Restrictive Physical Intervention in Secure Children's Homes

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National Children's Bureau (NCB)

NCB promotes the voices, interests and well-being of all children and young people across every aspect of their lives.

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Introduction

Introduction

The current review of restraint being undertaken by the Ministry of Justice will make recommendations about the operational efficacy, safety and ethical validity of restraint methods currently in use within juvenile secure settings and the circumstances in which they may be used. Young offender institutions (YOIs) use a method known as Control and Restraint (C&R) and secure training centres (STCs) use Physical Control in Care (PCC) but less is known about the variety of methods currently being used within secure children's homes (SCHs). There are also wider questions about the place of restraint within their overall approach to behaviour management.

Children and young people placed in SCHs may be subject to restrictive physical interventions in specified circumstances: to prevent harm to self or others, to prevent serious damage to property or to prevent escape (Department of Health 1991, 1993). Restrictive physical intervention (RPI) is defined here as any method that restricts the movement of an individual by physical means, including mechanical means, holding and physical restraint. Physical restraint is defined as direct physical contact to overpower an individual and is the main focus of this report. The methods of RPI that can be used within SCHs are not specified but left to local discretion: managers are responsible for selecting an appropriate method and for determining the arrangements for staff training.

Formats for recording are also left to local determination, as are detailed monitoring and reporting arrangements. This has resulted in a wide variation in the approaches taken to restraint. In a review undertaken in 2003, there were 15 different methods in use across the 29 SCHs operating at that time (Hart and Howell 2003). Although some methods may have been subject to individual evaluation, there has been no systematic review comparing their relative safety and effectiveness or assessing their suitability for use on this population of troubled children. The British Institute of Learning Disabilities (BILD) has established an accreditation system for trainers in physical restraint but it is voluntary and not all methods currently in use within SCHs are BILD accredited.

Aims and objectives of project

This project aims to provide information about the methods, systems and processes relating to restrictive physical intervention currently in use within SCHs. It does not claim to answer questions about safety and effectiveness or to define best practice. A detailed research programme, drawing on medical and psychological expertise and qualitative interviews, would be needed to provide such evidence. This report attempts to provide an initial scoping of key practice issues and to begin the process of developing an evidence base by establishing and describing:

- the methods of restrictive physical intervention currently in use within all SCHs;
- the way in which such methods are selected;
- what policies and procedures are in place locally governing the use of restraint;
- the processes for recording, monitoring and reviewing the use of restrictive physical intervention within SCHs;
- mechanisms for the medical examination of children following the use of restrictive physical intervention within SCHs;
- the arrangements for notification following the use of restrictive physical intervention within SCHs, including notification of serious injuries;
- the arrangements for training and supervision of staff who may be required to carry out restrictive physical intervention.

Following this initial mapping of methods, systems and processes, a number of case studies were undertaken. The objectives were to identify:

- the experiences and perceptions of staff and children in SCHs, and external stakeholders, about the use of restrictive physical intervention in general, and in relation to their local arrangements;
- evidence about the way systems and processes operate in practice;
- key dilemmas and issues that will inform the development of best practice.

Methodology

In order to address the above questions as quickly as possible whilst retaining a rigorous and systematic approach, the following methodology was adopted.

Phase 1

Analysis of relevant documents for each SCH. These included the behaviour management/ restraint policy, recording and reporting arrangements, training programmes and reports to the YJB and external agencies about incidents of restraint and injuries. It was initially intended to seek relevant documents from the local authority and Local Safeguarding Children Board (LSCB) but this did not prove to be a useful source of data. A proforma was developed to ensure that information was collected and analysed systematically.

Interviews with key informants. As anticipated, there were gaps in the information provided by the documents and, in order to fully understand systems and processes it was necessary to conduct interviews with key informants. Telephone or face-to-face interviews were conducted with a senior manager from each SCH. The planned interviews with service managers and LSCB representatives did not take place, partly because it was clear that they would provide only limited information and partly because of time constraints. Instead, it was considered more important to interview training providers. These interviews were conducted by telephone.

Statistical analysis of any existing data sets relating to physical restraint held by the YJB and Ofsted.

Phase 2

Case studies of four establishments. These were selected so as to illustrate a range of practice using criteria such as incidence of restraint and different techniques. The following sources of evidence were used to provide a detailed picture of restraint activity:

- Records of restraint for the last six months, including injuries, medical interventions, notifications, monitoring activity and post-incident reviews.

- Views of key stakeholders, including care staff, through group discussion and confidential individual semi-structured interviews.

- Views of children, through confidential semi-structured interviews.

Approaches towards behaviour management

All of the 20 SCHs operating within England and Wales in February 2008 were approached and asked to provide copies of relevant documents and to state which method of restraint they used. Full information was provided by 17 and partial information by the remaining three. One establishment that was about to close and the single establishment in Wales were amongst the three that provided only partial information and were excluded from aspects of the study. The detailed description below is based on the remaining 18 establishments unless otherwise stated. Qualitative information about the way policies are perceived to operate in practice gained from the case studies and stakeholder interviews is incorporated throughout.

Policies and procedures

The National Minimum Standards for Children's Homes (Department of Health 2002) require every establishment to have a behaviour management policy, specifying the measures of control, restraint and discipline that may be used. Of the 17 SCHs that provided copies of their policies, all were compliant with this requirement although their quality and range was variable. In the majority of cases, the policy was specific to the SCH: only four establishments are working to a council-wide policy although these appear to apply primarily to the authority's children's homes or other settings regulated by the Care Standards Act where children are living away from home, i.e. residential special schools or foster homes, rather than all children's settings. This is changing with the integration of children's services, and Directors of Children's Services are aware of the anomalies of having different policies and methods in social care and educational settings. The Association of the Directors of Children's Services is currently undertaking work on this with a view to issuing a protocol.

Local policies varied considerably, although all but two had integrated RPI into their overall guidance on behaviour management. It seemed that this integration had been adopted in order to emphasise that RPI was part of the overall repertoire of techniques required to manage children's behaviour and must not be seen in isolation. This was reflected in the names of the policies, such as *Positive Handling* or *Care and Control*.

The content of policies on behaviour management can be considered under three broad headings:

> *Level 1:* the establishment's overall approach, such as its culture and values, and the ways in which it seeks to promote positive behaviour in general.
>
> *Level 2:* the ways in which the behaviour of individual children will be supported.

Level 3: the response to challenging behaviour once it arises, including sanctions, single separation or RPI.

All policies contained at least a limited statement of their values and principles underpinning work in this area, describing the likely needs of children being cared for and the responsibility of the establishment to support their behavioural development. For example:

> *Guidance and control includes teaching acceptable standards of social behaviour in a way which the child can understand, providing a model for children to copy in terms of honesty, kindness, respect for others and establishing safe boundaries when behaviour is out of control.*

Otherwise, policies varied considerably in tone, with some settings placing considerable emphasis on Level 1, including the need for positive relationships and expectations regarding staff behaviour and pro-social modelling. This was linked to a recognition of the possible reasons for problematic behaviour, ranging from the child's previous experiences to the pressures they may encounter within the establishment. As a result, there was explicit acknowledgement that the establishment was responsible for preventing problematic behaviour rather than merely responding to it on a case-by-case basis.
For example:

> *The phrase 'positive management of behaviour' is used in this guidance to describe a child centred approach to care and control which recognises that behaviour is influenced by more than the simple application of rules and sanctions. For example, the home environment, the attitudes of the staff, resident mix, the extent to which children are involved in the day to day running of the home, are all factors that can and do influence behaviour.*

Level 2 approaches usually centred on a requirement for children to have individualised behaviour management plans or risk assessments that identified any behavioural issues. Risk assessments sometimes included particular physical or emotional health problems that may influence the appropriateness of certain behavioural management techniques. Where the establishment had in-house instructors in physical intervention, they were usually involved in determining the methods that were suitable for particular children with specific needs, whether these arose from their health problems or particularly challenging behaviour.

Other establishments' policies placed more of an emphasis on Level 3: responding to challenging behaviour once it had started, although all stressed the need to defuse and de-escalate difficulties before resorting to physical intervention. A range of possible responses were described from 'planned ignoring', the imposition of sanctions, single separation through to physical intervention. Such physical intervention did not necessarily mean restraint and various strategies were described from the mere 'physical presence' of staff, to guiding them away from the scene of conflict before using more restrictive techniques and physical restraint.

Behaviour management strategies

Even if it was not made explicit within their policy, most establishments had some form of needs-led behaviour management strategy. These involved the children themselves to a greater or lesser extent. In some, the aim was to actively involve children in devising and reviewing their own

behaviour management plan. This would include the situations that caused them stress, the behaviours that might ensue and the best way of managing those behaviours. Children may be invited to express a view on the types of physical intervention that they would prefer. For example, children may find it distressing to have people approaching them from behind or to be held face down on the floor. The following is an example of one establishment's approach to behaviour management planning and their format is attached at Appendix A.

All children must have a Behavioural Management Plan developed in consultation with staff and the child. The Behaviour Management Plan includes strategies such as the Behavioural Contract, Health and Physical intervention. The plan must focus on positive reinforcement of acceptable behaviour and must be regularly reviewed by staff and the child. A Behaviour Management Plan is a useful management strategy because it targets specific behaviours that may be displayed and is developed with the direct involvement of the child and key staff. The Key Worker should inform YOT worker/Social worker when developing the Behaviour Management Plan and allow them to contribute as well as the child. This facilitates a sense of ownership and personal responsibility. Behaviour management plans are to outline:

- the specific behaviour(s) to be addressed;
- known triggers for the behaviour;
- interventions which will address the behaviours;
- revision process for the plan;
- consequences for continued inappropriate behaviour.

In four establishments, Therapeutic Crisis Intervention (TCI) was used to support staff in understanding and responding to challenging behaviour. It is based on linking the behaviour to feelings and contains a strategy known as a Life Space Interview (LSI) in order to do this. Even where de-escalation has been unsuccessful and a child has been restrained, an LSI should take place in order to learn from the incident. TCI is also accompanied by physical intervention techniques but these are universally disliked, particularly their version of prone restraint, and are no longer in use in any SCHs although they continue to be used in other children's settings. TCI was thought to be useful in that it provided a structured approach to guide staff in their work with the children, although one SCH manager questioned whether it was always suitable. It uses language that is imported from the US and is felt by some staff to be 'jargon-y'.

Other strategies involve various reward and incentive schemes, with yellow and red cards to give children constant feedback about their behaviour. In one SCH, all children had a 'personal success plan' in order to promote positive behaviour, with an emphasis on making progress rather than losing ground. This is important because a manager from another establishment pointed out the difficulty for children who have lost their privileges and whose behaviour becomes even more unmanageable because they feel they have nothing more to lose.

One or two establishments have found Brief or Solution Focused Therapy models useful in engaging children in finding their own solutions to problems, and others are using variations of restorative justice and mediation for conflict resolution. SCHs have robust complaints systems and a variety of independent advocacy or

children's rights services that also help to solve problems before they escalate.

Through these mechanisms there was evidence, at best, of a partnership approach where children were engaged to work alongside staff to understand and overcome their behavioural problems whilst recognising the establishment's responsibility to create the right context for this to happen. It must be remembered, however, that the workforce also need to be engaged if these approaches are to succeed. Some staff expressed a feeling that they were not valued, which inevitably affects their commitment to their job.

Key points

- There is evidence that SCHs aspire towards a holistic approach to behaviour management, within which RPI is just one element.
- SCHs are exploring creative ways of promoting positive behaviour and reducing the need for restraint.
- Individual policies vary widely in tone and content, including the extent to which they are integrated within the policy framework of their local authority.

The place of restraint within behaviour management

Criteria for the use of restraint

The legal framework for the use of physical restraint in all children's homes is that:

> ... *restraint should be used rarely and only to prevent a child harming himself or others or from damaging property. Force should not be used for any other purpose, nor simply to secure compliance with staff instructions* (Department of Health 1991).

Guidance issued in 1993 clarified that there was an additional criteria specifically for SCHs:

> *Only if the child tries to run away would different criteria be appropriate... staff should intervene physically, including restraining the child* (Department of Health 1993.)

In 1997 the Chief Inspector of the Social Services Inspectorate offered further clarification of the criteria in the form of a letter (Department of Health 1997). This 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.*

Moreover:

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

The National Minimum Standards for Children's Homes have not brought about significant change although the word 'injury' is used instead of harm and damage to property must be 'serious'.

Local policies and procedures confirm that physical intervention should be a last resort, using the minimum force and for the shortest duration necessary to resolve the problem. For example restraint should only be used:

> ... *to prevent injury to self or others or significant damage to property* ***and is likely to succeed in resolving the situation without causing equal or greater injury or damage***.

Interestingly, individual establishments had interpreted and adapted the official criteria to some extent although all were clear that they must be based on the risk of harm. For example, the possibility of damage to property was qualified in various ways, such as:

> *Serious damage to property, which will result in serious injury;*

Serious damage to property that places people at risk of injury or would cause serious distress or trauma to others;

Damage to the fabric of the building.

Only seven of the 17 policies seen mentioned the use of restraint in order to prevent absconding.

The anomalies between the criteria for using restraint in education and care settings were explored within one policy and it was acknowledged that different criteria applied in different parts of the establishment, given that it provided full-time education as well as being a registered children's home. Within the classroom, it was stated that children could be restrained to prevent a crime or to maintain good order and discipline. Most establishments did not explore this difference, seeing themselves as primarily social care settings and therefore bound to comply with Children's Homes regulations.

There were clear statements about the fact that restraint must not be used just to secure compliance although one SCH listed '*serious threat to discipline*' as a possible reason for using restraint within their recording format. The guidance drawn up by the Secure Accommodation Network (SAN 2005) states that restraint can be used if a child is:

Inciting other children to cause physical harm or damage to property.

This is actually a criterion taken from the STC Rules and it is questionable whether it is valid for SCHs.

Interpretation of the criteria in practice

The meaning of 'last resort'

Children interviewed within the case studies were generally accepting that staff did sometimes need to use restraint, particularly if someone was going to get hurt.

It's for our own safety, isn't it?

Yes – if you're endangering yourself or others – it's fair – you could get into trouble with the police.

However, some offered examples of where they did not think it had been justified:

It's OK to use it but only where really necessary – it makes you harder if they do it for every little thing.

Although care staff were clear that restraint must not be used for non-compliance, the interpretation of what this means within day-to-day practice is difficult. Whilst situations where a child was self-harming or being aggressive are seen as reasonably clear cut, those where a child is being disruptive within the group or refusing to go to their room pose a difficulty. One manager said:

If they won't go to their room, we can't use restraint: Care Standards is very clear we can't restrain for non-compliance.

The children interviewed did not necessarily share that perception. A common reason they gave for the use of restraint *was* a refusal to go to your room.

If you're kicking off or something - if they ask you to go to your room and you refuse, they'll restrain you to your room.

The opinion of the adults was divided over this issue. Some said that it was not a problem, with one establishment saying that these situations would usually be resolved by '*bladder or boredom*'. In other settings, it *was* perceived as a significant problem. There were instances where staff had sat up all night with children who refused to go to bed but others that had ended in restraint:

> *People play a game with the criteria – if a kid refuses to go to bed, they put their hand out and, if he resists, there's your reason.*

Staff described the dilemma of having to make a judgment about the harm that might ensue to other children if they allowed a disruptive situation to go on, particularly at night when staffing levels are lower. For example, room checks need to be done on vulnerable children. Whilst staff did not want the power to restrain children for non-compliance or 'good order and discipline', there was a request for clearer guidance on this topic.

The philosophy of individualised behaviour management planning may be relevant in assessing whether restraint is justifiable. For example, staff knew from experience that one child tended to smash the TV when she was out of control so would move in to pre-empt it if they saw her moving in that direction. This raises another potential problem: that of consistency and accusations of differential treatment.

Using restraint to move children

A related problem is that of whether children should or should not be physically moved using restraint techniques. Opinion was divided: one establishment expressed a view that this was poor practice and that, if necessary, other children should be moved away from an incident.

> *Moving children is totally undignified, unnecessary and causes the potential for injury.*

There is also the issue of where they should be moved *to*: the child's bedroom is seen as a safe area and their only private space. If a child is taken there in an agitated state and the room has to be stripped of potentially harmful objects, it can be seen as a punishment. Some establishments were identifying other rooms that could be used for 'time out' without these associated difficulties.

In spite of these dilemmas, one establishment had recently changed their method of restraint specifically because it provided techniques for moving children to somewhere where the holds could be released, reducing the need for prolonged restraint. On balancing the risks, the managers considered this to be safer and to give the child the emotional and physical space to calm down. A potential difficulty with this approach was described by another setting:

> *In the past, teachers have said 'we want the child removing' and staff have got upset and said 'we're not your bouncers'.*

Others take a view that such decisions should be made on a case-by-case basis, and that a child could be physically moved but only if there was a clear risk if they remained where they were and that staff should ask themselves '*what is the safest thing to do here*?'

Inconsistent thresholds

The children sometimes suggested that staff within an establishment varied in the extent to which they would use restraint. There were accounts of staff who were too ready to intervene and did not give them enough opportunity to comply.

... the nastier staff get more hassle so they're going to do it more – if they're stricter they will get into conflict easier.

Say I refuse to move – some staff would talk you out of it. Some staff have no patience – they should give you time to think and calm down.

These views were echoed to some extent by staff, not in the sense that they felt restraint was used unnecessarily but in terms of colleagues over-reacting to a child's behaviour so that confrontation became inevitable. These are very difficult issues to raise, particularly for new or junior members of staff.

It's down to the personality of the member of staff – some end up doing more restraint than others. You have to know your own prejudices – what children will wind you up.

Children also differentiated between establishments, if they had the experiences to draw such comparisons. Interestingly, one boy had experience of two settings using the same restraint method but he detected a difference in approach.

Here, they prefer to do it without restraint. There, I got restrained just for saying to staff 'what the fuck are you going to do?'. About five of them took me down – I weren't getting physical.

A girl in the same establishment endorsed this:

It's always used fairly here – they wait ages. I was smashing up the classroom – they didn't want to restrain me until I started on the computers.

These differences were borne out to some extent by an examination of the records of restraint or other incidents in the case study sites. In the setting where the two children above were now placed, there were instances where staff had been assaulted but did not restrain whereas a lower threshold appeared to be applied elsewhere. Managers were very aware of the possibility of '*over-zealous*' staff and had ways of monitoring this. A number were actively trying to reduce the levels of restraint in their establishments through bringing about a cultural change, encouraging staff to take some calculated risks such as allowing a child to wreck their bedroom if there were no safety issues. Another manager had changed the way crises were responded to:

It used to be if a bell was pressed, everyone would run and the child would see it as an audience: 'I've got to kick off now'. Now, we ask them to stand out of view.

Key points

- The criteria for the use of physical restraint are not clear-cut, particularly in relation to disruptive rather than aggressive behaviour.
- The criteria can also be applied differently in practice, both within and across SCHs, and children, staff and managers are aware of these differences.
- Opinion is divided about the practice of using restraint to move children.
- More guidance on when restraint is justified, and its purpose would be welcomed.

The impact of restraint

Both staff and children talked about how it felt to be involved in an episode of restraint. Most experiences were negative, as might be expected. Staff talked about feeling drained and upset, and about the difficulty of having to carry on and complete a shift carrying those feelings.

It can be upsetting, particularly if you have a good rapport with them. I got punched at the start of a shift and was shaken up for a couple of hours – then had to carry on.

It's a very anxious, nervous time – you just don't know what's going to happen.

I get upset actually, particularly if the child is crying and pleading with you.

There is also the potential to get angry, which is acknowledged to be unhelpful. Staff and managers describe the importance of not seeing restraint as a 'competition' about who will win or as a fight. Instead, it is emphasised that restraint is about keeping everyone safe. One of the methods has code words whereby those involved and observers can indicate a need to withdraw and let someone else take over. Managers were particularly mindful of giving staff the skills to see beyond the child's behaviour:

It's vital they see the child as a bundle of anger and pain – it's not you they are getting at.

In some settings, it was acknowledged that there was an aging workforce who found restraint physically taxing and that the fitness of staff was an important consideration.

The impact on the children was more mixed but again mostly negative, including anger, and powerlessness.

It's horrible – men putting their hands on you – if you kick out they can get you done for assault and you can't do anything. I felt upset. I wouldn't come out of my room for ages – I cried – that's what I do when I get angry.

It's like they're invading your personal space when you don't want them to.

It makes you madder – you want to rip someone's head off. I felt like that for ages – pure adrenalin going round my body.

There was some evidence of more worrying reactions, particularly amongst the girls:

It makes you feel safe – because I love being restrained – I know that's weird – you can kick off and be restrained and nothing's going to happen to you.

For me, I'm happy when I get restrained because I like pain. I was gutted when I came here because it doesn't hurt.

However, the latter girl also felt that children should not be '*put in pain*' because some provoked restraint as a form of self-harm, and that staff should be aware of the heightened risk of self-injury after a restraint incident.

Staff were able to describe other instances of children who actively sought restraint for sexual or other gratification and found these situations very difficult to deal with. For children who have experienced trauma and violence, they may also want to be held and contained:

Young people want someone to take control of their chaos – they can understand it when it's physical but not emotional.

Complex feelings were described by the children as a result of witnessing others being restrained, including excitement, pity, anger – or indifference.

It makes you feel angry – you want to kill them – the children not the staff – the staff are my family.

It doesn't bother me – it's just them getting restrained.

One child endorsed the negative impact that an audience can have on restraint:

It's humiliating – you have to look like a strong person and fight more. They try to stop you looking.

The experience of being relocated to your room during restraint means that children may experience a period of single separation immediately afterwards and there is a need to understand more about the impact of this. One child described his experience:

Someone sits outside your door – they strip your room of TV and clothes. They don't talk to you – they seem generally pissed off with you.

Although most recording formats require detailed information about the restraint itself, only a minority require information about how incidents were concluded or the outcomes for the child.

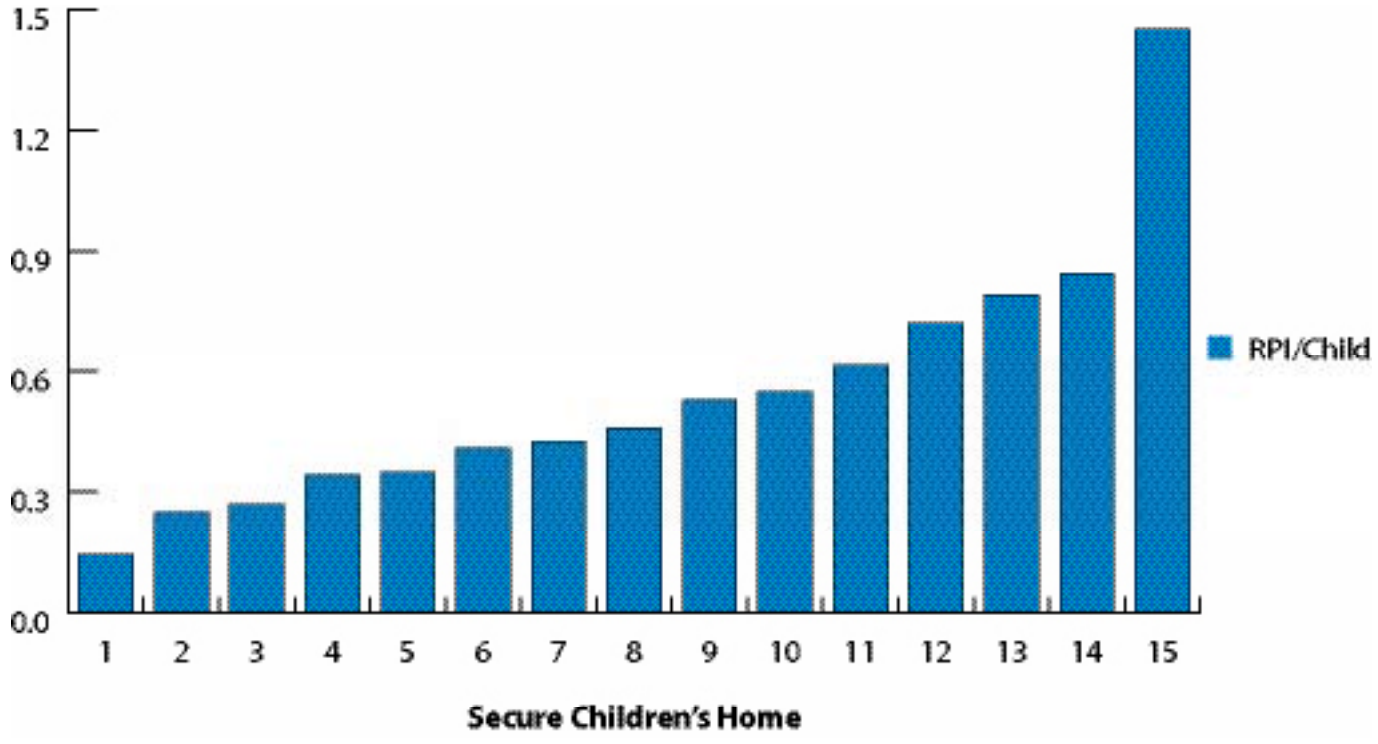
Key points:

- Physical restraint has a significant emotional impact on both children and staff.
- For some young people, restraint can trigger complex responses that make them actively seek it.

Incidence of restraint in SCHs.

The YJB require the secure settings in which they place children to send monthly returns on the use

Figure 1: Average Restrictive Physical Interventions per child per month in each SCH taking children placed by the YJB



of RPI, although the definition could more properly be classified as restraint:

> *A Restrictive Physical Intervention occurs whenever force is used to overpower a child/child.*

There is no equivalent data collected for children placed on welfare grounds, although some SCHs taking both types of placement send it to the YJB anyway. Because of the wide disparity in the size of establishments, the YJB break down the data into incidence of RPI per child placed in order to enable comparison. The following table illustrates the different incidence of restraint per child drawn from the YJB data from April 2007 to January 2008. The data is from the 15 SCHs used by the YJB, not the five that take only welfare placements. It demonstrates that the incidence is 10 times higher in the SCH that used restraint the most compared to the one that used it least. The range was from 0.14 to 1.45 restrictive physical interventions per child per month across the establishments with a mean average of 0.54.

Perhaps surprisingly, given the emphasis on a holistic approach to behaviour management and de-escalation, although the incidence of physical restraint appears from this data to be lower than in STCs where the average was 0.79 RPIs per child, it was higher than in YOIs, where the average for the same period was 0.12. This finding needs to be viewed with some caution for the following reasons:

- there may be differences in the nature of incidents that get reported because of different interpretations of the meaning of an 'RPI';
- the numbers of children in SCHs are low, and one particularly disturbed child can cause a dramatic increase in incidence data;
- some establishments perceive themselves as taking the more difficult and disruptive children, increasing their need to use restraint;
- the relative level of disturbance of the children, with SCHs taking particularly vulnerable children, and data may therefore include a high incidence of restraint to prevent self-harm.

There may be other factors such as the higher ratio of staff to children, so that incidents in a SCH are more likely to elicit an intervention from staff or as one child put it: '*they're in your face*'.

Key points:

- There appears to be a wide disparity in the use of restraint across the SCHs on children placed by the YJB.
- There also appear to be differences in the incidence of restraint between the three types of secure settings.
- More exploration is needed to confirm these findings: to establish the true extent of restraint, the extent to which incidence varies between individual establishments and types of secure setting and the reasons for variation.
- There is no centralised data on the use of restraint on children placed in SCHs on welfare grounds.
- Consideration needs to be given to determining the most useful way of collecting and analysing data in the future.

Methods of restraint

The National Minimum Standards for Children's Homes state that measures to manage behaviour must be '*consistent with any relevant government guidance on approved methods* (22.8)' but no such guidance exists. The official guidance relating to methods within children's homes only asserts that any in-service training in the use of restraint must be given as part an overall programme of care and control, which includes the creation of a positive ethos and the involvement of children. 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 children* (Department of Health 1993).

Decisions about the methods to be used within children's homes, including SCHs, are therefore devolved, whether that is to the local authority or a private provider.

The statements that do touch on methods of restraint are contained not in guidance but in a training pack (Department of Health 1996). Their status is therefore somewhat unclear but they suggest that pain, pressure across joints and methods that routinely take children to the floor are unsuitable.

A recent letter from the Department for Children, Schools and Families (DCSF 2007) reminded SCHs of their responsibilities to select a suitable method but also stated:

> *However, in light of the circumstances around the death of Gareth Myatt, we strongly advise that the seated double embrace should not be used in SCHs. In addition, a number of concerns have been raised relating in particular to the use of prone restraint. Both the Forum of Secure Training Centre Directors and a paediatrician, Dr Heather Payne, have raised concerns. Dr. Payne's advice is as follows:*
>
> *'Prone restraint, excited delirium and positional asphyxia may be associated with fatal outcomes. The use of prone restraint should be discontinued until it can be shown to be safe'.*

This has led to some SCHs deciding not to use prone restraint until further advice is issued whilst others have interpreted the letter to mean that they must have safeguards in place if they do use it. All would welcome clarification, particularly as children may end up being restrained on the floor even where this has not been the intention. As one SCH manager said:

> *We get circulars about what holds we can't use but when we ask for advice about what holds we should be using, neither YJB nor Ofsted would give advice.*

It was unclear from most of the local policy documents why a particular method of restraint had been selected. Only one policy mentioned it specifically and stated that the method had been chosen because it is flexible enough to be appropriate for use in a variety of situations, does not involve unnecessary movement or pressure on joints and is BILD accredited. In all other cases, this information was sought through direct contact with the SCH manager. Various reasons were given, such as the fact that the training provider was accredited by BILD, that the techniques did not include the use of pain or prone restraint, or that they included methods for removing children to their rooms.

Several SCH managers have taken the initiative themselves to look at other methods and have chosen either to continue as they are or to change because they were unhappy with some of the holds or thought them to be inadequate. Two had actively involved staff in selecting the method, having invited submissions from a number of potential providers. This had helped considerably with staff buy-in. In several cases, the reasons for adopting a particular method were unknown and had been taken before current staff were in post. Few approaches appeared to have been the subject of a procurement process, and they were rarely subject to service level agreements or formal review, although there are signs that this is changing. One local authority has instituted a system whereby there will be an annual review through a Behaviour Implementation Group. In ten cases, the method is used across the local authority's regulated settings: in the other eight, a decision had been made that the needs of the secure setting were different. A number of local authorities are planning to adopt a consistent approach across the council in the future, however.

It cannot be assumed that all the techniques available within a particular method are used. Local decisions may have been made that some techniques will not be taught at all, or that they will only be deployed in certain agreed instances as part of a negotiated plan for a particularly challenging child. Some of the providers were happy to become actively involved in such individual care planning whilst in-house instructors took on this role in other settings.

Key points

- Decisions about suitable RPI methods are left to local managers.
- Some SCH managers have been allowed to select their own method: others are required to use one in use across the local authority or establishments run by their provider.
- Managers take the responsibility seriously and attempt to select methods that will meet their needs, although this is rarely through formal procurement processes.
- There is no guidance to support managers in fulfilling their responsibility, and recent communications about what they cannot do rather than what they can is perceived as unhelpful.

The question of pain

The use of pain is a particularly contentious issue. It must be acknowledged that pain and injury are always a possibility to both staff and children during a restraint episode, however benign the method appears to be in theory. The BILD Code of Conduct (2006) acknowledges this but states that the *deliberate* use of pain should not be used, although there is no guidance that expressly forbids its use. Instead, the guidance refers to more general principles such as the minimum use

of force necessary, for the shortest duration and proportional to the risk being averted. It is also unclear what the use of pain actually means, and there are three possibilities:

- pain is an intrinsic and intentional element of the restraint technique;
- the restraint technique is 'pain-compliant', that is to say it is intended to hurt only if the person being restrained resists. This is usually through the use of pressure on joints, such as thumb, wrist or arm locks;
- pain is used as a 'distraction' only in specified and high-risk situations where other methods would be ineffective; for example, when a child has a grip on another child or is threatening someone with a weapon. The most commonly described are the nose, thumb and rib techniques that cause a short episode of pain and are meant to be followed by standard holds when the immediate danger has been averted.

Much of the recent reporting on the use of pain conflates and confuses these distinctions. It is surprisingly difficult to establish how far the methods in use do have elements of pain within them. All of the methods currently in use state that pain is not an intrinsic part of their techniques. Training providers and establishment staff were sometimes sceptical about these claims, saying that they thought some methods *were* painful or even dangerous and that there should be better regulation. BILD are in the process of developing a risk assessment tool that is designed to critically analyse techniques in terms of their safety, effectiveness and social validity.

It would require a more expert opinion than this report could provide to evaluate claims about the extent or level of pain that is being caused. Some methods do contain an element of pain compliance and/ or pain distraction for use in specified and high-risk circumstances only. For example, PRICE describes a nose distraction technique but only for use when the person is biting themself or another person. It is very difficult to establish how often distraction techniques are used in practice. The argument for training staff in such techniques is that it is preferable to provide a safe, albeit unpleasant, method for responding to extreme situations rather than to leave staff ill-equipped, putting both staff and children at greater risk of injury. The counter-argument is that anyone has the right under common law to defend himself or herself from attack using whatever means they can, including the infliction of pain, and there is a risk of distraction techniques being used where the level of risk does not justify it. A number of people commented that, where staff are anxious about their ability to exert control, there is a tendency to gravitate towards the 'heavier' techniques that they have been taught. As one manager put it,

> *Once you start teaching techniques, staff will think, 'that sounds good – I'll use that.'*

The experience of pain

The children interviewed during the case-studies said that restraint could hurt but it was not inevitable.

> *Sometimes – like where they grab your arms really tight. I've had marks afterwards.*

And, in relation to a method which explicitly claims not to use pressure on joints or pain-compliance:

> *Loads of people come running in: 'are you going to walk to your room?' – if you say no, they grab your arms in a special lock – you can't move because if you move it hurts. If that doesn't work, they put you on the floor face down.*

The staff in that establishment validated the child's view to some extent, in that they gave a very clear description of the principle of pain compliance in relation to their method:

> *It's only painful if they struggle – you could say the children are hurting themselves.*

This is an important reminder that rhetoric and reality can be very different and makes it difficult to reach any definitive view about the extent to which children are being hurt through the use of physical restraint in SCHs. It is also difficult to make definitive statements about whether some methods are more painful than others. Only four of the children had been in other secure settings but, between them, this amounted to knowledge of 12 SCHs, two STCs and one YOI. They described different degrees of pain caused in different establishments but numbers are too small to be able to categorically link these to specific methods. One young woman who had experienced PCC in an STC described it as painful but said of the method used in her SCH:

> *When I was getting restrained here, I was trying to make it hurt and wriggling but they stopped me wriggling – and it still didn't hurt.*

Again, the differences may lie less in the method than who is applying it and how. Another child who had been subjected to the same method as above but in another setting described being '*really hurt*'.

Children also drew distinctions between restraints that had taken place within a single setting, with some staff using more force than others. One girl said:

> *I'd wait till certain staff came on. One person who'd been in the army – I knew he'd use more force. I got to like it.*

Children also described the affect of adrenalin on their perceptions, so that pain was perceived differently or not until the incident was over.

> *It can hurt – you've got your adrenalin going so you don't always feel the pain.*

Key points

- It is impossible to establish the extent to which existing techniques are causing pain on the basis of current evidence, in spite of the claims that are made.
- There is confusion about the meaning of terms used in relation to pain, including 'deliberate' pain, pain compliance and pain distraction. This is hindering the debate that needs to take place.
- Opinion is sharply divided about the benefits of pain 'distraction' for use in high-risk situations as opposed to relying on the common law right of self-defence.

Prone restraint

Opinion is also sharply divided about the safety, effectiveness and validity of methods that deliberately take children to the floor. Some establishments have commissioned techniques that include prone, supine or side restraints as part

of their repertoire but have decided not to train their staff to deploy them.

> *We've banned it. The children had complained about being in discomfort. It's interesting, since we suspended it, we haven't done it. If they go to the floor, we just back off. Most staff injuries were caused when putting children to the floor – they got bitten.*

Other establishments feel equally strongly that restraints that take children to the floor, if done properly, are safer than many other methods such as basket holds. All acknowledge that children might 'end up' on the floor during an incident and have methods for moving them to a seated or standing position or, if that fails, to hold them safely on the floor. Where floor restraints are still used, managers were keen to stress that it was only as a last resort

> *Where damage to children and staff is becoming extreme and the safest place is to hold them on the floor for the shortest period of time – it's to allow them to calm down.*

Care staff sometimes saw it in a more positive light:

> *It's important to put them on the floor – they know they're overpowered.*

The children were not asked specifically about their experiences but some did volunteer an opinion:

> *They shouldn't put people on the floor – that does hurt: a big fat guy dived on top of me. You get carpet burns on the floor.*

> *I don't think you should be taken down hard like I was because that really hurt – I had a knee in my neck. I wasn't struggling or owt when I went down.*

Mechanical restraint

None of the SCHs use any form of mechanical restraint, such as handcuffs or straps. Again, views about good practice were sharply polarised. Most SCH managers were adamantly opposed to the possibility of these being introduced to SCHs, either because they were unnecessary or because they were in conflict with their relationship-based approach to working with such vulnerable children.

> *No. I don't want them. It's a fairly barbaric thing to do: it's the engagement part that's important here. Putting an object on doesn't seem as caring as holding.*

> *No thanks! Given the right level of hysteria, people will want Tasers. It's about anxiety and fear – you need to keep people in touch with the fact that these are damaged kids.*

Others felt that some forms of mechanical restraint could be more beneficial than certain holds:

> *Our technique would be to lie across a child's legs – staff get kicked. Everyone's dignity would have been better preserved using leg restraints, particularly with a girl who's been sexually abused.*

> *What frustrates me is seeing staff having to pin down children in prone restraint where there is an equivalent available that would prevent that. I don't want handcuffs but would like Velcro straps.*

A few settings were uneasy but felt the debate needed to take place.

> *Up until a year ago, I'd have said there was no place for it but, for some children, restraint goes on for hours with all sorts of emotional damage and it might be better to have something to bring it to an end.*

When SCHs are unable to control a child they sometimes call the police. This is rare but staff describe instances where the police have brought risky situations under control very quickly with the use of handcuffs, and some have questioned whether this might be a useful resource for them. The caveat would be that they could only be used in extreme situations and with the authority of a senior manager. However, there is an awareness that once a technique is available, it will be used and rigorous safeguards would need to be in place.

Key points

- As with the use of pain, there is no consensus about the safety, effectiveness or validity of techniques that deliberately take young people to the floor.
- Mechanical restraints are not currently in use within SCHs and most do not want them.
- A minority do feel that there is a place for mechanical restraints because they might avoid the need for prolonged restraint or police involvement in extreme situations, as long as safeguards are in place to avoid abuse.
- More debate about best practice, based on evidence, would be welcomed.

Training in restraint

Who should be trained?

All the establishments had clear statements within their policies about the need for training in behaviour management and the fact that staff must be trained in order to use physical restraint. There is variation in the type and level of RPI training that different staff groups receive but most establishments train all staff coming into contact with the children including managers and teachers. Support staff, such as cooks or maintenance staff, are usually trained in breakaway techniques and responses to challenging behaviour if not restraint itself.

Most SCHs say that there are situations when care staff have not yet been trained. Some take a pragmatic view about this, stating that situations may arise where untrained staff have no choice but to use restraint as part of their duty of care until trained staff are able to take over. Others stated that untrained staff may be required to assist but should never lead the restraint. In other establishments training was a prerequisite to having contact with the children and was part of the initial induction. For example, one establishment recruits twice a year and provides a five week induction before staff can take up their duties, including training on avoiding and de-escalating conflict and on restraint techniques. It is the manager's view that it would be legally indefensible to place a member of staff into the environment of an SCH without this training because of the risks that may arise. The issue of agency staff is problematic but larger local authorities with a number of children's homes were establishing a pool of trained staff that could be used to cover for staff shortages.

What is the nature of the training?

The amount of initial training in physical intervention varied from two to ten days but it is difficult to comment on the adequacy of this without considering the differing content of the training. Some providers deliver separate modules on various aspects of behaviour management, of which physical intervention is only one. In other packages, these are integrated into one course. Opinion is divided as to whether training in general behaviour management skills should be integrated with training on physical interventions: some felt this was essential in order to ensure a coherent approach, others felt that physical intervention would dominate in an integrated course and that de-escalation and other methods should be taught separately. Where establishments had adopted TCI as a formalised system for managing behaviour, training was delivered separately. Others had in-house or local authority training such as *Avoidance and De-escalation* which staff were expected to go on before they were taught physical techniques.

Writers on the topic have warned against the dangers of 'cascade' training whereby a staff member

is sent on an external course on how to restrain and is then expected to train colleagues. This did not appear to be taking place, in the sense that acquiring a skill was deemed sufficient to pass it on, but most training providers have developed specific 'train the trainers' or 'instructors' courses. Staff who have been through the basic training can go on to learn how to pass these skills on to colleagues. This could be directed at staff within establishments or within the local authority as a whole. Such courses tend to last between four and fifteen days with expectations that they will have refresher training at least annually. Some of the providers have their own certification scheme so that in-house instructors can only run courses if they have a current certificate allowing them to do so, although questions were raised as to how rigorously this is applied. The role of in-house trainers seems to vary, with some taking on additional responsibilities such as involvement in individual children's risk assessment and behaviour management planning. They may also be involved in monitoring incidents of restraint or communicating with the external provider.

A number of general concerns were expressed about training.

- Firstly, the commercially competitive nature of most of the providers made it more difficult to select an appropriate method because of the need to evaluate the information they provide. For example, questions were raised about whether providers may have incentives to fail participants in order to get additional revenue from repeat training. This difficulty was compounded by the lack of a mandatory and independent accreditation scheme. Even where training providers were accredited, there remains considerable confusion about the accreditation status of in-house instructors.
- Secondly, the complexity of some of the restraint methods taught raised concerns about how skills could be maintained, particularly if they were not practiced. There was a sense that some methods were more complicated than they needed to be and that, in reality, it would be better to have a more limited number of simple techniques that people were more likely to remember and use correctly. There has been little evaluation of how people learn physical skills and suspicion was expressed that most were instantly forgotten. Establishments had tried to build slots into team meetings, extra workshops or surgeries run by in-house instructors to support staff in-between the formal refresher courses. One manager also expressed a view that there is too much emphasis on maintaining physical skills and not enough on the more important skills needed in holistic behaviour management.
- Thirdly, a number of interviewees questioned the terminology associated with the range of methods. A 'Figure of Four' hold may mean something different within different methods. Others questioned the alarmist language used when describing breakaway techniques, such as 'strangle holds' or 'hair grabs' most of which are unlikely to be experienced but raise anxiety.

Training providers

The physical restraint techniques currently being taught are shown below.

	SCH	LA / Provider	RPI method used
1	Aldine House Secure Children's Centre	Sheffield City Council	MAPA®
2	Atkinson Unit	Devon County Council	GSA
3	Aycliffe Secure Services	Durham County Council	PRICE
4	Barton Moss	Salford City Council	DIVERT (based on PRICE)
5	Beechfield Secure Unit	West Sussex County Council	Team Teach
6	Clare Lodge Secure Unit	Peterborough City Council	CALM
7	Clayfields House Secure Unit	Nottinghamshire County Council	MAPA®
8	East Moor SCH	Leeds City Council	MAPA®
9	Gladstone House	Liverpool City Council	PRICE
10	Hillside Secure Centre	Neath Port Talbot County Borough Council	GSA
11	Kyloe House SCH	Northumberland County Council	CALM
12	Lansdowne Secure Unit	East Sussex County Council	PRICE
13	Leverton	Essex County Council	SCAPE (based on PRICE)
14	Lincolnshire Secure Unit	Lincolnshire County Council	ECC&R (UK) Ltd
15	Orchard Lodge	Glen Care Group	GSA
16	Red Bank Community Home	St Helens Metropolitan Borough Council	PRICE
17	St Catherine's Secure Centre	Nugent Care	PRICE
18	Sutton Place Safe Centre	Hull City council	PRICE
19	Swanwick Lodge	Hampshire County Council	Team Teach
20	Vinney Green Secure Unit	South Gloucestershire Council	GSA

Acronyms

PRICE	Protecting Rights in a Caring Environment
ECC&R(UK) Ltd	Ethical Care Control & Restraint (UK) Limited
GSA	General Services Association
CALM	Crisis, Aggression, Limitation and Management
DIVERT	De-escalation In Various Environments using Realistic Training
MAPA®	Management of Actual or Potential Aggression
SCAPE	Safe Care And Protection in Essex

Detailed descriptions of the restraint techniques are not in the public domain. The reasons for reluctance to make these widely available are partly commercial and partly because of concern about how the information could be misused. All the providers were asked for details of their methods for this project and were extremely helpful, making themselves available for interview, providing documents and access to restricted materials. There were certain common features:

- None of the methods were designed specifically for use on children although tailored packages may be developed for individual settings.
- All methods claim not to deliberately inflict pain to gain control.
- Most include an element of 'cascade' training whereby instructors are trained to pass the skills on to colleagues in their workplace.

Otherwise there are differences in relation to:

- course content;
- type and level of holds;
- the use of techniques that take children to the floor;
- the use of pain compliance;
- the use of pain distraction;
- the length of training;
- assessment of course participants;
- the relationship with commissioners;
- accreditation;
- monitoring of incidence/ injuries.

A description of the individual methods is provided in Appendix B

Key points

- There are eight different organisations providing training on RPI within SCHs.
- It is difficult to evaluate either the training itself or the techniques they teach because of the lack of a mandatory, independent accreditation scheme.
- There are concerns about the best way of training staff in physical intervention, within the overall context of behaviour management and supporting them to maintain those skills.
- Some staff may be operating without training and there is a question about the legal defensibility of this.

Following incidents of restraint

The holistic approach to behaviour management within SCHs means that there is an understanding of the need to support staff and children following incidents of restraint, although the extent to which these processes were spelled out within policies varied. There are several reasons for post-incident follow-up. One is for the individuals involved: to express their feelings about what happened and to receive support, to reflect on whether anything could have been done differently and to rebuild relationships between the children and staff. Another is to review the child's behaviour management plan and determine whether any changes are needed. Incidents also provide an opportunity to reflect more widely on practice within the establishment.

Debriefing

It is implicit within the policies that all SCHs expect children and staff to have opportunities for a form of debriefing although some arrangements appear more robust than others. Most establishments have space on their standard recording format for the child's comments and a small number have developed a specific format to guide and record the debriefing conversation (example attached within Appendix A).

Children

National Minimum Standards expect that 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. Opinion differs, however, as to the best way to conduct such a debrief. Should it, for example be undertaken by staff that were directly involved?

> *It needs to be someone involved in the restraint because they know what went on.*

> *The staff member may need to delay if the child is angry but the idea is that it repairs the relationship.*

… or would it be better to involve someone independent?

> *After the restraint, someone who wasn't involved will go to talk to them, give them a drink, ask them if they are injured. The assistant psychologist will then do a more thorough debrief – 'what can we learn from it?'.*

The children had mixed views about the opportunities to debrief, and sometimes their understanding of the purpose was very different from that of staff.

> *They come and make you say sorry and if you don't say sorry you don't come out of your room.*

Another child's ability to engage in the process varied depending on how she had experienced the restraint:

> *But if it wasn't fair, I'd just hit them and tell them to fuck off out of my room. It takes longer to calm down if it's not fair.*

Thirteen of the 16 recording formats seen offer the child an opportunity to sign the restraint record, which is to be welcomed. The way this is perceived, again, may not be as intended.

> *They asked me to sign a statement but I wouldn't because it wasn't right.*

> *They make you sign it – weeks later.*

More positively, some children did acknowledge that there was a genuine attempt to learn from incidents.

> *They'll take it as a lesson in learning – about how we react and that.*

The establishments had mechanisms for making changes to children's behaviour management plans following incidents and one establishment had recently set up Behaviour Support Panels specifically for this purpose with a view to reducing the level of restraint.

Although the children had access to advocates and could raise any issues of concern, they did not have any formal role following incidents of restraint except in two establishments, where an advocate or children's rights officer was routinely informed of all incidents. The advocacy service in another establishment had just introduced questions about restraint into the exit questionnaire undertaken with all children at release.

Staff

All establishments accepted the need to debrief staff as well as children. The most common method was to discuss incidents at the end of the shift although there were also opportunities in individual supervision. It was acknowledged that some people needed time out to recover immediately after an incident and colleagues might agree to cover to allow this to happen, depending on staffing levels. Because it is often an expectation that incidents will be observed by a manager or in-house instructor in the restraint method, this provides additional information for discussion after the incident is over. In other settings, there is a meeting between staff on duty and managers every morning where all incidents are discussed. Some establishments have introduced more opportunities for reflection, either by bringing all incidents to a weekly team meeting or establishing a separate forum.

> *Everyone is used to having fortnightly, facilitated [by a psychologist] support meetings where they talk about the impact of the work on them and issues about the children and staff. They can talk it though. It contains anxiety and is safe enough and allows people to articulate the vision.*

If a staff member needs more individual support, this can usually be arranged through the local authority's staff counselling service.

Managers expressed a commitment to ongoing reflection and challenge following incidents of restraint, feeling that these were a benefit to the establishment in providing the opportunity to reflect on the overall approach to behaviour

management, to raise concerns about the suitability of methods, systems and processes, or dynamics within the staff team. Most front-line staff were comfortable with this, stating that '*scrutiny is good*.' Not all were quite so positive, particularly if monitoring data had raised questions about the number of restraints that individuals had been involved with. This could be interpreted as a criticism, particularly if staff felt undervalued.

> *It can feel as if you're being criticised. None of the managers have been trained. It would be useful if the people who* had *been trained reviewed it.*

Although the aim of establishments was to develop a culture whereby staff could challenge each other's practice or admit to having been over-zealous in a particular incident, this can only realistically be achieved if staff are well-trained and supported. It was said that it might be easier for data on team activity to be shared rather than individual performance if staff do not feel secure.

Key points

- The importance of debriefing for both staff and children is recognised and it does take place.
- There is more work to be done to ensure that it fulfils its purpose and is not seen as punitive.
- SCHs are committed to learning from incidents of restraint to improve practice for individuals and the whole establishment.

Recording incidents of restraint

SCHs have to comply with the National Minimum Standards on the recording of restraint:

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

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. There is no single format on which records should be made, with local authorities, providers or establishments being responsible for devising their own.

In fact, rigorous recording arrangements were in place in all establishments. The 'bound book' causes some difficulties in the era of electronic recording and some staff complained of duplication and bureaucracy. Individual recording formats varied: some were specifically for use after restraint but most were generic *Incident* or *Significant Event* forms. A separate form might also be needed to report injuries for health and safety purposes. Most of the forms went beyond the minimum requirements and contained additional information, such as:

- the events leading up to the event;
- attempts to defuse or de-escalate the situation;
- a detailed description of the holds used;
- the way the incident was resolved;
- external people notified of the incident;
- staff debriefing;
- child's debriefing.

Most also required signatures by two separate managers.

Reporting arrangements

In terms of individual children, there was no standard approach to the notification of incidents of restraint to their professional network and parents/carers. Some establishments routinely send copies of all incident reports to the child's YOT and/or social worker; some will include the information in a regular update report whereas others will only notify external people if requested or there is a particular reason to do so, such as a complaint or an injury. Parents are less likely to be informed as a matter of routine, partly because of the complex relationships that may exist and a fear that parents might respond punitively to the child. Some establishments *always* telephone parents, so that they may be the first to know; others will notify them only if it has been agreed as part of the child's plan or will make decisions on a case-by-case basis.

There are differences in the central reporting arrangements for children placed by the YJB and those placed under Section 25 of the Children Act 1989 on welfare grounds. As described earlier in the report, since April 2007 the YJB has required monthly returns on the incidence of RPI. They also request information on any injuries caused and any 'exceptions' where a child had shown warning signs, such as nausea or breathing difficulty, following an incident of restraint. Although the SCHs are regularly reporting injuries, they are not consistently reporting on 'exceptions' although one or two SCHs have amended their recording formats to collect this information. The YJB are considering how to make the system more effective. Information about injuries will be considered in more detail below.

There is no requirement for reporting on the incidence of restraint, or injuries, on children placed under Section 25. Where SCHs have YJB beds, they sometimes include this data in their monthly returns to the YJB but it is not collated or analysed. Most SCHs do send regular data to the local authority through their line management arrangements but there is no standard approach to this and most local authorities do not necessarily analyse or monitor it even if they receive it. Some service managers for looked after children are more involved than others, spending time on site and asking for information. Other SCHs seem more isolated and autonomous. Local Safeguarding Children's Boards (LSCBs) currently have little direct involvement with issues of restraint other than those that lead to a child protection referral or allegation against staff and are dealt with by the Local Authority Designated Officer (LADO).

There is a requirement to report any 'serious incident' to Ofsted under Regulation 30 of the Children's Homes Regulations, including the death of a child, a serious accident, serious complaints about the home or child protection enquiries. They do not explicitly mention physical restraint in this

context and the threshold for deeming an incident to be 'serious' is open to local interpretation. SCH managers felt that the criteria for reporting were vague, and were unclear of the process following reporting. The system is not electronic and reports are sent to Ofsted's offices in Manchester. It appears they are then passed on to the Ofsted Inspector for the establishment but there is no standard response. Establishments say that some are not followed up at all and, for those that are, it is a slow process. Ofsted were approached to clarify the system and asked whether there was any data available on Regulation 30 reports arising from incidents of restraint. The response from the Chief Inspector was as follows:

Ofsted does not collate information regarding the use of restraint in secure settings. Incidents of restraint and how they are managed are monitored by inspectors during inspections. They ensure that providers have taken appropriate steps to refer relevant incidents of restraint to Local Safeguarding Children Boards, and they take action if allegations are made against staff. Inspectors will make recommendations in inspection reports if they have concern about the level of restraint being used or note other breaches of regulations. The use of restraint in a range of social care settings is an area that Ofsted will continue to monitor.

Key points

- Arrangements are in place for incidents of restraint to be recorded in accordance with National Minimum Standards.
- SCHs are using a range of locally developed recording formats, most of which provide useful information that supports reflective practice.
- There is no consistent approach towards notifying a child's external network about restraint. Most SCHs report automatically to professionals but practice is more variable in relation to parents.
- Incidents and injuries are reported to the YJB on the children they have placed but the 'exceptions' reporting system for medical warning signs has not been fully implemented.
- There is no central reporting on children placed on welfare grounds.
- Ofsted do not collate any information about restraint or undertake any central analysis of Regulation 30 notifications.

Monitoring

Internal

All the SCHs monitored their practice in restraint on a case-by-case basis. A manager saw individual records of restraint, and they would go back to staff if they had queries or concerns before signing them. One establishment had developed a specific form to guide managers through this process and to provide feedback to front line staff. This is attached within Appendix A. Other SCH managers also had a policy of approaching children directly following serious incidents to talk to them informally and to provide an additional opportunity to raise anything they were unhappy about. Where establishments had in-house instructors in their restraint method, they were available to advise if there had been problems about a particular incident, either in terms of staff skills or the safety and effectiveness of a technique. Some had a more generally developmental role and one instructor had systematically reviewed the last 100 restraints to see what lessons could be learned. Other SCHs had designated a specific post to lead on performance monitoring.

There is a level of sensitivity about the scrutiny of incidents. Managers are aware of the need to support their staff in the difficult job that they do whilst ensuring that the children are receiving the best care that can be provided.

> *There's an ethos that staff should be supported whatever… I don't quite see it that way.*

Care staff also expressed some unease about this scrutiny, although accepting that it is necessary. They were uncomfortable about the vagueness of some of the guidance about when restraint can be used, and one team said that when they asked for clarification, they were told that as long as it was their 'honestly held belief' that someone would be harmed if they did not intervene physically, they were justified in doing so. They then felt exposed if they perceived that belief to be questioned. The introduction of CCTV coverage into many SCHs has been broadly welcomed, after some initial unease. It is recognised that it can be a safeguard for both staff and children if there is a need to review an incident although one establishment had concerns about the message CCTV gave to the children, as they were keen to create a homely environment, as close to an open children's home as possible. Another had found it a useful tool in reviewing and learning from incidents, sometimes with the children themselves:

> *Just occasionally, we've taken children through what happened as well: 'look – why didn't you stop there?'.*

All SCHs also collated information to allow an examination of trends, whether that was in relation to individual children, individual staff or teams, times, locations and so on. These were sometimes entered into a database to facilitate analysis and reports were then considered either in the management meetings or other fora set up for the purpose.

External

Practice in all children's homes is regularly scrutinised by Regulation 33 visitors[1] who will have access to the records of restraint and other behaviour management measures. They also have an opportunity to talk to children. This role is undertaken differently in different local authorities. In some, elected members are very involved: in others council officers or independent consultants lead the process. This means that the level of skill and knowledge of the visitors varies widely, and consequently the usefulness of their involvement.

> *They don't get very involved. They look at the data but I can't honestly say they do anything with it.*

> *It's not the safeguard it should be…*

In a minority of settings, the process was more robust. One authority had recently reviewed the way it undertook Regulation 33 visits and strengthened the system:

> *There's a team of three now and they book them in advance. There used to be a bigger team but there was no critical evaluation. They look at a whole range of things, and see the children, see the staff and make recommendations.*

Other local monitoring tended to be minimal. Some SCHs regularly send their data to external managers within the local authority or to the safeguarding team but there was rarely any formal process for reviewing the information, which is not

1 Representatives from the local authority or other registered provider required to visit residential children's homes on a monthly basis. The equivalent in Wales is Regulation 32.

to say that scrutiny did not take place. One exception was a local authority that had recently adopted an authority wide approach and had instituted a system whereby the service manager would be automatically advised in the case of specified triggers: where a particular child had been restrained more than eight times within a calendar month or there had been a significant increase in the number of restraints within a home. The service manager was then expected to undertake a review with the unit psychologist and registered manager. In another local authority, reports were submitted to the Corporate Parenting Panel on violent incidents and restraint.

LSCBs were not routinely involved in monitoring restraint although they may be notified if there was a serious injury or complaint. Apart from one authority that had experienced two deaths of children in secure settings, LSCBs did not appear to be taking a proactive interest in this topic.

An additional level of scrutiny is provided by some of the training providers, who actively request regular reports from the establishments that use their method of restraint. This information may be on the total incidence of restraint, the use of particular techniques or injuries to staff and children. For example, CALM is particularly proactive in seeking feedback on all episodes of restraint and injuries and now has data on 12,000 restraints. They produce an audit report annually. Team-Teach requests information every six to ten weeks on any use of ground restraints or other 'high risk' techniques and injuries arising from them. The other providers also encourage dialogue and regular feedback through mechanisms such as discussion fora on their websites or AGMs.

All SCHs taking children through the criminal justice system also receive visits from YJB monitors but an inconsistent picture emerged about their role. One SCH manager said:

> *There's no consistency. Some look at the contract, some look at quality. It depends who you've got.*

In other settings, they were perceived more positively. Their role is currently being revised and it is too early to say what impact this will have.

Finally, all children's homes are inspected regularly by Ofsted, who have access to the records of restraint and other relevant documents, such as complaints, as well as talking to children and staff. One or two managers expressed a view that the less specialised inspectors did not necessarily know what they were looking for in relation to restraint, and that it was important to have standards and inspectors specifically for secure settings.

There is no system for systematic monitoring at a national level. Although SCHs return data to the YJB on the children they are responsible for, this is statistical information rather than qualitative data. The system is new and there has been no comprehensive analysis of the information yet. There is no equivalent data collection for children placed on welfare grounds, or indeed any children in other settings. It is impossible to say how many children are being restrained in schools, children's homes, foster care, psychiatric hospitals, detention centres or police stations or whether any of these incidents result in injury.

Key points

- All SCHs have systems for the internal monitoring of restraint incidents.
- External monitoring is more patchy. Although various agencies have access to the records, the robustness of the scrutiny is variable.
- At a national level, the YJB collects some data but there is otherwise no system for monitoring or reviewing the use of restraint across children's services.

Access to medical examination

Children in children's homes have the right to be examined by a registered nurse or medical practitioner within 24 hours following physical restraint. This is specified within the National Minimum Standards. Since the death of a child during restraint, concern about the potential for harm has been heightened and the recent letter from the Department for Children, Schools and Families to SCHs (2007) reminded them of their duty to make children aware of this right. Whereas medical screening after restraint is automatic in other secure settings, it is not in SCHs. Because of the size of the establishments, none have 24-hour health care staff on site and are reliant on local GPs to provide medical support. Most do have some nursing input but it has often been a struggle to get this. Some have managed to secure the presence of a nurse every weekday and an on call arrangement at weekends but others only have a nurse visiting once or twice a week and one unit had just had their Looked after Children nurse withdrawn completely. Children are asked if they are alright after incidents of restraint and usual practice would be to arrange examination by a medical practitioner only if the child specifically requested it or if staff felt there was a need. It is difficult for staff to justify calling out a GP for a child who appears well.

Immediately after a restraint may be a particularly turbulent time for children. They may be feeling that they do not want to co-operate with staff or be too agitated to be aware of any injuries. As one child said:

> *I think they asked me if I wanted to see a doctor but I wouldn't have said yes anyway.*

Others did not think it had been offered to them:

> *No – they just left me in my room – they didn't offer to see a nurse.*

Some SCHs take the view that they should take the initiative, not wait for the child. Two establishments with good nursing availability said that they automatically informed the nurse after every incident and she would check both staff and children, if they were willing. Others would automatically ensure that children were seen by a trained first-aider who would decide on any further screening needed. On-site nurses tend to be popular with the children and one described her open door policy, with children being free to wander in and chat to her if they were distressed.

The fact that medical or nursing examination is not routine in most settings means that recording formats do not have space for medical practitioners to contribute. Most forms do ask if either the child or staff has been injured and if treatment is required but these are completed by care staff. A minority contain body maps to indicate injuries and an even smaller minority ask for information about other 'warning signs', as specified by the YJB, that might be an indication of risks with a particular method.

The lack of an independent medical examination is a potential weakness in the systems within SCHs. There is no evidence at all that staff are neglecting children's medical needs after restraint, but there is a question as to whether they would always be aware of them without such an examination. In addition to the possibility of physical harm, children could be mentally distressed and might be better able to discuss their feelings with a doctor or nurse than with SCH staff.

Key points

- The lack of on-site health practitioners makes the right to medical examination difficult.
- Some children are screened routinely by a first-aider.
- Otherwise medical examinations are usually arranged only when there is perceived to be a need.
- Health practitioners do not contribute to the records of restraint and information about injuries is recorded by care staff.

Injuries

The YJB provided their data on the injuries within SCHs as a result of restraint between April 2007 and February 2008. Again, this only relates to the 15 units that take children placed through the criminal justice system. The three reporting categories and their definitions are:

Minor Injury (no medical treatment required)
This includes red marks on the skin, welts, superficial cuts and scratches, and bruises, which do not require medical treatment of any kind, including first aid. If a child is seen by a nurse or GP as a precaution (for example, to assess of any further injuries were sustained) this should not be counted as medical treatment.

Minor injury requiring medical treatment
This includes cuts, scratches, grazes, bloody noses, concussion, serious bruising and sprains where medical treatment is given by a member of staff or a nurse. Treatment could include cleaning and dressing wounds, providing pain relief, and monitoring symptoms by a health professional (e.g. in relation to concussion). This includes first aid administered by a staff member.

Serious injury requiring hospital treatment
This includes serious cuts, fractures, loss of consciousness, damage to internal organs and poisoning. Where 24-hour healthcare is available the child may remain onsite. At other establishments, the child will be taken to a local hospital. Treatment will reflect the more serious nature of the injuries sustained and may include stitches, re-setting bones, operations and providing overnight observation.

There were no serious injuries reported during this period, 62 minor injuries requiring no treatment and 23 requiring treatment. The highest rate of minor injury per RPI was 0.32, in one establishment where 9 of the 28 incidents had resulted in injury. This was exceptional and based on a low number of restraints overall. Other establishments reported no injuries at all and the overall average was 0.07.

In discussion with the establishments and an examination of records within the four case study sites, it is difficult to ascertain any patterns of injury. Carpet burns can occur when children are restrained on the floor and some children have sustained fingertip bruising where they have been gripped. Other injuries are more indirect, caused by events such as banging against a wall during the general mêlée. Staff appear to receive more injuries than the children and these include injuries as a result of assault, particularly being

kicked. One establishment noted that staff injuries had declined since they had banned prone restraint.

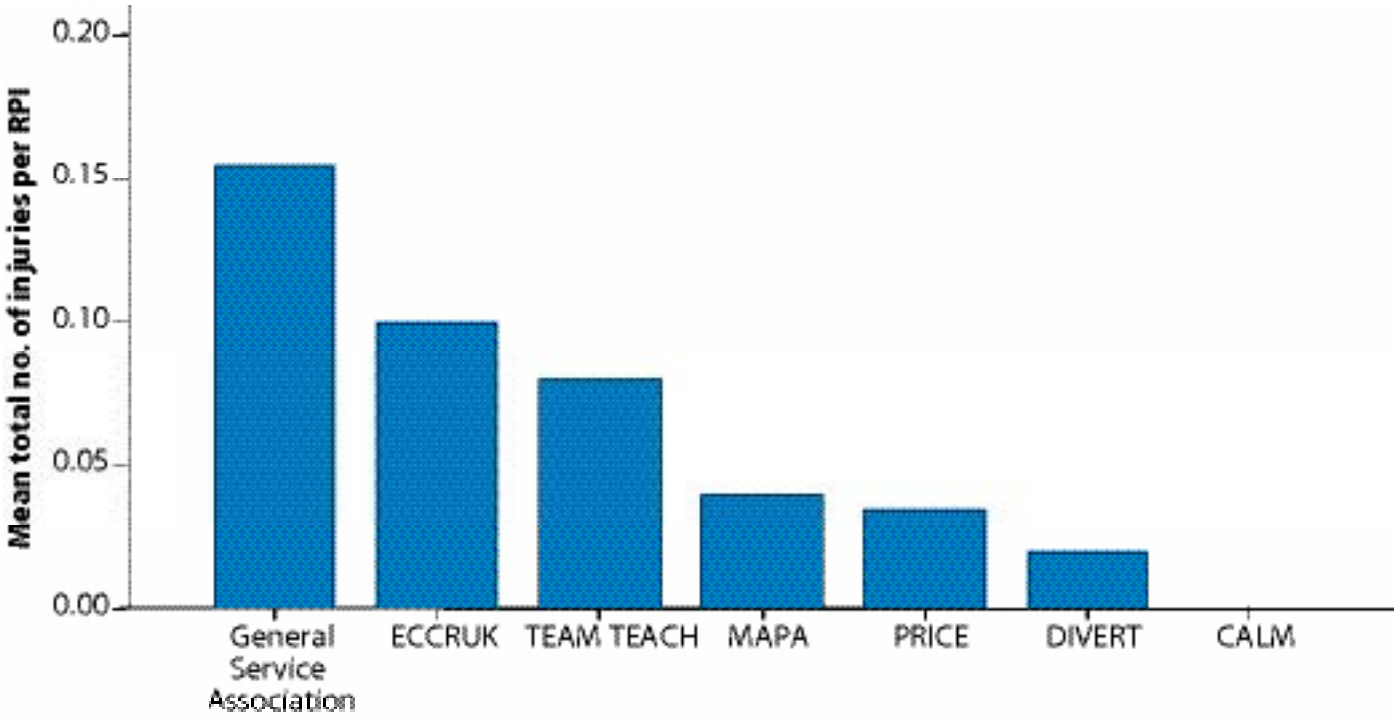
> *What used to happen, particularly if they were taken to the ground, we were getting bites to staff. If you pin their arms and legs, all they've got left is their mouth: it almost forces them into it.*

The injuries reported to the YJB were analysed according to the restraint method used. This information should be treated very cautiously and cannot be taken as definitive evidence about the safety of each method for the following reasons:

- numbers are too small;
- other factors such as a cramped environment or type of floor covering may account for some injuries;
- it is impossible to know if staff are using the methods correctly;
- the threshold for defining and reporting injuries may vary between establishments;
- there is no equivalent data on psychological harm;
- the threshold for using restraint may vary (if it is used rarely and only in extremely violent situations the rate of injury may be higher).

Given these caveats, what these figures and the following chart indicate is the need, identified in previous reports, for more rigorous research drawing on medical and psychological expertise to fully explore the merits of particular methods.

Figure 2: Injuries per reported incident of restraint by method.



Key points

- YJB data indicates that there have been no serious injuries to children arising from restraint in SCHs between April 2007 and February 2008.
- There has been a range of minor injuries with apparently wide divergence in injury rates between SCHs.
- The data could be interpreted to suggest that some methods are more associated with injury than others. Although there is insufficient evidence to draw firm conclusions, this confirms the need for research.

What needs to change?

> *Give us clear guidance so we don't have to make it up ourselves!* (SCH manager)

All the participants in the project, including children, were invited to give their views about what they would like to see changed in relation to physical intervention within SCHs. There was considerable consensus in some areas, and their views accord with the experiences described throughout this report.

The justification for using restraint

The criteria for using restraint in an SCH are based on the risk of harm to self or others, damage to property or escape. It is therefore the responsibility of staff to exercise a judgment about whether that risk is present or not and if physical intervention is the only way of dealing with it. This is a burdensome responsibility and interpretations of the criteria differ in practice, particularly in relation to children who are being disruptive and threatening rather than actively aggressive. This is exacerbated by the different, and lower, legal threshold for using restraint in educational settings. Since SCHs are providers of both social care and education, this puts them in the invidious position where they could restrain a child for threatening 'good order and discipline' in the classroom but not on the residential units.

Children do not feel restraint should be banned. They are well aware that there are situations where it is needed to keep people safe, but are equally aware that the threshold for deciding when restraint is justified is inconsistent. Examples were given where they felt restraint had been used without justification and their most consistent message was about '*not coming in too hard*'.

> *You shouldn't be restrained unless its proper dangerous – like hurting yourself. They should give you time out or just leave you.*

Suitable methods of restraint

A range of restraint methods are used within SCHs and most have been developed by training providers operating on a commercial basis. Local managers are responsible for selecting a suitable method. This is the biggest area of concern for staff and managers. Although most are reasonably happy with the method chosen for their establishment, they are uneasy about the lack of guidance about what are – or are not – suitable techniques. For most, this does not mean that they want a single method to be imposed for use across all SCHs but they would welcome something that set a national standard against which methods could be assessed. Although most are using training providers that are BILD accredited, there are doubts about the validity of the system. Instead, there is a call for a national, independent and mandatory accreditation system that would approve the methods suitable for use on the children placed within SCHs.

There is frustration about the lack of an evidence-based approach to restraint, leading to perceived 'knee jerk' advice about techniques that should not be used. It was noted that this is not balanced with advice about what would be better: research evidence is needed on the safety and effectiveness of methods, not only in relation to children but also to those applying them. Specific aspects of restraint where more information is needed include the use of techniques that take children to the floor, methods of holding and injury rates. In relation to effectiveness, concerns were expressed about children who present major behavioural challenges, where usual techniques prove inadequate. Staff sometimes resort to calling the police in these situations and would like evidence based guidance on what might work in those situations as an alternative.

There must also be questions asked about the impact of restraint, both in the short and longer term. It may be that a technique is effective in achieving the immediate aim, whether that is to remove a child from the classroom or to stop them cutting themselves, but if the impact of that intervention is to traumatise the child, teach them to enjoy pain or destroy their trust in staff, this needs to be brought into the equation.

Defining best practice

These questions go beyond the technical aspects of restraint. They relate to the culture and quality of relationships within establishments that provide the context for behavioural management. They also raise ethical issues, which SCHs cannot be expected to resolve on their own. Opinion is sharply polarised over some aspects of practice, such as prone and mechanical restraints, the use of pain and the validity of using holds to physically move children. Staff are looking for support in weighing the risks of, for example, a prolonged hold where the child was becoming increasingly distressed against a technique that would be more unpleasant but would bring the situation to an end. There are dangers, however, in authorising techniques on the basis of extreme examples rather than typical events. There is a constant risk of poor practice and excessive measures of control becoming institutionalised, particularly in a closed setting.

Staff are also looking for support in developing aspects of behaviour management other than restraint. They have developed a variety of approaches towards the promotion of positive behaviour or conflict resolution and would welcome opportunities to learn more. For example, one specific question raised was whether there is a place for the therapeutic holding of children who provoke situations of restraint in order to be held.

These are complex issues and staff expressed a wish for more debate and guidance about the meaning of best practice, again based on evidence. Those that took YJB placed children were aware of their Code of Conduct on behaviour management (YJB 2006) but it does not apply to children based on welfare grounds. It is also not enforced and encompasses practice in YOIs and STCs, which are very different types of setting. There were pleas for a set of agreed principles or standards that would provide a benchmark for good practice across SCHs.

Standards and scrutiny

The importance of monitoring the standard of practice is universally accepted, even where it is experienced by staff as critical. The processes for the internal monitoring of both individual cases

and overall trends are robust but arrangements for external scrutiny are generally weaker. SCHs would welcome more critical evaluation of their work by senior managers or others with sufficient understanding of both restraint itself and the nature of the establishments. The possibility of guidance to local authorities in order to strengthen their ability to review restraint was suggested. This reflects a frustration that those who are responsible for monitoring restraint do not always know what they are looking for.

A further gap is the role of medical monitoring, both of individual children and overall patterns of injury to staff and young people. Local authority health and safety departments may receive this data but there is no guarantee that they will have sufficient understanding of the issues to take a useful monitoring role. More debate is needed about the best way of screening for injuries or other ill-effects after incidents of restraint.

There is also a perceived gap in national monitoring. SCHs were keen to be transparent about their practice, sometimes sending data to agencies that had not requested it because they felt that *somebody* should be taking an overview of the incidence of restraint.

Conclusion

There is clear evidence that SCHs are committed towards a holistic approach to behaviour management, seeing restraint as part of a repertoire of responses when other methods have failed. This would probably be the position adopted in other sectors of the secure estate, but SCHs are able to demonstrate how they are trying to implement it. The extent to which the aspiration has become a reality throughout and across establishments is acknowledged to vary and it is not the lived reality of all staff or children. SCH managers recognise that their policies and systems are only part of the story and that staff ethos and culture are of more importance in ensuring that their theoretical approach is translated into practice.

This project and the wider Ministry of Justice review of restraint in the young people's secure estate were universally welcomed. SCH managers agree that there is a need for an informed debate - and direction – about the best way to care for the vulnerable children who pass through their establishments, whether they are there because of offending behaviour or on welfare grounds. They do make the plea, however, that these debates are based on a recognition and understanding of the task they are undertaking and the complexity of the children's behavioural needs.

What should the longer-term vision be for supporting the behaviour of this group of vulnerable children? Whilst it is not suggested within this report that physical restraint can or should be banned, neither should it be accepted as an inevitable response to challenging behaviour. The incidence of restraint varies widely in spite of the similarities of the children placed, which would suggest that the approach of the establishment is the crucial ingredient. Where the use of restraint is declining, managers described the changes that had contributed to this, such as stronger arrangements for debriefing, increased management scrutiny, better training on de-escalation, the introduction of behaviour support panels or brief therapy approaches. These measures give a clear message to everyone within the establishment: that the rhetoric about restraint being a last resort is taken seriously. Where these proactive measures are lacking, there is a danger of restraint becoming an institutionalised response. One child had learnt this very quickly. She had only been restrained once, but saw it as a rite of passage into the culture of the establishment.

> *It was just like a little testing to see what it was like – I'd seen other people get restrained…*

In view of this, it is suggested that establishments should be expected to have, not a restraint policy but a restraint reduction policy, setting out the steps they intend to take to bring their levels of restraint down.

The methods of restraint in use within SCHs vary widely and there appears to be a link between the method and the overall approach to behaviour management within an establishment. Some methods place more emphasis on de-escalation whereas others are primarily related to physical skills and the dynamic relationship between the choice of method and staff ethos requires further exploration. Does a 'heavier' method reflect the existing preferences of staff or, conversely, does it shape their attitudes by emphasising the risky nature of the children who are cared for? There is some indication that an establishment with a robust method of restraint leads staff to feel that they need additional, even more robust physical techniques whereas staff in settings with a more limited repertoire of techniques feel no need to increase them. This is an important consideration, particularly at a time when many local authorities are considering adopting a single method across children's services.

To summarise the measures that would improve practice:

1. Clarification of the criteria for using restraint in SCHs, particularly in relation to the discrepancy between education and social care settings.

2. Research on the safety, effectiveness and emotional/psychological impact of restraint, and different restraint methods, on children and staff.

3. A national, independent and mandatory accreditation system that would approve the RPI methods that are suitable for use on the children placed within SCHs.

4. Research on the most effective way of developing the competence and confidence of staff in behaviour management skills.

5. A debate about the meaning of best practice in relation to behaviour management and restraint leading to national principles or standards.

6. Guidance from central government that provides a clearer framework for policy and practice. This should be based on an understanding of the task being undertaken in all SCHs and the needs of children placed both through criminal justice and social care legislation.

7. A more robust system for the monitoring of restraint by independent people with appropriate expertise.

8. Consideration and guidance about the process for medical examination of children following restraint.

9. A national system of data collection and analysis, including the incidence of restraint and injuries caused.

10. An expectation that establishments will have a restraint reduction policy, setting out the changes they intend to make in order to bring down their incidence of restraint.

Appendix A: Sample recording formats from Aycliffe Secure Services

BEHAVIOUR MANAGEMENT PLAN

Young Persons Name_____

Date_____

This plan must be informed by the Asset, ROSH, PSR, PCR and Aycliffe Risk Assessment. The young person should take an active part in the preparation of the plan and sign to show their approval. Plans must be discussed at each planning meeting and changes agreed with the family/carer and YOT worker who should sign the original and initial any amendments. On first completion and following any amendment a copy of this plan must be sent to education within 24hours.

1	The expectations for my behaviour under the Behaviour For Life (B4L) scheme and House expectations have been explained to me in a clear manner. I understand that should my behaviour become unacceptable, measures of control such as separation or restraint may be used. I am also aware of my right to comment or complain about any use of separation or restraint and to contact Childline or NYAS if I require independent advice and support. Signed
2	Triggers to Unacceptable Behaviour. (Things that wind me up)
3	Tactics to Avoid or Defuse Unacceptable Behaviour. (What helps me stay calm)
4	Measures to Manage Unacceptable Behaviour. (How staff will react if I loose control)

6	Specific Medical Assessment in Relation to Physical Intervention e.g. consideration must be given to any indication of pregnancy or physical disability. Indicate if Asthmatic. Yes / No How will medication be administered, if required, during an incident? Indicate of suffers from Epilepsy. Yes / No If 'yes' a meeting must be convened between House staff and Health Advisors to agree a strategy for behaviour management. Outline strategy in brief below.
7	Physical Intervention (If unsure of the suitability of any intervention contact a PRICE Trainer)

Holding Techniques	Can be used	To be avoided	Not to be used
Cupped Fist			
Side Hug			
Straight Arm Hold			
Scoop (permitted Price variations)			
Embrace (permitted Price variations)			
Double Embrace			
Lower Basket			
Double Lower Basket			
Safe Location to Knees			
Tantrum Sitting			
Tantrum Lying			

Physical Intervention Strategy.

Please Sign Agreement to Plan:	
Young Person	
Family / Carer	
YOT Supervising Officer	
Social Worker	
Keyworker	

Critical Incident Form

House	Form No

When completing form please use *full names* and *not* initials.

Young person's name	
Date and time of incident	/ / 2006 AM/PM
Where incident took place	
Other young people involved	
Staff involved	
Witnesses to incident	
Status (Tick box)	DTO ☐ Sec91 ☐ Remand ☐ Welfare ☐

This form should contain full details of incident and be written legibly and succinctly using professional language.
This form may be required as evidence in an investigation and/or Police enquiries.

Section A

1) Which of the following interventions were used, how long were they used for?		
(1) Verbal persuasion, no physical intervention.	Duration	Min
(2) Guiding and leading away from situation.	Duration	Min
(3) Restraint, intervention, use of one person. (Phase 1)	Duration	Min
(4) Restraint, use of two persons. (Phase 2/3)	Duration	Min
(5) Restraint on floor area. (Phase 3)	Duration	Min
Total time involved during incident?	Duration	Min

2) Was anyone injured?	**IF 'YES', using definitions below write A, B or C in box indicated***		
Was young person injured?	Yes / No	Level of Medical intervention	*
Was a member of staff injured?	Yes / No	Level of Medical intervention	*
Was a visitor injured?	Yes / No	Level of Medical intervention	*
A: Minor Injury (no treatment required), B: Minor injury requiring medical treatment, C: Serious injury requiring hospital treatment			

3) Did the incident include an assault by the young person or a fight between young people?	
Please state if fight or assault. (Guidance is available in CIF file)	
If Assault who was the victim. (For staff and visitors complete back of this page)	

4) For incidents of self harm indicate with an 'X' in box below type of self harm.					
Asphyxiation		Insertion of object into the body		Electric shock	
Self-cutting		Head butting/ punching walls/doors		Other	
Self poisoning		Ingestion of non-ingestible object			
Was the Young Person injured from any of the above?				Yes / No	
If 'YES', using the definition contained in section A2 indicate the level of medical intervention					

5) Use of single separation.			
Was single separation used?	Yes / No	Time in separation?	Hr Min

Duty Manager informed?	Yes / No	Response time?	min
Duty Managers name			

Date section A passed on:		Date section B passed on:		Date section C & D passed on:		SMT completed on:	

Section A

What led up to the main incident?
(young person's state, group factors, trigger events)

Detailed description of main features of the incident:

How was the incident concluded?

Sign: ……..... Print name: …….. Date: ……Time: ……

Were the YOT, family and LASW (as appropriate) informed? If yes, record the dates and times below.								
YOT:	Date	Time	Family:	Date	Time	LASW:	Date	Time

Location	Form No.	

Section B

What led up to the main incident?
(young person's state, group factors, trigger events)

Detailed description of main features of the incident:

How was the incident concluded?

Sign: ……..... Print name: …….. Date: …… Time: ……

Section C2: Secondary young person's comments

Would you like help with filling in this form? Yes ☐ No ☐

What happened?

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……

Are you happy with what happened? Yes ☐ No ☐

Would you like to talk to someone else about it? Yes ☐ No ☐

Sign: ……..……. Date: ……. Time: ……

Print name: ……

Young Person declined to comment ☐

Sign: ……..…… Date: …….

Location	Form No.	

Section C1: Primary young person's comments

Would you like help with filling in this form? Yes ☐ No ☐

What happened?

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Are you happy with what happened? Yes ☐ No ☐

Would you like to talk to someone else about it? Yes ☐ No ☐

Sign: ……..…… Date: ……. Time: ……

Print name: ……

Young Person declined to comment ☐

Sign: ……..…… Date: …….

Section D1: To be completed by Team Manager

Corresponding Log & Daily events entries		Entry in Disciplinary Measures book	
Section A completed & checked		Referral to Police	
Section B completed & checked		Referral to Child Protection	
All Section C completed & checked		Home Office report	
Risk Assessment/Handling Policy reviewed		Accident/injury forms completed & checked	
Any complaint followed through		Medical check	

Have all required notifications been sent to:	Ofsted	Yes / No	YJB	Yes / No

Are any of the following special needs/circumstances relevant to the incident;

SASH/Vulnerability alert		Diagnosed mental illness		Learning disability	
Transferred for behavioural reasons			Prescribed controlled medication		
Bully /victimises others			Medical condition restricts use of RPI		

Team Managers comments:

Sign: …… Print name: …….. Date: ……Time: ……

Section D2: To be completed by Senior Manager

INCIDENT

Altercation between young people	
Attempted assault on Young Person	
Assault on young person	
Accidental/Incidental Assault on staff	
Deliberate Assault on staff	
Threatening behaviour	
Incitement	
Self-harm	
Runaway/Escape	
Influence of substances	
Breach of security	

RESULTING IN

Guiding	
Holding	
Restraint	
Separation	
Young person hurt	
Staff hurt	
Medical attention called	
Damage	
Police called	

Child Protection referral S47	

Senior Managers comments:

Sign: ……..…… Print name: …….. Date: ……Time: ……

Location	Form No.	

STAFF DEBRIEF

1. **Matters Arising from Incident** (Reflection of incident, i.e. Reasons for incident / use of force, etc.)

2. **Personal Issues** (i.e. Feeling about incident / reflection following incident)

3. **Actions** (i.e. Resulting from above / Supervision issues / Lessons to be learned?)

4. **Personal and Professional Support Following Violence Towards Staff**

Signature: .....

Team Manager / Assistant Team Manager

Location	Form No.	

Independent monitoring officer's comments:

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Signed: Date:

Managers reply to monitoring officer's comments:

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Signed: Date

Appendix B: Training providers and their methods

PRICE (Protecting Rights in a Caring Environment)

PRICE is the most commonly used method within SCHs being used in six of the 20 operating at the start of the project, although one of these has now closed. It was commissioned and developed in the early 1990s under the guidance of the Home Office following concerns that children had been injured through the use of restraint in the Aycliffe Secure Unit. PRICE has evolved from its early days and is now said to prioritise a preventative and de-escalation approach to challenging behaviour, whilst promoting the use of planned, phased, least intrusive restrictive physical interventions, as a last resort.

PRICE offers a modular approach to training. These are separated into three core modules, forming the basis of all introductory programmes:

- Developing a value base
- Structuring care environment
- Restoring the environment/post-incident support

There are a further three optional modules:

- Understanding and recognising challenging behaviour
- Psychological responses to challenging behaviour
- De-escalation and defusion toolbox.

Course participants are continuously assessed on both the theoretical and physical skills curriculum. Where competency is not demonstrated an individual development plan with specific targets and timescales is put in place and the organisation receives a copy at the conclusion of the course. A central database is maintained of all PRICE programmes and participants.

Organisations commissioning PRICE are asked to undertake a Behaviour Management Care and Control Audit or evidence where one is in place. This includes a training needs analysis and policy audit as well as an audit of the behavioural challenges presented by service users. Programmes are then tailor made to meet the organisation's needs and therefore vary in length and content. Programmes can vary from a one day course covering primary prevention strategies and de-escalation approaches to a five day course including restrictive physical interventions with a range of options in between.

Instructor training is currently offered through a ten-day programme but may increase to twelve. Prospective nominees must meet clear criteria for Instructor training:

- Have work based experience (at a senior/ management level) in dealing with challenging behavior;
- A background in adult teaching environments;
- Possess a strong theoretical understanding of behaviour;
- Possess good motor skills;
- Have successfully undertaken at least a four-day introductory course.

PRICE is working to achieving the standard of visiting newly qualified instructors within 12 -16 weeks to support training delivery as part of a quality assurance framework. Certificated instructors have access to network meetings and are encouraged to keep in touch with PRICE and to provide practice-based feedback. Organisations are asked to provide information on the number of restraints that take place, the effectiveness of the techniques and any injuries although at present only 25% to 30% do so. PRICE report that available data and anecdotal evidence suggests a reduction in the number of restraints and injury rates to both young people and workers. PRICE remains committed in partnership with commissioners to working towards a complete evidence base with an increased capacity to inform programme development.

The physical intervention element of the training teaches a graded (phased) response, designed to ensure that the least restrictive interventions are used wherever possible. Practice has shifted from the teaching of a generic set of techniques to specific interventions that the behavioural challenge audit suggests are likely to be used in the setting. PRICE advocates the use of Individualised behaviour plans in order to ensure that effective methods are available to support individual children.

PRICE holds are designed to hold children without putting pressure on their joints and are said to 'utilise Bio-Mechanical principles and maintain the ergonomics of the body structure'. Interventions include kneeling, seated and supine positions and the risks related to restraint positioning are central to the teaching. Protocols are in place for holding young people on the floor as it is felt this may be a necessity or preference with some young people. PRICE advocates the recognition of negotiation points and leaving options whilst re-assessment takes place.

PRICE believes in the delivery wherever possible of non-aversive techniques that cause no discomfort but does have a Phase 4 package that will only be taught if an organisation can evidence the need within the context of a clear risk assessment and agreement of the multi-disciplinary care team. The programme may include some pain compliant techniques that can cause discomfort if the young person struggles. Any intervention of this nature would be used only in the short-term with specified individuals and reviewed daily. PRICE does not teach Phase 4 skills to in-house instructors but provides training directly to staff if needed. There are two techniques that will cause temporary discomfort in situations where it is necessary to get someone to release a bite or hair grip. These are taught within the framework of reasonable force, proportionality and necessity as

a last resort, where the application results in the prevention of greater harm to the worker.

PRICE techniques have been independently risk assessed by a medical practitioner and occupational physiotherapist and the outcomes used to inform practice although that the fluid nature of movement and intensity in real life situations are acknowledged.

PRICE is accredited through BILD and promotes the BILD Code of Practice for trainers in the use of physical interventions. As with other organisations, this does not extend to all in-house instructors delivering PRICE programmes. They carry their own responsibility for promoting the implementation of the code of practice within their organisation.

PRICE would like to see development in the following areas:

- A mandatory accreditation scheme and a qualification framework for Instructors through universities;
- An expectation that every young person has an individual behavior management plan;
- Greater investment in the knowledge amongst the workforce about children's behavior including the impact of attachment difficulties, loss and bereavement;
- Greater knowledge of earning difficulties and autistic spectrum disorders;
- Continued and improved commitment to defusion and de-escalation training;
- Research with staff teams to explore the changing face of the challenges they encounter in modern practice;
- A universal risk assessment tool and independent expert panel with responsibility for the assessment of physical interventions resulting in consensus over the most effective techniques;
- Greater inclusion of young people in choices with regard to how their behaviour is managed and more coverage given to their views in relation to current practice.

SCHs using PRICE are generally happy with the physical intervention aspects of the method. Historically they have tended to supplement PRICE through commissioning additional training on the wider aspects of behaviour management but this may be changing as the PRICE curriculum is evolving.

GSA (General Services Association)

GSA is the name of the association which governs general services training. The Association was originally the National Control and Restraint General services Association (NCRGSA). It is an association of trainers who are not directly employed by the association but are self-employed or work for other organisations. They have developed and agreed a core curriculum of physical techniques that provides the basis of all general services recognised training. There are two levels of tutors: Tutor and Senior Tutor. Tutors can teach physical intervention techniques to staff in a range of settings, many of which are within health trusts, whereas senior tutors can also train other tutors.

Originally the techniques were adapted for use in special hospitals in the late 1980s from the C&R method used in prisons but, since its initial formation, the scope of GSA has increased to meet the needs of professionals in a range of health, educational and social care settings. The training is said to have evolved in order to enable staff to safely manage incidences of aggression without the application of pain, which remains an essential element of C&R itself.

The techniques are regularly reviewed by a Consultant in Emergency Medicine with particular expertise in trauma who gives an opinion on the level of risk each technique may pose to staff and subjects, categorised as likely, possible or remote risk, and describes what the possible adverse consequences could be of each technique. The medical review makes it clear that particular health problems of staff or subjects, and operational factors may have an impact on safety in practice. If any new techniques are developed in-between these regular reviews, course participants will be warned that they have not yet been subjected to medical evaluation. A recent review has just been done, so all techniques within the current core curriculum have been medically assessed. GSA collates information on injuries caused during training but expect individual organisations to have their own systems for collating information on operational injuries.

The core curriculum is primarily concerned with physical intervention skills but a theoretical curriculum is being developed. In the meanwhile, tutors are advised that all of the basic courses they deliver should consist of around 40% theory. Both the theoretical and practical training is based on a training needs analysis and risk assessment. The expectation is that tutors would identify the elements of the core theory curriculum that are suitable for inclusion in the training courses they develop. GSA offers advice to tutors on effective training, for example suggesting that it is unwise to train as a single tutor, that course size should be limited to six participants per tutor and that techniques should always be demonstrated on tutors, not course participants. The average length of basic courses is from three to five days. GSA monitors the quality of training provided by their approved senior tutors through an external moderator.

To become a basic GSA tutor, participants undertake a three-week intensive course. They are taught a range of physical techniques, given an opportunity to practice them and then practice teaching those skills to a group. They are continually assessed on their grasp of the techniques themselves but also their ability to teach them to others. There are three outcomes:

- pass as an A tutor, capable of training straight away;
- pass as a B tutor, considered competent but only approved to run courses with a more experienced tutor and reassessed after six months;
- referred (not considered competent to run courses). This could be because of a lack of physical skills, altering the techniques, being unable to teach them effectively or demonstrating a negative attitude towards the philosophies of GSA and towards maintaining a therapeutic relationship with an aggressor.

All tutors are expected to attend annual updates and they would not be allowed to continue training if they went beyond two years without having done so. After three years, tutors could

apply to become senior tutors. They would be expected to produce a portfolio of their learning through the courses they have run and assist on two tutor courses with different senior tutors. Recommendations from that would be submitted to GSA. Participants are either awarded senior tutor status or advised what further work is needed to meet the requirements.

The techniques themselves are designed not to cause pain or injury, or to go against the principles of dignity and respect for service users. They are phased, from a no contact intervention to higher-level team interventions for use only in extreme situations. These more restrictive techniques include one pain distraction that puts pressure below the jaw for use when someone is being bitten. There is a finger and thumb hold but the most commonly used hold is a Figure of Four. Holds in a prone or supine position are available as a last resort but, whenever possible, should be planned and individually risk assessed. These techniques should only be used when considered to be safer than the alternatives in situations of extreme violence.

GSA is used in four SCHs and they are reasonably happy with it, although some staff still refer to it as C&R. There is also some confusion about whether it does contain some pain compliant techniques or pressure on joints or not, and the large number of different holds that need to be remembered. It was generally acknowledged that it is primarily about physical skills and that other training or strategies are needed to ensure staff are skilled in holistic approaches to behaviour management.

In terms of the issues of concern to GSA, they are worried about the 'knee-jerk' reaction of banning prone restraint without any research evidence to justify it – or to demonstrate that alternatives are any safer. GSA as a body is not BILD accredited at the moment because, as it does not directly employ staff, they believe their structure as an organisation does not fit the scheme.

They also have some concerns about the validity of the BILD accreditation scheme as it stands and would welcome an alternative system that excluded potential commercial interests.

MAPA® (Management of Actual or Potential Aggression)

MAPA® is described as a specific person-centred approach to help staff, across the range of education, social and health care services, to manage challenging, aggressive and violent behaviour and to work positively with people who present such risk to themselves or others. The organisation that developed and delivers MAPA® training is Positive Options Limited, a UK based diagnostics, education and training provider.

The origins of MAPA® can be traced back to the work of a number of senior nurse managers who had been instrumental in introducing Control & Restraint (C&R) training across forensic, mental health and learning disability services. They had initially welcomed C&R training because, before that, there had been no taught methods of restraint and the response to challenging behaviour had been a 'free for all' or seclusion and medication. However, they subsequently became concerned that C&R was not appropriate for a number of professional and ethical reasons, including the fact that it is: too difficult to learn and remember and therefore to apply in real life situations; based on control rather than support; endorses the use of pain; is limited to physical skills.

The development of MAPA® was based on the practice experience of its founders, and feedback from staff and patients, and is continually reviewed and refined. Positive Options has set strong ethical standards, rejecting the use of pain and pressure on joints. Their approach is that physical intervention is about supporting people in crisis rather than enforcing compliance and that the key to sound practice is to support organisations and professionals in changing attitudes and working cultures.

All courses are tailored to individual settings based on a training needs analysis and risk assessment of service user needs undertaken with managers. It is considered important to train on the basis of typical incidents that staff are required to manage rather than extreme scenarios. Otherwise, staff are given skills for extreme situations which may not occur but which are then considered to be endorsed for routine use. Course programmes are then developed, piloted, and adapted if necessary, before being rolled out within a service. Positive Options insists on having a managers' workshop before training front line staff because of their ongoing responsibility for managing practice.

Positive Options offer a modular approach, including person-centred courses on promoting positive behaviour and supported decision making through person-centred risk management, in addition to the MAPA® theory and skills. Each 'direct delivery' programme varies in length, typically from 1 to 10 days, although the average MAPA® programme is 4 days. Staff must have annual refreshers and be fully retrained every three years. A number of instructors' courses are also available with the longest course linked to a degree-level programme at Keele University (40 days) and also require annual updates of at least three days. Positive Options never deliver training on physical skills in isolation of the underpinning theory, values and principles, even if this means losing commissions, because they want evidence that the organisations that they train have sound person-centred principles as well as clear procedures for safeguarding vulnerable people who may experience the use of restrictive physical interventions.

Each person completing a course receives individual statements of competency. Positive Options do not use a 'pass' or 'fail' criteria for course participants as they feel that the training environment is artificial and does not reflect the individual's abilities and attitude in the workplace. Instead, the individualised certificate of competence provides performance evidence for the participant and their manager to determine their ability to practice.

The MAPA® techniques themselves are designed to be simple to learn and apply. There are three levels of intervention. The first is holding to keep people safe, the second and third level are for disengaging from incidents where there is a risk of harm. Within level 3 there are three specific techniques that are delivered within the context of 'personal safety' and involve pain stimulus. However, these specific skills are only included in programmes following the commissioning process whereby the commissioning organisation has determined their relevance. The skills are only taught within the context of 'escape' situations and are not promoted to be used in any other situation (i.e. holding or disengagement). There is an expectation that the use of pain stimuli must only be used if a manager is present and must be written into individual behaviour management plans. All the physical skills within the MAPA® curriculum have been independently assessed by a

consultant physiotherapist and have been reviewed as part of the BILD Accreditation process.

Positive Options have undertaken research to find the position that causes the least reduction in oxygen levels. They do not teach methods for moving a child because they do not support the use of force to make people go somewhere they do not want to go, seeing this as enforcing compliance rather than supporting people in crisis. There is a risk matrix promoted by the Health & Safety Executive (HSE) and now adopted by NICE which is also used. Positive Options ask all the centres they have accredited (MAPA® Approved Training Centres) to send in a quarterly return on the training they provide, which includes relevant injuries and complaints. There is also a learning community section on their website for their 300+ Licensed MAPA® Trainers across the UK.

Positive Options initially approached the Royal College of Nursing to set up standards for physical interventions training but is now BILD accredited. Positive Options would like to see commissioners taking more responsibility and setting higher professional standards, such as the requirement that instructors have a professional qualification and experience. In common with other providers, they recognise the importance of the BILD Accreditation Scheme but would welcome a single, impartial scheme across all sectors. Positive Options would also welcome greater scrutiny of all education, social and health care settings for vulnerable people where restrictions to liberty are applied, particularly given their view that social and environmental restrictions are used to a far greater extent than physical restrictions and are often under-reported or challenged.

CALM (Crisis, Aggression, Limitation and Management)

CALM takes a Public Health model approach to challenging behaviour, seeing it as a phenomenon that can only be understood in the context of organisational culture and practice, rather than individual pathology or a failure of staff skills. Events before, during and after incidents must be taken into consideration. The agency response must extend beyond training as a quick fix, and it is CALM's view that training on physical intervention skills in isolation will make situations worse, a view they see as increasingly supported by research. CALM would always start with an examination of an organisation's policies and gain an understanding of agency practice and infra structure, and the specifics of the service user group. As with Positive Options, they would hold a managers' workshop and assist with training needs analysis and risk assessment.

The results of these activities would be followed by feedback to commissioners and support for remedial action. A programme of theoretical and practical training would then be agreed. Although a range of shorter courses is available, BILD accredited basic theory courses and physical intervention courses are each of two days duration. All physical intervention trainees must have completed the service specific theory course first. Ongoing consultancy and support is provided post training.

For effective facilitation CALM would prefer to deliver all training directly but acknowledge that, in response to commissioner's demands, they need to provide Train the Trainers programmes. Associates courses accredit in house staff to deliver the BILD accredited theory element and involve the submission of a portfolio, including a critical analysis of the literature underpinning the CALM

programme content. The complementary Instructors' courses are 5 days and allow the physical intervention module to be delivered within organisations. They take a rigorous approach to instructor training, requiring trainees to explore and make presentations on the law, followed by written assignments and the development of teaching plans. The aim is to change thinking, and organisations are encouraged to send competent, rather than merely physically fit staff on instructor courses. CALM aims to establish a long- term supportive relationship with agencies which use the method, and to develop instructors that have bought into their philosophy. Participants do occasionally fail the courses, which are externally validated.

The theory programme content employs a Cognitive Behaviourist approach which stresses the links between feelings, thoughts and actions. The physical techniques themselves are 'non-aversive' and do not cause pain or flex the joints beyond their middle-range or take the body outside its natural alignment. All techniques are assessed by independent bio-mechanical experts. The structure of physical intervention courses are hierarchical with five levels of response to challenging behaviour. This allows demonstration of 'minimum, proportionate force' only. The first two levels involve either no touch or minimal contact with the child, the third contains strategies such as an arm round the shoulder and levels four and five are more restrictive. Prone restraint is used only exceptionally by a very small number of CALM using agencies, consequent to a written application from the organisation's Chief Executive endorsing its use and stating why other methods are insufficient. They are also required to guarantee that prone techniques will only be used on the basis of risk assessment, with specified individuals. The particular method of prone restraint does not put pressure on the torso and no injuries have been reported to date.

CALM requires user organisations to submit data on the numbers of restraints and injuries and undertakes an annual audit (last injury rate = 0.04%). A number of independent research studies confirm their low injury rate.

CALM is accredited under the BILD scheme and the SCHs that use CALM confirm its effectiveness and safety. CALM would, however, like to see the regulation of the present free market training economy and a properly financed and resourced accreditation system. They also feel it is a national disgrace that restraint use is not monitored. All physical intervention methods should be rigorously risk assessed against specific bio mechanical criteria and any accreditation removed, where necessary. It is CALM's view that training staff to use high tariff techniques, in isolation from each other, and without service specific theoretical underpinning, is dangerous as it encourages power struggles between staff and service users. CALM would also like to see a move away from the view that service user pathology and staff competence are the key determinants of problem situations, towards an increased recognition of the cultural and organisational factors that shape challenging behaviour. They also believe that the strategic emphasis at national and agency levels should be placed on restraint reduction.

Team-Teach

Team-Teach was developed from GSA but has removed all elements that it considered to be deliberately painful. It is used in a large number of educational and care settings but expects each setting that intends to use Team-Teach to undertake an analysis of their specific needs and a

package of behaviour management techniques and training is then developed to meet those needs.

Team Teach evolved within a residential setting for children (10-18 years of age) with social, emotional and behavioural difficulties. Courses were developed which included both theoretical and practical elements. It is Team-Teach's view that it is essential to integrate these elements in order to ensure a holistic approach to behaviour management.

> *If you teach them separately, then staff will apply them separately.*

The theoretical element contains information that will support staff in their thinking about the 'before, during and after' of incidents of restraint. It includes understanding the origins and types of challenging behaviour, listening skills, de-escalation skills and underlying values.

The restraint techniques themselves, because they originate in GSA, were developed within health care settings but additional opinions about their safety have been sought from a panel of experienced Team Teach trainers with medical qualifications and a back care specialist. They also request information from organisations that use Team-Teach about injuries, including an evaluation form for 'high risk' techniques. They actively encourage an ongoing dialogue about any difficulties, and have occasionally given advice in child protection investigations about whether injuries are consistent with the techniques used. From the data they have collected over the years, including more than 3000 instances of prone restraint, only three have needed hospital attention. These three incidents were minor fractures to the forearm, caused by a feature of the environment rather than the hold itself. Team-Teach insist on all staff who will be using their high-risk techniques being trained in First Aid.

Team-Teach does not use pain compliant or pain distraction techniques and, in ten years, has not felt that they would have been needed. Their view is that, if you train staff in such techniques, they will use them and that this increases the possibility of abuse. Although pain can arise – and indeed restraint is unpleasant by definition – this is different from an intention to cause pain. Team-teach does use prone, supine and side restraint in the belief that these are safer than some of the alternatives as long as sufficient safeguards are in place. These include ensuring that no pressure is placed on the torso. 'Ground restraint' is thought to be more likely to bring an incident to a close and to avoid the need for prolonged, and therefore risky, restraint. They believe in taking an individual approach, however. Their work in special educational and care settings with children with social, emotional and behavioural difficulties, as well as autistic spectrum or learning difficulties has led them to ask children about their preferences.

As with most methods, Team-Teach provides training for in-house instructors who will then train staff in their own establishment or authority. This has the advantage of having expertise available locally to sustain and refresh staff skills. Team-Teach training on physical intervention itself is relatively short, with a minimum of six hours in low risk 'mainstream' settings but 12 hours usually being provided for medium-risk 'special' settings, with additional modules available. Course participants are tested on the theoretic elements of the courses and given opportunities to re-take the test at least three times. If they pass, they receive a certificate. Instructors' training is for four

days with two-day refreshers. Team-Teach is BILD accredited.

The issues raised by Team-Teach if restraint practice is to be improved were:

- a requirement for all staff who will be using "high risk" restraint techniques to be first aid trained, including in resuscitation techniques;
- more rigorous recording and reporting requirements;
- more honest definitions about restraint;
- an expectation that physical intervention skills should not be taught in isolation.

Establishments that use Team-Teach were happy with its ethos although there were some concerns that training was too short. The decision not to use ground restraints on the basis of the DCSF advice had reduced the repertoire of techniques available to staff and some concern was expressed about the adequacy of the remaining techniques, with children having got out of holds and a lack of techniques for moving children.

Ethical Care Control and Restraint (UK) Ltd (ECC&R (UK) Ltd)

The founder of ECC&R (UK) Ltd developed C&R for use in the prison service. When he left the prison service in the late 1980s, he adapted the methods for use in other settings, including psychiatric and children's services. The methods have evolved over the years to reflect changes in the legal and policy framework. Although ECC&R (UK) Ltd is used in a number of settings, it is only used in one SCH.

The aim of the majority of their courses is to achieve the ten learning outcomes of the Security Management Services (SMS) Promoting Safe and Therapeutic Services syllabus. These courses encompass the key elements of the theory (e.g. de-escalation and laws relating to the use of force) relevant to the Prevention and Management of Violence and Aggression (PAMVA) as well as the practical elements. The practical elements include breakaway and recommended restraint methods and procedures. Physical intervention methods are seen as part of a broader strategy for addressing challenging behaviour whether it is minor, moderate or extreme. They believe that the professional needs to be able to address these different challenges with different gradients of control which are ethical, dignified and legal. Courses are adapted to meet the needs of clients and basic training is delivered in two to four days with an extra day to cover the theory part, if required, and with homework. Training may be delivered to staff teams or to mixed groups of participants. Certificates of attendance are issued to the learners unless the instructor considers any unsatisfactory learner would constitute a health and safety risk to others within their workplace in the use of C&R. Ten day Instructors courses are also offered with an annual refresher of one week. Instructors must have a full First Aid at Work certificate, be CRB checked and have some teaching expertise. They are continually assessed and could fail the course if not considered competent.

The variety of physical methods taught offer a phased response but do not include methods that routinely take children to the floor. However, if a child was already on the floor methods are taught to turn them onto their back and then either sit or stand them up or monitor them as recommended by the Bennett Enquiry. They teach that no

pressure should be applied to the neck, throat, chest, and abdomen, upper and lower back, sexual areas and fingers. ECC&R (UK) Ltd profess that pain based and discomfort methods serve no therapeutic value and must only be used as a very last resort in extreme circumstances to ensure the safety of others and self.

ECC&R (UK) Ltd has devised individual care plans suitable for different challenging behaviours and physical limitations with their clients. They encourage feedback about injuries but do not have a formal system for this. The company is a member of BILD and follows most of its Code of Practice but has chosen not to have any of its courses accredited by BILD as it considers that this would restrict the level of training currently provided and wanted by many of its clients. In order to meet these needs they follow the physical intervention guidelines provide by NIHME and NICE. The Open College Network (Eastern Region) can accredit many of their courses and they are currently negotiating an Instructors course in association with Anglia Ruskin University. They would urgently like to see the introduction of national standards and guidelines for restraint methods and a government-led, fair to all, accreditation system for instructors.

DIVERT (De-escalation In Various Environments using Realistic Training)

DIVERT has been developed within one SCH but is now also used in other children's homes across the local authority. The SCH previously used PRICE but the managers became concerned about the lack of theoretical underpinning, such as the antecedents to challenging behaviour, and the fact that it did not pay any attention to emotional well-being. Two senior managers adapted and simplified the PRICE techniques and have developed their own training programme consisting of a one-day theory course and four days on responding to challenging behaviour, including physical intervention. Staff from different establishments are usually trained together. Refreshers are undertaken every two years but skills can be supported in between. Course content includes the legal context, reasons for challenging behaviour, types of aggression and the most effective responses including active listening, establishing rapport and de-escalation strategies. All participants get a certificate of attendance and individual feedback is given to line managers.

The techniques are primarily based on a Figure of Four hold, which is used in most circumstances and is thought to be more effective than the wide range of techniques previously taught. The holds are not pain compliant and there are no pain distraction techniques on the basis that once staff are trained in them, they will use them. Staff are told that they can cause discomfort if necessary in situations where they were being assaulted but the view expressed by others is endorsed: it is a mistake to teach skills based on worst case scenarios rather than typical events.

> *People say 'what if someone strangles you?' we say 'well how many times has that happened to you?'*

Restraints are said to have reduced by 60% under the new approach. DIVERT is not accredited but the managers responsible ensure that they attend external courses and continue to develop their skills and knowledge.

SCAPE (Safe Care And Protection in Essex)

SCAPE was devised by one of people who developed PRICE, and who still provided consultancy and trains the in-house instructors. It uses the same basic techniques although there may now be some divergence as the methods have developed separately. SCAPE is used across all Essex children's homes and there are in-house instructors at basic and senior level. (called Lead and Support Instructors) Instructors receive 10 days initial training and five day refreshers annually. They are expected to demonstrate not only physical skills but an ethos of care and there are written papers. All staff are expected to be trained and refreshed at least every two years although it is sometimes a struggle to achieve this. Basic courses contain two days input on conflict management and two days on physical skills, although this can be increased if necessary. The Children's Homes strategy specifies the requirements for staff to be trained and undertake refresher training within this specified timescale. In order to introduce an element of independence, at least one instructor would be from outside the home where courses are delivered. Staff can fail the courses and there are mechanisms for quality assurance involving one independent consultant in addition to those responsible within Essex. The Essex Restraint Policy and Practice Guidance sets the overarching expectations and boundaries and the SCAPE instructors make use of this as well as the SCAPE handbook to consider developments to specific holds or the training package. These are approved by the service prior to their use.

Instructors have regular meetings with SCAPE and there are problem- solving meetings every two months and development days of all the instructors in Essex. They can approach the consultants for advice if needed. A decision has been taken not to seek BILD accreditation because of the costly nature of the process and a feeling that it would not add value. There is a plan, however, to present the SCAPE package to Essex LSCB.

As with PRICE, SCAPE has a Phase 4 that is not taught as a matter of routine. It is developed only if and when there is particular young person who presents an additional challenge. If there is a problem, in-house SCAPE instructors would be asked to develop an individualised package of holds. A decision has been taken within Essex not to use the pain compliant elements of PRICE and there is no prone restraint. There is a regular review process whereby the training department ask operational managers about the usefulness of the training. In addition, within the SCH incidents are recorded on CCTV and is scrutinised by the in-house SCAPE Instructors and used as part of the de-briefing after all incidents within the home. Risk assessments held on the children may also be amended in the light of the incidents.

References

British Institute of Learning Disabilities (2006) *BILD Code of Practice for the Use of Physical Interventions: A Guide for Trainers and Commissioners of Training*

Department for Children, Schools and Families (2007) *Review of restraint in juvenile custody (November 2007). Letter from Director General, Children Directorate, to SCH managers.*

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

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

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

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

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

Hart, D and Howell, S. (2003) *Report to the Youth Justice Board on the use of Physical Intervention within the Juvenile Secure Estate.*

Secure Accommodation Network (2005) *The Use of Restrictive Physical Interventions (RPI) in Secure Children's Homes (England and Wales): Good Practice Guidance.*

YJB (2006) *Managing the Behaviour of Children and Young People in the Secure Estate: a Code of Conduct.*

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