Report to the Youth Justice Board on the use of Physical Intervention within the Juvenile Secure Estate

Di Hart & Steve Howell

Contents

Acknowledgements

We would like to thank the following who gave generously of their time and expertise in the preparation of this report.

Jon Fayle, Youth Justice Board
David Waplington, Peter Glynn, Peter Small and Jon Collier, Prison Service
Mark Burrows, Steve Hart and John Rowlands, Department of Health
Malcolm Stevens, Paul Cook, and Chris Wood, Rebound Group 4
Roy Walker, Secure Children's Homes Network
Roger Morgan, General Social Care Council
David Wilson, University of Central England
Steve Taylor, Shape project
Sharon Powell, BILD
Greg Watkins, Caldecott Community
Penny King, Fostering Network
Owen Davies, UNISON
Graham Ixer, General Social Care Council
Ronnie Hill, Scottish Care Commission
Andrew Hosie, Scottish Institute for Residential Child Care
Sandra Moody, Fostering Scotland
James O'Neill, Scottish Prison Service
David Allen, Welsh Centre for Learning Disabilities
Martin Price, Wales Office
Keith Ingham, University of Wales, Bangor
Elise Stewart, Children and Families Division, Welsh Assembly Government
Ronnie Orr, SSI Northern Ireland
Marion Reynolds, SSI Northern Ireland

Glossary of Acronyms

ACPC	Area Child Protection Committee
ACPO	Association of Chief Police Officers
BILD	British Institute of Learning Disabilities
C&R	Control & Restraint – approach to physical management of violence and aggression developed by the Prison Service
CALM	Crisis Anger Limitation Management
DfEE	Department for Education & Employment
LASU	Local Authority Secure Unit
NCSC	National Care Standards Commission
NFCA	National Foster Care Association
OFSTED	Office for Standards in Education
PCC	Physical Control in Care
PRICE	Protecting Rights in the Care Environment
PSO	Prison Service Order
RCN	Royal College of Nursing
RCP	Royal College of Psychiatrists
SSI	Social Services Inspectorate
STC	Secure Training Centre
TCI	Therapeutic Crisis Intervention
UN	United Nations
YJB	Youth Justice Board
YOI	Young Offender Institution

Executive summary

This report is concerned with the policy and practice of physically restraining children under the age of 18 who are placed in secure settings via the criminal courts. Its purpose is to assist the Youth Justice Board in deciding whether a uniform method can be adopted.

Care needs to be exercised in differentiating between the terms 'control and restraint', 'restraint', 'holding' and 'physical intervention', all of which carry different meanings. This report is concerned with restraint in the sense of direct physical contact between a staff member and child intended to physically overpower or restrict movement.

Current policy and practice in secure settings

Forms of restraint differ according to the type of secure establishment. Young Offender Institutions use Control and Restraint (C&R), Secure Training Centres use Physical Control in Care (PCC) and local authority secure units use a variety of methods.

There are basic principles which are common to all: physical restraint as a 'last resort'; the use of minimum force and for the shortest possible duration; restraint must not be used as a punishment. Otherwise, there is little commonality. Key differences are summarised below:

	YOI	STC	LASU
Based on risk assessment		√	√
Based on 'recalcitrance'	√		
Techniques are prescribed	√	√	
Pain-compliant	√		
Non-pain compliant		√	√
'Decking' can be used	√		√
Mechanical restraints used	√		
Unlimited single separation	√		
Child has a voice		√	√
Holistic approach to behaviour management		√	√
Training is regulated	√	√	
Culture of debriefing		√	√
Local monitoring	√	√	√
National monitoring	√		

When physical restraint can be used

The circumstances in which physical restraint can be used is inconsistent across the sector. In YOIs it can be used if behaviour is 'violent', 'recalcitrant' or 'disruptive' (terms open to interpretation and therefore abuse). Within STCs and LASUs, physical restraint should only be used when the child's behaviour is posing a risk of some sort, whether that risk is to self, others, property or the risk of escape.

In addition, there are differences as to whether physical intervention is located within an overall approach to behaviour management. Although all settings do make reference to the importance of de-escalation and the use of positive relationships between staff and children, this is not expanded upon within YOI guidance and staff are given no indication as to *how* they might achieve this.

Techniques

Both YOIs and STCs have clearly defined and detailed techniques for physical restraint. This has the advantage of clarity and accountability. It is not the case in LASUs where there is no single recommended system and a wide range of commercially driven methods are in operation.

The methods themselves have not been systematically evaluated and, apart from PRICE and PCC, there is no indication that they have been medically approved for use on children. In fact, inquiries have concluded that C&R should *not* be used on children. The use of 'decking', prone restraints and locks which put pressure on joints are particularly controversial. This does not apply solely to C&R: the unregulated nature of practice within LASUs means that some methods deployed there may also be dubious.

Another important difference is the fact that C&R starts where other methods stop i.e. with the use of pain-compliant locks. Prison Officers are not offered training in any of the holds which are said to be effective within other methods.

YOIs are the only setting where mechanical restraints can be used on children, albeit only on 17 year olds, and they can use ratchet handcuffs, again not available in other settings. There are also differences in the use of special accommodation or single separation. Children in YOIs can spend unlimited periods isolated in special accommodation whereas in other settings this is for a maximum of 3 hours in any 24.

It must, however, be acknowledged that both STCs and LASUs have the option of calling on the police and/or local prison officers if they are unable to control a particular young person. This is related to questions about the effectiveness of non pain-complaint techniques to address extreme situations.

Training

Training is tightly regulated within YOIs and STCs and no staff should restrain children unless they have been trained. This is not the case in LASUs, with at least the possibility that untrained staff may use restraint. Training is unregulated within LASUs and there is therefore no guarantee of its standard or suitability.

A weakness within both C&R and PCC training manuals is the fact that both concentrate solely on physical restraint. The do not incorporate any training on understanding challenging behaviour or on defusion/ diversion techniques.

Recording and monitoring

All settings require incidents where physical intervention has been used to be documented but only the prison service undertakes national monitoring, although the process is hampered by the lack of qualitative information and confusing terminology. The service does publish some national statistics.

Local monitoring is similar in STCs and LASUs, with managers being required to review all incidents and take any necessary action. Children are allowed or even encouraged to have their say. Local monitoring has also recently been introduced in the juvenile sector within YOIs, although there is no opportunity for children to express their views. The fact that few children complain about the use of restraint in YOIs is worrying. Whilst STCs and LASUs emphasise the need to learn from incidents and have a culture of debriefing, this is less evident in YOIs. Rebound has a policy of defining such complaints as child protection matters.

The role of the YJB in monitoring is unclear. It does not yet have its own inspection framework and inspections are currently undertaken by other Inspectorates in accordance with their own standards. YJB monitors do have a role but primarily to ensure compliance with contracts and the relationship between them and the Inspectorates is poorly defined.

Legal and ethical considerations

There are three areas of relevant law:

- employment law;
- civil law;
- criminal law (relating to assault).

Employers have a duty of care to both staff and children. Under Health and Safety legislation, they must ensure their staff's welfare against foreseeable risks and provide adequate training to ensure a safe working environment. This point is of particular relevance to establishments who care for those where there is little prior knowledge on which to base a risk assessment.

The latest UN Committee Report on the Rights of the Child has called for the Government to review the use of restraint and solitary confinement for

children across all settings. There is also case law to suggest that some practice may be open to challenge under the Human Rights Act, Article 3, which prohibits 'torture or inhuman or degrading treatment or punishment' and says that age and vulnerability are relevant factors.

It is a criminal offence to use physical force to restrict the liberty or autonomy of an individual unless the circumstances give rise to a 'lawful excuse'. Such justifications could be 'private defence'; that the action was undertaken 'in the best interests' of the person restrained; or to prevent a crime or a breach of the peace. It could also be legitimate if carried out by the exercise of statutory powers and duties – for example those given under the Mental Health Act. The question of intention, together with concepts such as reasonableness and proportionality in the degree of force employed, are also relevant.

The use of physical restraint is an emotive subject and staff are looking for clear direction, often perceived to be lacking. Key questions to be asked of any technique are: is it effective; safe; ethical; appropriate to the setting? A central distinction between methods of restraint is whether or not they rely on a degree of 'pain compliance' to be effective. If the decision is taken not to use pain on ethical grounds, staff need to be given effective alternatives.

Evidence base

There is a lack of rigorous research evidence in relation to managing challenging behaviour or associated training. There have been a few studies on the effectiveness of techniques, mainly C&R in health settings, but results are contradictory. Some studies report a reduction in staff or user injuries: others report the opposite. There are also methodological problems in judging whether a technique was being correctly performed.

The feelings of those who have been physically restrained have not been systematically researched but one study found that the majority of respondents rated their experiences negatively, with many believing staff used restraint as punishment and applied unnecessary force. A minority did report feeling 'safe' when restrained. Other studies suggest that users can recognise that restraint is sometimes necessary. The need for young people to feel listened to came out strongly, as did their sense of injustice if restraint had been applied unfairly.

Restraint in other services

Children in Public Care

The debate has been dominated by the possibility of abusive practice by staff. A number of Inquiries in the early 1990s recognised the need to keep children safe but called for clear government guidance and training materials. There is now guidance about situations when restraint should be used (to prevent harm to self, others or serious damage to property) but not specific methods. The particular challenges facing foster carers have not been adequately

addressed. Foster carers are trapped between the attempt to replicate 'normal' family life and their duty to care for children who may be challenging.

Education

Guidance issued in 1998 by the Department of Education and Employment aimed to reassure school staff that they could use reasonable force on pupils. The criteria are very different from those issued by the Department of Health, including the prevention of a child from committing an offence or 'engaging in any behaviour prejudicial to the maintenance of good order and discipline'. This has led to criticism, as has the fact that no methods of restraint have been suggested and there is no adequate training programme. It has also led to confusion within residential special schools, where staff are operating to two contradictory sets of guidance.

Health

Most guidelines for health service staff, such as those produced by the Royal College of Psychiatrists, are not age specific with the exception of the Royal College of Nursing. These emphasise the need for an ethos of care and respect, and the prior agreement of children and parents where restraint or 'safe holding' may be needed.

Services for people with learning difficulties

The only joint guidance across government departments is for people with learning difficulties or autistic spectrum disorder, issued by the Department of Health and Department for Education and Skills. The guidance states that planned interventions should only be used as part of a holistic strategy and when the risks of intervention are judged to be lower than the risks of not intervening. British Institute of Learning Disabilities (BILD) have been commissioned by the Department of Health to look at the issue of restraint for people with learning difficulties but their work can be applied to other client groups. They have published guidance on how to develop policy and a code of conduct for trainers and have a scheme to accredit trainers.

Discussion

There is a fragmented approach to the use of restraint across children's services. The dilemma is whether a common method is appropriate, given the very different functions, legal requirements and children's needs across settings. A major difficulty in achieving change is the paucity of research, resulting in decisions being based on opinion rather than evidence. We need to know more about the safety and effectiveness of different approaches, the views of staff and children and the effect of institutional culture. There is, however, scope to establish a sound ethical framework across settings which addresses staff and user needs and rights, supported by clear guidance and policy and relevant accredited training.

Conclusions

There are three options for the YJB and providers to consider:

1. *No change* - to continue with the current situation where YOIs, STCs and LASUs are operating different systems for the use of physical restraint.
2. *A single system across all settings* – to decide on a model of best practice in terms of policy, methods, training and monitoring which will be applied in all types of provision.
3. *A shared policy on behaviour management* – but operated through individualised systems designed to meet the particular needs of each type of provision.

Relevant factors in reaching this decision are:

Ethical and legal considerations

It must be questionable whether the use of pain complaint methods complies with the principle of 'minimum force' and with Article 3 of the Human Rights Act. Even if legally defensible, ethical doubts remain and it is contradictory to prohibit certain techniques in parts of the estate whilst endorsing them in others.

Effectiveness and safety of current techniques

The issue of effectiveness cannot be ignored, however. Opinion differs as to whether PCC or other non-pain complaint methods are adequate for all situations. This needs further exploration and clear guidance to staff on how extreme situations are to be handled. To inform the debate, there is an urgent need for sound evidence to be collected and evaluated on all methods under consideration focusing on:

- Medical safety;
- Psychological and emotional impact;
- Effectiveness.

Institutional culture

The use of physical restraint must be seen and understood in the context of the prevailing culture within the establishment. The ingredients of a successful residential environment are known: the challenge is how to incorporate these into practice. Although there are many positive developments being undertaken in YOIs, there is much to be done to facilitate regimes where children are understood and listened to. This problem is not restricted to YOIs: early inspections of Medway indicate that negative cultures may operate even with sound policies and adequate resources. England is unique in holding large numbers of juveniles in prison settings but there have also been concerns within other UK nations about the use of restraint, with some useful lessons to be learned from Northern Ireland.

Resources

Whatever is decided, the resource implications will need to be considered to ensure that change is achievable. These may include: policy development; training; staffing levels; environments; structures for debriefing; involving children; recording and monitoring systems. At the moment, the huge disparity in resources between YOIs and other settings may limit their ability to make some changes.

An agenda for change

Although pragmatic concerns are important, decisions also need to be ethically defensible. If it is decided that change is needed, we suggest that a starting point may be to discuss and agree a set of core values which will underpin a uniform approach across the secure estate, followed by the development of a policy framework, or Code of Practice, which encompasses all aspects of behaviour management within a single strategy.

If this change is to be achieved, it will require commitment and close cooperation between the relevant Government Departments, the providers of secure placements and the respective Inspectorates.

If it would be of assistance, the National Children's Bureau could undertake further research or development work.

Introduction

This report is concerned with the policy and practice of physically restraining children under the age of 18 who are placed in secure settings via the criminal courts. There has been increasing comment on the lack of consistency in the use of restraint between secure settings, despite their essentially similar population, and specific concerns about the treatment of children in prison. In response both the Youth Justice Board and the Prison Service have decided to review the issue of physical restraint of juveniles and to explore the possibility of adopting a consistent approach across the sector that recognises their legal status as children. This has coincided with a piece of work being undertaken by the National Children's Bureau to examine policy and practice in the use of physical intervention with children across social care, educational, health and secure settings. It was agreed that the Bureau would prepare a report to assist the YJB with their task covering the following:

- how restraint is currently used in different settings;
- legal and policy position;
- current staff training models and accreditation schemes;
- summary of published literature and research, including young people's experiences;
- recommendations from inspections and inquiries;
- a comparison with the other nations of the UK;
- advice about the factors that need to be considered in bringing about more consistency.

This report is based on documentary sources, including official guidance, inspection and inquiry reports and research literature, but also on information provided by a range of key staff within the sector who have shared their knowledge, experience and views. A list of those who contributed is provided in the Acknowledgments.

Background

Since the YJB was set up in 1998 it has been responsible for commissioning places for offenders between the ages of 12 and 17 who are remanded or convicted by a criminal court to a secure setting. There are three types of provision:

- Prison establishments: mainly Young Offender Institutions (YOIs) but with some girls being placed within adult prisons;
- Secure Training Centres (STCs): managed on contracts by the private sector;
- Local Authority Secure Units (LASUs): owned and managed by local authorities.

The arrangements for regulating and monitoring the activity within these establishments are complex. The YJB has no direct management control but has set out its requirements through contractual arrangements. This was perhaps most straightforward for the STCs, which were new establishments and dependent on the YJB for all their placements. The relationship is based

on a straightforward contractor/supplier relationship. This is not the case for the other types of provision. The Prison Service is responsible to the Home Office and only a small proportion of its beds are designated for juveniles, who should be held in separate accommodation from the adult population. It operates on the basis of a highly regulated set of systems and procedures designed to meet the needs of a predominantly adult male population. Local authority secure units are responsible only to their own local authority. Although operating within a national regulatory framework, policies and procedures are locally determined. Because they may take a mixture of 'welfare' children and young offenders, not all of their activity is covered by the YJB contracting process.

The diverse nature of this provision has resulted in diverse practice. Children entering each type of secure setting can expect to experience different regimes, although the YJB has done much to establish minimum standards for education and purposeful activity. A particularly stark difference lies in the varied approach to physical intervention, or control and restraint. This was raised in the House of Commons by Mrs Golding MP in May 2000. In his response, Paul Boateng acknowledged the differences and said that:

> *The (Youth Justice) Board intends to conduct a review of methods of physical control and restraint in juvenile secure accommodation with a view to identifying and promoting good practice* (Hansard Written Answers 8 May 2000).

An unannounced inspection of Castington in May 2000 called for a review of the use of wrist locks on juveniles and contrasted the treatment which young people of a similar age would have received in parallel establishments of the secure estate:

> *C&R techniques were used on all the population irrespective of size and physical maturity. Some of the trainees we met were physically immature and small in size. In a similar secure training establishment run by local authorities they would have been restrained using different techniques, on paediatric advice, that avoided the use of wrist locks (*HM Inspectorate of Prisons for England and Wales 2000 p.46).

Two years later, Hilton Dawson MP enquired as to the progress of this review and when methods used in STCs would be introduced uniformly across the juvenile secure estate. He was told by Beverly Hughes that a review of methods used in local authority secure units had been undertaken by the YJB but concluded that:

> *… it would be inappropriate to prescribe one method across all homes because of variations in size, ratio of welfare to criminal justice placements, and age groups. However, through its contracting arrangements the YJB requires homes providing criminal justice placements to use the control and restraint methods approved and specified by the Department of Health for use in this particular home* (Hansard Written Answers 21 May 2002).

In fact, the Department of Health neither approves nor specifies such methods. This point will be discussed in more detail later in the report. She then went on to say:

> *The board does not plan to extend the physical control and care methods used in secure training centres (STCs) to the rest of the juvenile secure estate for essentially similar reasons. Custodial facilities vary significantly in size, age groups, staff/trainee ratios and individual operational circumstances. But all facilities operate to the governing principle that their control and restraint methods should minimise the risk of injury to the young person, staff, and other residents.* (ibid.)

Criticism of this position has continued, however. The *UN Convention on the Rights of the Child* (Article 37) requires signatory governments to ensure that no child is subjected to torture or other cruel, inhuman or degrading treatment or punishment. The arrest, detention or imprisonment of children should be used only as a last resort and for the shortest period possible. All children deprived of their liberty are to be treated with humanity and respect, taking into account the needs of people their age. The Committee on the Rights of the Child which monitors implementation of the Convention last year expressed concern at the frequent use of restraint in UK residential institutions and in custody and called on the UK government to:

> *… review the use of restraint and solitary confinement in custody, education, health and welfare institutions throughout the State party to ensure compliance with the Convention* (Committee on the Rights of the Child 2002, p.8).

The Chief Inspectors also expressed their general concern about the safety of children in prison in their recent cross-departmental report, *Safeguarding Children* (Department of Health 2002a). They concluded that *most* children in prison are at risk of harm and there were high levels of injury. Finally, the recent ruling by Mr Justice Munby that children in prison are entitled to the protection of the Children Act 1989 must also contribute to the debate:

> *The State appears to be failing, and in some instances failing badly, in its duties to vulnerable and damaged children* (Mr Justice Munby 29 November 2002).

This report begins with a description of current practice in physical restraint across the secure estate, followed by a summary of the wider debate within children's services. It concludes with a discussion of the key factors which will inform decisions about future action.

Use Of Restraint In Secure Settings

Forms of restraint differ according to the type of establishment and, in the case of local authority secure units, even between units. Young Offender Institutions, in common with all prison settings, use Control and Restraint (C&R). Secure Training Centres use Physical Control in Care (PCC) and local authority secure units use a wide variety of methods and systems such as PRICE (Protecting Rights in the Care Environment), TCI (Therapeutic Crisis Intervention), CALM (Crisis and Aggression Limitation and Management) and C&R (General Services) – see *Appendix 1*. The following section describes current policies and practice across the three types of secure provision and examines some of the key issues arising from each approach. This information is structured under the headings of:

- when physical restraint can be used;
- techniques;
- training;
- recording and monitoring;
- strengths and weaknesses.

It is followed by a summary and comparative discussion of policy and practice across the settings.

Young Offender Institutions

C&R was introduced to prisons in 1983 as the approved method for dealing with violent or recalcitrant prisoners. Its techniques are based on the martial art of aikido (Cavadino and Dignan 1997, p.129). Prison staff spoken to in the course of this review considered it an improvement on the preceding, less regulated, system which consisted of:

> *… greater numbers of staff immobilising prisoners by attempting to get a hold of an arm or leg and 'lifting and shifting' them to a given area. This often resulted in unnecessary injuries to both staff and prisoners.* (Personal communication with Senior Officer)

C&R is used across both adult prisons and YOIs, which means that it may routinely be applied to children aged 15 and above of both genders. It is regulated by Prison Service Order (PSO) 1600, *Use of Force* (HM Prison Service 1999a) and the C&R methods themselves are described in PSO 1601*, Control and Restraint Training: Instructor's Manual* (HM Prison Service 2000). PSO 1600 states that:

> *The use of force by a prison officer is authorised under Prison Rule 47 and YOI Rule 47 which state: 'An officer in dealing with a prisoner shall not use force unnecessarily and, when the application of force is necessary, no more force than is necessary shall be used'* (HM Prison Service 1999a, p.1).

When physical restraint can be used

What is less clear is *when* the use of force is deemed to be necessary. The order says that C&R techniques are designed to enable staff to 'cope competently and effectively with violent prisoners and potentially disruptive situations' (2.2.1). Whilst judgements about what constitutes violence may be reasonably uncontentious, 'potentially disruptive situations' would seem open to a range of interpretations. The training manual (PSO 1601) suggests that C&R is the approved method for 'dealing with a violent or recalcitrant prisoner'.

The use of mechanical restraints and special accommodation *are* more clearly prescribed. Mechanical restraint, i.e. a body belt, can only be used:

> *… in order to prevent a prisoner causing self-injury, injuring another prisoner or member of staff, or damaging property, when its use is absolutely necessary to achieve the required objective and has been approved in accordance with this Order* (HM Prison Service 1999a, 4.4.1).

Similar conditions apply to the use of special accommodation i.e. special or unfurnished cells, but with the additional criteria that this can be used if a prisoner is 'causing a disturbance' (4.2.1). The duty governor must authorise the use of special accommodation or mechanical restraint and if use is to extend beyond 24 hours, there must be written authorisation by a member of the Board of Visitors. Medical opinion must also be sought. There is, however, no limit to the number of re-authorisations that can take place.

Body belts cannot be used on prisoners below the age of 17 but otherwise there are no restrictions on the use of restraint with juveniles. The fact that 17 year olds are in this respect treated as adults is at odds with other aspects of YJB policy and their status as children within the Children Act 1989. Ratchet handcuffs are not classified as mechanical restraints within the conditions of the order and can be used on juveniles. There are also no restrictions on the use of force with female prisoners, although some techniques are proscribed where they are known to be pregnant.

PSO 1600 states that force must never be used as a punishment. Neither should it be the first response to problematic behaviour. This is reiterated in the *Instructor's Manual* which emphasises that C&R should only be used when all else has failed and that force must be 'reasonable and proportionate':

> *It is not suggested that the appropriate response to disruptive or threatening behaviour is necessarily the use of force or that violence should necessarily be met with violence. Every opportunity should be taken to de-escalate the incident and only as a last resort should Control and Restraint techniques be used* (HM Prison Service 2000, Introduction).

These principles are particularly stressed in relation to juveniles. PSO 4950, *Regimes for Prisoners Under 18 Years Old* (HM Prison Service1999b) states

in an explanatory note that training must emphasise the importance of de-escalating violent situations by use of interpersonal skills and mentions 'the sensitivities of using C&R on young persons'. The note also goes on to say that the 'traditional concept of segregation has no part in working with young people'. If it is used:

> *Such separation must be accompanied immediately by work with the young person to enable their return to the full range of daily activities.* (HM Prison Service 1999b, 7.5.3).

Techniques

PSO 1600 states that only authorised C&R techniques, as described in the manuals, are to be used and with minimum risk of injury either to the person being restrained or the person applying the restraint. It specifies that use of C&R involves three officers and must be supervised and that normally this supervisor will be of 'at least senior officer rank although competence and experience are as important as rank'. Where no senior officer is available and immediate intervention is necessary the accountable officer will be the one in charge of the team. Each officer has a clearly defined role and the lead officer is responsible for controlling and protecting the prisoner's head. Wherever 'reasonably practicable' a member of health care staff is to attend a restraint and a prison doctor must be informed if restraint has been used, must examine the prisoner as soon as possible and record any injuries.

C&R techniques use arm locks and wrist locks which mean pain can be applied if deemed necessary. There are a series of manoeuvres, depending on the circumstances and prisoner's response, including the use of prone restraint where the prisoner is taken to the floor in a face down position. Although the use of pain is explicitly acknowledged within PSO 1601, it also places limitations:

> *The application of C&R holds may cause pain to a prisoner and if, for the purpose of restraining and controlling the prisoner:*
> *(i) it is not necessary to cause pain; and*
> *(ii) the prisoner is compliant*
> *the holds must be relaxed so as not to cause pain* (HM Prison Service 1999a, 2.2.5).

As stated above, special accommodation, often referred to in lay reports as segregation or solitary confinement, and mechanical restraints can also be employed. Prisoners in special accommodation must be observed every 15 minutes and those in body belts as often as directed by the governor. Staves, mini-batons and shields can be used in defensive situations although staves cannot be used routinely in juvenile or female establishments. Ratchet handcuffs can be used to move prisoners from one part of the establishment to another following a violent outburst.

Training

There are two levels of C&R training, basic and advanced. Advanced training is offered to selected and experienced officers for use primarily in riot or

exceptional situations and is not explored within this report. Each Prison Officer receives 29½ hours training in basic C&R on entry and 8 hours refresher training a year. C&R should therefore only be deployed by trained and competent staff.

C&R training is delivered only by qualified instructors. They are told to stress that C&R is only one strategy within the overall response to threatening or violent behaviour and discouraged from presenting the techniques with a 'macho' approach as this is likely to be carried across to the manner in which trainees perform restraints:

> … *to the serious detriment of their performance, their inter-personal relationships with prisoners and ultimately to the reputation of the Prison Service* (HM Prison Service 2000, Annex D)

The *Instructor's Manual* covers dangers such as positional asphyxia and notes that there had been, at the time it was published, seven deaths in custody associated with physical or mechanical restraints. It cautions staff to be aware of signs and symptoms which may indicate a prisoner is in distress.

Recording and monitoring

Incidents where force has been used are to be recorded by the supervising officer. However, force is not clearly defined: it extends beyond C&R and may include the separation of prisoners who are fighting or instances where officers have broken away from an attack. The report details:

- the date, time and location of the incident;
- the name, gender, age and ethnicity of the prisoner;
- the nature of the incident including the circumstances prior to the use of force;
- the name and rank of the authorising officer;
- the type of force employed, including whether C&R was used and the use of staves or ratchet handcuffs;
- the rank and names of all officers involved;
- whether a member of Health Care was present;
- whether a body belt was used;
- the date and time of informing the duty governor and Prison Doctor.

Individual officers must also give their own accounts. Records are held on a central file in a secure cabinet to which only authorised staff have access and an entry is made on the prisoner's file. Monthly statistical returns are sent by each prison to the National Operations Unit of the Prison Service, who scrutinise and analyse them, although the fact that the statistics are not supported by qualitative information limits their ability to judge practice standards. The requirement is to report on the Use of Force, which is not completely synonymous with C&R. Prisons are also required to record each use of mechanical restraint and special accommodation and submit these records for central analysis. These statistics are published annually by the Home Office and the most recently available show that 216 boys were kept in such accommodation in 2001 (Home Office 2003). Care needs to be taken in interpreting statistics because it is easy to confuse the use of force, C&R and

the use of restraints, terms which all carry a different meaning, and only the last are published.

The procedures themselves do not specify a system of local monitoring, nor is there any mention of any need to inform parents or external professionals about incidences where force has been used. In spite of this, the Juvenile Operations Management Group has recently introduced a review process within YOIs. Principal Officers are responsible for reviewing incidents which take place when they are on duty and Governors are required to hold monthly meetings when all the Use of Force forms are examined and action taken where necessary. This process is said to have resulted in a reduction of the use of C&R in some establishments.

YOIs are visited regularly by a Board of Visitors but they do not have a specific role in reviewing the use of force. Independent advocates are shortly to be introduced into units for juveniles and may ensure an increased level of independent scrutiny. Each establishment is inspected by HM Inspectorate of Prisons for England and Wales every three years and there is also a system of unannounced inspections.

Strengths and weaknesses

There is no doubt that the system enjoys widespread confidence amongst prison officers and C&R training is sought after by other services such as health and probation. In an area of professional practice often characterised by vague guidelines, the prison service must be commended for providing staff with explicit guidance and clear expectations. The proponents of C&R see it as a well understood, relatively quick and effective way of regaining control in a situation where escalation could have very serious consequences. It also has the benefit of having clearly defined techniques with each officer having a designated role. Requirements about the involvement of health care, levels of authorisation and recording mean that the system is transparent and accountable. There is also a system for national monitoring and some statistics are available in the public domain. It must also be acknowledged that the Prison Service is dealing with some of the most disturbed and violent children in our society with limited resources and in poor environments.

However, there are a number of concerns about the use of C&R.

Thresholds for using force

As stated earlier, although the techniques are clear, the occasions when force can be used are not. They are open to considerable interpretation in their use of terms such as ‘recalcitrant’, ‘disruptive’, ‘causing a disturbance’. Perhaps linked with this, there would appear to be wide variations between establishments in the frequency with which force is used. According to Hansard provisional data on the use of force on juveniles in YOIs from April 2000 to January 2002 were as follows:

	Number
Ashfield	368
Brinsford	312
Castington	450
Feltham	511
Hollesley Bay	215
Huntercombe	436
Lancaster Farms	120
Onley	309
Portland	129
Stoke Heath	413
Thorn Cross	1
Werrington	184
Wetherby	167

(Hansard 30 Jan 2002)

Of course such variations might be related partly to the nature of the children placed there and certainly this view is reflected in staff comments in some of the inspection reports:

> *Insufficient recognition was given to the problems [one establishment] faced. It was continually being compared to other young offender establishments but in fact it was holding more dangerous, difficult and impulsive young offenders. Comparisons of assaults were unfair because [they] had to take all those that other establishments could not handle* (HM Chief Inspector of Prisons for England and Wales 1998, p.97).

It would seem likely however that the prevailing ethos or culture of an establishment plays a part in the threshold for the use of force. One inspection report says:

> *The level of assaults was disturbing and the use of control and restraint techniques alarmingly frequent. We received a high number of complaints from young prisoners that they felt intimidated by staff, and in particular that they were being bullied and subjected to a range of informal and illegal punishments. In an inspection lasting only a few days it was not possible to validate such allegations but these complaints were expressed right across the establishment* (Children's Rights Alliance for England 2002, p.85).

In *Young Prisoners: a Thematic Review by HM Chief Inspector of Prisons for England and Wales* the then Chief Inspector made clear his concerns about the use of control and restraint techniques, especially on children, and suggested:

> *It is no coincidence that those young offender institutions with the poorest regimes have the highest incidence of the use of control and restraint* (HM Inspectorate of Prisons for England and Wales 1997, p.32).

For example, Onley YOI has recently been heavily criticised by the Inspectorate (HM Chief Inspector of Prisons for England and Wales 2002) for the paucity of its juvenile regime and clearly makes more far more use of force than Lancaster Farms despite housing a similar, or even less challenging, population of children.

Children's perspective

Although official complaints may be few in number, this cannot be taken as an indication that children are content with a practice which many refer to as 'being twisted up'. Unlike other settings, prisons do not offer children the opportunity to record their own account of incidents or to have a de-briefing discussion. They do not, as yet, have access to independent children's advocates (although this is about to change) and there is no routine practice of informing parents or external professionals of the use of force.

The Children's Rights Alliance found in their review of Prison Inspectorate Reports that young people complained of provocation by staff – despite the explicit prohibition of this by the Young Offender Institution Rules 2000 '*No officer shall act deliberately in a manner calculated to provoke an inmate*' (See also Prison and Young Offender Institutions (Scotland) Rules 1994).

Concerns expressed by the children

- *Officers have pushed me about for no reason*
- *One screw comes in my pad and twists me and expects me to hit him back so all the screws have a go*
- *Officers call me thick and stupid*
- *Some staff are OK, but most would say, so what*
- *A prison officer said he had had my mother – totally uncalled for*
- *The officers are violent up here – the screws are the biggest bullies*
- *Staff are always shouting and swearing at me*
- *A member of staff in the visiting room slapped me when I was getting searched*

(Children's Rights Alliance for England 2002 p.82)

Safety of techniques

The Chief Inspector's report on Castington in 2000 called for a review of the techniques to minimise avoidable injuries to juveniles. Of the total 3615 incidents reported in Hansard between April 2000 and January 2002, 296 had resulted in injuries, including five fractures. According to the Children's Rights Alliance for England an inspection of Feltham in 2000 demonstrated that a high proportion of injuries are caused by the use of C&R:

Injuries in one establishment, June to October 2000

	Assault	Control and Restraint	Fights	Self Harm	Sport	Other
June	15	19	82	39	7	27
July	25	23	74	30	10	24
Aug	16	11	51	9	7	21
Sept	26	19	67	16	3	20
Oct	14	22	34	9	2	8

(Children's Rights Alliance for England 2002, p.85)

It is difficult to assess whether injury is caused by

- excessive force;
- techniques being incorrectly applied; or
- the techniques themselves being inappropriate for juveniles.

Regarding the level of force used, the Chief Inspector (HM Inspectorate of Prisons 1997, p.32) commented that the commitment to minimum necessary use of force in PSO 1600 and PSO 1601, while humane and commendable, is capable of a very wide range of interpretation. Livingstone and Owen (1999, p.314) comment that it is quite normal to find that officers' descriptions of incidents on Use of Force reports do little more than specify which part of the body was restrained with a standard claim that 'no more force than was necessary was used' (all the officers involved in the case of Kenneth Severin who died following the use of C&R denied the use of excessive force) but clearly this is inadequate information in terms of monitoring the reasonableness or proportionality of any intervention.

In a comment in the C&R *Instructor's Manual* that has implications for all forms of restraint and restraint training it is acknowledged that theory and practice may vary:

> *Operational experience will not always mirror tutorial contrived situations… In daily operation of these techniques, the local geography of the establishment or physical inability of staff to perform the techniques as described in this manual, may require staff to adapt those techniques to enable them to gain effective control of the prisoner* (HM Prison Service 2000, Introduction).

While this is in one respect simply a statement of the obvious it has potentially worrying implications in respect of any application of restraint. It is generally agreed that while a system may be quite reasonable and safe in theory - 'adaptations' whether because of the pressure of the moment, ignorance or inexperience, lack of practice or simply malice, can be highly dangerous. The Inquest into the death of Alton Manning, a 33 year old black remand prisoner at Blakenhurst Prison, who died in 1995 of asphyxia during a restraint, identified several elements of his restraint which were contrary to Home Office Control and Restraint Guidance. The two most senior officers involved in the restraint claimed to be ignorant of guidance issued in August 1992 which warned of the dangers of restraining prisoners in the prone position or

applying pressure to the neck, chest or abdomen. According to Inquest, which campaigns against deaths in custody and for changes in the Coroner's Court system,

> *Mr Manning was brought down on to the floor and held prone, face down, with officers putting his arms in locks and restraining his head and legs. Reynolds testified that he put a knee at the base of the spine on the right hand side for 2 to 3 seconds. This was in direct contravention to Home Office directives on Control and Restraint. Home Office, 3 August 1992: Paragraph 4* (Inquest 1998).

The deaths of Denis Stevens at Dartmoor Prison in October 1995, and Kenneth Severin in November of that year also highlight the danger of positional asphyxia resulting in death as a consequence of excessive and inappropriate application of pressure during restraints, and of officers failing to follow, indeed claiming ignorance of, correct procedure and practice.

Perhaps a more fundamental concern, however, is the question as to whether a technique which is based on pain-compliance, pressure on joints and prone restraint is suitable for children at all. In its training materials for residential childcare workers issued in 1996, the Department of Health stated:

> *Controlling children through pain is hardly any different from child abuse. Holds should not apply pressure which works against the joints, partly because this is painful and partly because it can result in the young person being seriously injured* (Department of Health 1996 Module 6, p.3).

This document also suggests that children should not be 'taken to the floor':

> *… partly because there is a risk of falling over and causing injury – but there is another, more important reason. It is a position of extreme vulnerability and it can be highly traumatic for young people who have been sexually abused* (ibid).

A group of medical, psychiatric and government personnel advised the Home Office in 1997 of their view that pain compliant methods were inappropriate for children because of the immaturity of their bone development, the possibility of their abnormal response to pain and the psychological consequences, particularly where they had experienced previous abuse (Howard League 2002, p.13). These recommendations are not in the public domain. Their opinion is said, however, to have influenced the decision to adopt an approach within STCs which does not rely on the use of either pain or prone restraint.

Perhaps the final word should go to someone who has experienced C&R:

> *There ain't no dangerous people in this jail, but they treat you like a 10ft man, twist you up, and it really hurts and they'll be laughing, saying 'that doesn't hurt'* (Howard League 2002, p.13).

Lack of evaluation

Wright (1999) suggests that there is a lack of objective research evidence into the effectiveness and safety of C&R (as is the case for other restraint systems), nor has there been any systematic research on its acceptability to both restrainers and restrained. Most studies of C&R relate to its use in adult psychiatric settings and findings of these studies are contradictory (*see p.41*).

Although there is a clear system for recording the use of force, the information does not lend itself to critical analysis.

> *The former Chief Inspector of Prisons, Judge Tumin, frequently expressed concern that staff did resort to control and restraint techniques, as well as the use of body belts, too often and that 'use of force' reports are not correctly filled out by staff, thus making it difficult properly to assess if staff have acted reasonably* (Livingstone and Owen 1999, p.314).

Trends may be apparent but it is difficult to evaluate whether particular instances are appropriate or necessary from statistical returns alone. There is no requirement on officers to discuss an incident where force has been used with colleagues or supervisors to consider whether it was valid, effective or safe or to learn lessons for the future. Moreover, to evaluate the use of force fully, consideration would need to be given to the overall approach to behaviour management within an establishment. Are officers able to understand and prevent behavioural problems before they require restraint? Does the environment encourage or reduce the risk of violence? Is there a macho culture or do officers engage positively with the children in their care? Are officers able to question their own and others practice?

Secure Training Centres

When the STCs were being introduced, the Prison Service was asked to design a system specifically for the first one to open (Medway) and this method, Physical Control in Care (PCC), must now be used in all the STCs.

> *The resultant package was the culmination of two years work and research to produce an effective, legally defensible, humane system that caters for the needs of young persons in care, and the staff who work for them* (HM Prison Service 1998).

PCC is a development of PRICE (Protecting Rights in the Care Environment) which was devised after children had been injured through the use of C&R at Aycliffe Centre for Children. This was said to follow extensive consultation with County Councils and others on the problems they faced in working with challenging children and young people. Although STCs are not currently regulated settings within the terms of the Children Act 1989 or the Care Standards Act 2000 and therefore do not have to comply with the regulatory framework for children's homes, the techniques used in PRICE/PCC are said to be based on the *Children Act Guidance (Volume 4)* and the Department of Health's 1993 *Guidance on Permissible Forms of Control in Children's*

Residential Care. PRICE techniques are those used in the *Taking Care Taking Control* training pack (Department of Health 1996). They are also said to be medically approved for use on young people. The description of PCC is found primarily in the Training Manual (HM Prison Service 1998).

When physical restraint can be used

Secure Training Centre Rule 38 relates to Physical Control. It sets out the criteria when physical restraint can be used:

1. *No trainee shall be physically restrained save where necessary for the purpose of preventing him/her from:*
   a. *escape from custody;*
   b. *injuring themselves or others;*
   c. *damaging property; or*
   d. *inciting another trainee to do anything specified in paragraph (b) or (c) above, and then only where no alternative method of preventing the event specified in any of paragraphs (a) to (d) above is available.*

These criteria are similar to C&R guidance in stressing that physical contact to resolve problems is a 'last resort'. In other respects they are both clearer and based on a different conceptual framework: that of 'risk' rather than 'recalcitrance'. It is not enough for the child's behaviour to be challenging: it must also be likely to lead to harmful consequences if not checked.

Techniques

The PCC system is based on a series of 'holds', suitable for use by one, two or three members of staff (phases 1,2 and 3). These holds are designed to be phased in response to the situation so that no more force is used than necessary at any point. Systematic de-escalation of physical holds is said to be central to the technique:

> *Dialogue between staff and the young person should occur throughout the use of holds. As the young person regains self-control staff should seek to phase down the holds when in their assessment it is safe to do so* (HM Prison Service 1998, 2.2.5).

The system is not designed to inflict pain or to rely on pain-compliance for its effectiveness, although it must be acknowledged that some pain may result if the child struggles. There are, moreover, three 'distraction' techniques designed to deliver a short, sharp episode of pain to the child if, for example, there is a need to get them to release their grip on another person. These are aimed at the child's nose, ribs or thumb.

PCC has a 'non-decking' policy: there are no techniques which deliberately take the person being restrained to the floor – aiming instead to maintain them in the standing or sitting position. If there is a likelihood that the child might end up on the floor, staff are instructed to release the hold. However, if the child is already on the floor, a technique for holding them safely is provided.

There is an acceptance that PCC may not always be safe or effective and where the safety of staff or children is thought to be compromised, there is always a 'hold release option'. This notion of continually assessing risk also relates to whether physical means of control should even be initiated. Staff are told to assess:

1. *Their own physical ability*
2. *The physical ability of the trainee*
3. *Known history of the trainee*
4. *The minimum intervention phase required to successfully resolve the situation*
5. *The availability of other staff*
6. *The presence of other trainees*
7. *The environment.*

Having considered the above factors will determine or not whether staff can intervene (HM Prison Service 1998, Principles of P.C.C.).

If staff are unable to effectively restrain a child, they can request support from the police or officers from a local prison who will then use their own methods of restraint.

The PCC manual states that the young person's safety must not be secured at the expense of staff's. The system includes breakaway techniques and is said not to depend on the size or strength of the care worker for its effectiveness:

> *These techniques offer a structured response to attacks within the care environment, giving minimal risk of injury to staff and the young person* (HM Prison Service 1998, Safety).

The importance of team work is emphasised but PCC does not clearly designate the role of each staff member involved in a restraint in the way that C&R does, although there are indications that this may have evolved in practice. It is suggested that non-involved staff should act as observers if possible. Following each incident, the nurse should be informed and the child offered a medical examination.

STCs do not have the special accommodation or unfurnished cells available within prisons. They do, however, have the option of 'single separation' where the child is confined to their bedroom for a maximum period of 3 hours in any 24 with observation every 15 minutes. Neither do STCs currently have access to mechanical restraints or the use of shields. Where staff need to protect themselves from a child with a weapon, it is suggested that they use a chair.

Training

As with C&R, there is an expectation that only approved techniques should be used and that all staff should be trained in their use. The *STC Rule 38* says that:

> *No trainee shall be physically restrained under this rule except in accordance with methods approved by the Secretary of State and by any officer who has undergone a course of training which is so approved.*

All training was delivered initially by Prison Service Trainers but they have now trained instructors within each STC to deliver this training to their own staff. These Instructors receive annual refresher training. At Rebound, who are the main provider of STC placements, PCC training is provided as part of the 7 week induction training for new staff and therefore incorporated into the overall approach of the establishment.

Recording and Monitoring

Rule 38 states that:

> *Particulars of every occasion on which a trainee is physically restrained under this rule shall be recorded within 12 hours of its occurrence.*

Rebound take the question of recording and monitoring seriously and go beyond the regulatory requirements. They require their staff in Medway and Rainsbrook to record every incident of problematic behaviour, whether physical control was used or not. As with the Prison Service Use of Force format, staff must record the date, time and exact location of the incident; all the staff and trainees involved; whether physical control was used and, if so, which holds; whether single separation was used and, if so, for how long; injuries to trainee or staff and the involvement of nursing or medical staff. Where the format does differ from that used within the Prison Service is in the qualitative information it requires. Staff are asked to code why the problematic behaviour may have occurred e.g. 'after a family visit', 'received mail'. They are asked to consider the trainee's response to the incident, including whether they showed remorse or apologised. They are also asked what happened before, during and after the incident and how it was finally resolved. There is therefore more emphasis on understanding the incident as well as managing it. There is a trainee incident sheet completed for each child involved and they receive a letter following each incident. In addition, there must be recording in the 'Physical Control Log book'.

Each incident report form is then seen by three levels of management for comment and a copy given to the YJB Monitor for the establishment within 12 hours. It is the expectation that a manager will inform the child's parents/carers and the child's post-release supervisor of incidents 'as appropriate'. Each Residential Service manager is responsible for collating incidents of physical control in their own unit and for identifying patterns involving particular staff or trainees. Staff who are never involved in incidents may give rise to as much concern as those who are often involved. The Residential Service Manager will also meet each trainee involved in an incident to ascertain their views and feelings, which will then be documented

on their file. A PCC Monitoring Group is held monthly involving managers, PCC Instructors, a Nurse and 2 trainees to review practice.

It is Rebound policy to treat any complaint by children arising from the use of physical intervention as a child protection matter and these are referred initially to the YJB monitor who will decide whether to pass them to the local ACPC agencies for investigation. Children do complain about physical restraint: it is estimated by Rebound that such complaints constitute about 20% of the total. STCs have input from independent children's advocates which ensures that children have access to support if they wish to complain.

The system for monitoring the use of PCC on a national level is unclear. Monthly reports are sent to the YJB but statistics are not published and there does not appear to be an equivalent process to the regular Use of Force meetings held by the prison service.

STCs are currently inspected jointly by the Social Services Inspectorate (SSI) of the Department of Health and the Office for Standards in Education (OFSTED) on an annual basis. There is a proposal that responsibility may shift from the SSI to the new Commission for Social Care Inspection but this is still uncertain.

Strengths and weaknesses

It cannot be disputed that if children's behaviour can be managed without pain-compliant methods, this must be preferable. Practice in the STCs is more akin to that within children's homes and its approach to behaviour management in general and physical control specifically are compatible with the Children Act, although they are not legally bound by Children Act regulations. There is an emphasis on understanding problematic behaviour and talking to troubled children about their responses rather than simply controlling them. Recording and monitoring systems are used within Rebound establishments to learn from incidents, both in terms of good practice generally and in order to plan for individual trainees. They are also happy to account for their practice to outsiders, informing parents, carers and other professionals of incidents. The decision to define complaints about physical control as child protection concerns adds to this accountability and is an important safeguard, although the practice of filtering these through the YJB monitor is open to question.

There are some potential difficulties, however.

Theory and practice?

As ever there may be a gap between theory and practice either because staff 'innovate' or stray from the taught techniques in the heat of the moment or possibly even from malicious intent. The early days of Medway STC were troubled and an inspection report in September/October 1998 found that restraint was being used without proper supervision and in situations where, in the inspector's view, defusion could have worked. Moreover despite the fact that the Inspectors were told all staff had been trained in PCC, unacceptable holds were being employed:

> … *we observed instances when wrist and neck locks were used in restraint. These methods have been criticised by the medical profession as being potentially injurious to young people whose bodies are still developing. They are also in contravention of the STC rules* (Department of Health 1998, p.20).

The Inspectors found on the one hand that staff drafted in from elsewhere were not comfortable using PCC methods and on the other that young people felt unnecessary force was used in some restraints which resulted in injuries and a sense of grievance, fuelling 'their sense of injustice and powerlessness'. The Inspectors pointed to the negative consequences of this:

> *The over reliance on the use of restraint and single separation as a primary means of control, and the fact that trainees felt aggrieved and powerless confirmed them in a 'victim' role. This perception enabled them to justify their own aggressive and destructive behaviour and strengthened their criminogenic tendencies* (Department of Health 1998, p.30).

A later report on Medway found that there were differences of approach within the staff group with some behaving in a more provocative way:

> *Staff themselves observed that 'Group4 don't abide by some (restraint) procedures. ... Medway staff know this, but turn a blind eye' …records from Voice of the Child in Care (independent persons working under contract from the Home Office) between July 1998 and May 1999 … listed more than 20 complaints of 'assault' or 'rough treatment during restraint*' (Hagell et al 2000, p.53).

A comment recorded from one trainee illustrates that whatever method of restraint is supposedly being sanctioned, without proper supervision, it can be abused:

> *Group4 are always threatening yer ...when you argue with 'em they give you a quick dig and that, a sly dig. And when they restrain yer they slap you all over, batter you and that. Looking at 'em they're massive compared to us aren't they?* (Hagell et al 2000, p.52).

An additional question must be asked about the meaning of the term non-pain compliant. The technique sanctions three 'distraction' techniques such as the 'nose distraction' which does inflict pain. It must also be conceded that children may experience pain if they struggle against holds and some injuries, albeit minor, are said to have been caused during PCC. It is not clear whether information about injuries are centrally collated in the same way as in the Prison Service. The YJB role in centrally monitoring practice is less than clear because of the lack of their own Inspection Framework. Whilst SSI Inspectors and the YJB Monitor have access to recording about the use of physical control, there is not the same framework for centralised control as that which exists within the prison service.

Effectiveness

PCC was designed originally for 12-14 year olds, the expected population of STCs. The pressure on places means that STCs sometimes have to accept older children and it may be questioned whether the methods are then always sufficient. During a meeting held at the YJB to discuss the different forms of restraint across the Juvenile Secure Estate it was claimed that some STC staff have concerns at the adequacy of PCC for responding to very difficult/disturbed inmates and were said to have requested some form of pain compliance procedures, a 'Phase 4' restraint, for use in these situations. However this is said not to be the experience of staff at Rainsbrook STC who apparently feel that the system is effective in its current form. It would be useful to explore the reasons for this seeming difference between similar institutions to identify the factors that make PCC apparently work well in one place and less well in another. As the differences cannot be explained by the nature of the children, it is likely that the answers lie within the management and culture of the establishments.

The report cited earlier (Hagell et al 2000) noted that increases in staff experience and confidence at Medway appeared to result in less confrontations and use of restraint. There is no consensus about this, however. One suggestion has been that there is not necessarily less physical intervention used at Rainsbrook but that the confidence of staff allows them to intervene at an appropriately early stage. Those with knowledge of Rainsbrook suggest that the key factors in making PCC, and behaviour management in general, effective were the confidence of the staff group, communication between staff, relationships between staff and the children and sound knowledge of the children and their difficulties. Perhaps as a result of this, Rainsbrook does not have the same staff recruitment and retention problems as the other STCs which in turn has an impact on the skills and experience of the group. Clearly anecdotal claims are interesting but do not constitute objective, verifiable evidence and this requires further comparative research and analysis of data.

A consequence of this debate about effectiveness is the question of what happens in those situations where PCC is deemed to be unsuitable or proves to be ineffective. Staff have the option of calling on the police or prison officers who will use pain-complaint techniques. Is it unfair to criticise the prison service for their practice if it is tacitly acknowledged that such techniques may be called on where PCC has failed? The prison service has no recourse to external sources of help if they are unable to control a prisoner.

> *In some situations, where agencies have specified that pain will not be used, or there is a 'no touch' policy in place, the calling of the police to take control of out-of-control situations with young people effectively means that other parties are being called on to use methods that the agency has decided are ethically unacceptable. In short, ethical considerations are important, but must always be matched with a realistic assessment of what the actual method can be expected to achieve, and how those situations it cannot*

> *reasonably be expected to handle will now be dealt with (*Lindsay and Hosie 2000, p.13).

Safety

It has been suggested to us that PCC results in fewer injuries to children but more injuries to staff than C&R. This is said to have been raised as a concern by the Health and Safety Executive and requires further analysis.

In response to the concerns about both effectiveness and safety, recommendations are being made by the Prison Service Trainers about possible modifications to PCC but these have not yet been approved. These relate to:

- the use of 'soft' restraints – a form of net which immobilises a young person without harm;
- the use of shields for staff to defend themselves against the use of weapons. It is suggested that these would be both more effective and safer than the use of chairs;
- a more realistic approach to situations where children are likely to end up on the floor. At present, staff are told to release their hold but in practice this is risky for both children and staff.

Resources

There are resource implications in operating the PCC system. It is said that a restraint can go on for a long time – meaning more staff have to be involved. The people applying the restraint may become stressed, tired or their hands sweaty and hence grips less secure. This could make injury more likely and consequently there is a need for more staff backup. We also need to know how the young people feel about being restrained for long periods – does this add to their resentment or could it contribute to their need for negative attention – leading them to actively provoke interventions?

Local Authority Secure Units

LASUs provide a very different environment and working context to the YOIs and STCs. The activity of local authority units is determined by the Children Act 1989 and its associated guidance for children's homes. They must also comply with the *National Minimum Standards: Children's Homes* issued in 2002 by the National Care Standards Commission (NCSC) in accordance with the *Care Standards Act 2000*. Interestingly, the Standards currently make little distinction between the expectations of secure units and other types of children's home:

> *Children in secure accommodation within a home are cared for consistently with these national minimum standards, with only those adaptations essential in the home concerned for the maintenance of security* (Department of Health 2002b, p.21).

This statement is being reconsidered with a view to having an additional module on secure settings as the above is open to wide interpretation. For example, there is no consensus by Care Standards Inspectors as to the

extent to which CCTV surveillance is acceptable with a view to the 'maintenance of security'.

LASUs are typically small establishments and operate with high staffing ratios of 5 staff to 10 children as a minimum. Children and young people placed within them fall into two main categories, welfare placements under Section 25 of the Children Act 1989, that is children who are in danger of absconding and a risk to themselves or others, and youth justice placements of children remanded or convicted under Criminal Justice legislation. As in all children's homes the use of restraint is an area of practice which attracts a lot of anxiety – the often very challenging behaviour of young people and the child-centred commitments of the Children Act can seem difficult to reconcile.

When physical restraint can be used

LASUs operate to the same criteria as other children's homes excepting:

> *Only if the child tries to run away would different criteria be appropriate. Subject to what follows staff should intervene physically, including restraining the child in accordance with the following principles:*
> 1. *The staff member must have reason to believe that the attempt to escape has a realistic chance of success unless some sort of intervention is made.*
> 2. *Physical restraint should be attempted only where there is sufficient staff at hand to ensure that it can be achieved safely.*
> 3. *Physical intervention should not be substituted for waiting patiently when, for example, a child has got onto a roof and, although in some danger, is unlikely to escape further; physical intervention could create greater danger* (Department of Health 1993a, p.5).

The Children Act 1989 Guidance and Regulations. Volume 4: Residential Care (Sections 1.82 to 1.91) set out official guidance on behaviour management and restraint in children's homes whilst making it clear that care and control are linked:

> *Systems of control and discipline cannot be divorced from systems of management and systems of care practice and planning within the home* (Department of Health 1991, p.15).

The guidance specifies prohibited disciplinary measures, such as corporal punishment, and makes the important point that 'a major determinant of good behaviour and positive ethos of the home is the quality of the relationships between the staff and the children*'.* The guidance calls for relationships within homes to be based on honesty, mutual respect and good professional practice where the children receive a quality of care which compensates for earlier negative experiences or neglect. The criteria for use of physical restraint are as follows:

> *Physical restraint should be used rarely and only to prevent a child harming himself or others or from damaging property. Force should*

> *not be used for any other purpose, nor simply to secure compliance with staff instructions* (Department of Health 1991, p.15).

In 1993 it was felt necessary to issue more specific guidance on exactly when physical restraint might be applied: *Guidance on Permissible Forms of Control in Children's Residential Care* (Department of Health 1993a). This sets out seven guiding principles relating to the use of physical restraint:

- *Staff have good grounds for believing immediate action is necessary to prevent significant injury to the child or others or serious damage to property.*
- *Staff should take pre-emptive steps to avoid the need for restraint (dialogue and diversion).*
- *Only the minimum force necessary to be effective should be used.*
- *Every effort should be made to secure the presence of other staff before applying restraint –as assistants or witnesses.*
- *As soon as it is safe restraint should be relaxed to allow child to regain control.*
- *Restraint should be an act of care and control, not punishment.*
- *Restraint should not be used purely to force compliance with staff instruction when there is no immediate risk to people or property* (p.10).

Yet more 'clarification' was issued in 1997 in the form of a Chief Inspector's letter, *The Control of Children in the Public Care: Interpretation of the Children Act 1989,* in response to criticism that the guidance was too vague and that staff were not intervening in potentially risky situations because of a concern that they would be criticised for infringing children's rights. This was particularly the case where young people wanted to leave the premises without permission.

> *Children must be listened to and their wishes and feelings taken into consideration. But this does not mean that local authorities, social workers or carers are constrained to abide by the wishes of the child. The wishes and feelings of children can, and indeed should, be overridden in decisions that affect them if this is necessary to safeguard and promote their welfare and protect others* …(Department of Health 1997, p.3).

The letter emphasised that staff have the duty to intervene immediately to prevent children putting themselves or others at risk or seriously damaging property, and it was the *action* that needed to be immediate – not the *risk*:

> *… .if necessary staff have the authority to take immediate action to prevent harm occurring even if the harm is expected to happen some time in the predictable future* (Department of Health 1997, p.4).

Moreover:

> *… they have the responsibility and the authority to interpret 'harm' widely and to anticipate when it is clearly likely to happen* (p.3).

The *National Minimum Standards for Children's Homes* have not brought about significant change. Standard 22 defines the desired outcome of a home's approach to behaviour management:

> *Children assisted to develop socially acceptable behaviour through encouragement of acceptable behaviour and constructive staff response to inappropriate behaviour* (Department of Health 2002b, p.32).

Each establishment is expected to have a behaviour management policy which is clear to staff, parents and the children themselves. Measures to manage behaviour must be:

- *appropriate to age and individual need (22.5);*
- *not excessive or unreasonable (22.6);*
- *only used to prevent injury to child concerned or others or to prevent serious damage to property. It is not used as punishment or to enforce compliance with instructions (22.7);*
- *consistent with any relevant government guidance on approved methods (22.8)* (Department of Health 2002b, pp.32-33).

At the time of writing, the Department of Health are considering issuing revised guidance although this will not significantly differ from the current approach and will not specify a standardised method for physically controlling children. This will be discussed in more detail at a later point.

Techniques

The YJB apparently requires LASUs to use the form of restraint 'approved by the Department of Health' but one of the constant issues in the history of this debate has been the search by providers for such an endorsement matched by the reluctance of the Department of Health to approve specific forms of restraint (as distinct from offering general guiding principles and approaches). Guidance was drafted by the Department of Health in 1997 which would have given more explicit direction but was never published following legal advice. This has left Units to search for their own solutions from amongst the large number of systems and approaches on offer from commercial organisations.

> *The situation is a lot less clear in the local authority secure units, where there are no approved methods for the physical restraint of young people, and although there is a requirement to record incidents there are no standard national procedures as to how this should be done or how such incidents should be reviewed* (Rose 2002, p.92).

Reference has been made earlier in this review to incidents at Aycliffe which resulted in litigation after the use of C&R resulted in fractures. This led to the development of the alternative form of restraint (PRICE) mentioned earlier and currently in use in a significant proportion of the LASUs (see *Appendix 1*). Otherwise there are an enormous diversity of restraint techniques in use in the LASUs – including C&R General Services – all of which would probably claim to be non-pain compliant in their execution. However, at least one method does appear to make use of face-down prone restraints and the straddling of children on the ground: techniques which have been heavily criticised on the grounds of safety, sexual inappropriateness and psychological harm. There is nothing to stop establishments from modifying the technique they have selected or even inventing their own methods provided they ostensibly comply with the principles of minimal force and are said to be 'non-harmful'. There is currently no system of mandatory quality control for assessing whether methods are safe, effective or ethical.

The use of mechanical restraint is not expressly mentioned in guidance. Neither is single separation but custom and practice indicates that children may be confined to their bedrooms in the same way as they are in STCs – i.e. for no more than 3 hours in any 24 and with 15 minute checks.

Following any physical intervention, the child has the right to be examined by a doctor or nurse within 24 hours but this does not happen automatically.

As with the STCs, there is an acknowledgement that physical intervention will not always be feasible or effective and that the police may need to be involved. The *National Minimum Standards* require homes to have procedures and guidance on police involvement which have been discussed and agreed with local police.

Training

Department of Health guidance asserts that any in-service training in the use of restraint must only be given as part an overall programme of care and control which includes the creation of a positive ethos and the involvement of young people. It states that this is essential for workers in secure units but 'a matter of judgement' for workers in open accommodation. Noting that there are several forms of restraint training being offered it states that:

> *Above all, managers should satisfy themselves that any training sought is relevant to a Social Services setting and appropriate for use with children and young people* (Department of Health 1993a p.19).

The *National Minimum Standards: Children's Homes* state only that all staff should be:

> *… aware of, trained in, and follow in practice the registered person's policy. Training covers reducing or avoiding the need for physical restraint. All staff have signed a copy of the policy and*

evidence of this is retained on their personnel file (Department of Health 2002b, 22.8).

There is thus the same expectation as within YOIs and STCs that staff should be trained in restraint but, unlike these settings, training may not necessarily take place before staff are working in the Unit. It is not clear whether new staff who have not received the training are allowed to become involved in physical restraint and the situation with agency staff, who may be untrained or trained in a different method, is also unclear.

Whichever system is chosen by a particular setting Rose emphasises the importance of training. He discusses the difficulties of the client group in secure accommodation and the need for staff to be trained not to rise to the bait of insults or attempts to embarrass them by provoking loss of temper. He also points out that any act of restraint inevitably occurs at the very moment when both the staff member and the young person are likely to be fearful of attack and profoundly anxious about losing control. He argues that this is why formalising training and giving staff confidence in what they are doing are so crucial:

> … *staff need to be very well rehearsed in the application of whatever approved or agreed techniques are in operation in their unit. Maintaining a rigorous practice, in which only approved techniques may be used, assists staff in remaining detached and sensitive in situations where emotions are running high* (Rose 2002, p.92).

Recording and monitoring

Department of Health guidance (1993a) states the following:

i. *The circumstances and justification for using physical restraint must be recorded immediately.*
ii. *Afterwards, the child should be counselled on why it was necessary to restrain him. He should also be given the opportunity to put his side of the story.*
iii. *The care worker's line manager should discuss the incident with him within 24 hours.*
iv. *A full report of every incident should be prepared within 48 hours and submitted by the head of home to his line manager/ supervising officer.*
v. *Senior managers are required to monitor every such incident and take any action indicated. They should be prepared to investigate homes where, for example, there is a pattern of children absconding or where there is frequent use of physical restraint by staff.*
vi. *Arising from (v) senior managers must ensure that arrangements exist for children who run away to be interviewed about the reasons and circumstances by someone who is not connected with the home in question; for example, the field social worker.*

vii. *Where it is clear that the care worker concerned needs further advice/support/training the line manager should take prompt action to ensure that it is provided.*

viii. *Staff meetings should provide the opportunity for a 'post mortem' of the incident. Such discussion is essential to prevent the development of a culture where a physical response becomes routine.*

The *Minimum Standards* have specified in more detail the nature of the recording which should take place:

> *A record of the use of restraint on a child by an adult is kept in a separate dedicated bound and numbered book, and includes the name of the child, the date, time and location, details of the behaviour requiring restraint, the nature of the restraint used, the duration of the restraint, the name of the staff member using restraint, the name(s) on any other staff, children or other people present, the effectiveness and any consequences of the restraint, any injuries caused or reported by the child or any other person, and the signature of a person authorised by the registered person to make the record* (Department of Health 2002b, 22.9) .

This book should then be regularly monitored by the registered person (i.e. person responsible for the home) to ensure compliance with policy and identify any patterns which require intervention – either amongst specific staff or children or practice in general. The registered person must record their comments about the appropriateness of each restraint and any subsequent actions and sign the record to indicate that the monitoring is taking place. Children should be given the opportunity to discuss incidents, either individually or as a group. They should also be actively encouraged to write their own views following an incident or to have someone else record their views for them and to sign this.

Information about incidents are not, however, monitored on a national level and there is no single format on which records should be made. There is no requirement to submit returns to the Department of Health, although the SSI do get a number of reports, and there is also a YJB monitor responsible for each LASU, but not based on site. There are no statistics issued about the use of restraint in LASUs. There is a requirement to report any 'serious incidents' to the NCSC but these do not specifically mention injuries as a result of restraint. This agency is still developing its systems and no data is currently available which would indicate the information likely to be provided.

LASUs are inspected annually by the SSI and by Inspectors from the National Care Standards Commission. The latter see their role as inspecting the care provided by the establishment whilst the SSI are responsible for its secure aspects. Although there is no requirement on them to do so, the inspecting agencies usually work in partnership. The SSI and the NCSC will soon be combined into one unit, the Commission for Social Care Inspection, but details are not yet available. Inspections are undertaken annually and it is part of their remit to examine policies and procedures on physical intervention and the

book used to record incidents. The SSI have considerable experience of secure settings and current inspectors have acquired invaluable experience in evaluating the 'culture' of establishments including their approach to behaviour management.

Strengths and weaknesses

The fact that LASUs are defined and regulated as children's homes means that they are better placed than other secure settings to see their residents as children first and foremost. This is particularly represented in the expectation that they will talk to children about incidents and encourage them to express their side of the story and take those accounts seriously. The small size of LASUs and high staff/child ratios means that they are able to take a much more individualised approach to the children's behavioural difficulties and to get to know the children more quickly than in a large anonymous setting. The emphasis in guidance that the use of physical intervention must be seen within an overall context of behaviour management, including a recognition of the importance of relationships between staff and children, helps to create a culture where there can be a range of responses to challenging behaviour. It is also of benefit that this approach is meant to be incorporated into any training so that physical intervention techniques are not taught in a vacuum.

The flexibility offered to establishments in developing their own policies and techniques for managing behaviour could allow them to ensure that their approach is tailored for their setting rather than being imposed from above.

The system in place for LASUs is not without its weaknesses however.

Lack of regulation: methods and training

The very flexibility mentioned above can also mean that LASUs are at the mercy of a range of commercial providers of unknown quality. Policy on physical intervention is inextricably linked with training and there must be a close fit between them if staff are to have clear direction. This fit is difficult to achieve given the unregulated nature of training provision. Because of the lack of quality control, LASUs may find they have selected a dubious model. The fact that some models still include the option of 'decking' children, a technique specifically banned in STCs, would suggest that the Department of Health guidance needs to be more specific. There are enormous obstacles to transplanting behaviour management programmes found to work in one context and culture to another with a completely different culture.

The importance of this point was illustrated in two reports into events at the Aycliffe Centre in County Durham, one by the Department of Health in 1993 and another by Durham County Council in 1994. *A Place Apart* (Department of Health 1993b) gave the findings of an investigation into allegations of serious injuries sustained by young people during restraint by staff. The report found an unusually high level of restraint, although monitoring of such incidents was also deficient, and that the methods of restraint associated with the injuries were those which had been adapted from methods used in adult prisons (C&R). Although the Council Report did not find that the methods of restraint contravened Regulations and Guidance, nor that the regime was

abusive, it did criticise the confrontational culture of the Centre, in which an insistence upon compliance led to angry responses from the young people which in turn led to further acts of restraint.

> *Reference was made to the potential for the premature use of force with the care philosophy setting out an order of priority which places management and control before care, assessment and treatment* (Durham County Council 1994, p.16).

Training is perhaps particularly important in LASUs because of the somewhat vague nature of national guidance yet will vary widely because it is dependent on the method selected by the provider and therefore the training package which accompanies it. Neither the duration, frequency, content, size of training group, style or method of training are regulated. Most 'off the shelf' methods are the commercial property of those who have devised them and their materials are not in the public domain. Training is often delivered directly by these, largely commercial, trainers and there is no formal requirement for them to be approved or accredited in any way. There has been considerable concern that trainers may have little knowledge of the needs of the establishments for which they are asked to provide training. There have been instances where trainers are delivering the same course, for example, to security guards and homes for young disabled children. The unregulated nature of training may also lead to situations where training is 'cascaded down' through organisations by staff who have received the training themselves. This is tempting on cost grounds but there are no formal requirements regarding their level of competence or the need for refresher training to ensure that skills are maintained.

Unclear expectations

A further danger if guidance is vague is that individual staff members may be left with an inappropriate level of responsibility in deciding what to do. A key point in the 1993 guidance was the latitude allowed for the individual worker to judge not only whether but how far to intervene:

> *The onus is on the care worker to determine the degree of restraint appropriate and when it should be used. In particular, staff must be careful that they do not overreact* (Department of Health 1993a, p.9).

Rose points out the need of staff to know that in tackling a serious conflict, if they respond appropriately using the approved methods in the correct way, they will be supported by their managers. He claims that over recent years staff have become more dubious that they will get such support:

> … *there has been a steady erosion in belief amongst residential social work staff about how reliable this support is likely to be, and this has had dangerous consequences as staff have been left uncertain about how they should act* (Rose 2002, p.95).

There is an underlying assumption that, beyond setting out broad indicators of good practice founded on concepts such as 'proportionality' (do not intervene if the consequences of intervening are likely to outweigh the consequences of not intervening) and 'reasonableness' (only intervene for as long as necessary and in ways appropriate to the particular context), government should not get involved in matters of professional judgement (Hudson 2000, p.15). Critics would argue that this places far too much responsibility on the individual worker and that, although staff do inevitably have to exercise judgement and discretion, it is the responsibility of management and government to give very clear guidance (supported by context-relevant training) for making such decisions and the degree of intervention appropriate (See Harris et al 1996). Critics of the 1993 Guidance have claimed that it is in fact just too vague and generalised to be of much practical help (see Ross 1994, in Hughes 2001, p.23; Utting 1997, p.122)

In a study carried out for an English local authority social service department at around the same time it was found that as might be expected, where guidance is unclear and training and monitoring mechanisms deficient, the way is left open for people working in a challenging environment to use 'inappropriate' interventions:

> *The current situation with respect to advice, training and recording leaves staff, and indeed the Department, in a vulnerable position in relation to allegations that inappropriate methods of restraint are being used. It is clear that the great majority of staff feel that they need the option of using physical restraint … It is also clear that a range of pragmatic methods of restraint and 'holding' are used by staff* (Hayden 1997, p.35).

The study found there was a need for clear advice from the Authority as employer as to the methods to be used and which were appropriate to the age, size and disability of the children and young people.

Evaluation and monitoring

Although the registered person has responsibility for the monitoring of each establishment, this does not necessarily allow for any overview or sharing of good practice because of the devolved nature of LASU management. In addition, any messages from practice may not be fed back to those with ownership of the method and training so that they can make improvements or adjustments. Methods risk becoming set in stone and increasingly removed from practical needs without this dialogue.

A further weakness as a consequence of the devolved nature of responsibility for physical intervention is the difficulty of undertaking any national monitoring. There is no requirement on LASUs to provide data on their use of restraint to external agencies. Although they must report serious incidents to placing Local Authorities and the NCSC, this information goes to regional offices, allowing for little overview. The YJB appears to have deferred to these systems and does not require information to be passed directly to them.

Comparative discussion

Each of the approaches to physical intervention within the three types of provision has strengths and weaknesses. There are some basic principles which are common to all: those of physical restraint as a 'last resort'; the use of minimum force and for the shortest possible duration; and that it must not be used as a punishment. Otherwise, it is striking how little commonality there is across the sector, although the STCs do serve to act as a bridge, aiming to be both highly regulated *and* welfare based. Key differences are summarised below:

	YOI	STC	LASU
Based on risk assessment		√	√
Based on 'recalcitrance'	√		
Techniques are prescribed	√	√	
Pain-compliant	√		
Non-pain compliant		√	√
'Decking' can be used	√		√
Mechanical restraints used	√		
Unlimited single separation	√		
Child has a voice		√	√
Holistic approach to behaviour management		√	√
Training is regulated	√	√	
Culture of debriefing		√	√
Local monitoring	√	√	√
National monitoring	√		

Each system is detailed in tabular form in *Appendix 2*. The implications of the above differences are now discussed.

When restraint can be used

The fundamental question as to when children can be restrained is inconsistent across the sector, and is a particular weakness within the prison service. Terms such as 'recalcitrant' and 'disruptive' are open to extremely wide interpretation and therefore abuse. There is a danger that YOI staff will use restraint to enforce compliance in situations where it is unnecessary. Within STCs and LASUs, there is a clear indication that physical restraint should only be used when the child's behaviour is posing a risk of some sort, whether that risk is to self, others, property or the risk of escape.

In addition, there are differences as to whether physical intervention is located within an overall approach to behaviour management. Although all settings

do make reference to the importance of de-escalation and the use of relationship between staff and children, this is not expanded upon within YOI guidance and staff are given no indication as to *how* they might achieve this.

Techniques

Both YOIs and STCs have clearly defined and detailed techniques for physical restraint. This has the advantage of clarity and accountability. If it is very clearly prescribed what can be done, then it is also clear what cannot, affording children (and staff) a measure of protection. This is not the case in LASUs where there is no single recommended system and a wide range of commercially driven methods are in operation.

The methods themselves have not been systematically evaluated and, apart from PRICE and PCC, there is no indication that they have been medically approved for use on children. In fact, the Aycliffe inquiry clearly concluded that C&R should *not* be used on children and is said to be the reason PRICE/ PCC was developed. The use of 'decking', prone restraints and locks which put pressure on joints are particularly controversial. This does not apply solely to C&R: the unregulated nature of practice within LASUs means that some methods deployed there may also be dubious.

Another important difference is the fact that C&R starts where other methods stop i.e. with the use of pain-compliant locks. Prison Officers are not offered any of the holds which are said to be effective within other methods. It may well be the case that officers are using such holds, but if so these are unofficial and therefore unregulated. They are also not given the benefit of any training in safe or effective holds.

YOIs are the only setting where mechanical restraints can be used on children, albeit only on 17 year olds, and they can also use ratchet handcuffs, again not available in other settings. There are also differences in the use of special accommodation or single separation. Children in YOIs can spend unlimited periods isolated in special accommodation whereas in other settings this is for a maximum of 3 hours in any 24.

It must, however, be acknowledged that both STCs and LASUs have the option of calling on the police and/or local prison officers if they are unable to control a particular young person. This is related to questions about the effectiveness of non pain-complaint techniques, particularly for bigger children, which requires specific research beyond the remit of this review.

Training

As with the techniques themselves, training is tightly regulated within YOIs and STCs and no staff should restrain children unless they have been trained. This is not the case in LASUs, with at least the possibility that staff who are untrained or trained in other methods may use restraint. Training is unregulated within LASUs and there is therefore no guarantee of its standard or suitability.

A weakness within both C&R and PCC training is the fact that both concentrate solely on physical restraint. They do not incorporate any training on understanding challenging behaviour or on defusion or diversion techniques. This does not support an approach which ostensibly sees physical restraint as the last resort in a range of strategies to manage behaviour. This is not to say that such training is not being delivered, but it is not clearly linked into an overall behaviour management strategy. LASUs, in contrast, are guided to include training on physical intervention within an overall training approach to behaviour management.

Recording and monitoring

All settings require incidents where physical intervention has been used to be documented shortly after the incident.

The prison service are the only setting where there is national monitoring of the use of restraint, although they are hampered by the lack of qualitative information and some lack of synchronicity between the terms 'use of force', 'C&R' and the 'use of restraints' which make the information more difficult to analyse. The service does make some national statistics available.

Local monitoring is similar in STCs and LASUs, with managers being required to review all incidents and establish any patterns that need action. This relates to issues for the staff, children or practice in general. Children are allowed or even encouraged to have their say, verbally, in writing and sometimes in meetings to review practice. Local monitoring has also recently been introduced in the juvenile sector within YOIs, although there is no opportunity for children to express their views. It is also unclear whether parents/carers or external professionals are informed by YOI staff when restraint has been used. Whilst STCs and LASUs emphasise the need to learn from incidents and have a culture of debriefing, this is less evident in YOIs and certainly does not involve children. The fact that few children complain about the use of restraint in YOIs is worrying as such complaints make up a substantial section of complaints in the other settings. Rebound has a policy of defining such complaints as child protection matters.

The role of the YJB in monitoring is unclear. It does not yet have its own inspection framework and inspections are currently undertaken by HM Prisons Inspectorate (YOIs), SSI (STCs) and SSI/NCSC (LASUs) with a contribution by OFSTED. YJB monitors do have a role but primarily to ensure compliance with contracts, and the relationship between them and the Inspectorates is poorly defined.

Other nations of the UK

As part of this review, we examined practice in other parts of the UK. England is unique in holding large numbers of juveniles, including 15 year olds, in prison settings. The situation is the same across all UK nations in that prison establishments use C&R whilst other settings do not. Wales does have a few juveniles on remand. The Scottish Prison Service states that it does not hold juveniles in prison: in fact children of 16/17 *are* placed in prison facilities but

within the overall category of ‘young prisoners’ up to the age of 21. Statistics are not available to indicate how many of them are legally children but indications are that numbers are low, with most being placed in local authority secure units. Northern Ireland does hold 17 year olds in Young Offender Centres but otherwise children in custody would be placed in one of their Juvenile Justice Centres. These cater for children between the ages of 10 and 16 but from June 2003 there will only be one unit, with a maximum capacity of 50. Lisvnevin, one of the Juvenile Justice Centres, has only recently abandoned the use of C&R following external criticism following a number of injuries. They were also heavily criticised for the use of a segregation block. These matters will be revisited in the final section of the report.

However, it is not only the secure sector where there has been concern about the use of physical restraint and it may be useful to now consider aspects of this wider debate.

The Use of Restraint in Children's Services: the Wider Debate

Definitions

The terminology used to describe the topic varies across settings and it is important to clarify what is meant. Although the term 'control and restraint' is widely used, care needs to be taken to differentiate its more general application from instances where it refers to C&R techniques:

> *… the term 'Control and Restraint' has become almost synonymous with the process of physical control in general. However this is not the case. The term 'Control and Restraint' properly refers only to those approaches to the physical management or violence and aggression that are derived from the original version developed by the Prison Service* (Wright 1999, p.460).

Restraint

> *Restraint occurs whenever a client has his or her movement physically restricted by the use of intentional force by a member of staff. Restraint can be partial; restricting and preventing a particular movement; or total; as in the case of immobilisation* (Healy *in* Hayden 1997 p.8).

Holding

The Department of Health differentiates between 'restraint' and 'holding' as follows:

> *PHYSICAL RESTRAINT is defined as 'the reasonable application of the minimum force necessary to overpower a child with the intention of preventing them from harming themselves, others or from causing serious damage to property'*
> *HOLDING would discourage, but in itself would not prevent such an action* (Support Force for Children's Residential Care 1995, p.89).

This distinction is also referred to in the Guidance to nurses offered by the Royal College of Nursing (1999) which describes the need to 'hold still' a child who is suffering a painful procedure:

> *Holding is distinguished from restraint by the degree of force required and the intention* (Royal College of Nursing 1999, p.2)..

Physical Intervention

The term 'physical intervention' is increasingly used as an over-arching term because it encompasses a range of approaches.

> *Firstly, it is necessary to be clear what physical intervention is, and that it is not synonymous with physical restraint. The term 'physical intervention' is, as it suggests, any method of intervening physically with a young person in order to resolve an unsafe situation. For example, techniques of guiding a young person from one place to another, or of escaping from a young person's grasp, are methods of physical intervention, but are not restraint techniques. Restraint also means much what the term suggests, i.e. techniques of physical intervention that involve restraining the movement of a young person in order, for example, to prevent them assaulting another person or injuring themselves* (Lindsay and Hosie 2000, p.11).

In this report we are largely concerned with restraint in the sense of direct physical contact between the staff member and the child intended to physically overpower or restrict movement, as distinct from the use of barriers or equipment. However the different forms cannot be entirely divorced from each other, as the Welsh Assembly review noted:

> *in all the forms of restraint mentioned … it is likely that physical restraint by a person or persons is required in the early stages of a restraint incident* (Hughes et al, p.3).

Legal considerations

Lindsay and Hosie (2000) found that three areas of law are all potentially relevant to the use of restraint:

- employment law;
- civil law;
- criminal law (relating to assault).

> *The legal issues are therefore complex … Several areas are potentially relevant and could involve charges of assault against staff by a young person where a restraint has been used; parallel charges by staff against young people in the same circumstances; accusations of failure of the duty of care where a restraint has not been used and injury has resulted; cases brought by staff for injuries received in the course of their work where a restraint either has or has not been used and injury has resulted to the member of staff; and cases where a member of staff alleges that s/he has not been adequately trained for a working situation known to present a risk (*Lindsay and Hosie 2000, p.10).

Employer's responsibility: a duty of care

Leadbetter and Trewartha (1995) noted employers have to give equal priority to both staff and young people in terms of ensuring their safety. Under Health and Safety legislation (Health and Safety at Work Act 1974), they must ensure their staff's welfare against foreseeable risks and provide adequate training to ensure a safe working environment. This obligation has been reinforced by

civil cases successfully brought by employees against their employers. Leadbetter and Trewartha cite the case of Walker v. Northumberland County Council (1994) where the judgement against the council hinged on a failure in their duty of care in that they had not taken action to avoid or mitigate 'reasonably foreseeable' risks to their employee's health.

> *The precise outcome of any case is hard to predict, but it would be likely to depend on the ability of the agency to demonstrate that it had made a responsible assessment of risk within its services; that in situations where violent behaviour is foreseeable, clear policy and procedural guidance was in place; that this was understood by staff, and that staff were well and regularly trained in these policies, procedures and practices* (Lindsay and Hosie 2000, p.141).

This point is of particular relevance to establishments caring for those where there is little prior knowledge on which to base a risk assessment: the temptation may be to assume that *all* residents are dangerous.

Lindsay (1995) states that, faced with possibly serious liability issues, organisations have responded to questions of restraint policy in two main ways. Firstly, many have looked for a 'Holy Grail' solution in the form of a government endorsement for a specific form of restraint. Secondly, many have bought in whole packages of training, sometimes without sufficient regard for the fact that the approaches may have been originally designed for very different operational or cultural settings. As Lindsay (1995) points out the absence of official endorsement leaves commissioners and workers exposed:

> *This position reinforces the existing focus on individual employers and their duty of care. Whilst some employers may choose to delegate this responsibility to training 'experts' or the suppliers of training packages we should be clear that these individuals and organisations do not hold the main 'duty of care' and may or may not stand by an employer in the event of litigation* (Lindsay 1995, p.38).

Lindsay and Hosie (2000) state that in the case of litigation employers would have to demonstrate that the method of restraint they chose best suited the needs and circumstances of their clients and, on the basis of the best available advice, was likely to address the demands of day to day practice. The problem is that there is a striking absence of evidence about the respective merits of the various techniques.

It could be expected that Trade Unions or professional bodies would have developed a position on these matters but this is not the case. UNISON and the General Social Care Council say that they can only consider each case on its merits. If an employee is disciplined for an incident where they have used (or failed to use) physical restraint, it must be considered whether they have complied with their employer's policy and on more general considerations about the 'reasonableness' of their actions. This brings us back, again, to the importance of policies to be explicit.

Lindsay (1995), writing for the Centre for Residential Child Care in Scotland, suggested one set of criteria by which employers might assess the suitability of a particular form of restraint for their situation.

- *Are there a hierarchy of responses?*
- *Are the grips secure?*
- *Is the head protected during descents?*
- *Is unnecessary pressure on the subject's back avoided?*
- *Are descents controlled?*
- *Is risk to staff considered and minimised?*
- *Are 'Breakaway' techniques included?*
- *Is dignity compromised unnecessarily?*
- *Is unnecessary pain avoided?*
- *Is it age appropriate?*
- *Is it gender appropriate?*
- *Will the average staff member be able to master the techniques?*
- *Does it require excessive staff numbers?*
- *Will it work in a confined space?*
- *Are there any contra indications? (e.g. will it work in your settings?)* (Lindsay 1995, p.48)

A modified variant of this list published in *Clear Expectations, Consistent Limits: Good Practice in the Care and Control of Children and Young People in Residential Care* (Centre for Residential Child Care 1997, p.37) adds further questions against which employers must assess whichever system they opt for:

- *Does it contain techniques which would enable staff to move the subject safely whilst under restraint?*
- *Does the system have a formal mechanism through which the approved techniques can be evaluated and adapted on the basis of operational experience?*
- *Does the system have a formal quality assurance mechanism to accredit and regulate instruction and practice?*

Human rights

The UN Convention on the Rights of the Child does not have the force of law, although the UK is committed to its implementation. As stated earlier, the latest UN Committee Report on the Rights of the Child (Committee on the Rights of the Child 2002) has called for the Government to review the use of restraint and solitary confinement for children across all settings. It also noted that the commitment to having the 'best interests' of the child as the primary consideration in all activities had not been implemented within the criminal justice system.

The Human Rights Act 1998 *is* legally enforceable and establishes important protections from abuse by state organisations or employees. Article 3 prohibits 'torture or inhuman or degrading treatment or punishment'. In a case

involving the Prison Service, Price v United Kingdom (2001) 34 EHRR 1285, it was ruled that any judgements must take into account the circumstances of the case:

> *… such as the duration of the treatment, its physical and mental effects and, in some cases, the sex, age and state of health of the victim.*

Similarly, in Z v United kingdom (2001) 34 EHRR 97, the judge ruled in relation to Article 3:

> *These measures should provide effective protection, in particular, of children and vulnerable persons and include reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge.*

Particular consideration thus needs to be given as to whether a method of restraint thought not to breach the rights of an adult may still breach those of a child.

Criminal law

It is a criminal offence to use physical force to restrict the liberty or autonomy of an individual unless the circumstances give rise to a 'lawful excuse' or justification for that action. Paterson et al (1997) give assault and false imprisonment as two possible criminal charges that could arise but in practice there are several legitimate defences against such an accusation. For example using the argument of 'private defence' it might be argued that 'reasonable' steps had been required to prevent injury to a carer or others (Lyon 1994; Lyon and Ashcroft 1994; Lindsay 1995). Other legitimate defences could be that the action was undertaken 'in the best interests' of the person so restrained or to prevent a crime or a breach of the peace. It could also be legitimate if shown to be carried out by the exercise of statutory powers and duties – for example those given under the Mental Health Act. The question of intention, for example where it is claimed that the restraint was carried out to prevent a greater harm, together with concepts such as reasonableness and proportionality in the degree of force employed, are central to professional, and ultimately legal, judgements on the appropriateness of restraint. Context and client group will be powerful factors affecting judgements as to what is reasonable or proportional minimum force. There is also a delicate balance of interests to be struck between an employer's responsibilities and duty of care towards young people and towards their employees.

Ethical and policy considerations

The use of physical restraint in institutional care settings is an emotive subject, especially when that restraint is carried out by adults on children. Although the validity of restraint within secure settings is not usually contested, this is not the case for all services:

> *For some people, any form of physical intervention is seen as unethical. Some agencies have tried to adopt 'no touch' policies. In some services, groups of staff hold this view. This can be an intensely held position, and tensions can arise between individuals and within teams. What is clear is that whatever position is agreed, answers have to be provided to the practical issues faced by residential staff in managing the challenging and violent behaviour of some of the young people they work with* (Lindsay and Hosie 2000, pp.11-12).

Where these answers are lacking the staff, children and others are placed at increased risk. Much of the literature on the topic nonetheless complains of just such a lack of clarity and consistency at both governmental and institutional levels:

> *This issue is one which causes considerable anxiety at agency level, because of perceived legal and medical complexity. As a result, agencies have often tended to be somewhat vague about exactly what workers may do in such situations, while being a good deal more specific about what they may not do. This has had the effect of making workers feel unsafe and unsupported* (Lindsay and Hosie 2000, p.134).

They noted that this anxiety and lack of clarity has had the effect in some cases of either pushing incidents of restraint 'underground' where they cannot be monitored and 'improvisations' discouraged, or in cases where workers have failed to intervene and a more dangerous situation has been the result.

Where guidance has been forthcoming it has not always been perceived as helpful for either workers or the children and young people.

> *Proactive guidance is often drowned in a sea of qualification, leaving staff feeling de-skilled and ambivalent. This can generate uncertainty and erode confidence contributing to unpredictable or inconsistent interventions which, in turn, may leave residents feeling insecure and unsafe* (Leadbetter and Trewartha 1995, p.10).

Leadbetter poses four key questions to be asked of any technique or system:

- Are the techniques effective?
- Are they safe?
- Are they ethical?
- Are they appropriate to the specific setting? (Leadbetter 1995, pp.33-48)

He also indicates practices which are most likely to compromise the dignity of young people, for example:

- all techniques which involve 'flooring';
- techniques which involve holding the trunk such as Bear Hugs;
- techniques which involve 'straddling' a young person on the ground;
- techniques which involve pain compliance such as wrist locks;

- techniques which push a young person's face into the floor (Kent 1997, p.228).

One of the central distinctions drawn between methods of restraint is whether or not they rely on a degree of 'pain compliance' in their execution to be effective. Lindsay and Hosie (2000, p.13) point out real difficulties, including ethical ones, in simply opting for the apparently more humane non-pain compliant option in all cases and settings because, in their opinion, this avoids the reality that an element of pain makes restraint more effective. If the decision is taken not to use it on ethical grounds, then the consequences of this need to be thought out and staff given viable alternatives. A major difficulty in developing ethical policy is the lack of evidence.

A limited evidence base

The literature expresses a recurring and fundamental concern at the lack of rigorous research evidence for 'what works' in dealing with challenging behaviour or associated training.

> *There is very little scientifically robust research on the use of physical restraint with children, methods of restraint that are safe for use with children, training effectiveness, or comparisons of different training methods. This lack of knowledge contributes to government reluctance to set clear guidelines, the difficulty for service providers in selecting appropriate training, and the development of systems of accreditation for training providers* (Hughes et al 2001, p.94).

The research which has been conducted has focused on safety and effectiveness, although there are also a small number of studies looking at user perspectives.

Safety and effectiveness

There have been a few studies on the safety and effectiveness of methods, mainly C&R in health settings. According to Southcott (2002) these have produced contradictory results. Mortimer (1995) concluded that the use of the techniques was a plausible explanation for the fall in the number and severity of violent incidents in the medium secure unit where the research was carried out. However Parkes (1996) compared incidents involving manual restraint of patients prior to and after training in C&R and found that after training there were more staff injuries while restraining patients, although staff expressed a preference for C&R techniques in moving and holding a patient once immobilised. Parkes' study contradicted the findings of an earlier evaluation carried out for the Home Office when C&R was implemented in the prison service (Brookes 1988). This found that there was a significant reduction in injuries to staff following the introduction of the technique and a dramatic reduction in numbers of days sick leave taken in response to assault.

McDonnell (1996) questioned the safety of holds applied against the joints and following the death of Orville Blackwood, a patient at Broadmoor, the Committee of Inquiry recommended that research be initiated into the effectiveness of C&R techniques in a health setting. According to Wright (1999) the modified form of C&R – C&R General Services – which was designed for delivery in a wide range of care services and which removes as far as possible the risk of pain occurring when holds are applied, is equally effective and hence may be more ethically acceptable:

> *…anecdotal reports suggest that these variations are just as effective as the more conventional techniques* (Wright, S 1999, p.467).

Such 'anecdotal' reports continue to be the main source of data.

Clinical practice guidelines issued by the Royal College of Psychiatrists (1998) summarise published research evidence into the use of restraint in hospitals. They were looking for evidence to test the working hypotheses that:

- Restraint, when skilfully applied by trained and supervised staff according to monitored protocols and in the context of other methods of care, is an effective and safe means of coping with overtly violent behaviour.
- When properly used and explained, restraint can be acceptable both to users of services and to staff.
- Seclusion is unnecessary if restraint is properly applied in association with other methods of good clinical practice.

They conclude that the evidence to be gained from the published studies is incomplete or deficient in terms of judging effectiveness. The majority of papers they identified were from the USA and differences in terminology and legal systems made it difficult to translate the findings to the UK. They concluded that there was insufficient evidence to prove their hypotheses.

Research into effectiveness, however, is not straightforward. Bell and Stark (1998) in their study of the factors involved in assessing competence in physical restraint skills noted the limited amount of research which exists on the acquisition and retention of physical restraint skills but that similar research, for example into resuscitation skills, indicates there may be difficulties. This pointed to the need for a high level of practice during training, frequent refresher training and effective monitoring and assessment of practice.

Moreover they found that it was highly problematic even for 'experts' observing the practice of restraint in 'laboratory' conditions (studying videos of practice sessions) to judge whether a given method or restraint was being correctly performed. Restraint involves a series of quite intricate actions performed quickly and if the experts in this study found assessment of competence difficult, one can assume it is correspondingly harder for the occasional bystander or even an inspector to assess whether the restraint they observe is being done properly. The study examined the possibility of

developing instruments to measure competence in physical restraint skills which would be more valid and reliable than mere 'expert judgement' but concluded that these would inevitably be imprecise.

The authors suggest that organisations and individuals might assume their current training and levels of competence to be adequate but that there was no way of knowing if this was in fact the case. They concluded that it was 'imperative' (ibid p.27) to develop independent, clearly validated methods of assessing the effectiveness of both individual techniques and of the training and trainers.

User perspectives

According to Wright (1999) the feelings of patients who have been physically restrained have not been systematically researched despite the relevance this would have in framing effective preventive or de-escalation strategies. One study which did research service user perspectives found that the vast majority of respondents rated their experiences negatively, with many believing staff used restraint as punishment and applied unnecessary force (Sequeira and Halstead 2002). Feelings of anger, anxiety and mental upset were reported. On the positive side however some reported feeling safely contained and experiencing a cathartic release of frustration and anger:

> *That's a pain that I enjoy … not enjoy as such that it's sort of fun, but it helps me to realise I'm safe … Made me feel like safe and comfortable. Make sure that nobody hurt me apart from them making me feel safe* (Sequeira and Halstead 2002, p.14).

In an Appendix to the Royal College of Psychiatrists Guidelines (1998) an account is given of user and carer discussion groups. Patients and carers agreed that sometimes physical restraint is necessary to protect other patients and staff when someone has been violent but that its use can also escalate violence. They thought that service users and carers should be involved in developing policies for de-escalating violence.

Staff groups agreed that restraint should only carried out by trained and permanent staff – the presence of unfamiliar staff could make things worse. They also agreed that using restraint inappropriately could exacerbate the situation and thought that all staff, clinical and non clinical, should be trained in both breakaway techniques and control and restraint. Training in these techniques should be mandatory with regular refresher courses.

YoungMinds have been carrying out a 2 year project on developments in inpatient care for adolescents with mental health problems. The issue of control and restraint did not apparently come out as a main issue, but young people did raise a number of significant issues for consideration, according to Jenny Svanberg, Research Assistant to the project:

- Where a young person themselves had been restrained this could be traumatic especially at an already confusing time, and consequently

there is a need for 'debriefing' after the situation has calmed to reduce the 'them and us' feeling it causes.

- There was a need to ensure all staff are trained in safe control and restraint methods, and are confident in their ability to use them.
- Young people watching the restraint happen could be disturbed by it and need to talk through the situation afterwards.
- Many young people felt that their frustration, which often came out of boredom or feelings that their opinion was not being listened to, was not properly addressed, and seen as part of their presenting problem rather than 'normal' behaviour.
- The need for young people to feel listened to came out very strongly.
- Linked to the last point, time spent with staff was a key factor in young people feeling that they were able to build the relationships that allowed them to open up and begin to work through their problems without flare-ups.
- Where staff numbers allow this, training in de-escalation skills appear to be key in preventing incidents occurring.
- Restraint is not needed if a potential situation is defused before it reaches crisis point.

Finally, Lindsay and Hosie (2000) talked to managers, residential staff and children following an inquiry into practice within Edinburgh. Of the children, 68% had been the subject of restraint and 44% had experienced prone restraint. Interestingly, not all their comments were negative and complaints were more likely to centre on restraint being used unfairly than on the method used.

Restraint in other services

Some of the key elements of the debate on physical restraint within these distinct sectors will now be considered.

Children in Public Care

The debate has been dominated by inquiries into, and concerns about, the dangers of abusive practice by staff. Following the Pindown Inquiry (Levy and Kahan 1991) there was an understandable pre-occupation with proscribing dangerous or abusive measures. Inquiries were undertaken by Utting (1991) and Warner (1992) and, in Scotland, by Skinner (1992) to examine practice within residential homes, all of which highlighted restraint as a significant issue for all concerned. However this seemed to some staff to lead to a situation in which they were far clearer about what they could not do than about what they could:

> *… there is an understandable feeling that, while antiquated and inappropriate methods of physical control have quite properly been forbidden, staff have very little help, advice or training in better methods to replace them* (Utting 1991, p.43).

Recommendation 76 of Warner's Report was that the government issue full guidance for staff on issues of control, restraint and physical contact with

children in residential care and that this be kept up to date and supported by the provision of training materials which helped the staff apply guidance in real situations. Similar recommendations were made by Utting and Skinner but it is arguable whether this 'full' guidance has ever been achieved.

Children's Homes Regulations (1991; 2001) and Department of Health guidance (1993a; 1997) specify when restraint should be used, i.e. when staff have good grounds for believing that immediate action is necessary to prevent the child significantly injuring himself or others or causing serious damage to property, but not the specific methods which can be used. The statements which do touch on methods of restraint are contained not in guidance but in a training pack issued by the Department of Health in 1996. Their status is therefore somewhat unclear:

> *Physical restraint techniques which are suitable for children and young people observe certain principles. These include:*
>
> - *the techniques should only be used in children's homes where there is an ethos of anticipating and defusing children whenever possible;*
> - *they take account of the young person's age, gender and stage of development;*
> - *they do not rely on threatening or inflicting pain;*
> - *holds do not apply pressure that works against the joints;*
> - *they do not rely on routinely taking a young person to the floor but preferably to a seated position;*
> - *they minimise movement, particularly the risk of toppling over;*
> - *you can continue talking to the young person as you restrain them;*
> - *you approach the young person from the side, not face to face;*
> - *techniques allow you to phase down the hold or restraint as the young person regains control;*
> - *you can break away at any time – so that staff are not tempted to escalate the restraint using desperate and inappropriate techniques* (Department of Health 1996, pp.33-34).

The debate so far had focused on residential settings but equally challenging children may be placed in foster homes. Utting pointed out the lack of attention given to providing guidance for foster carers and this is confirmed in a National Foster Care Association (NFCA) publication which attempted to fill the gap – *The Care and Control of Children and Young People in Foster Homes*. This makes the point that none of the previous guidance had referred to foster care and there was a need for clarification for both carers and young people:

> *Many young people will move between the different forms of accommodation. A consistent policy on care and control practices*

> *will ensure that these young people do not experience variations in discipline* (NFCA 1996, p.1).

Emphasising the need for carers to create an environment and ethos where the need for restraint is minimised the paper concedes that some incidents will require them to 'intervene positively' in the way that a reasonable parent would. Fostering agencies should ensure that their carers are given training on managing difficult behaviour and on approved and safe methods of restraining children.

The *National Minimum Standards* relating to Foster Care (Department of Health 2002c) also require fostering agencies to have a policy: the difficulty, as always, is what those policies should say. Should foster carers seek to stop a vulnerable child from going out without permission? If so, what methods should they use? This is not straightforward: for example whilst a worker in residential care may take one view of the relative seriousness of structural damage to a building which is simply their place of work, foster carers facing damage to their own home and property might take a very different view.

Fostering agencies and individual foster carers have struggled with this and ambivalence remains. This is evident in the evaluation of a scheme in Scotland where fostering was used as an alternative to secure accommodation, where challenging behaviour was an everyday occurrence (Walker et al 2002). Foster carers are trapped between the attempt to replicate 'normal' family life and their duty to care for children who may have had very abnormal experiences. A review of fostering agencies in Scotland highlights this dilemma. They vacillated about whether it was appropriate to provide guidance and training on physical intervention and one authority acted out the dilemma by offering training and then changing their mind. There have been particular concerns about the potential risks of foster carers using methods designed for professional staff working in group settings when they are operating at home and possibly on their own. Techniques of restraint which require three people are scarcely practical in foster care settings. Of course, if guidance and training are not provided, carers have to do the best they can but without adequate support.

The Chief Inspector's letter *The Control of Children in the Public Care: Interpretation of the Children Act 1989* (Department of Health 1997) did extend guidance to children in placements other than children's homes. Although introduced as a 'clarification' some saw the letter as a confusing shift of emphasis to a more assertive and proactive use of physical interventions:

> *In all the previous guidance staff had been told to 'back off' immediately if young persons resisted attempts by staff to exert control over them. It seemed that, outside secure accommodation, almost any attempt to stop young people from doing what they wanted should be avoided. Staff who attempted to enforce the agreed rules would either be accused of assault or unlawful restriction of liberty* (Allen 1998, pp.184-188).

Now the emphasis seemed to have shifted from avoiding the risks and consequences of taking action, to avoiding the risks and consequences of inaction. The injunction to interpret 'harm' widely and anticipate when it is likely to happen seemed to contradict previous interpretations that staff should not intervene unless they could specifically identify a specific risk to a specific person.

Education

Section 550A of the 1996 Education Act came into force on September 1 1998 and was again intended to 'clarify' an earlier piece of guidance or legislation – in this case the 1996 Education Act. The DfEE Guidance to Section 550A states that the powers set out are not new 'but in the past they have been misunderstood' (DfEE 1998). It says that it is merely restating principles derived from common law and statute and specifically challenges the 'common misconception' that since the Children Act 1989 any physical contact with a child is in some way unlawful.

Section 550A empowers a member of school staff to use in relation to any pupil at the school:

> *Such force as is reasonable in the circumstances for the purpose of preventing the pupil from doing (or continuing to do) any of the following, namely –*
>
> *a) committing an offence,*
> *b) causing personal injury to, or damage to the property of, any person (including the pupil himself), or*
> *c) engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils, whether that behaviour occurs during a teaching session or otherwise* (Education Act 1997. Section 4).

As the accompanying Circular to the Act concedes, there is no legal definition of 'reasonable force' and hence:

> … *it is not possible to set out comprehensively when it is reasonable to use force, or the degree of force that may reasonably be used*. *It will always depend on the circumstances of the case* (DfEE 1998, p.5).

The Circular makes clear that the use of force is unlawful if the particular circumstances do not warrant it – for example over-reacting to prevent a pupil committing a minor misdemeanour like dropping litter. Furthermore the degree of force must be '*the minimum needed to achieve the desired result'* and should take into account the age, understanding and sex of the child. The parallel Circular in Wales (Welsh Office Circular 37/98) is essentially the same as its English counterpart but it also states that the purpose of 550A is to empower staff in schools to intervene even where there is no immediate risk of injury or serious damage to property. The Welsh Circular also contains a

separate section emphasising the value of alternatives to restraint (Hughes et al 2001, pp.29-30)

While it is difficult to see how any guidance and legislation can prescribe for all occasions and circumstances it is equally possible to see how the reliance on concepts such as 'reasonableness' and 'proportionality' in determining whether the amount of force used could be a 'recipe for uncertainty and litigation' (Hamilton 1997, pp.14-16). Critics fear such lack of definition will lead to inconsistency between schools and result in divergent disciplinary practices.

The Guidance to Section 550A outlines the form physical intervention might take:

- physically interposing between pupils;
- blocking a pupil's path;
- holding;
- pushing;
- pulling;
- leading by the arm;
- shepherding a pupil away by placing a hand in the centre of the back or
- 'in extreme circumstances' using more restrictive holds.

The Circular also specifies some measures which should not be taken 'except in the most exceptional circumstances where there is no alternative' since they might reasonably be expected to cause injury. Such measures include holding a pupil around the neck or in any way which restricts their ability to breathe, slapping, punching or kicking a pupil, twisting or forcing limbs against a joint, tripping a pupil or holding or pulling a pupil by the hair. Staff should always 'avoid' touching or holding a pupil in a way that might be considered indecent. The authority to use reasonable force is allowed not only to teaching staff but also non-teaching staff authorised by the head teacher.

The Government introduced Section 550A to give some protection to teachers against charges of assault when enforcing discipline. However it has been criticised as allowing too much discretion to teachers and compared unfavourably to the more highly regulated situation pertaining to children in public care. Commenting on the examples given in the guidance of situations where restraint might be appropriate Hamilton wrote:

> *The envisaged scenarios include the breaking up of playground fights, and intervening to prevent disruptive behaviour both inside and outside the classroom. The level of restraint to achieve this will need to be significantly more than minor. The use of physical restraint in such circumstances, and indeed in any circumstances where more than a touch of the arm is required, requires a high level of specific training, as the Department of Health recognise only too well* (Hamilton 1997, p.15).

As Hamilton says it is hard to see how the range of staff potentially allowed to use physical restraint in schools can be adequately trained to ensure their own safety and that of the child. She also draws attention to the danger that a

member of staff applying physical restraint might be unaware of a child's personal history. Most discussions of restraint caution against its application in certain forms on a child or young person who has a history of being physically or sexually abused.

The allowance for physical intervention where no actual offence or act of serious damage is being committed but the child is merely '*engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school*' was felt to be particularly questionable:

> *The UK would benefit from a careful consideration of Article 19 of the UN Convention on the Rights of the Child before implementing this section. Article 19 requires all States Parties to take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical violence …. Section 550A appears to be in violation of this article* (Hamilton 1997, pp.14-16).

Residential Special Schools

The new National Minimum Standards for residential special schools set various quality measures for control, discipline and physical intervention. As in the other standards described earlier, they specify the need for schools to have a clear written policy and procedures on the control and disciplinary measures which may be used and the need for positive reinforcement of acceptable behaviour (Department of Health 2002d, 10.2). They adopt the principles found in the Children's Homes standards whereby children should have the opportunity:

> …*to discuss incidents and express their views either individually or in a regular forum or a house or unit meeting where unsafe behaviour can be discussed by children and adults* (Department of Health 2002d, 10.22).

However, residential special schools are in the complex position of having to comply with both the Minimum Standards *and* the DfEE's Section 550A. These are not entirely compatible in their differing approach to the criteria for using physical restraint and it remains to be seen how this will develop. It may be the case that Care Standards Inspectors disagree with an instance where restraint has been used in the interests of 'good order' whilst OFSTED Inspectors endorse the action. This is another illustration of the confusing messages to staff arising from the lack of a cross-Departmental approach.

Health

Violence towards health workers generally is a serious issue and the risk is particularly acute in psychiatric settings. Whittington (1994) gave a rate of one assault every eleven days per ward in a survey of violence in inpatient psychiatric settings and Gournay et al (1998) found that on average an assault occurred twice a week with staff being the victims in two thirds of these cases. Since the Ritchie Report following the death of Michael Martin (a patient at Broadmoor Hospital) in July 1984, staff in secure health care

settings have received training in restraint, often C&R (see Wright 1999, p.460). As in other professional settings Wright notes the ethical dilemma presented to workers where the use of physical restraint goes against personal and professional codes:

> …*physical restraint implies the violation of other socially and professionally valued aspects of the helping relationship, such as the promotion of the clients dignity, autonomy and self determination, even if it is performed to preserve life and prevent suffering after other means of stopping the dangerous behaviour have failed* (Wright 1999, p.462).

The Royal College of Psychiatrists (1998) offer some guidance. They suggest that the system of restraint chosen should:

- *include allocation of responsibilities to team members for coordinating team response;*
- *allocate responsibility to an identified team member for clear, direct uncomplicated communication throughout the procedure;*
- *be appropriate to the age, size and gender of the patient;*
- *not be dependent on the height or weight of staff members or the patient;*
- *not involve neck compression;*
- *offer a hierarchy of responses;*
- *use secure grips;*
- *minimise pain;*
- *maintain dignity;*
- *protect the patient's head during a descent;*
- *protect the patient's air supply;*
- *use controlled descents;*
- *avoid unnecessary pressure on the patient's back or chest.*

Health guidance does not usually differentiate between adults and children but the Royal College of Nursing did issue guidance specifically relating to children in March 1999, which is currently being revised:

> *This Royal College guidance has been produced following anxiety about the rights of children in health care settings in relation to physical restraint and restriction of liberty. One concern is that many nurses do not feel confident in the techniques of holding and containment* (Royal College of Nursing 1999, p.2).

The guidance sets out general principles for policy and practice, requiring that there is in place in institutions:

- an ethos of care and respect for the child's rights where restraint is a last resort rather than a first line of intervention;
- openness about who decides what is in the child's best interest in relation to restraint with clear mechanisms for staff to be heard if they disagree;

- a policy relevant to the particular setting and client group which details when restraint may be necessary and how it may be done;
- a sufficient number of staff who are trained and confident in safe and appropriate techniques of restraint and also in alternatives to it.

The RCN also says that the need for restraint should be anticipated wherever possible and prior agreement obtained from the child and parents. Physical restraint is never to be used in a way that could be considered indecent or that could arouse sexual feelings and:

> *… debriefing of the child and, where appropriate, of parents and staff, takes place as soon after the incident as possible* (Royal College of Nursing 1999, p.3).

The revised version of the guidance will also call for an effective audit of the circumstances and use of restraint.

Police

According to Hansard (8 July 2002) since April 1996 there have been a small number of deaths in police custody where restraint may have been a factor and there has been a continuing review of appropriate restraint techniques. Police officers are trained in a number of restraint methods but as in other sectors all uses of force must be reasonable and necessary and an individual police officer's actions must be accounted for under common law or statute.

> *Legal powers to use reasonable force are derived from various sources: Section 3 Criminal Law Act 1967, Section 117 Police and Criminal Evidence Act 1984, Common Law (Breach of the Peace) and Common Law (self defence)* (ACPO Guidelines).

According to a spokesperson at the Metropolitan Police approached for this review, the Association of Chief Police Officers (ACPO) Guidelines on the use of force are guidelines only - to which local forces may or may not sign up. Chief Officers of police are free to make their own operational decisions for their areas regarding training and choose the tactical options (batons, CS gas and so on) most appropriate to their officers' needs. There is no real distinction made between adults and children. The guidelines divide restraining techniques into two categories: those that aim to secure officer safety and those that aim for the resolution of a conflict. Although they make no explicit allowance for the age of the individual being restrained, it should be one of the factors they take into account when assessing perceived threat within a situation. The grounds for handcuffing a violent male adult would clearly be easier to prove than handcuffing a violent six year old, so age and size are relevant.

We were told by a spokesperson at the Officer Safety Unit at New Scotland Yard that in general, forces employ a conflict resolution model, which is intended to assist officers to make appropriate and timely decisions. The model introduces a structure to an officer's decision-making process based on

what they perceive they are faced with (for example the nature of the suspect/s, weapons, poor street lighting and so on), the relevant powers and policies and the tactical options at their disposal. This process is continuous until the situation is controlled.

The Police, as all other employers, are responsible for providing a safe working environment. For police, threats to health cannot be eliminated but control measures including self-defence training, body armour and so on have been introduced. As with prison officers, the police are often asked to provide training for other agencies because of their experience of dealing with violent behaviour.

Immigration Centres

The Immigration Service have produced a set of Operational Standards for the containment of children and families in their centres but these do not cover the issue of the use of physical restraint on children. They do however highlight the need for all Centre staff to have basic childcare training; for selected staff to undertake Level 3 GNVQ Caring for Children and Young People; for each Centre to develop (alongside relevant childcare and welfare agencies) a policy to detect child abuse; and for each Centre to implement a policy for liaising with the appropriate Area Child Protection Committee on child protection issues. A further children's policy paper is apparently being planned for the future, in response to criticism of the Operational Standards.

Services for people with learning difficulties or autistic spectrum disorder

In July 2002 the Department of Health and Department for Education and Skills issued the first joint guidance on physical interventions for those working with people with learning disabilities – *Guidance for Restrictive Physical Interventions: How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder*. The guidance focuses on the need for provider agencies to have effective behavioural policies, procedures and training for staff. It states that planned interventions should only be used as part of a holistic strategy and when the risks of intervention are judged to be lower than the risks of not intervening (4.4). Any intervention should (4.5) :

> …*employ the minimum reasonable force to prevent injury or serious damage to property, to avert an offence being committed and, in school settings, to prevent a pupil engaging in extreme behaviour prejudicial to the maintenance of good order and discipline at school or among any of its pupils* (Department of Health and Department for Education and Skills 2002, p.15).

The guidance stresses the importance of a proactive approach based on risk assessment and on using organisations which have the expertise to provide for this particular client group, specifically the British Institute of Learning Disabilities (BILD).

The BILD Policy Framework, Code of Practice and Physical Interventions Accreditation Scheme

After the BBC documentary Macintyre Under Cover exposed the abusive treatment of residents in a unit for people with learning disabilities (MacIntyre 1999) the Department of Health commissioned BILD to look at the issue of restraint for people with learning difficulties. This work is the most systematic attempt to date to provide some consistent policy on restraint across agencies and settings.

Although the BILD publications have been developed with a specific user group in mind (persons with learning disabilities and/or autism) they represent in the view of Hughes et al (2001) 'a distillation of current best practice on the use of physical interventions'. They could form the basis for moving towards a consensus view of good practice standards and criteria for other client groups. *Physical Interventions: A Policy Framework* (Harris et al 1996) sets out nine categories which should form the basis of any policy on physical intervention.

1. What are the legal responsibilities of the service and what are the legal protections of users?
2. What are the values and ethical standards of the service against which any decision to use or not use physical interventions can be judged?
3. How can the use of interventions be minimised through preventative strategies and alternative approaches?
4. What steps can be taken to ensure physical interventions are always used in the best interests of the service users?
5. What risks are involved for service users, staff and members of the public and how can these be minimised?
6. How can physical interventions be used without compromising the safety or the well-being of service users?
7. What can service managers do to ensure that policies are properly implemented?
8. What responsibilities do employers and managers have towards staff?
9. How can staff training assist in the development of good practice? (p.7)

In addition to the nine categories the book offers a further 32 key principles which taken together form a value base on which to judge policy and interventions. The book offers examples of good and poor practice and, like much of the literature on the subject, it stresses that physical interventions should never be used in isolation from a wider behaviour management strategy designed to minimise the need for its use:

> *Used in isolation physical interventions can easily become self-maintaining; they are an effective response once the behaviour has occurred, but because they do nothing to promote other forms of behaviour, they increase the chances that the challenging behaviour itself is repeated* (Harris et al 1996, p.26).

Principle 19 states that 'Physical interventions should not cause pain' and observes that some methods do involve the application of painful pressure in the form of wrist, thumb or arm locks – the amount of pain or discomfort being

increased or decreased by the amount of pressure applied to the 'lock'. The authors conclude, and here the specific user group which is BILD's concern has to be noted, that there are a number of 'compelling arguments' why the deliberate application of pain or discomfort is unacceptable and unnecessary in their sector:

- Such techniques were developed for other settings and to control very different groups of people.
- Effective alternatives which do not rely on pain are available.
- Since alternatives are available applying pain breaches the 'minimum force necessary' defence in law.
- Techniques using pain carry considerable risk of the user being injured.
- There is some evidence that using such methods increases rather than decreases the anger and aggression of the service users.

Goble (1999) welcomes the attempt to establish a body of generally accepted opinion but criticises the sections on management responsibility as being too limited in scope. He points out that staff training is not the panacea to cure all ills if management fails to do its job by allowing situations such as those created by 'grossly inappropriate mixing of service users' or unplanned admissions.

BILD have also produced a Code of Practice for Trainers (2001) intended to identify the essentials of good quality training. The code covers policies, best interest criteria, techniques for physical intervention, health and safety, course organisation, monitoring and evaluation and professional conduct.

Together, the Code and Policy Framework underpin the BILD Physical Interventions Accreditation Scheme, an initiative launched with Department of Health assistance in April 2002. The process of accreditation requires that trainers or training organisations:

- adopt the BILD Code of Practice;
- apply for accreditation;
- receive a pre-panel assessment visit from BILD representatives;
- attend a panel and give oral presentation and answer questions posed by the panel.

It is hoped that commercial pressures will eventually encourage most trainers to apply for accreditation and inclusion on the BILD Database, as this will in effect become the 'authority file' from which organisations select trainers. Although the scheme currently only applies to trainers of those working with people with learning disabilities, the shared value base of all its trainers should help to provide some consistency across the field. The latest BILD Directory of Physical Interventions Training Organisations (BILD 2003) lists only five organisations as fully accredited and there is a much larger section giving details of organisations which have so far just 'adopted the Code of Practice'. It is envisaged that many of these will come forward for accreditation in the next few years.

Discussion: is a consistent approach possible?

From the above, it can be seen that it is not just the secure estate where there is a fragmented approach to the use of restraint. Where policies do exist they have usually been developed by a single agency or Government Department, with few examples of cross-agency collaboration. Yet young people often move between institutional settings, for example from a children's home to a YOI, or are dealt with by more than one setting at a time, for example school and foster care, and may be subject to different practices:

> *There is a real need for 'joined up thinking' in development of policy guidance across different service provider sectors and government departments …the development of separate, uni-sectoral guidance is no longer desirable* (Hughes et al 2001, p.15).

The National Assembly for Wales commissioned the above report by Hughes and colleagues as it saw 'an urgent need' to inform the process of developing a consistent framework for physical restraint policy across social care, health and education. Worryingly the authors of the report found that:

> *Children are being placed at risk by unregulated use of physical interventions. Staff feel impotent to act and wary of litigation. They need a clear explanation and they can't get one. Services are refusing to acknowledge and give formal guidance about physical intervention. There is pressure to develop guidance so that services can: protect children we work with, families, ourselves, colleagues and others; avoid unacceptable or negligent practices; explain, justify and defend the decisions we make, the strategies we employ and the actions we take; defend ourselves from unwarranted inquiry or litigation* (Hughes et al 2001, p.15).

In spite of identifying this need for guidance, the authors concluded that it would be difficult to establish a common policy because each setting has unique functions, legal requirements and needs, but that a set of fundamental principles *could* be agreed. The Wales Office, in response to the above, are currently attempting to develop guidance which will be applicable across children's services.

At the time of writing the Department of Health is considering amendment to the Guidance on physical interventions with children. It is acknowledged that there is both a lack of uniformity and no consistent correlation between the use of restraint and children's needs. Informal discussion with the Department indicates that this further guidance will again locate the use of physical restraint firmly as a last resort, and one which must fit within the agency's overall Health and Safety, Behaviour Management and Risk Assessment policies. The emphasis is likely to be on an individual, needs-led approach whereby each child has an assessment of risk and an explicit strategy about how crises will be avoided or managed. It will also be applicable to the specific needs of foster carers.

It is still the case that the Department of Health is unlikely to endorse any particular form of intervention for any specific setting or situation. However it will almost certainly draw attention to the BILD Accreditation Scheme for Training Providers, funded by the Department and discussed above.

For ethical decisions to be made, there needs to be solid evidence about the effects of different approaches and, as described above, this is lacking. In the absence of this, decisions are arbitrary. Perhaps as a result of this uncertainty, there is a tendency to turn to training as the solution. Yet without an evidence-based policy, training takes place in a vacuum and may be beset by problems. One of the findings of *Edinburgh's Children* was that:

> *There seemed to be more emphasis on going on the course than on evaluating whether it worked* (Marshall et al 1999 p.170).

The Welsh Review noted that, valuable as it is, even much of BILD's own Code of Practice and Policy Framework is based on opinion and professional belief rather than empirical evidence. Allen (2001) identified this as a key deficit and spoke of the need for comparative studies of the effectiveness of different systems and different training programmes and the risks involved to restrainer and restrained. We also need to know much more about how staff and children experience restraint, the factors which determine these views and the relationships between institutional cultures and the use of restraint. We can never hope to entirely eliminate either the need for restraint in some situations and contexts nor can we eliminate instances of malpractice. However by establishing a sound ethical framework which addresses staff and user needs and rights, supported by clear guidance and policy and relevant accredited training we can hope to minimise harm and safeguard staff and users.

Conclusions

Current policy and practice regarding physical intervention within the secure estate is diverse in every aspect. The decision about whether to move towards a more uniform approach and if so, the form that approach would take, are beyond the remit of this review but there would appear to be three options for the YJB and providers to consider:

1. **No change** - to continue with the current situation where YOIs, STCs and LASUs are operating different systems for the use of physical restraint. This would be the appropriate decision if it is thought that the systems are working well and change is therefore unnecessary or because a uniform approach is thought to be completely unfeasible, given the differences in client group and resources.

2. **A single system across all settings** – to decide on a model of best practice in terms of policy, methods, training and monitoring which will be applied in all types of provision. This would need to be based on clear evidence about the most appropriate approach and agreement that it should/could be applicable in all settings whatever the operational difficulties.

3. **A shared policy on behaviour management** – but operated through individualised systems designed to meet the particular needs of each type of provision. This option could offer a common value base and a uniform approach but allow for some flexibility according to the needs of the establishment and the population they serve.

We would suggest that the following factors need to be considered in arriving at a decision.

Ethical and legal considerations

The use of techniques designed to inflict pain is clearly controversial. It must be acknowledged that YOIs are dealing with some extremely violent children, a number of whom are as large and as strong as adults. They are also dealing with some very small and fearful children. The system of C&R does not provide officers with any techniques for managing minor incidents or those involving these more vulnerable children because it was designed for use on adult males. It must be questionable whether this approach complies with the expressed principle of using only the minimum force required. Article 3 of the Human Rights Act bans cruel, inhuman or degrading treatment of prisoners and says that age and vulnerability are relevant factors when assessing whether this right has been breached. The fact that the *lowest* level of physical control specified in YOIs involves three officers: one bending the child double whilst the others apply arm locks, could be deemed to be excessively cruel. The same could be argued for the use of body belts on 17 year olds and the possibility of children spending unlimited periods alone in

special accommodation. Even if legally defensible, there must be ethical doubts about these practices. There is a transparent contradiction in specifically prohibiting them in parts of the estate whilst endorsing them in others. Although STCs and LASUs usually accommodate younger children, the age range is relatively narrow and does not necessarily reflect size or strength: all establishments are dealing with some level of violence. If it is the experience of establishments within the estate that children can largely be controlled without these methods then it becomes hard to justify their blanket use. The Juvenile Operational Group within the Prison Service have independently come to the same conclusion and are actively exploring alternatives. It will be important to ensure, however, that any method is linked to an overall strategy.

> *…physical interventions are only one element of developing effective, ethical responses to challenging behaviour* (Allen 2002, p10)

Effectiveness and safety of current techniques

The issue of effectiveness cannot be ignored, however. As discussed earlier, STCs and LASUs have the option of deciding not to attempt restraint in the first place, or of abandoning it if they are unable to control a young person. In these instances they can call for back-up from police or prison staff who are likely to use C&R or other pain compliant methods. Opinion differs as to whether PCC would be adequate in a prison setting and this could have serious consequences. The size of units within YOIs, unsuitable environments and low staffing ratios mean that a loss of control would put both children and staff at serious risk. Lindsey and Hosie considered this in their review:

> *What is clear is that elements of pain compliance do make a method more effective, and it has been argued possibly safer, as there may be longer term risks to the health of the person restrained if restraints last an excessive length of time. This should not persuade us to re-introduce the use of pain into the methods used. However, it is not realistic to expect that a method will be effective in as wide a range of situations if the decision has been taken for ethical reasons to ensure that pain is not inflicted deliberately* (Lindsay and Hosie 2000, p.13).

If such a decision is taken on ethical grounds then a rigorous assessment must be made of the reduction in effectiveness in a range of situations, and staff given clear guidance on how extreme situations are henceforth to be handled. If a restraint using a non-pain compliant method means that the act of restraining lasts longer, and involves more staff this raises practical, emotional, ethical and safety considerations which need addressing and costing.

With regard to safety, there is a surprising lack of data about the risks to children, or staff, of current methods. It is said that PCC has been approved

as being safe but no published evidence for this opinion is available. Conversely, there is also said to be evidence that C&R is unsafe for children but it continues to be sanctioned. The range of unregulated methods used by the LASUs are of unknown quality. There is some data about injuries caused during restraint but this does not appear to be centrally collated or analysed. Injuries to staff are said to be more likely when using PCC than C&R but this data again does not appear to have been analysed.

This lack of a sound evidence base is a major obstacle to reaching an informed position. Although there have been a number of small scale studies, there has been no systematic research of either the effectiveness or safety of methods of restraint. There is an urgent need for sound evidence to be collected and evaluated on all the methods currently in use focusing on:

- *Medical safety* - in general and for children/adolescents in particular. There appear to be specific risks associated with prone restraint and techniques which put pressure on joints but it would be useful to seek opinion on all techniques. Orthopaedic and paediatric experts would need to be involved in this work. A review of injuries caused to both children and staff may also provide useful data.

- *Psychological and emotional impact*. The fact that any form of restraint inevitably involves overpowering the child may have adverse psychological consequences, particularly where children have been abused or have other pre-existing mental disorder. Adolescent responses may differ from those of adults and it would be important to seek an opinion from a child and adolescent psychiatrist. This would also need to include the use of special accommodation. Again, the impact on staff is relevant. It is clear that some staff are more likely to become involved in physical restraint than others and the factors which are in operation need to be understood, both in terms of identifying pathology and ensuring suitable supports.

- *Effectiveness.* There is a need to review 'what works' in methods of physical restraint. The lack of research evidence has led to a reluctance to change from familiar and tested methods to unknown techniques which have not been 'proved'.

Some of the above data would be relatively straightforward to obtain whilst others would need research projects to be initiated. For example, there is a striking lack of information about the experiences of those directly involved in incidents, both children themselves and the staff who exercise restraint.

Institutional culture

Rose contends that no guidance can prescribe for every eventuality and that the use of physical control must be seen and understood in the context of the prevailing culture within the secure unit (Rose 2002, p.93):

> *It is this culture which determines the routine ways in which problems are solved and the manner in which adults and young people behave to each other. Such matters are a commonplace*

> *part of life and their handling reflects the way in which formal procedures and practices interact with a whole number of informal dynamics which are established between adults and young people in the day to day life of a secure unit (*Rose 2002, p.92).

This point is confirmed by other sources:

> *Research studies discussed in Locking Up Children show that much difficult adolescent behaviour is contextual in that it is influenced by the regimes experienced by the young people* (Dartington Social Research Unit 1991, p.4).

To address institutional culture is perhaps the most challenging task. It is nebulous to identify and difficult to change. Without this dimension being addressed, however, changes in policy will be doomed to failure. The culture described in relation to 'successful' children's establishments is one of effective leadership, caring relationships, shared goals and excellent communication. Staff are in tune with the children and alert to subtle indications that all is not well. They are also in tune with each other so that their response is consistent rather than fragmented (Dartington Social Research Unit 1991). This type of positive regime is recognised and described to some degree in the guidance to all the providers of secure accommodation. The question which needs to be answered is how far this ideal has been translated into reality within individual establishments.

During the course of this review, it has been suggested to us that some prison officers do not see juveniles in YOIs as children and will not be willing to change their practice. There is also some evidence of ambivalence in the messages prison officers are receiving from above. Whilst PSO 4950 sets out a clear description of a child-focused approach in its references to 'young people' and their need for 'advice' and 'counselling', this does not appear to have been fully integrated into prison life. PSO 1600 refers to violent and recalcitrant prisoners and does not make any distinction according to age. There is also no culture of allowing children to have a voice or to make complaints and prison officers are given little help in understanding the behaviour they are asked to deal with. Although a training package was devised (Lyon and Coleman 1996) to equip officers to understand and deal with adolescents, there does not appear to have been a real commitment to delivering this training. This is not to deny the very real change which is taking place and the fact that many officers would welcome more opportunity to engage positively with the children. It also does not mean that all is well in other aspects of the secure estate – the early inspections of Medway indicate that negative cultures may operate even with sound policies and adequate resources.

Recent experiences in Northern Ireland may provide useful information about changing culture. Lisnevin, the juvenile justice unit criticised in 2000 by the SSI for the frequency with which it used restraint and the C&R method, introduced a rapid programme of change in the face of staff hostility. This combined non-pain compliant techniques (PCC) with strategies for de-escalation (TCI). The decision was based on a view that the holds within PCC

were the safest and most suitable, but that the system lacked an overall approach to managing difficult behaviour which was present within TCI. The change was phased, with PCC being introduced first. Interestingly, when TCI training was added, the numbers of incidents seems to have reduced significantly although this data is still being collated. Initial indications suggest that staff have been able to make the transition successfully in spite of their initial scepticism.

When aspiring to culture change, it must be acknowledged that the purpose of the criminal justice section of the secure estate is not designed to be therapeutic. The emphasis is on bringing about cognitive and behavioural change within a limited time-scale determined by the courts rather than the child's circumstances. Given this, it may be unrealistic to expect secure establishments to completely adopt the individualised needs-led approach to behaviour management possible in other settings.

Resources

Whatever is decided, the resource implications will need to be considered to ensure that change is achievable. These may include:

- new policies and procedures to be drafted and implemented;
- programmes of initial and refresher training for all staff if new approaches are adopted;
- the suitability of environments to be considered and necessary improvements made;
- staffing levels to be reconsidered and possibly increased if new approaches are more labour intensive, not just during episodes of restraint but before and after;
- formal and informal opportunities for staff de-briefing;
- new structures for de-briefing and involving children;
- improved systems for recording and monitoring both on a national and local level.

At the moment, the huge disparity in resources between YOIs and other settings may limit their ability to make some changes.

An agenda for change

All the above factors will need to be considered in order to arrive at an informed decision. Although pragmatic concerns are important, decisions also need to be ethically defensible. If it is decided that change is needed, we suggest that a starting point may be to discuss and agree a set of core values which will underpin a uniform approach across the secure estate. This would be followed by the development of a policy framework, or Code of Practice, encompassing all aspects of behaviour management within a single strategy. The extent to which practice within this overall strategic framework is allowed to be flexible could be the subject of further debate but we would suggest that some level of consistency is achievable and desirable.

An overall strategy towards behaviour management

The use of physical intervention should be seen in the wider context of managing problematic behaviour. Guidance within each of the three types of provision makes some reference to the use of physical methods as being a last resort, and to the need for some level of post-incident monitoring. An effective approach should therefore make it clear to staff how they should respond before, during and after any episodes of problematic behaviour. If this is to go beyond vague statements of intent, there will need to be much clearer policies, procedures and training for staff so that they are equipped to translate good intentions into reality. The components of an overall approach to behaviour management would need to include:

1. Understanding the origins of problem behaviours in adolescence.
2. Awareness of the early indicators that problems are occurring.
3. Self-awareness and ability to recognise personal trigger points/ weaknesses.
4. Knowledge of group processes and how to manage groups.
5. De-escalation and diversion strategies to pre-empt or limit problematic behaviour.
6. Clear thresholds for when physical intervention is both necessary and justified, and whether these thresholds are based on 'risk' or 'recalcitrance'.
7. A hierarchy of techniques for physical intervention so that the level of force is appropriate to the age/size of the child and the seriousness of the situation at any given point.
8. Keeping carers and relevant external professionals informed of any incidents.
9. Allowing the child to express their views about incidents and to take those views seriously.
10. A recognition of the need for post-incident support for children and staff.
11. A willingness to discuss and learn from incidents in respect of the individual child, staff members and good practice in general.
12. Allowing the child to complain if they feel they have been unfairly/roughly treated, and to have access to independent advocates.
13. Taking complaints seriously and being open to independent scrutiny, including child protection enquiries.
14. A system for local monitoring of incidents which will highlight specific or general action needed.
15. A system for national monitoring across and within each sector, to identify trends, abuses and the need for change.
16. Having written policies so that everyone knows what they can expect, including children and their families.

If this change is to be achieved, it will require commitment and close cooperation between the relevant Government Departments (the Home Office, YJB, and Department of Health) in order to develop joint guidance. It will also require collaboration between the providers (the Prison Service, STC contractors and Local Authorities) and the respective Inspectorates who

currently cooperate on an informal level but have no statutory relationship. They are likely to have a valuable contribution to make to any discussion about best practice and the way to effectively monitor that practice.

If it would be of assistance, the National Children's Bureau could undertake further work. This could take the form of:

- additional qualitative analysis, based on more detailed interviews with staff and young people within secure settings, and with others who could inform the debate such as medical and psychiatric experts and relevant Inspectors. This would provide additional evidence to inform decisions about good practice;
- an invited seminar of experts, policy makers and managers to begin the task of developing the overall strategy of behaviour management described above.

Appendix 1 Methods Used by Secure Children's Homes

Compiled by Roy Walker, Secure Children's Home Network

1	Sutton Place	T.C.I.
2	Atkinson Unit	'Aidan Healey' Method
3	Lincolnshire	Ethical Escape and Caring Control
4	Derbyshire	H.E.A.R.T. Handling Emotion Aggression and Restraint Training
5	Hillside	'Control and Restraint' Training
6	Kyloe	C.A.L.M.
7	Aldine	Method taught by Psychiatric Senior Nurses, North Staffordshire Health
8	Clayfields	Method taught by Psychiatric Senior Nurses, North Staffordshire Health
9	Leverton	P.R.I.C.E. now known as S.C.A.P.E.
10	Aycliffe	P.R.I.C.E.
11	Liverpool - Gladstone	P.R.I.C.E./T.C.I.
12	Redsands	Space/ P.R.I.C.E. – Space = Safety prevention in a caring environment
13	Beechfields	P.R.I.C.E.
14	Swanwick	Team Teach
15	Orchard Lodge	In House Approved Training
16	Stamford Lodge	In House Approved Training
17	St. Johns Northampton	C & R General Services, NHS Newcastle
18	Watling House	H.E.A.R.T.
19	Eastmoor	T.C.I.
20	Redbank	P.R.I.C.E.
21	Barton Moss	D.I.V.E.R.T.
22	Clare Lodge	Ethical Escape and Caring Control
23	Dales House	C.P.I. (Crisis Prevention Institute)
24	Earlswood	H.E.A.R.T.
25	Lansdowne	P.R.I.C.E.
26	St. Catherines	P.R.I.C.E.
27	Thornbury	P.R.I.C.E.
28	Vinney Green	General Services Control and Restraint Services
29	Briars Hey	P.R.I.C.E./C.P.I.

Appendix 2: Summary of current practice in the use of physical restraint in the juvenile secure estate

Setting	Law and regulations	When physical restraint can be used	Techniques	Training	Recording and monitoring
Young offender institutions	Prison Act 1952 Young Offender Institution Rules 2000 Prison service orders 1600, 1601 and 4950	Prisoners who are: 'violent', 'recalcitrant' or 'disruptive'. →	Control and restraint (pain compliant locks to joints, prone restraint) Mechanical restraints – i.e. body belt - if age 17	All officers to receive basic C&R training before working in establishments – initially 29 ½ hours then 8 hours refresher per year. Delivered by Prison Service Instructors Advanced C&R for selected officers Initially 5 days then 2 days refresher per year Training is detailed and specific and assigns clear roles to each officer Training establishes the expectation that C&R is a 'last resort' but does not cover other aspects of behaviour management	Detailed record by supervising officer of all occasions when force used (not just C&R) Monthly statistical return to Prison Service Monthly use of force meetings held centrally to review these returns Detailed record of each occasion when mechanical restraints or special accommodation used These are also submitted to Prison Service Statistics published annually No formal de-briefing following incidents Children do not have opportunity to express their views
		'To prevent a prisoner causing self-injury, injuring another prisoner or member of staff, or damaging property' →			
		As above or 'causing a disturbance' →	Single separation in 'special accommodation'. No maximum period but must be re-authorised every 24 hours.		
		To move prisoners from one part of the establishment to another following a violent outburst →	Ratchet handcuffs		
		Exceptional measures to prevent injury to an officer or another →	Mini-baton		

		person or damage to property NB Above are Basic C&R techniques only – Advanced techniques not covered in this report.			Inspection every 3 years by HM Prisons Inspectorate
Secure training centres	Prison Act 1952 STC Rules (no. 38)	For the purpose of preventing trainees from: 2. escaping from custody; 3. injuring themselves or others; 4. damaging property; or inciting another trainee to do anything specified above	Physical Control in Care (PCC) Non-pain compliant holds designed for use by 1,2 or 3 people 3 'distraction' techniques based on pain to support above No 'decking' i.e. prone restraint No mechanical restraints Single separation for a maximum of 3 hours in 24.	Training incorporated into induction training for new staff Delivered by approved instructors who have themselves been trained by Prison Service trainers Covers general behaviour management, not just PCC	All incidents of physical restraint recorded within 12 hours YJB monitor sees all records Trainee is interviewed by a manager to give his/her side of the story (Rebound) Staff de-briefing Parents/ post-release supervisor informed Monthly PCC meetings, including trainees (Rebound) Management information collated Annual inspection by SSI
Local authority secure units	The Children Act 1989 Guidance and Regulations. Volume 4: Residential Care (1991) Guidance on permissible	Attempt to escape – with realistic chance of success if no intervention Immediate action is necessary to prevent significant injury to the	Range of techniques - many commercially devised Not pain-compliant	Training should be delivered within an overall approach to behaviour management All staff should be trained at some point	All incidents should be recorded immediately in a special book Child and staff member interviewed and de-briefed

	Forms of Control in Children's Residential Care (1993) The Control of Children in the Public Care: Interpretation of the Children Act (1989) National Minimum Standards for Children's Homes (2002)	significant injury to the child or others or serious damage to property	No formal use of single separation No routine use of mechanical restraints	point Training unregulated	Child encouraged to make their own record 'Responsible person' for the home to comment on and sign every report and take any action necessary Discussion in staff meetings to learn any lessons No national returns or monitoring but serious incidents reported to NCSC Annual inspection by SSI/NCSC

References

Allen, B (1998) New guidance on the use of reasonable force in schools, *British Journal of Special Education*, 25, 4, 184-188

Allen, D (2001) *Training Carers in Physical Interventions: research towards evidence-based practice*. BILD

Allen, D (2002) *Ethical Approaches to Physical Interventions: responding to challenging behaviour in people with intellectual disabilities.* BILD

Bell, L and Stark, C (1998) *Measuring Competence in Physical Restraint Skills in Residential Child Care*. Scottish Office Central Research Unit

British Institute of Learning Disabilities (2001) *BILD Code of Practice for Trainers in the Use of Physical Interventions*. BILD

British Institute of Learning Disabilities (2003) *BILD Directory of Physical Interventions Training.* BILD

Brookes, M (1988) *Control and Restraint Techniques: A Study into its Effectiveness at HMP Gartree.* (DPS Report, Series II, No.156). Home Office

Cavadino, M and Dignan, J (1997) *The Penal Service: An Introduction*. Sage

Centre for Residential Child Care (1997) *Clear Expectations, Consistent Limits: Good Practice in the Care and Control of Children and Young People in Residential Care*. The Centre

Children's Homes Regulations 1991. (1991) (SI 1991 No.1506). HMSO

Children's Homes Regulations 2001 (2002) (SI 3967). HMSO

Children's Rights Alliance for England (2002) *Rethinking Child Imprisonment: A Report on Young Offender Institutions.* CRAE

Committee on the Rights of the Child (2002) *Consideration of Reports Submitted by States Parties Under Article 44 of the Convention*. *Concluding Observations of the Committee on the Rights of the Child: United Kingdom of Great Britain and Northern Ireland*. Geneva: United Nations

Dartington Social Research Unit and National Children's Bureau (1991) *Secure Provision for Children and Young People: a Summary of Research Findings*. National Children's Bureau

Department for Education and Employment (1998) *Section 550A of the Education Act 1996: The Use of Force to Control or Restrain Pupils*. (Circular 10/98).The Department

Department of Health (1991) *The Children Act 1989 Guidance and Regulations. Volume 4: Residential Care.* HMSO

Department of Health (1993a) *Guidance on Permissible Forms of Control in Children's Residential Care*. The Department

Department of Health (1993b) *A Place Apart: an Investigation into the Handling and Outcomes of Serious Injuries to Children and other matters at Aycliffe, Centre for Children, County Durham*. The Department

Department of Health (1996) *Taking Care Taking Control*. The Department

Department of Health (1997) *The Control of Children in the Public Care: Interpretation of the Children Act 1989.* (CI(97)6). The Department

Department of Health (1998) *Inspection of Medway Secure Training Centre*. The Department

Department of Health (2002a) *Safeguarding Children: a joint Chief Inspectors' Report on Arrangements to Safeguard Children.* The Department

Department of Health (2002b) *Children's Homes: National Minimum Standards. Children's Homes Regulations.* The Department

Department of Health (2002c) *Fostering services. National minimum standards: fostering services regulations*. The Department

Department of Health (2002d) *Residential Special Schools: National Minimum Standards. Inspection Regulations*. The Department

Department of Health and Department for Education and Skills (2002) *Guidance for Restrictive Physical Interventions: How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder.* Department of Health

Durham County Council (1994) *Review of Aycliffe Centre for Children: Working Papers: Volume 1: the Background to the Review of Aycliffe Centre for Children.* The Council

Education Act 1997 Chapter 44. Stationery Office

Goble, C (1999) Physical interventions: a policy framework. Review*, British Journal of Developmental Disabilities,* 45, 1, 88 , 72-74

Gournay, K (2001) Violence in mental health care – are there any solutions? *Mental Health Practice*, 5, 2, 20-22

Gournay , K , Ward , M, Thornicroft, G and Wright, S (1998) Crisis in the capital: in-patient care in inner London, *Mental Health Practice*, 1, 10-18

Hagell, A, Neal, H and Shaw, C (2000) *Evaluation of Medway Secure Training Centre.* Policy Research Bureau

Hamilton, C (1997) Physical restraint of children: a new sanction for schools, *Childright,* 138, July/August, 14-16

Harris, J (1996) *Physical Interventions: a policy framework*. BILD

Hayden, C (1997) *Physical Restraint in Children's Residential Care. Report No.37. University of Portsmouth.* Social Services Research and Information Unit

Healy, A (1997) 'The prevention and management of violence' in Hayden, C (1997) *Physical Restraint in Children's Residential Care. Report No.37. University of Portsmouth.* Social Services Research and Information Unit

Health and Safety at Work Act 1974. HMSO

HM Inspectorate of Prisons for England and Wales (1997) *Young Prisoners: A Thematic Review by HM Chief Inspector of Prisons for England and Wales*. *October 1997*. HM Inspectorate of Prisons

HM Chief Inspector of Prisons for England and Wales (1998) *HM Young Offender Institution: Aylesbury. Report of a Full Inspection 8-12 June 1998*. HM Inspectorate of Prisons

HM Inspectorate of Prisons for England and Wales (2000) *HMYOI and RC Castington: Report of an Announced Inspection 15-19 May 2000 by HM Chief Inspector of Prisons.* HM Inspectorate of Prisons

HM Inspectorate of Prisons for England and Wales (2002) *Annual Report of HM Chief Inspector of Prisons for England and Wales 2000-2002*. HM Inspectorate of Prisons

HM Prison Service. Training and Development Group (1998) *Physical Control in Care Manual.* HM Prison Service

HM Prison Service (1999a) *The Use of Force*. (Prison Service Order 1600). HMPS

HM Prison Service (1999b) *Regimes for Prisoners Under 18 Years Old*. (Prison Service Order 4950). HMPS

HM Prison Service (2000) *Control and Restraint Training. Instructor's Manual* (Prison Service Order 1601). HMPS

Home Office (2000) *Prison Statistics: England and Wales 2000*. National Statistics

Hopton, J (1995) Control and restraint in contemporary psychiatric nursing: some ethical considerations, *Journal of Advanced Nursing*, 22, 110-115

Howard League (2002) *Children in Prison: Barred Rights*. *An independent submission to the UN Committee on the Rights of the Child*

Hudson, J R 'Care and control' *in* Barlow, G *ed.* (2000) *Safe Caring: Issues of Care, Control and Sexual Abuse in Residential Settings. International Perspectives on Residential Child Care.* Centre for Residential Child Care

Hughes, J C, Berry, H, Allen, D, Hutchings, E, Ingram, E and Tilley, E F (2001) *A Review of Literature Relating to Safe Forms of Restraint for Children with Behaviour that is Difficult to Manage*. Bangor Child Behaviour Project: University of Wales (Pre-publication draft)

Human Rights Act 1998. Chapter 42. Stationery Office

Kent, R (1997) *Children's Safeguards Review*. Scottish Office

Leadbetter, D 'Technical aspects of physical restraint' in Lindsay, M (1995) *Physical Restraint – Practice, Legal, Medical and Technical Considerations*. Centre for Residential Child Care

Leadbetter, D and Trewartha, R (1995) A question of restraint, *Care Weekly*, 18 May, 10-11

Leadbetter, D (2002) 'Good practice in physical interventions' in Allen, D *Ethical Approaches to Physical Interventions: responding to challenging behaviour in people with intellectual disabilities*. BILD.

Lee, S, Wright, S, Sayer, J, Parr, A. Gray, R and Gournay, K (2001) Physical restraint training for nurses in English and Welsh psychiatric intensive care and regional secure units, *Journal of Mental Health*, 10, 2, 151-162

Levy, A and Kahan, B (1991) *The Pindown Experience and the Protection of Children: The Report of the Staffordshire Child Care Inquiry*. Staffordshire County Council

Lindsay, M (1995) *Physical Restraint – Practice, Legal, Medical and Technical Considerations*. Centre for Residential Child Care

Lindsay, M and Hosie, A (2000) *The Edinburgh Inquiry – Recommendation 55. The Independent Evaluation Report.* University of Strathclyde and the former Centre for Residential Child Care.

Livingstone, S and Owen, T (1999) *Prison Law*. Oxford University Press

Lowenstein, L (1998) The physical restraining of children, *Education Today*, 48, 1, 47-54

Lyon, C (1994*) Legal Issues Arising from the Care, Control and Safety of Children with Learning Disabilities who also Present Severe Challenging Behaviour*. Mental Health Foundation

Lyon, C and Ashcroft, E (1994*) Legal issues arising from the care and control of children with learning disabilities who also present severe challenging behaviour: a guide for parents and carers.* Mental Health Foundation

Lyon, J and Coleman , J (1996*) Understanding and working with young women in custody : Training pack.* HM Prison Service and Trust for the Study of Adolescence

McDonnell, A (1996) The physical restraint minefield: a professional's guide, *British Journal of Therapy and Rehabilitation*, 3, 1, 45-8

MacIntyre, D. (1999). *MacIntyre Undercover. One man, four lives*. BBC.

Marshall, K., Jamieson C and Finlayson, A. (1999) *Edinburgh's Children. The Report of the Edinburgh Inquiry into Abuse and Protection of Children in Care*. Edinburgh Council

Millham, S, Bullock, R and Hosie, K (1978) *Locking Up Children.* Saxon House

Mortimer, A (1995) Reducing violence on a secure ward, *Psychiatric Bulletin*, 19, 605-8

National Foster Care Association (1996) *The Care and Control of Children and Young People in Foster Homes.* (Making it Work) NFCA

Parkes, J (1996) Control and restraint training: a study of its effectiveness in a medium secure psychiatric unit, *Journal of Forensic Psychiatry*, 7, 3, 525-534

Paterson, B, Tringham, C, McComish, A and Waters, S (1997) Managing aggression and violence: a legal perspective on the use of force, *Psychiatric Care*, 4, 128-131

Ritchie, S (1985) *Report to the Secretary of State for Social Services Concerning the Death of Mr. Michael Martin*. SHSA

Rose, J (2002) *Working with Young People in Secure Accommodation: from Chaos to Culture*. Brunner-Routledge

Ross, S (1994) *Controlling Children's Challenging Behaviour*. Scolag

Royal College of Nursing (1997) *The Management of Aggression and Violence in Places of Care: an RCN Position Statement*. RCN

Royal College of Nursing (1999) *Restraining, Holding Still and Containing Children: Guidance for Good Practice*. RCN

Royal College of Psychiatrists (1998) *Management of Imminent Violence: Clinical Practice Guidelines to Support Mental Health Services.* The Royal College

Sequeira, H and Halstead, S (2002) Control and restraint in the UK: service user perspectives, *British Journal of Forensic Practice*, 4, 1, 9-18

Skinner, A (1992) *Another Kind of Home: a Review of Residential Child Care*. The Scottish Office, Social Work Services Inspectorate for Scotland.

South Birmingham Mental Health NHS Trust (2002) *Physical Interventions: restraint*. The Trust

Southcott, J, Howard, A and Collins, E (2002) Control and restraint in acute mental health care, *Nursing Standard*, 16, 27, 33-36

Special Hospital Services Authority (1993) *Report of the Committee of Enquiry into the Death in Broadmoor Hospital of Orville Blackwood*. SHSA

Support Force for Children's Residential Care (1995) *Good Care Matters: Ways of Enhancing Good Practice in Residential Child Care*. Department of Health

Utting, W (1991) *Children in the Public Care: a Review of Residential Child Care*

Utting, W (1997) *People like us: the Report of the Review of the Safeguards for Children Living Away from Home*. Department of Health and Welsh Office

Walker v Northumberland County Council 1994. LexisNexis Case Citation

Walker, M, Hill, M and Triseliotis, J (2002) *Testing the Limits of Foster Care*: *Fostering as an Alternative to Secure Accommodation.* BAAF

Warner, N (1992) *Choosing with Care: the Report of the Committee of Inquiry into the Selection, Development and Management of Staff in Children's Homes.* HMSO

Waterhouse, R , Le Fleming, M and Clough, M (2000) *Lost in Care: Report of the Tribunal of Inquiry into the Abuse of Children in Care in the former County Council areas of Gwynedd and Clwyd since 1974.* Stationery Office

Whittington, R (1994) Violence in psychiatric hospitals *in* T. Wykes *ed*. *Violence and Health Care Professionals*. Chapman and Hall

Wright, S (1999) Physical restraint in the management of violence and aggression in in-patient settings: a review of issues, *Journal of Mental Health*, 8, 5, 459-472

The Young Offender Institution Rules 2000. (Statutory Instrument 2000 No.3371). HMSO

National Children's Bureau, 8 Wakley Street, London EC1V 7QE
Registered Charity number 258825, Registered in England and Wales No 952717
A company limited by guarantee

Tel +44 (0)20 7843 6000 Fax +44 (0)20 7278 9512 www.ncb.org.uk