

Report on the use of Physical Intervention across Children's Services

**Di Hart
&
Steve Howell**

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Glossary of Acronyms

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
DfES	Department for Education & Skills
DH	Department of Health
HMIP	Her Majesty’s Inspectorate of Prisons for England and Wales
LASCH	Local Authority Secure Children’s Home
LEA	Local Education Authority
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
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

The use of direct physical contact in order to overpower a child raises complex legal, ethical and practical issues. There are times when such intervention is necessary in order to protect the child or others from harm but clear guidance is essential in order to safeguard both the child concerned and the practitioner exercising the restraint. It is debatable whether such clarity currently exists in the UK.

A review of policy and practice within children's services in England has highlighted a number of inconsistencies. There are some basic principles which are common to all settings: 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. The following table can be used to classify key differences in approach:

Policy and practice	Approach
Threshold for using restraint	Is it based on risk assessment?
	Or on risk AND 'recalcitrance'?
Specificity of techniques	Can only specified techniques be used?
Nature of techniques	Are methods pain-compliant or non pain-compliant?
	Can 'decking' be used?
Other forms of restraint	Are mechanical restraints allowed?
	Is single separation/ segregation allowed?
	If so, is use regulated and is there a maximum period?
Training	Is training regulated? – amount, frequency, refreshers
	Can only trained staff use restraint?
	Must training/ trainers be accredited?
Overall approach to behaviour management	Is there a holistic approach, including de-escalation etc?
	Or is restraint seen in isolation?
Involvement of child	Is child allowed/ encouraged to express their views - about restraint policy and individual incidents?
Involvement of family/other professionals	Is there an expectation that the child's family or professional network will be advised of restraint episodes?
Debriefing	Is there a culture of debriefing/ opportunity to learn from incidents?
Monitoring	Is there local monitoring?
	Is there national monitoring?

These differences stem partly from the legal and policy framework and partly from professional values and institutional culture. There is no single policy

that applies to the many settings and services which children may encounter. This leads to many anomalies: for example, a child in a Young Offender Institution can be held indefinitely in an 'unfurnished cell' and restrained though the use of arm locks whilst an identical child in a Secure Training Centre cannot be held on their own for more than 3 hours in 24 and must not be subjected to any pressure on their joints. In other settings, guidance tends to be at the level of general statements of principle rather than describing what staff should actually *do*. For example, in children's homes the ways in which children can be restrained are locally determined. Managers may purchase training in restraint techniques from private, commercially driven, providers who are not accredited. Alternatively, staff may be authorised to restrain children with no advice on appropriate techniques or training. Given this lack of clarity, children's rights may be breached and the UN Committee on the Rights of the Child has called for a review of practice across the UK. There are also risks for staff, who want to be clear about what they can and cannot do when using physical intervention with children.

The situation is compounded by a lack of clear evidence about what works when dealing with challenging behaviour in children and young people. There have been few studies of the safety and effectiveness of different restraint techniques, particularly in respect of children. Neither has the emotional and psychological impact of physical restraint, both on those undertaking the restraint and the children on the receiving end, been systematically researched. Basic information about the incidence of restraint is also inadequate. Although most settings are required to record incidents, local monitoring arrangements are patchy and national monitoring virtually non-existent.

Not only are there disparities across the various settings, but also between England and other nations of the UK and Eire. Scandals in children's homes have occurred in all nations, leading to Inquiries and recommendations that the use of restraint be reviewed. Work is currently being undertaken in Scotland to address the problem through trying to develop more uniformity through Care Standards. In both Northern Ireland and Wales there are cross-Departmental groups drafting guidance specifically on the use of restraint. There is currently no commitment to a cross-cutting review in England although work has been undertaken to develop joint guidance and a training accreditation scheme within learning disability services.

There is an urgent need for debate within the 4 nations of the UK about the practice of restraining children. Specific questions to be asked are:

- Does current policy and practice breach the UN Convention?
- Is there a need for more explicit Government guidance on the circumstances in which children can be restrained and the appropriate methods to use?
- Can such guidance be common to all settings and all children?
- Could there be a common approach across the 4 Nations?
- How can a robust evidence base be established to inform the development of policy?

http://www.ncb.org.uk/resources/res_detail.asp?id=597

- How can episodes of restraint be effectively monitored?

Introduction

... 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 use of physical restraint by health or social care staff is an emotive subject. Where that restraint is exercised by adults on children, the impact is greater still. This report is concerned with the policy and practice of physically restraining children under the age of 18 across social care, educational, health and secure settings in England. It 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.

Definitions

The terminology used to describe the topic varies across settings and it is important to clarify what is meant.

Control and Restraint

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' – a specific technique:

... 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 of 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 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 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 a recent Welsh Assembly review noted:

... it is likely that physical restraint by a person or persons is required in the early stages of a restraint incident (Hughes et al 2001, p.3).

Legal considerations

Lindsay and Hosie (2000) found that several aspects of the law may be applicable to the use of restraint:

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 that employers have to give equal priority to the safety of staff and service users. 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 hinged on the council's 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 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, as will be discussed later, that there is a striking absence of evidence about the respective merits of the various techniques.

Lindsay, 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 (Centre for Residential Child Care 1997, p.37) adds further criteria:

- *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?*

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. It is important, therefore, that such policies are as explicit as possible.

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. The latest UN Committee Report 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) suggest 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 the 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 1983. 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.

Ethical and policy considerations

The use of physical restraint is an emotive subject, especially when that restraint is carried out by adults on children. Indeed, the validity of using restraint at all is sometimes contested:

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 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 specific guidance has been forthcoming it has not always been perceived as helpful.

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, p.33)

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 on which to judge methods of restraint.

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).

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

Safety and effectiveness

Most studies on the safety and effectiveness of methods relate to the use of C&R in adult health settings. According to Southcott (2002) these have produced contradictory results. Mortimer (1995) concluded that the use of the C&R 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 before and after training in C&R and found that there were more staff injuries while restraining patients *after* training. 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 the amount of 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 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.

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 that similar research, for example into the

acquisition and retention of 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 have no way of knowing whether their current training and levels of competence are adequate. They concluded that it was 'imperative' (p.27) to develop independent, clearly validated methods of assessing the effectiveness of both individual techniques and of the training and trainers.

User perspectives

Again, studies have focused almost exclusively on the experiences of adults. Lindsay and Hosie (2000) did talk to children as well as managers and residential staff following an inquiry into practice within Edinburgh. Sixty-eight per cent of the children reported that they 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 experience itself.

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.

The views of adult service users have not been systematically researched either although, as Wright (1999) points out, this would assist in framing effective preventive or de-escalation strategies. One study of adults with learning difficulties 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 (p.14).

Staff who implement restraint measures are also, in a sense, users. 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 be 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.

Where staff in children's homes have been asked for their views, a wide range of responses were elicited (Bell 1997; Lindsey and Hosie 2000). A number of factors seem to influence staff perceptions of restraint: personal values about the ethical justification for restraining children; concern about potential physical and emotional risk to the child; worry about restraint as a substitute for proper assessment and case planning; level of personal confidence and skill in using restraint techniques; unit culture; management support; clarity of guidance and opportunities for debriefing.

Restraint in specific services

Some of the key elements of the debate on physical restraint within different children's services 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 within children's homes. 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.

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. It 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'. This guidance has been further developed through more detailed subsequent Government directives and by the Care Standards Act 2000.

When can restraint be used?

The criteria within the original Children Act guidance for the 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 (DH 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* (DH 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).*

This guidance seems to raise the threshold: injury must be **significant**, the damage to property must be **serious** and the risk must be **immediate** to justify restraint.

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 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 ... (DH 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 (DH 1997, p.4).

This is in direct contradiction to the above 1993 guidance. Moreover, staff:

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

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, p.184).

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 *Children's Homes: National Minimum Standards* (DH 2002a) have not brought about significant change. The matter of restraint falls within Standard 22 which 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 (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) (pp.32-33).*

Methods of restraint

In fact, none of the Government guidance actually specifies such 'approved methods'. 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 (DH 1996, pp.33-34).*

The extent to which these principles have been adopted in practice is unclear. Certainly the Department of Health has not, and does not intend to, endorse specific techniques. This has left the providers of children's residential care to search for their own solutions from amongst the large number of systems and approaches on offer from commercial organisations. 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.

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 such training 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 (DH 1993a, p.19).

In the absence of firm evidence or specific guidance, it is difficult to see how managers can make these judgements.

Recording and monitoring

It is important that incidents of restraint are taken seriously. 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, in a '*separate dedicated bound and numbered book*'. 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 down their own views following an incident or to have someone else record their views for them and to sign this.

There is no single format on which records should be made and, although they are seen by Care Standards Inspectors, they are not necessarily collated at Local Authority or Regional level. There is a requirement to report any

'serious incidents' to the National Care Standards Commission (NCSC) but these do not specifically mention injuries as a result of restraint. The Commission is still developing its systems and no data is currently available which would indicate the information likely to be provided in future. There appear to be no plans to undertake any national monitoring. Returns are not routinely submitted to the Department of Health, although the SSI do receive a number of reports relating to individual incidents, and there are no statistics issued about the use of restraint.

Fostering

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, confirmed in a National Foster Care Association publication which attempted to fill the gap – *The Care and Control of Children and Young People in Foster Homes* (NFCA 1996). This highlights the need for clarification in the interests of 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 (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. It recommends that 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 (DH 2002b) 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.

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. This is evident in the evaluation of a scheme in Scotland which used fostering as an alternative to secure accommodation, where challenging behaviour was an everyday occurrence (Walker et al 2002). A review of fostering agencies in Scotland undertaken by Fostering Network found that agencies vacillated about whether it was appropriate to provide guidance and training on physical intervention and there was widespread inconsistency. There have been particular concerns about the potential risks of foster carers

using methods designed for residential workers in group settings when they are operating at home and possibly on their own. Techniques of restraint requiring 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.

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

The Secure Estate

There are three types of secure provision in England for children under 18.

- 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 Children's Homes (LASCHs): owned and managed by local authorities.

Most placements result from a remand or sentence from the criminal courts, but a small number of children are placed in LASCHs on 'welfare' grounds. Children entering each type of secure setting can expect to experience different regimes, with a particularly stark difference in the varied approach to physical intervention. 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).

Two years later, Hilton Dawson MP enquired as to the progress of this review. He was told by the Minister, 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, as mentioned earlier, the Department of Health neither approves nor specifies such methods. 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 and it can be questioned whether this right is being breached in relation to physical restraint. The Chief Inspectors also expressed their general concern about the safety of children in prison in their recent cross-departmental report, *Safeguarding Children* (DH 2002c). 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 (Howard League for Penal Reform 2002a).

The key differences in current practice across settings within the secure estate are now explored.

Local Authority Secure Units

The activity of local authority units is determined by the guidance described earlier for children in public care. They must also comply with the *National Minimum Standards: Children's Homes*. 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 (DH 2002a, p.21).

When can restraint be used?

LASCHs also operate to the same criteria for the use of restraint as other children's homes, i.e. risk to self, others or property, 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 (DH 1993a, p.5).*

Methods of restraint

LASCHs, in common with other children's homes, do not have to use a prescribed method. Enquiries undertaken by the Chair of the Secure Children's Network reveal that, of the 29 units, there are at least 15 different restraint models being employed with all the problems of quality control described earlier.

Single separation, i.e. keeping the child on their own in a room away from the group, is not expressly mentioned but custom and practice indicates that children may be confined to their bedrooms for no more than 3 hours in any 24 and with 15 minute checks. 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.

Recording and monitoring

LASCHs are expected to record and monitor incidents in the same way as other children's homes. 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 LASCH 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. 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 undertake any national analysis.

Comment

The fact that LASCHs 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. The small size of establishments also means they can adopt a more individualised behaviour management approach. The system is not without its weaknesses however. As with other children's homes, LASCHs are at the mercy of a range of commercial providers of unknown quality. Because of the lack of quality control, LASCHs 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.

The importance of this point was illustrated in two reports into events at the Aycliffe Centre in County Durham, one by Durham County Council and another by the Department of Health. *A Place Apart* (DH 1993b) gave the findings of the 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 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).

Young Offender Institutions

Control and Restraint (C&R) was introduced in 1983 as the approved method for physical restraint in all prisons, which means that it may routinely be applied to children aged 15 and above of both genders. The terminology within the prison service differs significantly from that within other children's establishments, illustrated by the title of the relevant guidance: *Use of Force* (HM Prison Service 1999a).

When can restraint be used?

Although prison officers are instructed not to use force unless it is necessary, this is not clearly explained. Instead of the risk-based model adopted with children in LASCHs, there is reference to the use of force to control 'recalcitrant' prisoners or in 'potentially disruptive' situations in addition to those where there is violence.

Methods of restraint

C&R techniques are specific and regulated, being designed for use by three officers who must be supervised. Each officer has a clearly defined role and the lead officer is responsible for controlling and protecting the prisoner's head. 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. C&R should only be deployed by trained and competent staff and there is a clearly established programme of basic, advanced and refresher training delivered by qualified instructors within the Prison service.

Handcuffs can be used on all ages and 'body belts' on prisoners aged 17 or above, although both are regulated. The use of 'special accommodation', i.e. special or unfurnished cells, is also allowed in certain circumstances. Although this must be re-authorised every 24 hours, there is no maximum limit to the number of re-authorisations. The legality of this has recently been challenged by the Howard League.

Recording and monitoring

All incidents must be fully recorded and records are open to inspection by Her Majesty's Inspectorate of Prisons (HMIP). There is a system of national reporting, which allows the opportunity for some comparison and monitoring. On a local level, however, monitoring is just being introduced within establishments to enable staff to examine and question their own practice. A verbal report from one establishment suggested that the incidence of restraint had declined once this scrutiny had been introduced. There is no opportunity, however, for the children themselves to comment on incidents and no requirement to inform their family or professional network.

Comment

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 has the benefit of having clearly defined techniques and the system is transparent and accountable. There is 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 and there would appear to be wide variations between establishments in the frequency with which force is used. These are likely to arise from the prevailing culture of the establishment rather than major differences in population. One inspection report says:

The level of assaults was disturbing and the use of control and restraint techniques alarmingly frequent. (Children's Rights Alliance for England 2002, p.85).

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 have not, until very recently, had access to independent children's advocates and there is no routine practice of informing parents or external professionals of the use of force.

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 (HMIP 2000 p.46).

The report 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. It is difficult to assess whether injury is caused by

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

This debate will be revisited in the conclusion but 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 2002b, p.13).

Secure Training Centres

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, their approach is said to be based on Children Act and Department of Health guidance.

When can restraint be used?

The circumstances in which physical restraint can be used are set out in the STC Rules as follows:

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 clear and based on the same conceptual framework as those for children's homes: 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.

Methods of restraint

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. 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. 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. PRICE techniques are those used in the *Taking Care Taking Control* training pack (DH 1996). They are also said to be medically approved for use on young people.

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. 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. 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'. 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. 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.

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 before working with the children.

Recording and monitoring

As in the Prison service, all incidents should be recorded but there is greater emphasis on understanding why the incident occurred and the lessons to be learned for the individuals concerned and practice in general. Records are scrutinised by managers, SSI and a YJB monitor. Any complaint by children arising from the use of physical intervention is treated as a child protection matter. Children do complain about physical restraint: it is estimated by one STC provider 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.

Comment

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, with an emphasis on understanding problematic behaviour and talking to troubled children about their responses rather than simply controlling them. There are some potential difficulties, however.

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 (DH 1998, p.20).

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 do inflict pain. Linked with this, the effectiveness of PCC has been questioned. It was designed originally for 12-14 year olds, the expected population of STCs, and there are indications that some STC staff have concerns at the adequacy of PCC for responding to very difficult/disturbed children. 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. The option to call on prison officers, who *will* use pain compliant methods, raises ethical issues.

Finally, 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?

Other settings

Education

Section 550A of the Education Act 1996 provides the legislative basis for the use of force to control or restrain pupils. In 1998 additional guidance was provided (DfEE Circular 10/98) to assist education staff with implementation which states that the powers set out are not new ‘but in the past they have been misunderstood’. 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. More detailed guidance has recently been issued in relation to pupils with severe behavioural difficulties, primarily in special school settings (DfES 2003).

When can restraint be used?

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 1996. Section 4).*

Circular 10/98 concedes that 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 (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 such as 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. Each headteacher has responsibility for developing detailed procedures for implementing the guidance within their school, although it is suggested that some LEAs may choose to assist by providing model policies.

Methods of restraint

Circular 10/98 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. There is no requirement for staff who are authorised to use force to be trained.

Recording and monitoring

Although incidents must be recorded by the member of staff concerned and reported to the head or senior member of staff, there is no formal requirement to monitor the use of force either by the school, LEA or OFSTED. There is also no mention of the need for post-incident support for staff or pupils, or opportunities to learn from incidents. It is deemed 'advisable' to inform parents of incidents but not mandatory.

Comment

The Government introduced Section 550A to give some protection against charges of assault when enforcing discipline in schools. However it has been criticised as allowing too much discretion to teachers. While it is difficult to see how any guidance and legislation can prescribe for all occasions and circumstances the reliance on concepts such as 'reasonableness' and 'proportionality' in determining whether force has been justified could be a 'recipe for uncertainty and litigation' (see Hamilton 1997, pp.14-16). Critics fear such lack of definition will lead to inconsistency between schools and result in divergent disciplinary practices. Furthermore, the allowance for physical intervention where no actual offence or act of serious damage is being committed but the child is merely compromising 'good order and discipline' 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).

The means of restraint have also been compared unfavourably to the more regulated situation pertaining to children in public care.

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.

An evaluation report on the impact of Circular 10/98 (Fletcher-Campbell et al 2003) points out weaknesses in the monitoring process. Although schools were, as directed, recording incidents, this information was not uniformly returned to LEAs. Neither was there any system for analysing the data on a local or national basis. It is impossible therefore to estimate the incidence of restraint and there is no opportunity to learn from experience or to improve practice. Interestingly, although LEA staff and parents were consulted in the evaluation, the pupils themselves were not. Neither were the authors asked to consider the threshold for the use of restraint, in spite of the critical

comment this has received. The report concludes that the implementation of the guidance has been uneven. Whilst most LEAs had developed policies as a result of the Circular, these had not necessarily filtered down to schools with many deciding the issue of restraint had no relevance for them. This was not the case with special schools who had developed local policies, but they were critical of the fact that restraint was considered in isolation from a wider approach to behaviour management. For this reason, they had found the joint guidance for people with learning difficulties (DH & DfES 2002) more helpful. The authors consider that this multi-agency approach to behaviour management would also be of more relevance to mainstream schools and would reduce anomalies between different children's services. Additional comments from schools were that they wanted greater attention given to the importance of training, examples of good practice and greater clarity about 'reasonable force'.

Residential Special Schools

The new National Minimum Standards for residential special schools, as in the other standards described earlier, 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 (DH 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 (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 arising from the lack of a cross-Departmental approach.

Health

There is no Government guidance specifically on the restraint on children in health settings, although those in psychiatric hospital would be covered by the Mental Health Act 1983 Revised Code of Practice (DH 1999). This is based on a risk model, whereby staff can use restraint to 'take immediate control of a dangerous situation', defined as:

- *Physical assault;*
- *Dangerous threatening or destructive behaviour;*
- *Non-compliance with treatment*
- *Self-harm or risk of physical injury by accident*

- *Extreme and prolonged over-activity likely to lead to physical exhaustion (section 18.6).*

Force may also be used to prevent a patient leaving the hospital in certain circumstances.

The Code of Practice describes restraint within the context of care planning, requiring staff to consider the circumstances in which individuals are likely to need restraint, and what form that restraint should take. The Code does not specify the methods that can be used, but does state what cannot: restraint which involves tying; neck holds; slapping; punching or kicking patients.

Although they do not differentiate between adults and children, the Royal College of Psychiatrists (1998) does offer some suggestions about the system of restraint chosen: it 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.*

Only staff in secure psychiatric settings are required to have training. This arose from the Inquiry into the death of Michael Martin, a patient at Broadmoor Hospital (Ritchie Report 1985). Such training is often C&R (see Wright 1999, p.460).

Within the Code of Practice, episodes of restraint must be recorded, including the reasons for using it and the methods used. Hospital managers are responsible for monitoring and auditing these records. The Hospital Managers should also appoint a senior officer who is to be informed of any patient being subjected to any form of restraint that lasts for more than 2 hours. They should see the patient as soon as possible and visit and talk to them about the incident, ask if they have any concerns and if so help them to put these forward. The senior officer may delegate this task to a staff member who has a good relationship with the patient. The position regarding national monitoring is unclear: there is no information in the public domain.

The only guidance specifically relating to children was issued by the Royal College of Nursing in 1999 and updated in 2003.

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 need for nurses to restrain children arises not only as a response to problematic behaviour but also because of the need to hold children still during clinical procedures. The guidance sets out general principles for policy and practice, requiring that institutions have in place:

- an ethos of caring and respect for the child's rights where restraint is a last resort rather than a first line of intervention;
- consideration of the legal implications of restraint;
- 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, and that the child parents and staff should be de-briefed. Physical restraint is never to be used in a way that could be considered indecent or that could arouse sexual feelings. The revised version of the guidance also calls for an effective audit of the circumstances and use of restraint.

The British Medical Association (2001) has addressed the issue of restraint of children in medical settings where restraint may be needed to prevent injury or to give essential medical treatment. This publication does not constitute guidance but is a description of considerations in determining good practice.

Police

Since April 1996 there have been a small number of deaths in police custody where restraint may have been a factor (Hansard 8 July 2002) 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).

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 and autistic spectrum disorder of all ages (*Guidance for Restrictive Physical Interventions: How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder*). They

suggest that it is also relevant to other settings, such as EBD schools. 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 (DH & DfES 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 they represent, in the view of Hughes et al (2001) 'a distillation of current best practice on the use of physical interventions' and 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?

- | |
|--|
| <ol style="list-style-type: none">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.

Other nations of the UK and Eire

As part of this review, we examined practice in other parts of the UK and Eire. In respect of secure settings, England is unique in holding large numbers of children, including 15 year olds, in prison. In Scotland and Eire, some children of 16/17 are placed in prison facilities but within the overall category of 'young prisoners' up to the age of 21, making it difficult to be clear about numbers. There are also reports of 15 year olds being detained in prison in Scotland if beds are not available in secure units. In response to a request to the Scottish Prison Service for data, however, it was stated that 'the Scottish Prison Service does not hold juveniles in custody' but this highlights inconsistencies in definition rather than in practice. Northern Ireland does not place children in prison service establishments under the age of 17. Wales does have a few juveniles on remand but has very few secure beds at present, although there is a proposal to open an STC. The main secure provision for juvenile offenders in the other 3 nations is therefore more akin to England's local authority secure children's homes. In Eire these are called Children Detention Schools and in Northern Ireland Juvenile Justice Centres. The latter cater for children between the ages of 10 and 16 but from June 2003 there has only been one unit, with a maximum capacity of 50.

The methods of restraint are, again, similar to England in that C&R is used in prison establishments but not otherwise. Interestingly, it was used until recently in one Juvenile Justice Centre in Northern Ireland, Lisnevin, but abandoned following an inspection by the SSI when the Centre was re-designated from a training school. They found that restraint was used too often, in circumstances where alternatives may have been sufficient, and was unnecessarily confrontational in style. Prone restraint and arm/ wrist locks were used resulting in pain and injury. Criticisms were also made about the

inappropriate use of a segregation block to punish children. Incidents were not properly monitored and children did not feel empowered to complain. Given that Lisnevin housed children as young as 10, this also aroused concern within the Northern Ireland Rights Commission. The SSI recommended a review of the way children were restrained and the whole approach to behaviour management. Since then, the use of C&R has been replaced by PCC techniques, coupled with a model (TCI) which provides for an overall approach to de-escalating problematic behaviour, and debriefing in order to learn from it.

Similarly, concerns about restraint in other children's residential establishments are evident across nations. These can be found in the detail of specific Inspection Reports but occasionally there have been specific scandals or complaints giving rise to public scrutiny in the form of Inquiries or reports by Children's Rights Organisations (for example re Scotland, Skinner 1992, Marshall et al 1999, Lindsey and Hosie 2000). Perhaps of more importance than the fact that scandals occur is the response of Governments. Interestingly, the regulatory framework does not differ greatly across the 4 nations: all have a version of the Children Act based on principles of paramountcy, all are signatories to the UN Convention on the Rights of the Child and, recently, all have developed National Minimum Standards for social care. They also share a reluctance, possibly for sound operational reasons, to prescribe a single approach to restraint for mainstream children's services.

There is, however, a sense that not all are satisfied with this situation. At the end of their independent evaluation into the use of 'CALM' in Edinburgh, Lindsey and Hosie (2000) recommended that

- *There should be a national reporting system of physical restraints.*
- *There should be continued research into violence towards welfare and health workers.*
- *The Scottish Executive should establish a National Standing Committee on Physical Intervention Techniques, with multi-disciplinary membership (p. vi).*

These recommendations do not appear to have been acted upon but a National (Scottish) Care Standards Working Group was set up in response to the 'marked differences' with respect to restraint across different Standards. This included physical, mechanical, environmental and pharmacological restraint. The Group is attempting to develop a Framework of areas to be considered when developing restraint policies in order to bring about a more consistent approach. Again, their draft report makes recommendations for the Scottish executive including the development of model care and control policies, the introduction of thematic inspections on restraint, the issuing of practice guidance and the commissioning of research.

Similarly, the Welsh Assembly saw 'an urgent need' for a consistent framework for physical restraint policy for professionals working with children,

http://www.ncb.org.uk/resources/res_detail.asp?id=597

young people, adults and older people in health, education and social care settings. They are in the final stages of drafting Physical Intervention/ Restraint Guidance to be issued for consultation in the Spring of 2004.

In Northern Ireland, a Government working group is currently examining the issue, again with a view to issuing guidance on restraint and seclusion in health and personal social services settings. This will not be specific to children.

Concluding discussion

It is clear that there is a huge disparity in policy and practice across services in the use of restraint on children. 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 and that restraint must not be used as a punishment. Otherwise, there is little commonality. These differences stem not only from the legal and policy framework (summarised in Appendix 1) but from professional values and institutional culture. The following table can be used to classify key differences in approach:

Policy and practice	Approach
Threshold for using restraint	Is it based on risk assessment?
	Or on risk AND 'recalcitrance'?
Specificity of techniques	Can only specified techniques be used?
Nature of techniques	Are methods pain-compliant or non pain-compliant?
	Can 'decking' be used?
Other forms of restraint	Are mechanical restraints allowed?
	Is single separation/ segregation allowed?
	If so, is use regulated and is there a maximum period?
Training	Is training regulated? – amount, frequency, refreshers
	Can only trained staff use restraint?
	Must training/ trainers be accredited?
Overall approach to behaviour management	Is there a holistic approach, including de-escalation etc?
	Or is restraint seen in isolation?
Involvement of child	Is child allowed/ encouraged to express their views - about restraint policy and individual incidents?
Involvement of family/other professionals	Is there an expectation that the child's family or professional network will be advised of restraint episodes?
Debriefing	Is there a culture of debriefing/ opportunity to learn from incidents?
Monitoring	Is there local monitoring?
	Is there national monitoring?

These differences raise practical and ethical questions – both for staff and the children themselves:

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).

Implications for children

Children may be subjected to unnecessary suffering as result of this lack of direction. There is nothing in current guidance which forbids the deliberate use of pain, pressure on joints and prone restraint on children. This is perhaps the issue of greatest concern. 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 (DH 1996, 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).

Yet if these methods are abandoned, is there evidence that alternatives are effective? This has raised concern, particularly in some secure settings. Lindsey and Hosie considered this in their review:

What is clear is that elements of pain compliance do make a method more effective ...(Lindsay and Hosie 2000, p.13).

If it is decided not to use such methods on ethical grounds, then there must be consideration of the consequences. Similarly caution should be exercised in criticising police or prison officers who may use pain-compliant techniques if called in to deal with children where other methods have failed.

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).

Children may not only suffer physically: there is a risk of disempowerment and humiliation in being physically restrained, particularly if the child is given no opportunity to discuss what has happened.

Implications for staff

A further danger of the current lack of regulation 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 (DH 1993a, p.9).

Critics of this Guidance have claimed that it is too vague to be of much practical help (see Ross 1994, in Hughes 2001, p.23; Utting 1997, p.122). Rose points out the need for 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).

The case for regulation?

Given these dangers, it can be argued that there is a need to impose a single model of best practice across services. This is a particular challenge, given the range of needs exhibited by children of different ages and stages of development. A model which works well for an out-of-control 15 year old in an STC may be too heavy handed for a slippery 6 year old with conduct disorder, yet staff still have a duty to protect him from harm. (In Scotland, a need was identified to set standards for very young children in day care following an incident where a toddler was strapped into a chair). Nevertheless, 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).

Existing policies 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).

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. In response to this, the Wales Assembly is developing a policy framework across children's services. Similar attempts to bring more coherence are being undertaken in Scotland and Northern Ireland.

In England, at the time of writing, there is no commitment to a cross-cutting review, although some work is being done within individual sectors. The Department of Health is considering amendment to their Guidance on physical interventions with looked after children in acknowledgement of the lack of uniformity or consistent correlation between the use of restraint and children's needs. 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. However, the Department of Health is unlikely to endorse any particular form of intervention for any specific setting or situation. Instead it will almost certainly draw attention to the BILD Accreditation Scheme for Training Providers, funded by the Department and discussed above. There are also moves within the secure estate to achieve more consistency. As part of this project, a detailed report on the use of restraint in secure settings was commissioned by the YJB and they are currently developing a code of practice.

Both of these developments may bring about improved practice but still fall short of a policy across children's services. This will allow the situation to continue whereby children cannot be guaranteed a consistent approach in different settings.

Ethics or evidence?

Decisions about restraint policy must have some basis in ethical judgement – how children should be treated - but this needs to be supported by sound evidence about the effects of different approaches. This is lacking and, in its absence, 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. There is a clear need for further research in the following areas:

- *Incidence*

There is very little data on the nature and extent of restraint both within and across children's services. Although it is a requirement that individual incidents be recorded, this information is not systematically analysed, particularly on a national level.

- *Effectiveness and safety:*

There is an urgent need for studies to inform decision-makers about the safest and most effective methods of restraint

- Medical safety - in general and for children/adolescents in particular.
- Psychological and emotional impact – on children and staff
- Effectiveness - 'what works' in methods of physical restraint.

- *User feedback*

Similarly, little is known about the views of those who have been involved in restraint incidents.

- Children who have experienced or witnessed restraint
- Staff who have restrained children, or who have witnessed colleagues using restraint.

Restraint within the context of behaviour management

The use of physical intervention should be seen in the wider context of managing problematic behaviour. An effective approach would 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:

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

It is suggested that we can never entirely eliminate the need for restraint in some situations nor 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.

Appendix 1: Summary of current practice in the use of physical restraint in children's services

Setting	Law and regulations	When physical restraint can be used	Techniques	Training	Recording and monitoring
Children's Homes	<p>The Children Act 1989 Guidance and Regulations. Volume 4: Residential Care (1991)</p> <p>Guidance on permissible Forms of Control in Children's Residential Care (1993)</p> <p>The Control of Children in the Public Care: Interpretation of the Children Act (1997)</p> <p>National Minimum Standards for Children's Homes (2002)</p>	<p>Immediate action is necessary to prevent significant injury to the child or others or serious damage to property</p>	<p>Range of techniques - many commercially devised</p> <p>Not pain-compliant</p> <p>No formal use of single separation</p> <p>No routine use of mechanical restraints</p>	<p>Training should be delivered within an overall approach to behaviour management</p> <p>Staff training is optional</p> <p>Training unregulated</p>	<p>All incidents should be recorded immediately in a special book</p> <p>Child and staff member interviewed and de-briefed and child encouraged to make their own record</p> <p>'Responsible person' for the home to comment on and sign every report and take any action necessary</p> <p>Discussion in staff meetings to learn any lessons</p> <p>No national returns or monitoring but serious incidents reported to NCSC</p> <p>Annual inspection by SSI/NCSC</p>
Local authority secure units	As above	As above but with additional criteria if attempt to escape – with realistic chance of success if no intervention	As above	<p>Training should be delivered within an overall approach to behaviour management</p> <p>All staff should be trained at some point</p>	<p>As above</p> <p>Additional scrutiny by YJB monitor for children in criminal justice placements</p>

				Training unregulated	
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'. Additional criteria (mainly → element of risk to self, others or property) if other methods to be used	Control and restraint (pain compliant locks to joints, prone restraint) Some restricted use of mechanical restraints, handcuffs and single separation in 'special accommodation'.	All officers to receive basic C&R training before working in establishments – initially 29 ½ hours then 8 hours refresher per year. Delivered by qualified Prison Service Instructors Training is detailed and specific and assigns clear roles to each officer	Detailed record by supervising officer of all occasions when force used (not just C&R) Monthly statistical return to Prison Service and national monitoring meetings Detailed record of each occasion when mechanical restraints or special accommodation used and statistics published annually No formal de-briefing following incidents and children do not have opportunity to express their views 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: 1. escaping from custody; 2. injuring themselves or others; 3. 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 or 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 Annual inspection by SSI

Education	1996 Education Act – Section 550 DfES Circular 10/98	To prevent a pupil from 1. committing an offence, 2. causing personal injury 3. damage to property or 4. engaging in behaviour prejudicial to the maintenance of good order and discipline	No specific techniques Suggested measures include: <ul style="list-style-type: none"> • holding; • pushing; • pulling; • leading by the arm; and ‘in extreme circumstances’ using more restrictive holds.	Training unregulated No requirement for staff to be trained	All incidents to be recorded Inspection by OFSTED If residential special school, also inspected by NCSC. No systematic monitoring, locally or nationally
Health	Mental health Act 1983 (Revised Code of Practice 1999)	To prevent a patient leaving the hospital To take immediate control of a dangerous situation To end or reduce significantly the danger to the patient or those around	Not specified, other than ‘tying should never be used’. Staff are cautioned not to use neck holds and not to slap, kick or punch.	Training should be given to staff who might have to manage aggression. Trainer should have training appropriate to health settings, ‘preferably’ validated	Record must be made of reasons, and type of restraint used. Care plans should include circumstances when restraint can be used and what form Should be ‘post incident analysis’ and review and support for staff/patient Incidents must be reported and audited by Hospital Managers No national monitoring

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 (1997) The physical restraint of young people. *Child and Family Social Work*, 1, 37-47.
- 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
- British Medical Association (2001) *Consent, Rights & Choices in Health Care for Children and Young People*. BMA
- Brookes, M (1988) *Control and Restraints Techniques: A Study into its Effectiveness at HMP Gartree*. (DPS Report, Series II, No.156). Home Office
- Care Standards Act 2000. Chapter 14*. HMSO
- 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*. Centre for Residential Child Care
- 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

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). Department for Education and Employment

Department for Education and Skills (2003) *Guidance on the Use of Restrictive Physical Interventions or Pupils with Severe Behavioural Difficulties*. Department for Education and Skills

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*. Department of Health

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*. Department of Health

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

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

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

Department of Health (1999) *Mental Health Act 1983 Revised Code of Practice*. Stationery Office

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

Department of Health (2002b) *Fostering Services. National Minimum Standards: Fostering Services Regulations*. Department of Health

Department of Health (2002c) *Safeguarding Children: A Joint Chief Inspectors' Report on Arrangements to Safeguard Children*. Department of Health

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

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*. Durham County Council

Education Act 1996 Chapter 44. Stationery Office

Fletcher-Campbell F, Springall E and Brown, E (2003) *Evaluation of Circular 10/98 on the Use of Force to Control or Restrain Pupils: Research Report RR451*
Department for Education and Skills

Goble, C (1999) Physical interventions: John Harris, David Allen, Marion Cornick, Alan Jefferson and Richard Mills, *British Journal of Developmental Disabilities*, 45, 1, 88, 72-74

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, Allen, D, Cornick, M, Jefferson, A and Mills, R (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

Health and Safety at Work Act 1974. HMSO

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

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 for England and Wales

Howard League for Penal Reform (2002a) *Children in prison given protection under landmark ruling* (Press Release 29 November). Howard League

Howard League for Penal Reform (2002b) *Children in Prison: Barred Rights. An Independent Submission to the UN Committee on the Rights of the Child.* Howard League

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 M, 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, McCornish, 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 Nursing (2003) *Restraining, Holding Still and Containing Children and Young People: Guidance for Nursing Staff*. 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
- United Nations (1989) *Convention on the Rights of the Child*. UN
- Utting, W (1991) *Children in the Public Care: A Review of Residential Child Care*. HMSO
- 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 , Clough, M and Le Flemming, 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
- Welsh Office (1996) *The Use of Reasonable Force to Control or Restrain Pupils*. (Circular 37/98). The Welsh Office
- 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