons (n=17). These collectively became ‘weapon(s) of opportunity’. The use of these weapons was determined not to be a distinct phenomenon but rather a facet of the violent behaviour being presented. When taken with other impacting variables the conclusion was that ‘Violence is complicated and difficult to manage’. This became one of the main themes.

Respondents answers	Initial codes	Sub category	Main theme
‘Throwing furniture’, ‘Throwing electrical items’, ‘Picked up TV to throw’, ‘Picked up a screwdriver’	Use available household object	Weapon(s) of opportunity	Violence is complicated and difficult to manage
‘Things being thrown down the stair’, ‘Pushed parent down the stairs’, ‘Dropped kids wooden table and chair over the bannister’	Exploit the environment (stairs)		
‘Attack father with hockey stick’	Use what’s at hand (to hurt)		

MAIN FINDINGS

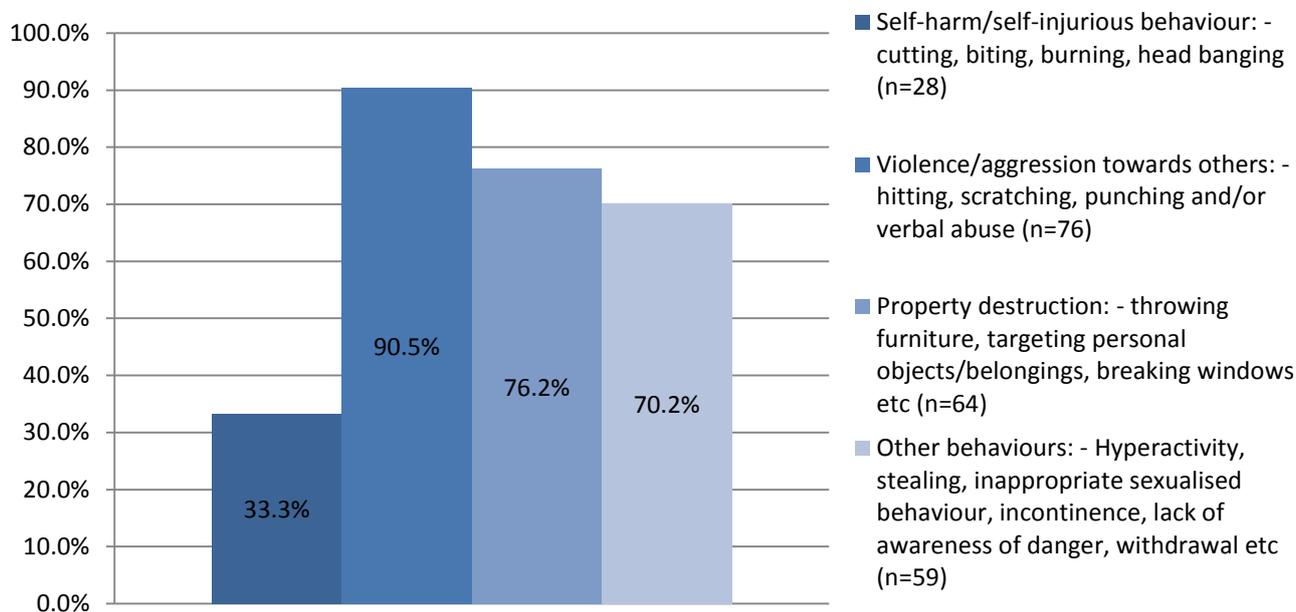
The four main themes that emerged from the data are shown within the graphic below. It was felt that situating them within the incident cycle (based on Kaplan and Wheeler, 1983) was a useful visual way to convey three key issues. Firstly the findings of this survey relate to the lived reality and immediate practical challenges arising from a child’s behaviour when they are in crisis, specifically a physical crisis. Secondly, all of the issues are inter-related and need to be understood in order to appreciate the perspective of the adoptive parents that were surveyed; violence was occurring, de-escalation wasn’t universally successful and so restraint was sometimes necessary. Thirdly and finally was the parent’s clear desire for the knowledge and skill in order to respond safely, lawfully and effectively underpinned everything. It was here where the unmet needs of parents came through most strongly. Hence the working title of this document: ‘A cry for help’.



1 – Violence is Complicated and Difficult to Manage

This survey found that violence was a very real and a very serious issue for a significant number of adoptive parents. 90.48% (n=76) indicated their children were engaging in ‘Violence/aggression towards others: - including hitting, scratching, punching and/or verbal abuse’.

What type of challenging behaviour does your son/daughter engage in?



A striking feature of the violence that was reported was its nature; its complex nature and how its unpredictability and the child's age made it very difficult to manage. Many parents reported what were coded as 'Multiple/Concerted Attacks'. The reality of child to parent violence (and child to sibling violence) was not simply 'a punch', 'a kick' or 'a grab' in isolation. It was far more sustained and multi-dimensional; 'hours of screaming, throwing objects, kicking, punching (and) biting us or other family members (was a) common occurrence..', 'Regularly punching, kicking, hitting..', 'Punching, kicking, spitting, biting mum' and '..involves hair pulling, hitting, biting, spitting, kicking. By constant I mean CONSTANT'. It was possible to find this echoed in 'Beyond the Order' by Selwyn *et al* (2014): "She beat her dad up, she just started punching, and punching, kicking, and punching him, absolutely going berserk, I mean unhinged berserk..." (p.148) Boorman (2016) has also spoken of the intensity of her child's behaviour, "violence came out of the blue. Before you knew it an ordinary day could turn into one which may involve broken glass, chaos, blood, spit, vomit, urine and tears.."

A particularly troubling aspect of the violence was the fact that it was often complicated, and the risks further increased, by the presence of some form of 'Weapon of Opportunity'. Parents spoke of already high stress situations being made worse by the child brandishing, and in some cases using, a weapon. Broadly speaking these seemed to be divided into two main categories: heavy/hard objects used to strike or impact upon the intended target, and sharp or pointed objects that could be used to puncture and slash.

Examples of weapons discussed included: 'tables', 'chairs', 'plates' 'a hammer' and a 'hockey stick', as well as 'Child throwing electrical items still plugged in, child throwing pointed objects at me (head and upper body), rage continuing for 2-3 hours with hitting, kicking, biting, throwing items, slamming doors..', 'Trying repeatedly to stab me with a screwdriver...' and 'Trying to break the car glass window with head..' There was also a mention of 'holding shards of broken glass' and using a 'knife' (n=5). This once again concurs with Selwyn *et al* (2014) who noted that weapons factored in violent incidents, with a particular emphasis on knives: "We were surprised to find that 19 parents (27%), without prompting, reported worrying behaviour shown by their child around the use of knives. Parents described children who had used knives to threaten, intimidate, or control others. Girls as well as boys had used knives.." (p.151). The environment also emerged as a 'weapon of opportunity' or at least

something that was used to facilitate violent actions: 'Pushing sibling down the stairs', 'Push(ing) parent down the stairs' and 'holding young sisters head under water in the bath' were examples given by different respondents.

Violence was not limited to the home. There was a sense that violence could happen 'any time, any place, anywhere' meaning the adoptive parent had always to be mindful, and prepared for, incidents that could occur with little warning. They had to be ready to implement behavioural management strategies on the hoof, and often in public. Respondents revealed that incidents occurred 'on (the) pavement next to road', 'in A&E', on a 'hospital ward' and at 'school'. It is worth noting that several parents reported incidents taking place in the car; 'Trying to break the car glass window with head..', 'Slammed the car door on another child's hand on purpose..' and 'Opening a moving car door on a fast road..'

The age of the children using violence was also notable. 100% of the 17-18 year old cohort (n=5) were reported to be engaging violence as well as property damage. Perhaps a higher incidence was anticipated amongst older children, but at the other end of the age spectrum the picture was surprising with 89% (n=9) of those under 5 also reported to be engaging in violence. This once again rose to 100% (n=42) of the children aged between the age of 5 and 10. This represented 50% of the total number of children covered in this survey. Thorley and Coates (2017) reported that child to parent violence was noted amongst those children aged between 6 and 11. As we shall see in theme 3 a child's ages, size and strength is a risk factor in any restraint situation and needs urgently addressing.

One shouldn't be shocked however as these findings are echoed by parents on websites and social media throughout the adoption community, for example Meadows (2016) and Bonnicksen (2016). Drawing on such sources isn't to fail to refer to the literature but an indication that there is a significant discourse on the topic, and much support and information to be found within such places. They offer first-hand experience now in a world where support from official bodies isn't always felt to be forthcoming in real time, as we shall see elaborated in theme 4.

2 –De-Escalation Is Easier Said Than Done

Clearly such concerted and complex violence needs to be managed, before any harm is done. Parents reported their children being 'dysregulated', in a 'rage', experiencing a 'meltdown', being 'scared by his level of anger and aggression' whilst others reported their child perpetrating an 'attack', or an 'assault'. In light of this when asked 'How frequently is your son/daughter engaging in a level of 'Challenging Behaviour' that you find difficult to manage?', 39.3 % (n=33) indicated 'daily' and a further 40.5% (n=34) said 'weekly'.

43% of parents (n=36) felt they knew enough de-escalation strategies to deal with their children's escalating behaviour. In qualifying their answers there was a sense, from some at least, that the journey to finding effective techniques had been an arduous one: 'having researched and privately paid for support we were able to instigate de-escalation and develop a programme that has turned this suicide risk child into one that derails infrequently now and is able to manage own behaviour 90% of time.. The urgent CAMHS (Child & Adolescent Mental Health Services referral) took 6 months to go on waiting list... ..I appreciate daily how lucky we were to be able to go private as soon as we needed outside help..' and 'At 7-9 I was frequently hit, spat at, kicked and damage was done of food/drinks thrown. We have had years of DDP (Dyadic Developmental Psychotherapy)/Theraplay and therapeutic parental support and now starting on NVR (Non-Violent Resistance) programme. I can put myself in mental safe place...visualisation and walk away...'

When considering the totality of such answers it seems clear that there are a variety of strategies that have been referred to. These include primary preventative measures aimed at reducing the incidence of violence by removing or reducing those factors that cause it (e.g. interventions designed to influence how events are cognitively framed such as those delivered under the auspices of CAMHS, as well as affect regulation techniques covered in Theraplay sessions, but could also include control of environmental conditions giving rise to sensory overload) They can also include secondary reactive measures such as de-escalation techniques (e.g. diversion, distraction, active listening etc) that are instituted once it is recognised that a child is getting dysregulated and expressing or acting out on anger. Ultimately physical restraint would be considered a tertiary level intervention because it is designed to mitigate the impact of a behaviour that it has been impossible to stop.

By contrast 57% (n=48) answered 'No' to the question: 'Do you feel you know enough about de-escalation and calming techniques?'. From those who provided supplementary information the underlying message seemed to be 'De-escalation doesn't always work'. They said:

- 'De-escalation is easier said than done..'
- 'Often diffusing is not a possibility...'
- 'Words bounce off...'
- 'I have found no tactic that can stop a meltdown once it has started...'
- 'Tried lots of different things but nothing seems to work...'
- 'Words enrage her, silence enrages her, walking away enrages her, getting too close brings more violence..'
- 'I don't know what to do once he has escalated as often eyes glaze over and he isn't able to process information i.e. to calm down. Telling him to breathe once in the moment doesn't help. What should I do when he 'flips' i.e. throwing furniture, items at me, scratches me?..'

Something else that came through from those who didn't believe they knew enough about calming and de-escalation techniques was the extent to which they reported 'Help has been hard to find'. Many parents stated that they were often self-taught in relation to de-escalation and that 'official' help was not forthcoming:

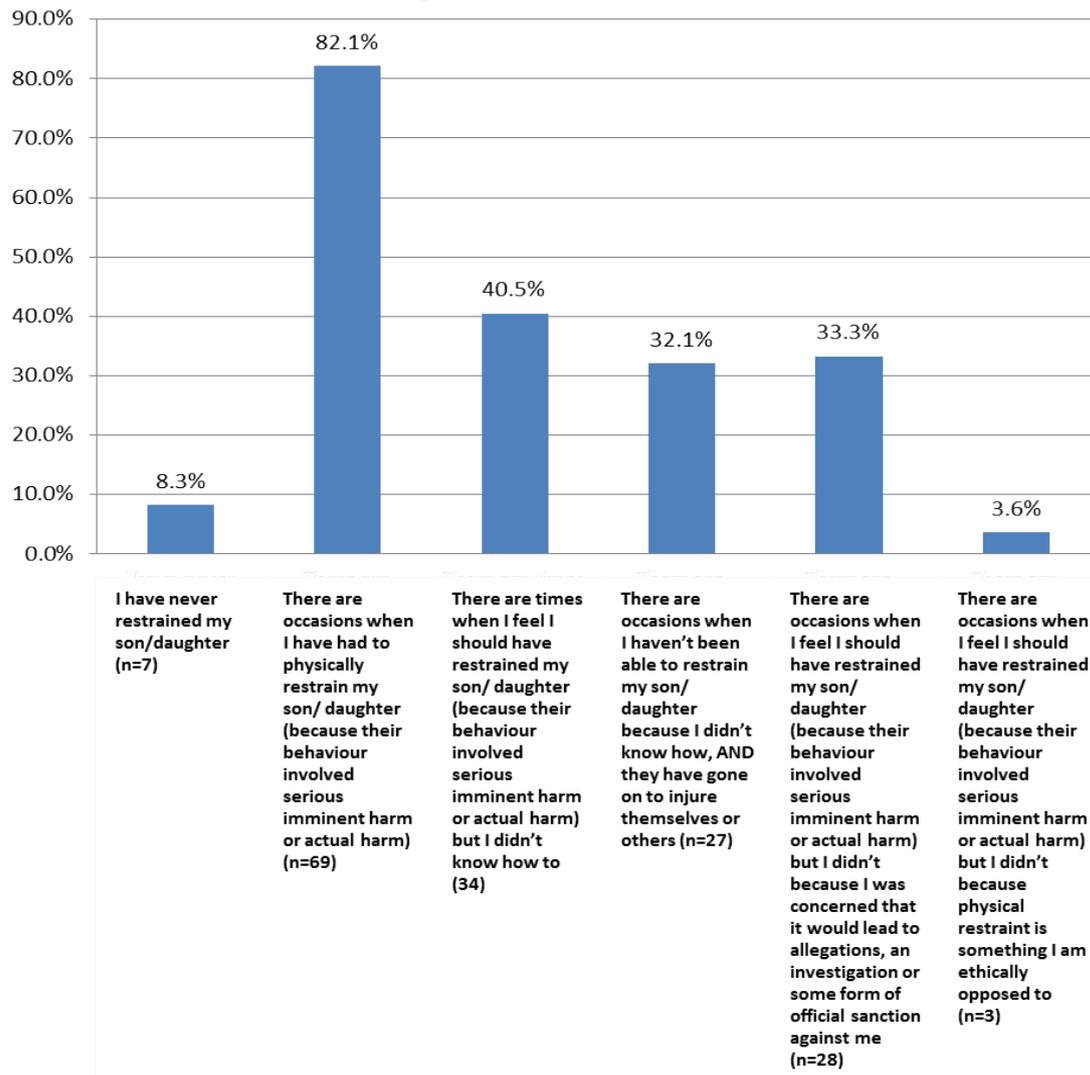
- 'We haven't had any training on this whatsoever..'
- '(I) find any training very difficult to find and little support from SWD (Social Work Department)..'
- 'We've had no official training, but what we do seems to work. Something else might work better though...'
- 'The training for adopters focuses very much on how to keep the child safe but not on parenting techniques that help in aggressive situations...'
- 'I have never received any information training or techniques to use from our social worker or CAMHS psychologist. I have found out a bit of information for myself or through The Open Nest charity I would love to receive more training and support around this issue..'
- 'We need practical strategies..'

This was a sentiment echoed by Selwyn *et al* (2014) again: "Parents reported great difficulty in getting professionals to understand the problems they were facing. A phrase that was frequently used by parents about their interaction with professionals was 'They just don't get it! Parents had mainly sought help from the local authority post adoption support services and from child and adolescent mental health services.." (p. 180)

3 – Restraint Is Sadly a Complex Reality

The findings from this survey revealed that physical restraint was very much a lived reality for a significant majority of the parents who participated. There was a sense that 'Restraint wasn't a choice', it was a necessity. 82.1% (n=69) parents indicated that there were occasions when they had to physically restrain their son or daughter (because their behaviour involved serious imminent harm or actual harm) whilst 40% (n=34) agreed that 'There are times when I feel I should have restrained my son/daughter (because their behaviour involved serious imminent harm or actual harm) but I didn't know how to'. 33.3% (n=28) also agreed with the statement 'There are occasions when I haven't been able to restrain my son/daughter because I didn't know how, AND they have gone on to injure themselves or others'. The diagram below reveals the answers parents provided to the question: 'in respect of physical restraint which of the following statements are true?'. Six descriptive statements were provided.

In respect of 'physical restraint' which of the following statements are TRUE?



When asked 'How often do you currently need to use some form of 'Physical Restraint' to manage your son/daughters 'Challenging Behaviour', 41.3% (n=26) said 'Weekly' with 6.4% (n=4) indicated 'Daily'. It's difficult to make any meaningful comparisons to restraint amongst other vulnerable populations because statistics are few and far between. Emerson (2003) however suggested that over 50% of people with intellectual disabilities and challenging behaviour were regularly exposed to restraint. Allen *et al* (2006) looked at parents' and their use of physical interventions in respect to the management of their children's challenging behaviour. They found 87.5% of respondents to a postal survey conceded they had used physical interventions. 20.8% reporting that they did so 'Frequently'.

Respondent's written feedback indicated that the decision to use physical restraint was a 'Tough choice'. Answers revealed something about the ethical and emotional difficulties experienced by some of the parents in making a decision to apply some form of restraint technique. Parents said:

- 'I hate it..'
- 'My experience has been that physical restraint escalates child's fear and anxiety and increases their attempts at further violence, looks like child is traumatised..'
- 'This is difficult to answer as in some senses, using appropriate physical restraint to prevent harm to my son, myself or my other child is an ethical no-brainer. To do nothing to prevent such harm if it was in my power to do so seems perverse. However, I am aware that my child finds being physically restrained mid-meltdown very distressing, and it does upset me to inflict further distress on him at these times...'

There was of a sense of resignation that unfortunately action was required to take control of a situation that was out of control. It seemed to be a choice not taken lightly, rather one born of necessity and required to ensure safety. Parents said:

- 'It's difficult as a parent but I know it's necessary..'
- 'I never thought I would ever restrain. However over a period of 5 days I restrained at times when my child was at risk or another person was at risk. I still do not 'Know if this was the best they could have had but I do believe it stopped a very fast moving downwards spiral of really concerning behaviour...'
- 'Having to restrain your own child is awful but is sometimes the only way to keep them, you or sibling (or house) safe..'
- 'It's scary to restrain a child safely without causing them or you harm.. ..particularly when they shout you are hurting them although you know this isn't the case physically Also concern restraint makes it worse if it may trigger early trauma memories..'
- 'I was ethically opposed to physical restraint before meeting my son. Now it's an imperative strategy for all our safety..'

When asked 'What is the longest period of time that you have applied 'physical restraint' for? the majority of parents 37% (n=24) said between 1 and 5 minutes, a further 18.5% indicated that restraints lasted for longer than 10 minutes. From elaboration on this it could be concluded that 'Restraint can sometimes be prolonged'. Parents said:

- '20-30 minutes as often he would say he was calm and then start all over again so I needed to 'feel' he was calm rather than just him saying he was..'
- 'Up to 40 mins..'
- '45-50 minutes..'
- 'About an hour...'
- 'Well over an hour unsuccessfully..'
- 'I have held my son for over an hour..'

More information needs to be gathered about the nature of the restraint/holding referred to in these answers in order to answer a question like: are significant risks likely to develop as a result of prolonged restraint (or 'holding')? Researchers elsewhere have tried to establish a safe window of time for physical restraint but the conclusions have proved elusive. In part this is due to such data being difficult to obtain. O'Halloran and Frank (2000) examined 21 case reports relating to restraint related deaths. They found that the time that individuals were held in the prone restraint position (face down) before fatal collapse ranged from 2 to 12 minutes. Miller (2004) has asserted that the average time between first application of forceful prone restraint and the point at which full cardiopulmonary arrest was first noticed was 5.6 minutes. This is echoed by Stratton *et al* (2001) who reported struggles of 5 minutes and less prior to cardiopulmonary arrest. It is important to state here that the dynamics of a restraint, namely; the techniques used, the position the individual is held in, the numbers of restrainers involved, levels of exertion, the health of the person being restrained and the readiness and willingness of those restraining to modulate the amount of force/type of force they are using are all vital to understanding the extent to which risks may develop over time so no conclusions should be drawn from the findings here other than more inquiry and research is necessary.

When considering the implications of any physical struggle associated with restraint it is important to draw attention to another theme that came through. This was the observation made by a number of respondents (n=12) that children grow to become 'Bigger and stronger' and sometimes they are too big and too strong for their parents to restrain safely and therefore prevent injurious behaviour. Parents were looking for answers. They said:

- 'I'm not very strong, and have 'weak points' which my child is aware of, so feel vulnerable...'
- 'My child is much stronger than me..'
- 'It's very hard to restrain when my son is physically much stronger than me now..'
- 'If I were to try we would be injured. He is bigger and stronger than me..'

The increasing intensity of behaviours that challenge adoptive families seems to peak going into adolescence according to Selwyn *et al* (2014, p.142) "Parents typically described one of two patterns to the onset of difficulties. The first pattern was characterised by an early onset of difficulties, with increasing intensity during

adolescence. This pattern was the most common and reported by 80% of parents. The second pattern comprised difficulties that began at the time of puberty, with rapidly escalating intensity. This was reported by 20% of parents." This is around the time that a child experiences a significant surge in growth. There are three significant physical changes, amongst others, that take place during this time; Rapid acceleration in height and weight, an increase muscle mass and body fat as well as changes in circulatory and respiratory function supporting the development of strength and stamina (Steinberg, 2010). This highlights the parents dilemma. When faced by a situation wherein it seems difficult for them to attempt to restrain their child, yet dangerous for their son or daughter if they don't: how should they proceed?

Physical restraint is undeniably a risky process. There is always the very real potential of injury being caused not only to the technique recipient but to the technique applicant as well. The literature in healthcare settings supports this (Lancaster *et al*, 2008, Southcott and Howard, 2007). Even when the physical stresses that come to bear are non-injurious the process of applying physical restraint can be a distressing and anxiety provoking experience for both parties (Bonner *et al*.2002, Fish & Culshaw 2005). These risks need managing, and in order to do this the questions that are being asked by adoptive parents need answering.

4 – I Am Desperate For Answers

A final theme that came through strongly was that adoptive parents wanted and needed answers about physical restraint. In order to restrain safely and lawfully they need the right knowledge and the right skills. Both of which seemed not to be immediately forthcoming or available according to respondents. From parents facing up to the continuing reality of violence and aggression, who were required to take action to protect themselves, their adopted son or daughter as well as any other children and family members the message was: 'I don't have the knowledge and skills I need'.

A fundamental tenet of the law is the use of force is unlawful unless it is justified. With lawful authority, or legitimate excuse, the non-consensual application of force by one individual on another is likely to be deemed an assault. It is the nature of any damage done by any force that subsequently determines the severity of the assault. Therefore adoptive parents need a thorough understanding of the law if there are to respond lawfully to those situations that we know from the survey findings are possible; an attack on oneself or one's spouse, violence directed at another child or self-injurious behaviour. To do nothing is not an option. Overall 82% (n=56 of 65) of respondents in this survey answered 'No' to the question 'Do you believe you fully understand the law in relation to the 'Use of Force/Physical Restraint'? When this group was filtered, and their other answers looked at specifically, it was discovered that 92.5% (n=49) of these parents had also answered 'Yes' to the question 'There are occasions when I have had to physically restrain my son/daughter (because their behaviour involved serious imminent harm or actual harm)'. Of this population 75.5% (n=40) also agreed with the statement 'I have never attended a formal/official training session' and 65% said that 'I have used a technique(s) that I spontaneously developed myself'.

68% (n=57) of all respondents indicated 'I have never attended a formal/official training session'. Of those who hadn't attended any formal training 81% (=46) said 'There are occasions when I have had to physically restrain my son/daughter (because their behaviour involved serious imminent harm or actual harm)'. 37% (n=15) of which indicated they were having to physically restrain weekly to manage their son or daughters challenging behaviour. Parents were apparently hungry for knowledge: 'What is the law?, where do I stand legally?' seemed to be a clarion call. They said:

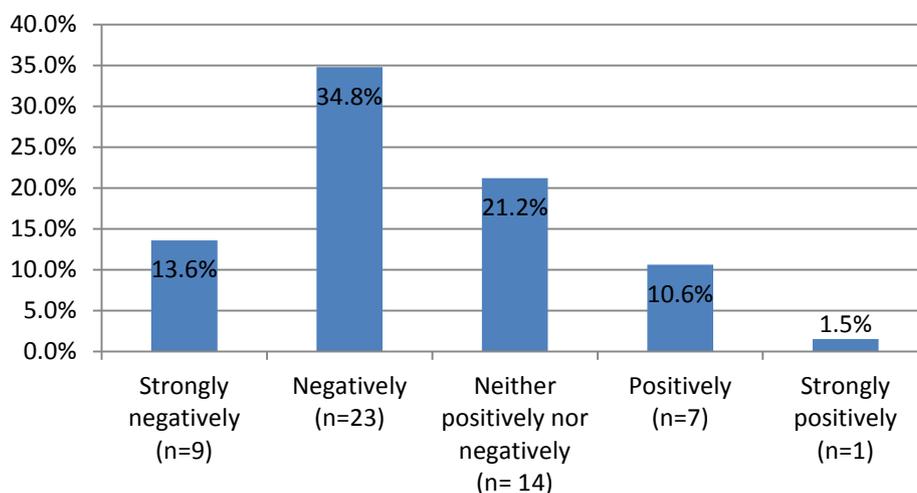
- 'I know nothing about this law..'
- 'I have no idea what the law says..'
- 'What is the law?'
- 'I don't know what the law is..'
- 'No idea..'
- 'Where do I stand with the law in relation to physical restraint?..'
- 'I didn't know there was a law about it, we just do what we have to do to keep everybody safe and help our son soothe and calm..'
- 'When we're in crisis I don't give the law a millisecond of thought! You just react spontaneously to keep everyone safe..'

When asked ‘Do you believe you fully understand the risks arising from the ‘use of force/physical restraint?’ 45.5% (n=30) answered ‘Yes’, whilst 54.5% (n=36) answered ‘No’. The extent of the knowledge held by both groups wasn’t something that was assessed, however when those that had indicated ‘No’ were given opportunity to qualify their answers. They said:

- ‘(I) have heard about children dying through restraint and this would worry me more than broken bones etc inflicted by child..’
- ‘I am a nurse by profession. This is the very reason why we want training as want to make things as safe as possible..’
- ‘I understand some children have died and in residential settings there are usually 2/3 adults present to record details which I don’t have at home..’
- ‘How to restrain him safely without risk of injury or asphyxiation, including injury to me..’
- ‘What do I do if my child gets a bruise during restraint? What technique am I actually meant to use with my child when his behaviour is physically violent? If you child head-butts, jaw hits you in restraint what can I do? If a child spits at you, on you during restraint what can I do?..’
- ‘Consideration of joint hypermobility..’
- ‘I have had no training & don't feel safe doing it..’

One risk that wasn’t explicitly inquired about but came through in the answers was the possible impact on the child. Parents indicated overall that in both the long and short term they believed that physical restraint could impact negatively their relationship with their child. 66 respondents answered the question: ‘How do you think the use of physical restraint techniques has impacted on your relationship with your son/daughter in the short term’. Their answers are illustrated below.

How do you think the use of physical restraint techniques has impacted on your relationship with your son/daughter in the short term?



It was a similar case when asked about the impact of physical restraint on their relationship with their son or daughter in the long term: Strongly negatively 8% (n=5), negatively 17% (n=11), neither positively nor negatively 39.5% (n=26), positively 20% (n=13) and strongly positively 1.5% (n=1). They said:

- ‘What is the risk of further traumatising my son?..’
- ‘What long term impact is this having..(?)’
- ‘Whether it would emotionally harm my child..(?)’
- ‘Just what restraint can keep me safe and de-escalate my child..(?)’

The question of perceived self-rated competency to apply physical restraint was also explored. Only 3% (n=2) said ‘I feel very competent’ when asked ‘How would you rate your level of physical competence in applying some form of effective physical restraint technique?’, whilst ten times as many parents answered ‘I don’t feel competent at

all' to the same question (30%, n=20). Only 14.3% (n=12) said 'I have attended a formal/official training session and only use the skills/techniques I was shown'. Those formal training sessions/systems referred to in their answers included; SecuriCare (n=7), Team Teach (n=5), NVR² (N=3) NAPPI (N=1), CPI (n=1), MAPA (n=1) and Family Futures (n=1)

When it came to accessing advice or training in physical restraint techniques it was clear that many parents voiced their opinion that 'the authorities don't or won't help me'. 'Authorities' itself is a nebulous term and it is unclear who parents are alluding to when they are not specific in their answers. Selwyn *et al* (2014, p.180) however found that on the whole "parents had mainly sought help from the local authority post adoption support services and from child and adolescent mental health services..." The perceived lack of support may have been down to the fact that representatives of the various departments didn't have the knowledge or skills required, or as seemed to be implied by various comments that there was a clear philosophical opposition to restraint on the part of some. Whether this was a personal or professional perspective (or both) was unclear. Parents said:

- 'The training for adopters focuses very much on how to keep the child safe but not on parenting techniques that help in..'
- 'Aggressive situations. I would feel more comfortable if I knew it was approved by children's support organisations..'
- 'I was refused formal training as my local council does not believe parents should have it as they should use other methods..'
- 'Asked for training and told it wasn't allowed..'
- 'We requested restraint training when we learnt about the previous violence in Foster care. We were not given it..'
- 'Have had to find support online e.g. FASD UK network. Previous adoption social worker would come to chat but no strategies..'
- 'Many social workers told us not to restrain..'
- 'I have been asking for training to restrain him safely since he was 7. Told not appropriate for adoptive families even though open about use of restraint since placement age 4. Later told 'controversial' then not sure how to fund..'
- 'Social workers and therapists are very negative about restraint of any kind, but when I ask what they suggest I do to keep us safe during violent incidents they say that they don't know. I end up feeling like whatever I do is wrong..'

There was a sense of isolation, and being cut loose, when it came to restraint training in particular. The message coming through from many was 'We've been left to our own devices'. There was evidence of a DIY ethic that came through as in desperation parents sought their own restraint training solutions:

- 'I don't know any techniques and never been offered training or information..'
- 'Learnt basics from ex-partner who was trained for previous job. Generally just tried to make sure he couldn't move and kind of made it up..'
- 'I used to be a nurse and did restraint as part of the mental health module but that was many many years ago..'
- 'Some were even self-taught; we've had no official training, but what we do seems to work. Something else might work better though..'

DISCUSSION

The evidence from this survey seems clear: violence is a reality and is occurring as we speak in adoptive households. It is sometimes extreme and complex violence. The survey found that violence was characterised by 'Multiple/Concerted Attacks', complicated by the presence sometimes of 'Weapons of Opportunity' on occasions, and could occur 'any time, any place, anywhere'. It was notable that parents tried very hard to calm their children down as their behaviour escalated, to prevent them slipping into physical crisis, but the message coming back was that 'De-escalation doesn't always work'. A significant number of respondents disclosed that restraint was a lived reality for them, but that 'Restraint wasn't a choice'. It was simply a way of trying to prevent injury when words bounced off, behaviour intensified and safety was compromised. Given that these behaviours were reportedly

² NVR = Non-Violent Resistance does not cover physical restraint skills

presented regularly, sometimes weekly, sometimes daily by children of all ages it must be concluded that there are an array of risks that need to be managed not least of which are to the child and arise from the application of restraint (Davidson *et al*, 2005). Parents need support in dealing with such risks, and at present too many parents are being left to their own devices to source the appropriate solutions. If nothing else this survey has concluded that parents are telling us: 'I don't have the knowledge and skills I need'.

It is imperative that the most vulnerable members of society, in this instance children and often traumatised children, are protected from any unnecessary and all overzealous use of force. This statement carries added weight in light of the fact that time and again the authorities, or those with a direct duty of care to vulnerable individuals, have tragically failed (Paterson *et al*, 2003). The deaths of children during restraints include Gareth Myatt in a secure training centre (Inquest, 2007a) and Angelika Arndt in a treatment centre (Disability Rights Wisconsin, 2008). In the US Nunno *et al* (2006) looked at 38 separate deaths occurring within residential placements. We must conclude that restraint will never be a decision taken lightly, and that any application of force must be considered very carefully.

Reading the literature we know from bitter experience that 'good' force, or at least well intentioned force, sadly goes 'bad' for many reasons. The wrong type of force at the wrong time is one possibility. This is surely more likely when no one is willing to talk about restraint with those faced with managing crisis after crisis. The 'Slippery Slope' or 'Thin End of the Wedge' argument (McDonnell *et al*, 2014) is another explanation. It contends that restraint can become normalised and the use of force end up as a routine instrument of control. Evidence of this attitude toward the use of force and physical coercion has been sadly in evidence during many high profile abuse scandals (Flynn, 2012, Inquest, 2007a, Paterson *et al*, 2003). The Winterbourne View care home scandal is burned vividly into the public psyche given that the actions of staff were captured by undercover journalist working for the BBC's Panorama programme. Eleven staff, including nine support workers and two nurses, were subsequently prosecuted and admitted 38 charges of neglect and ill-treatment directed at five adults with severe learning difficulties. Ultimately five of which were jailed. During the trial Barrister for the prosecution Kerry Barker said care watchdogs failed to act on repeated warnings of "inhumane, cruel and hate-fuelled treatment of patients. So-called restraint techniques were used to inflict pain, humiliate patients and bully them into compliance with the demands of their carers.." (Guardian, 2012).

Conclusions are drawn from the available evidence, other times they may be drawn from what's not present. What was not discernible from any of the answers given was any expressed intention by parents to punish their children for wrongdoing or to teach them some discipline. There was no sense of 'he/she needed to be taught a lesson' or 'I want to show them who is boss..', the punitive attitude that has so often sadly been in evidence in those settings where cultures have become corrupted and staff coercive and cruel (Inquest, 2007b). Within the context of this survey we are considering restraint as it is applied to a child who has often suffered neglect or abuse at the hands of their birth mother or father. It's evident from the tone of many of the answers that the adoptive parent, extremely mindful of this, seems to be seeking to contain the immediate prospect of any pain, injury or re-traumatisation and give their son or daughter a chance at feeling loved and flourishing in their own right. Boorman (2015), along with many other members of the adoptive community, has spoken of the tireless journey to find the right support and do the right thing by their child. Adoption is a hard fought for, and hard won investment, in another human being. The way in which parents view this commitment was elegantly articulated by actress Jamie Lee Curtis who said; "We look at adoption as a very sacred exchange. It was not done lightly on either side. I would dedicate my life to this child...". It is through the prism of this sacred exchange that any potential restraint (or safe holding strategy) should be examined and understood, and not through the one employed by individuals using force to compel others to submit to their will such as Police officers, prison guards and nightclub bouncers, or by staff groups working within corrupted cultures (Paterson *et al*, 2011).

CONCLUSION

The opposition to restraint is entirely understandable and long standing across the various care communities. At present across health and social care settings there is a concerted move afoot to move to a post-restraint world with the publication of 'Positive & Proactive Care' (Dept. of Health, 2014) and the rise in extremely valuable restraint reduction and restraint prevention initiatives (Bowers *et al*, 2014 and Huckshorn, 2004). This is how it should be. However there are practitioners who point to the implications of distancing oneself from the validity and utility of restraint, and making it an intervention that dare not speak its name. Paley (2016) and Hollins (2016)

have drawn attention to the rise in euphemisms designed to render the practice of restraining people invisible and eliminate the imperative for recording applications. Both assertions made after first hand observations. As unpalatable at face value as physical restraint may seem there is undoubtedly a role when all else fails and an individual is in a damaging and injurious behavioural crisis. It needs to be discussed openly and honestly.

The findings from this survey (however limited it may be) do capture the sense that adoptive parents are facing up to frequent behavioural crisis damaging intensity and duration, and feel they don't have the knowledge and skills required to manage it safely and effectively. Yes the implications for getting restraint wrong are significant; re-traumatising a vulnerable child, causing pain and inflicting injury (Family Law, 2016). But they are also the same for not intervening. In extremis the spectre of adoption breakdown hangs over both eventualities (Ridley and Hall, 2015). A safe middle ground would seem to be the goal. Just enough intervention to ameliorate immediate harm, done in a way that communicates love and empathy and one that is never a replacement for striving to provide the sort of support that helps a child regulate themselves and go on to reach their full potential. Which is fundamentally the purpose of the adoption process; giving a child a second chance at living a rewarding life unencumbered by the legacy of physical, emotional and psychological harms.

The survey that was conducted was focused on capturing the reality of the use of physical restraint use within the adoptive family setting. It captured data relating to surrounding circumstances including types of behaviour, parents self-reported knowledge levels and perceived competencies. It set about describing the experience of the respondents and connecting its findings to published literature. It made no comment on the cause of the behaviours. This is a vast and understandably complex area. As Coates (2017) has stated, 'speaking to many parents and carers the underlying issues that precipitate violence vary significantly, from FASD (Foetal Alcohol Spectrum Disorders), early trauma, loss and separation, witnessing IPV (Intimate Partner Violence)'. He concludes, and this reports author concurs, 'the pressing issue right now is to raise awareness to force services and authorities to provide an appropriate response..'

Thorley and Coates (2017) called for an honest discussion around child-to-parent violence to factor in the preparation for any adoption. Their contention was that acknowledgement of this issue by a d o p t i o n professionals, and the provision of timely interventions and adequate support, could underpin placement success and ultimately its longevity. This in turn would meet the needs of the '*best interests of the child*', which is a fundamental tenet of the Children Act 1989. They concluded that this "points to a need for families to be equipped both in their knowledge and understanding, as well as skills for keeping these children (and those around them) safe from harm" (p.6). Strategies for managing harmful behaviours must surely include the reality of some form of 'physical restraint' or 'safe holding'. It must be concluded that from this relatively small sounding of adoptive parents that the withholding of both training and the philosophical 'approval' for restraint isn't stopping violence from occurring, nor is it preventing the uncontrolled and unregulated use of physical restraint from happening.

This document shouldn't be read and understood to be advocating the physical restraint of children, rather it should be looked upon as describing the reality of what is actually happening in loving homes across the country. The answer isn't to say restraint is bad and to dismiss it out of hand. Rather it should be to concede this is a pragmatic reality and that there are parents out there who are crying for help. What they need is help to implement child-centred, trauma informed strategies that can be used with sensitivity and care to prevent harm and injury. Adoptive parents want to focus on creating a supportive environment that is nurturing and empowering, but be ready and prepared to respond in a safe, lawful and effective way should an emergency arise. It is fitting then that the last words come from once such parent: "*I think it is quite likely that anyone adopting a traumatised child will have to keep them and siblings safe during violent outbursts. I believe all adopters should be offered safe holding training courses, and not criticised for wanting to protect their children from the emotional consequences of losing control and hurting people..*"

*A NOTE ON TERMINOLOGY

The working definition of 'Restraint' used in this survey was based on one provided by The Scottish Institute for Residential Child Care in the 2005 publication 'Holding Safely. The author is aware that various other terms are used in different settings, including 'physical restraint', 'physical intervention', 'restrictive physical intervention', 'therapeutic holding', 'safe holding', 'small holding' and 'strong holding' to name a few. The author is also aware that these terms, will have different meanings to different people. The term 'restraint' for example will, for many, be forever associated with the 18th and 19th century asylums, along with the special hospitals and the prison estate. The association is very much a negative one, and is linked strongly with the controlling regimes that have historically prevailed within these institutions. Notwithstanding this, a pragmatic decision was taken to use the term 'restraint' in this survey because it was likely to be immediately understood on a practical level by the majority of potential respondents. The operational definition was provided in order to qualify its meaning within the context of the survey instrument. A discussion on the nuances of terminology is important, but beyond the immediate scope of this document.

LIMITATIONS

This survey was an informal scoping exercise. There are significant limitations to this type of data gathering process, including the lack of a trained interviewer to clarify understanding and probe for more detailed, in depth answers.

There is the potential for bias in the findings as respondents are likely to have self-referred after having visited 'The Open Nest' or 'Holes in the Wall' blogs. Both sites offer support to adoptive families struggling to come to terms with their child's behaviour. The author however does believe it captures the lived reality of a significant number of adoptive parents. More detailed and rigorous research is required to confirm this and deepen our understanding of both causes and solutions.

DECLARATIONS

The author is a self-employed risk assessor/trainer. He works in the field of preventing and managing challenging behaviour, with a special focus on managing risk within the context of physical interventions. He has a working relationship with SecuriCare, but this project was self-developed, self-completed and self-financed.

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IN-DEPTH FOLLOW UP INTERVIEWS AIMED AT GAINING FURTHER CRITICAL INSIGHT INTO THIS IMPORTANT TOPIC ARE DUE TO BE SCHEDULED SOON.

CONTACT DETAILS

Lee Hollins, **Email:** leehollins@winchesterscott.co.uk or **Mobile:** 07760 788712

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