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From MORAL PANIC to MORAL ACTION: Social Policy and Violence in Human services

"An *expert is a person who avoids small error as he sweeps on to the grand fallacy."*
Benjamin Stolberg

Abstract

The management of high-risk behaviours from consumers of human services remains a controversial area of practice. Within this broader agenda the use of physical restraint has emerged as a key, if implicit, dilemma for social policy agendas on both sides of the Atlantic. The nature of acceptable methods is the focus of contending perspectives and belief systems. This paper will examine the beliefs and paradigms which sustain the current absence of effective regulation of physical restraint, and suggest that the impact of specific attributional and explanatory paradigms effectively maintains the current social policy vacuum on acceptable approaches and the continuing use of high risk methods. Achieving safer practice in behavioural management requires a paradigm shift which involves the recognition and rejection of the current individualising paradigm in favour of a broader, holistic approach in which the significance of contextual service factors are recognised and addressed and the use of high tariff restraint techniques rigorously monitored and restricted.

INTRODUCTION

Violence in society remains an emotive issue with competing conceptualisations of the roots and solutions to the problem. Social perspectives on the acceptable treatment of deviant or criminal social groups have changed through time, evolving in line with prevailing social mores and power relationships. Within this debate, often polarised as one between the rights of victims and the rights of perpetrators, increasing attention has been paid to the need to balance the retributive responses of criminal justice with the human rights of perpetrators.

The emergence in the UK of Community Care and Social Inclusion as core social policy principles has fuelled the perception that specific professional groups such as teachers, health and social care workers etc, who have traditionally operated within a humanistic ethical framework in which the rights of the client were paramount, are now increasingly exposed to behaviours which place them at risk. The perception of increased levels of violence in such services may reflect actual increases in violence and/or decreased tolerance of violence (Walker & Caplan 1993). However, the tensions and lack of clarity in many services around the boundary between the Duty of Care to support service users and the workers right to safety, has led to an increasingly heated debate between representative and stakeholder groups.

Frequently the obligations imposed under various statutes and regulations, including Health and Safety at Work, Employment Rights and Education and Social Work legislation have been used to justify partisan positions, whilst many commentators have argued that the lack of clear guidance on the obligations of employers and employees has maintained a confusion, in which the courts are likely to be the key arbiters in regard to the delineation of expected standards and "reasonable" practices.

Within this broad agenda the rights of those whose behaviour is deemed to be the result of factors beyond their immediate control, yet which also poses a potential risk of harm to themselves or others, has received growing attention. Such groups include individuals with Mental Health and Learning Disabilities. Socially vulnerable individuals with social care needs, such as young people in public care, young people with intellectual, behavioural and emotional problems in the education system, mentally impaired older people etc. Such groups are supported by a broad spectrum of services which range from forensic and penal institutions to community support in their own tenancies.

The emphasis on the importance of controlling challenging behaviour from service users and the potential legal penalties on defaulting employers has resulted in a rapid expansion of staff training, which now frequently includes training in methods of physical restraint. Given the lack of research and the unwillingness of executive authorities to regulate such training, a wide range of methods are now employed across the whole spectrum of human services, including those developed for use in criminal justice settings. However, the appropriateness of individual methods and/or approaches for specific client groups and services has received little formal attention until relatively recently.

The problems created by this "dangerous" situation (Hughes et al 2001) have historically been masked, by a tendency to frame both injuries and deaths as individual tragedies relevent only to the individuals and/or services involved. CW Mills, (1963) famously distinguished between what he termed "private troubles" and "public issues" that is, social problems observing that,

> "When, in a city of 100,000, only one man is unemployed, that is his personal trouble, and for its relief we properly look to the character of the man, his skills, and his immediate opportunities. But when in a nation of 50 million employees, 15 million men are unemployed, that is an issue, and we may not hope to find its solution within the range of opportunities open to any one individual (Mills1959:9)

'Issues' are by implication, not fixed in their status and can "cross over", from private sorrow to public problem and vice versa. Peelo and Soothill (2000:133) suggest that such transitions are mediated by negotiation in which the media can play a crucial role. We have seen in respect of the issue of violence in human service generally and restraint particularly a prime example of this process in the seminal papers by the Hartford Courant whose efforts we should be particularly grateful for.

However, as Cobb and Ross (1997:41) suggest negotiations involve at the least two sets of actors "the initiators and the opponents". The former seek to define or redefine 'problems' and their explanations in order to mobilise public opinion and/or political support. The latter seeking to maintain the status quo may have of course vested interests in restricting the political agenda to those issues already under discussion and excluding consideration of other issues.

Framing such events as personal tragedies injury and fatality rates. More recently in both Nations this situation has become the focus of increased media attention and social policy initiatives. Largely driven by the publicity resulting from successive restraint related deaths of service users in a range of settings including foster care, residential care, education and hospitals (Paterson et al 2003. The use of restraint on specific groups has been the focus of criticism from the courts? and in the UK Challenges under the Human Rights Act , Article 3, which prohibits torture are anticipated. In the context of children's rights, the United Nations has now called for the UK Government to review the use of restraint and solitary confinement for children across all settings (Hart & Howell 2004).

The issue of violence in such settings creates however, a dilemma for policy makers. Policy makers will perhaps only too readily recognise the need to equip staff with methods which will allow them to protect themselves. Safety as a political issue carries significant capital and promising to improve the safety of human service workers from assaults by drunks, the disturbed and the delinquent by increasing the sanctions which the perpetrators will face is an attractive and in many respects low risk strategy for most policy makers. However, recognition that restraint may be used inappropriately as a form of punishment and that some methods may actually increase risks to both staff and service users clearly requires recognition and action.

There are however, a number of reasons why action on this agenda may be politically risky. Firstly, announcing that a review or inquiry or scheme of regulation will take place carries the risk of suggesting that the government or at least that section of it responsible for policy and practice in the specific sector has been at fault for failing to do something up to this point. Secondly, the evidence base about what actually works remains poor, ambiguous and even conflicting. The nature of the actions necessary to deliver in terms of robust regulatory frameworks, dynamic schemes of training staff which deliver high levels of competence to enable staff to deliver an agenda based on therapy rather than containment remain subject to debates amongst the expert community. This means that policy makers cannot even count upon the united support of the relevant policy community because any action may attract criticism from within a deeply divided policy community.

Worse perhaps from a political perspective Therapeutic approaches may already be difficult to 'sell' to a public wedded to beliefs that see punishment as a more appropriate strategy. In addition such approaches may seem potentially expensive at least in the short term with any gains likely to be seen only in the longer term. In a present culture of quick fixes expensive, politically high risk solutions whose benefits are likely to be seen only in the longer term will always struggle to receive support.

As Wolf (2002:802) notes risk aversive policy makers display an inveterate tendency to choose "*strategies that minimise the impact on the political official rather than equitably balancing risks*". It is this fear of 'liability' in terms of both legal and financial as well as political dimensions influenced strongly by the lack of an expert consensus which may have contributed to the avoidance of regulation and/or the specification of acceptable practices by politicians on both sides of the Atlantic. Whilst issuing general guidance, executive authorities have by default left the problem to commercial forces. The impact of the nature of the claims made by some commercial training providers on current practices certainly merit scrutiny and the widespread concern about the practices employed by some "Guru" trainers to promote their products in increasingly recognised (Allan 2004)

The general emphasis of many recent national initiatives in both the UK and USA has been to attempt to identify the nature of safe restraint methods. Whilst such a focus is crucial, aspects of the current debate may also be illusory, and shaped, if not driven, by the nature of some of the assumptions brought to the occupational violence debate.

It can be argued that a Moral Panic has occurred in respect of occupational violence in some settings whereby lurid media reports have exacerbated the nature and extent of the risk of violence. Moral panic as a concept has latterly become associated with the notion of a disproportionate response, something out of all proportion to the actual risk of the issue. In this context violence as a risk factor is only too real and in some settings very frequent the question of proportion is thus less significant. What is evident, at least in some settings, is an inappropriate response in social policy terms i.e. one characterised by strategies which are at worst unidimensional focused on the criminalisation and or exclusion of service users who challenge services and at best two dimensional, training staff in how to de-escalate situation of conflict and more safely manage violence. What is perhaps needed now is a return to the principles of moral management.
This paper attempts to explore the impact of the current beliefs brought to the debate on behavioural management and physical restraint; the nature of emergent social policy initiatives; and the effect of the market economy of training. It will suggest that, in combination these perspectives act to sustain traditional ineffective approaches to occupational violence and the use of dangerous and high risk methods of physical management.

ATTRIBUTIONAL PARADIGMS

The concept of risk is a social construct as old as civilisation, first appearing in the Hammurabic code in the 18th century BC (Jaeger et al 2001). However, as Stalker (2003) suggests little attention was paid to risk in welfare institutions prior to the 1980's. Despite Health and Safety legislation mandating pro active action by employers, arguably the culture of many welfare agencies supporting clients with risk imposing behaviours remains inconsistent and reactive. Assaults on staff often being seen as merely " *part of the job*"(DoH 1988). Seminal articles on risk from service user behaviour (e. g Prins 1975, Rowett 1986, Brown et al 1988 etc) have however helped to define the problem as one worthy of recognition and action. Successive homicides of UK social services workers in the 1980's (Leadbetter 1993) also provided a potent catalyst for a debate in which it was suggested that " *social workers face a greater risk of violence than any other profession apart from the police*." (New Society 21 September 1986)

The growing perception of violence from ungrateful recipients of welfare state services inevitably reinforced many prominent stereotypes of disadvantaged groups inherent in the wider debate on criminal justice. A situation suggestive of Moral Panic.

Cohen's (1972) influential study of Mods and Rockers defined a " Moral Panic" as
"*A broad public reaction to a threat where, during the reaction or after the fact of the reaction, the perceived threat or danger was more substantial than was warranted by a realistic appraisal* (Cohen - in Crow & Hartman)Social policy responses are invariably driven, less by empirical data, than the ability of effected groups to make credible claims as to the nature of the problem. (Spector & Kitsuse 1977). The nature of any social policy response is again heavily influenced by the attributions and paradigms used to define the nature of the problem.

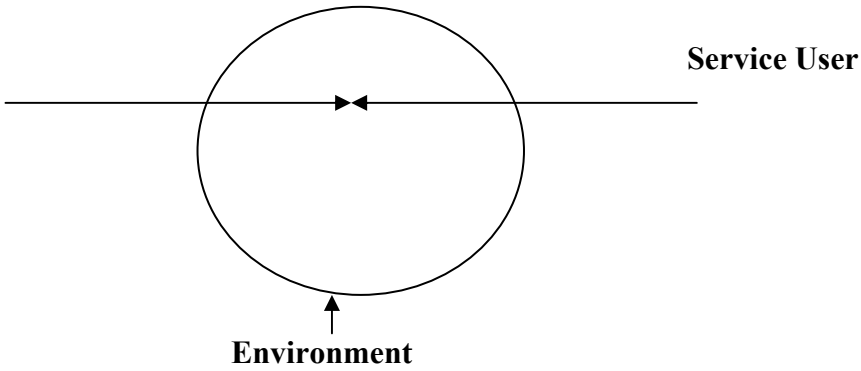
Kemshall et al (1997) suggest that "*public policy is now focused on the forensic rather than the predictive use of risk, that is, as a means of investigating situations that go wrong*. " and that " *The process of individualisation in modern societies encourages agencies to seek out scapegoats rather than accept corporate responsibility "*

This tendency to individualise responsibility for aggressive incidents has many roots and may partly rest on the, albeit incorrect perception, of professional groups as "experts" in the prediction and management of risk (Stalker op cit) as well as the legalistic and forensic approaches to risk management inherent in the legislation. Content studies on social service policies (e.g. Johnstone 1988) confirm the tendency to present behavioural management in highly individualistic terms. Placing the responsibility on workers to anticipate, manage, and recover from aggressive client behaviour. A tendency which inevitably places increased, and potentially counter productive emphasis, on the potency of training as a risk reducing response. As Gurney (2000) points out:-

" The responsibility for risk taking and allocation of blame when things go wrong vary according to how far risk is seen as a consequence of social structures and conditions, and thus a shared responsibility, or is attributed to individual behaviour of shortcomings"

Historically internal attributional paradigms, explanations which locate the source of a behaviour to factors within the person (i.e. they are " mad, bad or sad") have tended to dominate causal explanations of violence. However, contemporary Ecological (reference) or Co Creationist (reference) explanatory paradigms conceptualise occupational violence as an interaction between three elements. The factors impacting on the aggressor's behaviour, the staff members behaviour and the context in which the interaction occurs. Studies give increasing weight to the recognition that violent behaviour is often a reaction by the service user to aversive factors within the environment.

Ecological Model of Violence



Attributional theory (e.g. Kelley; Heider etc) , the study of the judgements made to explain behaviour, suggests that potent biases operate which influence the judgements brought to the explanation of the behaviour of both staff and service users involved in violent incidents. Such biases promote the "Individual Fallacy", tending to over emphasise individual culpability, whilst placing less emphasis on environmental factors.(see Rowett 1986; Lanza). Hence the hegemony of the security perspective, and the current emphasis on the provision of aggression management and restraint training as a primary response is consistent with this "individualising" or" reductionist " paradigm. In that it inherently reduces a complex problem to that of a staff skill deficit.

In so doing such training programmes, which often include high tarrif restraint techniques, invariably only address one element of this interactive triad and may sustain and reinforce organisational blame cultures and institutional practices which define the problem of aggression primarily in individualistic terms. A dynamic which may partly explain research conclusions which point to the ineffectiveness of such training as a stand alone intervention.

Similar attributional processes are brought to causal explanations of the factors promoting service user aggression. Crighton (1997; 2002) demonstrated that staff responses to patient aggression in mental health settings is significantly influenced by a process of moral judgement. Such judgements contain three inseparable dimensions:-

- Containment of the unsafe
- Underlying pathology
- Moral Censure

Patient behaviours judged by staff to result from causal factors outwith the patients' control e.g. psychosis) were more likely to be considered " mad" whilst those patients deemed capable of exercising increased self control (such as personality disordered patients) were more likely regarded as " bad". In turn such judgements shaped the nature of staff responses. " bad " behaviours attracting an increased likelihood of punitive responses whilst mad" behaviours more helpful or therapeutic responses. As Towell (1975) suggests " *where the medical treatment ideology was a dominant influence patients who are not regarded as " ill" thereby lost their claim to receive help. Instead the deviant behaviour of such patients was likely to seem as intentioned, the deviant judged responsible, and attempts made to control the behaviour through the application of negative sanctions".*

A similar patterning of staff responses to aggressive behaviour on the basis of underlying causal judgements has been demonstrated in child care (e.g. Sherman & Cormier 1974) and learning disability studies ( ) where judgements of intentionally and the degree of control over unacceptable behaviours again emerged as a crucial criteria shaping staff responses.

Hence moral judgement is a central influence on the likely staff response to aggressive conduct in human services. Where such behaviours are deemed to be premeditated and under the control of the individual, punitive staff responses are likely to be regard as carrying increased legitimacy. Where they are deemed to be involuntary or driven by factors outwith the individuals control, therapeutic or supportive staff responses are more likely.

SOCIAL POLICY RESPONSES

The categories of moral judgement identified by Crighton (op cit) offers however, a useful framework which can be applied to the analysis of social policy responses and the current debate on the use of physical interventions. The drivers implicit to any given social policy initiative be located within the three competing paradigms inherant to clinical decision making :-

1. **Security** or containment of the unsafe. The response is justified on the basis that the persons behaviour presents a risk. Hence the aim of the specific response is to reduce or eliminate that risk

2. **Therapy** or underlying pathology. The behaviour is a product of an underlying pathology. Hence the aim of any specific response is to address the problem and to promote adaptive alternative behaviour.

3. **Punishment** or Moral Censure. The aim of the specific response is to punish the person for the behaviour. Punishment may be justified on the basis of the behavioural argument that this will act to eliminate the behaviour.

The production of authoritative reports on aggression management in human services and the use of physical restraint in UK public services has become a growth industry. Although a rigorous conclusion must await a coherent content analysis, it can be argued that many of the current UK initiatives appeal differentially to the three moral justifications:-

MORAL JUSTIFICATIONS AND PHYSICAL INTERVENTIONS

On the one hand advocates of the necessity of force often appeal primarily to the Security paradigm. On the other, a range of arguments have been raised from a human rights perspective, questioning prevailing practices. The dominance of specific paradigms has shifted over time, and has been significantly influenced the development history of physical intervention systems.

The evolution of physical restraint training

The use of physical restraint to control " deviant " behaviour in human services has a long, if not always honourable, tradition. It has generally been an accepted part of practice in many human services. (HMSO: Murray & Turner 1990; Leadbetter 2003). The dominance of the Security argument was significantly fuelled by the increased publicity resulting from high profile assaults and fatalities of human service workers, strikes by assaulted labour groups and publicity surrounding fatalities of service users incurred in ad hoc restraints (examples - Broadmoor & early examples) .

In response to the recognition of the need for more structured approaches, the first systematic UK restraint model was "Control and Restraint" or C & R, developed originally for use in the Prison service and based on martial arts techniques. It was then introduced into the Special Hospital service and from there into the wider National Health Service. Although not a unitary model, C & R variants have been heavily dependent on the use of hyperflexion and pain compliance.

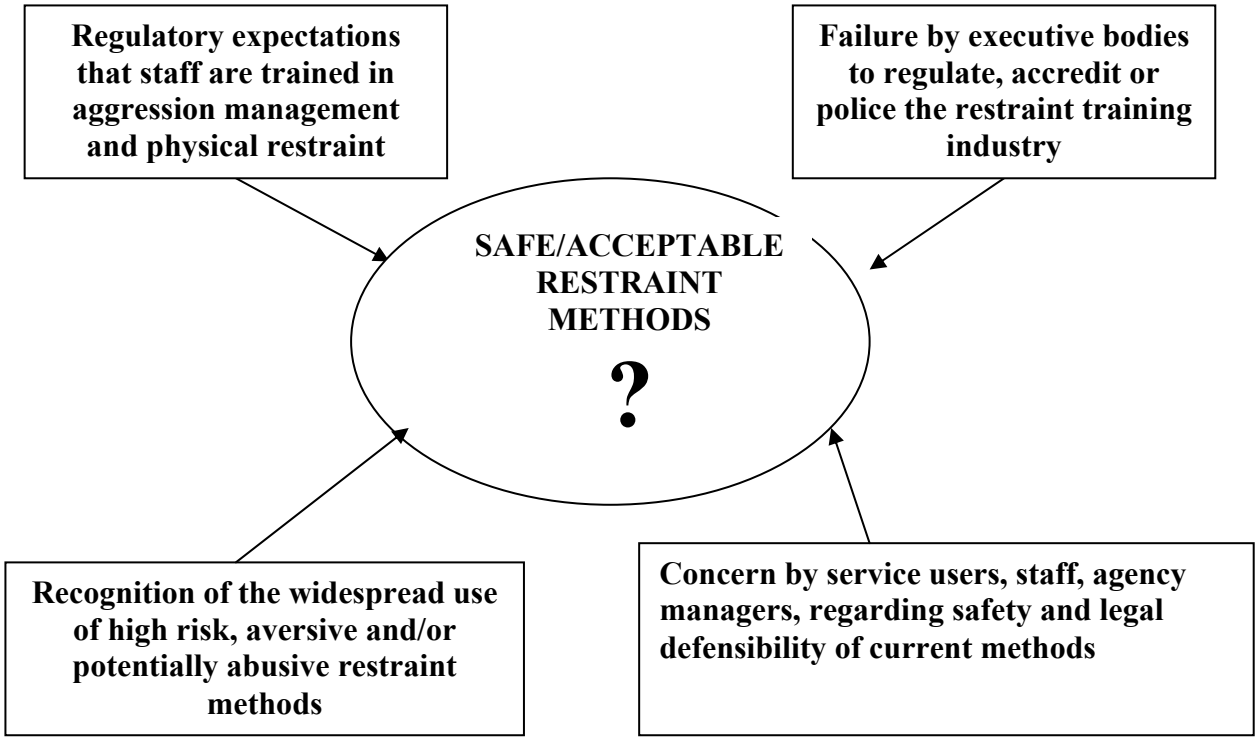
Within the context of ethical and legal criticisms of the use of pain compliance in human services (examples) commentators (e.g. Paterson & Leadbetter; RCP) have expressed the specific concern that the C & R system operates within a security based paradigm and promotes a culture of control and coercion in user organisations. A concern reflected by the reported high level of significant injuries to service users (11%) and to staff (19%) in operational situations and to staff in training (27%) (SNMAC, 1999; see also Parkes, 1996).

Imported US training models have been a further major influence on UK practice, particularly in child care and learning disability services. Many systems appeal for their legitimacy to the "Institutional" or academic status of the providing agencies. A practice which obscures the fact, as one commentator suggests that *"a Vendor of training is just that, a vendor*" (Budlong 2004) The curricula of many leading systems has included techniques which have subsequently attracted increasing concern.

Many processes associated with Cohens' Moral Panic model can be identified in the transformation of restraint training into a legitimate aspect of human service practice. These include however, not just anxieties about violence to staff, but anxieties about violence to service users. The recommendation that the special (i.e. high secure mental disorder) hospitals in England adopt Control and Restraint came from the recommendation of an inquiry into a restraint related death. Certainly the media have played a leading role in the portrayal of professional groups as victims of violence, further embedding the problem within a Security paradigm. The social policy response has been to legitimate restraint as a practice tool with successive authoritative documents, not only discussing the circumstances of use, but mandating training (Examples) Decisions further enhanced by court decisions (e.g. McLeod vs Aberdeen City Council), and Health and Safety legislation. However, in such a technically complex area, in addressing the Security perspective, executive authorities and the courts in both the UK and USA appear, until relatively recently, to have ignored the fact that implications for risk of allowing an unregulated market economy to develop in" physical restraint" or "physical interventions "

In the context of an emergent discovery of the previously hidden, high levels of injuries and fatalities incurred in restraint situations the situation, in the UK at least involved a what has emerged as a seemingly massive paradox. On the one hand a body of legislation and case law has developed which effectively mandates restraint training for many professional groups. On the other hand a social policy context which fails to regulate, monitor or proscribe high-risk procedures. A situation described by authoritative reports as " dangerous " (Hughes et al op cit) and by commentators as a vast but uncontrolled experiment in which the welfare of staff and service users has in effect served as dependant variable (Leadbetter & Paterson 2005). See fig 2

Fig 2



THE EMERGENCE OF THE MORAL ACTION PERSPECTIVE

The provision of training in aggression management and physical restraint offers an attractive "quick fix" solution to problems of occupational aggression and appears to have face validity. It provides a simple solution to the pressures imposed on agency managers and executive authorities by guidance, inspection regimes and litigation. It is consistent with, and a product of, prevailing beliefs and attributional paradigms which associate assault with worker culpability. This is not to suggest that this is not the case in many specific instances. However such an essentially "Reductionist" approach which concentrates on reactive crisis management or "Secondary Prevention" (see Paterson, Leadbetter & Miller 2005) ignores the principal causal factors of violence in many settings, which are often associated with contextual issues, relating to the quality of the service and the inadequacy of the agencies "Primary Prevention" measures. They may also serve to confuse the basis of control in care organisations which ultimately rest on relationships, rather than sanctions or coercion.

Training provision continues to be central to many current policy responses to occupational violence, for example the £1/2 billion NHS Counter Fraud SecurityManagement Ssrvice 1 day training initiative for all staff in the NHS. Commentators continue to promote training as a key solution. (insert quote from Gurney). Partisan advocates also point to anecdotal evidence of the positive impact of training and single research studies. Such studies encounter problems of validity. Often they fail to isolate training as the dependent variable. Consequently positive results may be simply a " Hawthorn Effect (reference) , the product of the act of observation itself and/or leadership from agency managers. Other studies have been undertaken by the training provider themselves and thus are not independent. The seminal Cochrane analysis, the most robust approach to the analysis of available yielded 2,155 studies on restraint and seclusion. However none met the minimum inclusion criteria. (Sailas & Fenton 1999)

Overviews of the literature are invariably an initial step in recent policy initiatives in the UK. However most fail to employ a systematic approach. The conclusions from recent comprehensive analyses appear to uphold concerns about the impact of training as a stand-alone intervention. Indeed they suggest that some training approaches, not only have a minimal impact, but may in fact increase risk (see for instance Parkes; Baker & Bissimere). For example the Cochrane analysis undertaken by the Royal College of Psychiatrists concluded:-

" *There was weak quantitative evidence that training and experience in coping with aggression reduced injuries to staff. It is not clear whether incidents of violence are reduced.* " Royal College of Psychiatrists 1998: 33.

Similarly the literature overview conducted on behalf of the British Institute for Learning Disability concluded: -

" *The existing research literature suggests that training carers in behaviour management skills can produce a variety of positive direct and indirect benefits. Staff that receive training appear to be more knowledgeable about appropriate behaviour management practices. They are also likely to feel more confident (although this effect may be less significant for female staff), and can be effectively taught physical intervention skills. In the workplace staff training can decrease rates of challenging behaviour and the use of reactive strategies. Injuries to both carers and service users may also be reduced. Unfortunately, the research indicates that none of the above outcomes can be guaranteed from training, and negative results have also been observed in each of the above areas. "* Allan 2000: 23

The Security paradigm has however been undermined by the growing publicity attracted by successive restraint related fatalities. Investigative journalism has played a crucial role in exposing abusive practices and raising public concerns, notably around the abuse of service users through the inappropriate use of restraint in both the UK and USA. A BBC expose by journalist Donal McIntyre (BBC 2001) led directly to the publication of the joint DoH/DfES guidance in the UK, and the development of the physical restraint training accreditation scheme administered by the British Institute of Learning Disability BILD ( ) . Similarly, in the USA the data base collated by the Hartford Courant newspaper (Weiss 1998) listing 142 restraint related deaths of which 26% were children, led directly to the federally funded restraint reduction project co ordinated by the Child Welfare League of America (CWLA 2004). This involved a study on the impact of training and agency action in 8 child care sites , over a three year period. It has been suggested that annual restraint related fatalities in the USA may be as high as 150 per year (GAO).

Similar restraint related fatalities (e.g. X, - Asian patient in Midlands Mental Health Service David Bennet, Gareth Myatt) in UK Mental Health and Secure Child Care services have increased the momentum of a growing dichotomy. On the one hand, advocates of the legitimacy of severe or high tariff restraints invariably appeal to the Security paradigm. That any concerns about the method of restraint is negated by the unacceptability of the presenting behaviour. A view which one commentator (McDonell) has described as " *The Mind Over Matter*" approach

" I don't mind what I do to you - because you don't matter!"

On the other the client welfare lobby have increasingly raised concerns at the infringement of rights.

The focus of the debate has sometimes narrowed with great emphasis on the attempt to distinguish between safe and unsafe restraint, which, given the failure of executive authorities in either the UK or USA to centrally collate restraint related injury or fatality data, combined with the universally acknowledged poor quality of empirical research, currently represents an unattainable goal. Various official English and /or Scottish documents (DoH/Scottish Office, 1996; HMSO, 1996: Royal College of Psychiatrists, 1998; HMSO, 1997; Centre for Residential Child care, 1997; DoH, 2000; DoEE 2000) list criteria for acceptable restraint method approaches. However these are not policed and hence non compliant high tarriff techniques continue to be used and promoted

The discourse of safety has thus become mired amidst competing claims for authority derived from experience, apparently successful application in single settings, qualifications in martial arts or associations with academic institutions . Unfortunately the nature and quality of the available evidence effectively renders such claims redundant.

Given the current lack of regulation of the market place, training in aggression management and restraint can be delivered by anyone, regardless of qualifications, experience or compatability with the value base of the customer agency. It is therefore difficult for commissioning managers to distinguish between responsible training providers and others(Harris 20020) . Reference to the marketing materials of many training providers reveals overt reference to both the Security and Therapy paradigms. Various systems being described as "safe" and by implication capable of increasing security. Claims about the therapeutic nature of restraint are also prevalent. Some models containing this concept in their designations. Given its socially unacceptable connotations the relevance of the third, dimension, "punishment", is less explicit but must also be considered.

Security and Containment of the unsafe

Claims about the safety of specific restraint methodologies belie the poor quality of the evaluative research literature). National Governments have failed to impose a centralised reporting system for restraint related fatalities and/or significant injuries, which would be required for an empirical approach to the determination of restraint safety.

Neither, historically have the main training vendors collated and/or published restraint related injury rates. In response to post fatality concerns some commonly blame the misapplication of their techniques by involved staff. Many commentators view this as a disingenuous, reductionist argument, which fails to acknowledge the contextual factors which compromise safety and the high-risk nature of the techniques themselves.

It is axiomatic that restraint implies the probability of active resistance. Consequently the reality of operational situations is very different from the controlled conditions of the training room. Safety is therefore a relative concept. Given the residual risks it is difficult to isolate the relative risks attached to specific restraint techniques.

Almost any technique can be applied safely, given certain conditions:-

- Staff competence
- Staff confidence
- Staff fitness
- Effective teamwork
- Emotional self control
- Professional , non punitive attitudes
- Absence of any pre existing medical risk factors
- A safe environment
- Limited levels of physical exertion
- Absence of resistance or aggression by the service user

The focus in current debates has been on the safety of specific techniques and systems. However claims that any restraint technique is "safe" sits within a false paradigm, as it invariably removes the question from its practice context. Two of the key determinants of safe practice centre upon staff fitness and skill retention.

Staff in human services vary enormously in their level of fitness and, as one study noted are likely to be " *skewed towards the lower end of the normal distribution continuum"* (Grimley & Morris 2000). Many will also have pre existing injuries. A significant proportion of the human service workforce are female, with a significant proportion being over 40. For instance the workforce data on the Scottish social care workforce (SIRCC 2005) conform that % are women with % being over 40.

Additionally motivation, a further key dimension of skill mastery in any motor skill may well be minimal, given strong prior beliefs about restraint. The literature on motor skill development also emphasises over learning through constant repetition as the key to motor skill competence. For instance one study suggested that it takes around 1 million repetitions to achieve consistent basket ball shooting and 1.6 million repetitions to achieve proficiency in baseball pitching (Kotke, Halpern, Easton, Ozel, & Burell 1978, cited in Bleetman & Boatman 2001). Although , the literature also questions the competence of some " experts" (Stark & Kidd)

Consequently, claims about the safety of specific techniques must be considered within the proper practice context. It is likely that a significant proportion of the workforce will be unable to achieve mastery and/or retention. A more helpful concept may therefore be that of " fragility". Many restraint techniques must be considered to be "fragile", as safe application is heavily dependent on staff fitness , motivation and skill. In situations where these are impaired a high probability exists that such techniques will not be implemented correctly with a resulting significant increased risk of injury and use as a punitive measure . Whilst such techniques may hypothetically be capable of safe application under ideal conditions, realistically such conditions rarely occur in user agencies. Pain compliance, hyper flexion (bending over), basket holds (hands held across the chest from behind) and prone techniques will merit particular consideration in this respect.

Therapy or underlying pathology

Various commentators (e.g. Ziegler 2005) and leading training vendors point to the "therapeutic" value of restraint. Whilst the use of restraint can be justified and indeed necessary to achieve short term goals, such as prevention of harm, the concept of "*therapeutic*", defined by the Oxford concise dictionary as "*relating to the healing of disease"; "having a good effect on the body or mind*" implies long term remedial benefits and behavioural change. Such an intrinsic suggestion effectively ignores the processes of social learning and the actual experiences of those subjected to restraint.

For key social groups such as Learning Disabled adults (Hastings & Remington 1994) and Adolescents, aggression (Goldstein et al 1998) is primarily a functional, learned behaviour.

"*For a growing number of adolescents, aggressive thoughts and behaviours are over learned, consistently successful, and generously supported by the important people in their lives"* (Goldstein et al 1998:6).

Aggression prone individuals " model" the behaviour of other role models, which may include parents, peers, media portrayals etc. Such behaviour is also positively reinforced by rewards such as status, escape from demands, tangible gain etc. Individuals for whom the use of aggressive behaviour achieves an "*Avoidance Goal*" are likely to experience restraint as highly aversive with consequent increased resistance. Conversely, the restraint individuals for whom aggressive behaviour achieves " *Approach Goals*", such as attention or status, is likely to act as a positive reinforcer, leading to the creation of "*restraint junkies*" who actively seek such interventions (Harris).

In the context of claim making regarding the therapeutic value of restraint many stakeholders suggest that specific restraint methods are non aversive, in that they avoid the generation of negative physical or emotional responses. Although sparse, the literature on the experiences of those subjected to high tarriff restraints almost uniformly points to the devastating emotional nature of the experience. Words such as "*I felt raped; coerced; assaulted; humiliated; sexually harassed; traumatised*; appear in service user accounts across services. (NAMI 2002: Moss; Who Cares; Care Commission; Sequeira & Halstead. Leadbetter 2003) The perception that restraints implemented for petty reasons to support staff power and to enforce control is also a prominent theme within such accounts. For instance from a 12 year old boy:-

"*I think they manhandle kids. It's not right. I'm not here to be touched or manhandled. I don't know them. They won't do it to their own kids. They put me on the ground when my face is on the floor like we were animals putting our faces on the floor. That's some sort of child abuse innit*?" (Barnardos 2002)

The perception that resrtaint is commonly used for trivial and punitive purposes to maintain staff authority recurs in thenliteruare on service user experience. The available evidence suggests that, the concept of the therapeutic impact of high tariff restraint must be rejected as highly unlikely, if not impossible (Jones & Timbers 2002). Whilst care must be taken to distinguish between marketing claims and clinical evidence an attempt to base the debate on empirical evidence may represent a false dichotomy.

The uncritical and routine use of physical restraint by care services must be rejected, not only on ethical grounds, but on the basis that it will in many instances model and consequently reinforce the prior experience of those social groups most likely to experience restraint. As Marshall McLuan suggested "*The medium is the message*". Over use of restraint is likely to merely reinforce the message that " *might is right*".

Punishment or Moral Censure

The concept of punishment is a traditionally accepted method of discouraging deviant behaviours and, when used appropriately may form one keystone of parental and institutional behavioural control. In its academic sense it can be historically located within a Behaviourist paradigm In this context punishment refers to the addition of an unwanted factor following a specific behaviour (Positive Punishment), or the removal of a desired factor (Negative Punishment). However even in this legitimate context the concept and use of " punishment" has been increasingly questioned on ethical grounds , and most behaviourists would now reject its clinical validity. .. Particularly in the context of its use with vulnerable individuals whose
" Challenging Behaviour " may be promoted by factors beyond their control. (see La Vigna & Donnellen; Paterson etc al)

The use of restraint as a form of coercion to maintain staff status and control and as a form of punishment has received increased attention as a result of successive high profile revelations of abusive staff practice, most notably the Pindown regime. (see also SSI 1993; BBC 1999 + other examples) . Whilst the provision of restraint training is often a necessary and legitimate control measure to ensure safety, ethical practice is heavily dependent on robust management accountability and a constructive service culture, sadly lacking in many services (see article on Allan 2003) . Effectively restraint training hands staff a potential weapon. Many severe, and/or "fragile" techniques require strict physical and emotional control by staff to implement safely. The pressure and consequent pain and restriction levels can be easily increased and consequently used to punish deviant and non-conforming service users.

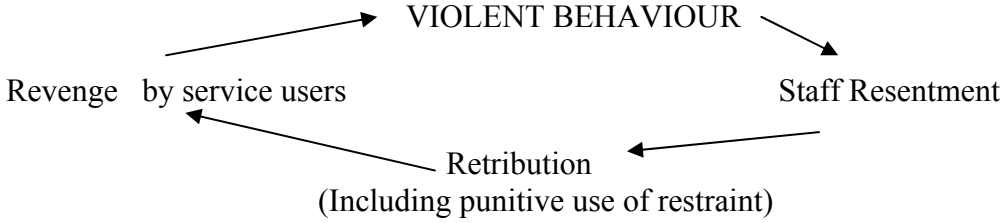
The individualising paradigm, characterised by the "victim blaming " of assaulted staff inevitably supports service cultures in which the prevailing attitude towards service user aggression as one of " *its part of the job, get on with it* " DoH op cit) Such regimes however fail to address the emotional legacy of working with challenging behaviour. Lack of attention to staff stress through a supportive culture, regular supervision, post incident de briefing, the provision of counselling etc can reap a bitter legacy. Polarised industrial relations can lead to staff/management alienation, high sickness rates and dysfunctional practices. Inter staff tensions also invariably reinforce service user aggression. The Stanton-Schwartz effect, described by Fisher (2003)

AN ALTERNATIVE PARADIGM

The general topic of risk management can be located within a number of competing paradigms. Whilst the perception of risk and harm as the " Will of God" have been superseded (Stalker op cit), the location of public policy in a primarily forensic and legalistic framework in which the establishment of culpability for harm is a key priority obscures the fact that, as Jaeger et al (2000) suggest, *" humans are embedded in uncertain environments, both natural and of their own making, containing desirable and undesirable risks* ". Exposure to threatening or aggressive behaviour invariably generates primitive self protective and punitive instincts. As Maslows Hierarchy of needs (Maslow) reminds us, safety needs are a fundamental pre requisite for all other areas of human growth . Hence the " Just World " perspective is seductive. The regrettably incorrect assumption *that "bad things only happen to bad people*".

Such beliefs systems promote absolutist perspectives on risk management. The assumption that, for any given risk, there exists a solution which will absolutely remove it. As the old adage goes " *For every problem there is a solution which is quick, simple and wrong*"! In reality, when dealing with complexities of aggressive behaviour is human service settings, short of the exclusion of clients from the service, an albeit common response which merely re locates the problem, residual risks are inevitable. Hence we must reject the absolutists paradigm and replace it with a relativistic approach to risk assessment. Invariably in supporting service users with embedded behaviour patterns and complex needs human service workers are dealing with a "Dilemma" A situation which, in Health and Safety terms, offers no cost free outcomes. The task is therefore to identify the response option with the lowest relative costs through systematic risk assessment. In perhaps better example of ethical principles might be that of equity terms, "the greatest good of the greatest number", it may be the case that the increased safety promised by security perspectives alone is illusory . Some residual risk is inevitable. Whilst perhaps less technically robust, lower tariff methods of restraint may well increase overall safety, given that they are more likely to preserve the relationships upon which authority and control in human services rests . Conversely the increased safety of high tariff techniques inherent in the Security paradigm is a false promise, given the increased risk of injury and the inevitable cycle of resentment, retribution & revenge which such methods are likely to initiate. (fig 3)(see Roberts 2000). Hence in the context of a strategic agency approach and training delivery based firmly on a " whole organsiational paradigm" lower tariff techniques may allow services to control a broader range of behaviours without crossing the Rubicon involving the use of high tariff techniques in which the risk of injury is likely to be exponentially increased.

Fig 3



The need to equip staff with the tools necessary to ensure safe practice is essential. However the dangers inherent in the previous dominance of the Security paradigm and the argument that high tarriff techniques are therefore required to acheive this goal is that, even if such a proposition were correct, it risks buying the safety of one group at the expense of another. This dynamic can be discerned in the response of excutive bodies to recent restraint related fatalities. For instance the report on the restraint related death of David Bennet rightly identifies the need to protect patients cared for by UK mental health services and the inherent dangers of prone restraints. However its recommendation for a 3 minute limit on the use of such methods begs the question of what staff can do at the end of this period in situations in which the patient remains highly assaultative. (see Paterson & Leadbetter) . The complicating factor is therefore one of achieving the correct balance. One which protects the rights of all parties.
The current reductionist debate on occupational violence and behavioural management is a product of the prevailing explanatory paradigm. This has historically tended to emphasise individual client pathology as a key factor in aggressive behaviour. Similar attributional biases have been commonly applied to explain aggressive incidents inhuman services primarily in terms of a staff skill deficit. These "Individualising " or "Reductionist" paradigms have been further implicitly reinforced by training programmes which focus primarily on interpersonal skills and which often include training in escape and restraint techniques. These effectively reduce the problem to a " staff skill deficit" and risk further reinforcing prevailing individualising causal explanations and agency blame cultures. This is not to suggest that unprofessional and unskilled staff behaviour is not a key element in the generation of aggression in many services. It must, however be considered in a wider context.

Emergent research has however highlighted the relative ineffectiveness of training as a stand-alone response. However it continues to hold attractions for many managers and executive bodies as an easy and available response to occupational violence. The key lesson from emergent research (RCP; Allen 2003: 2004) is that training can be the keystone of the arch. However to achieve positive outcomes in terms of incident and injury reduction it must either be delivered in a context where the agency has developed the necessary setting condition in terms of leadership, effective management safe systems, therapeutic milieu etc. (See Braverman 2000: Paterson Leadbetter & Miller 2005, Fisher 2003; Colton 2004) Alternatively the training delivery strategy must adopt a " whole organisational perspective" in which effecting such changes is an explicit aim. The approach adopted by the Site E in the CWLA restraint reduction study, which returned the lowest injury rates.

Whilst the claims made by vendors of aggression management restraint training appear to have face validity and are superficially attractive, where such programmes ignore the primacy of contextual factors and /or include contain high tariff restraint techniques the possibility must be recognised that they may produce an outcome in which incident and injury levels increase, as suggested by emergent research.

CONCLUSIONS

We have argued that the current social policy crisis surrounding occupational violence, and the specific sub set problem of physical restraint, has its origins in prevailing paradigms and beliefs in which debates around occupational violence are historically located. These tend to individualise the problem and obscure the crucial role played by agency factors. The focus of attention in policy initiatives on restraint injury reduction has tended to centre on the establishment of safe restraint methods. The traditional calls for further research and for the proper regulation of the training industry must be supported. However , without a paradigm shift towards the recognition of Primary Prevention and agency milieu factors as key determinants of much occupational aggression we will continue to merely shift the deckchairs on the Titanic.

The seriousness and consequences of occupational violence requires urgent action at al levels. However we must also recognise that the process of Moral Panic may have led the debate down a narrow and unhelpful road. Dominated by Security perspectives. The consequences of which, particularly in relation to the use of high tariff restraint techniques, now requires Moral Action to put the genie back in the bottle. We must seriously consider the possibility that "reductionist " training programmes, those which solely address de escalation and restraint skills may have a paradoxical effect, in that they may well increase risk by obscuring the dominance of agency related factors as the key probable determinant of incident rates. A conclusion clearly indicated by emergent resaerch including the seminal CWLA SAMSAH grant initiative.
Whilst high tariff restraint methods may be both necessary and legal in some high risk services, such as Forensic mental health and some criminal justice services, their application to other services must be rigorously debated, given their strong potential. to produce counter productive outcomes and to further fuel the dynamics which produce violent conduct from service users and staff alike. The expectation that high tarrif restraint techniques will increase safety does not seem to be supported by the albeit limited literature. Their continuing atraction may therefore be a product of underlying assumptions and belief systems. The benefits offered from the security perspective may therefore be largely illusory and counter productive as the use of severe techniques are likely to erode, rather than increase staff and service user safety. Prevailing moral judgements must be expanded to include the ethical dimension of Beneficence " First do no harm". Hence one priority for training providers must be to convincingly demonstrate the relative risk and effectiveness involved in the application of procedures such that the principle of least restricitive intervention is honoured in deed as well as word. A process which will require rigorous auditing, the publication of injury rates by training providers and rigorous quality assurance.

Whilst the use of physical restraint will regrettably still continue to be necessary to ensure safety, the methods appropriate to specific services and service users must be individually considered, and the current one size fits all approach abandoned,.

The continuing ambiguity about the nature of acceptable restraint practice merely serves to undermine the confidence of dedicated human service staff. The continuing unquestioning use of high tarrif methods and those closely linked to injuries and fatalities also merely sustains the service user perception of the essential paradox upon which many services rest. The use of inhuman control methods by human services. The potential costs of the continuing failure to resolve this question are high. Not only in terms of the political costs of failing to maintain vulnerable individuals within the community and the consequent viability of the community care and welfare agendas. The physical means sanctioned by society to control the behaviour of dependent individuals also ultimately defines their status in that society.

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