Guardian for Children
and Young People

Inquiry into Policy and Practice in the Use of Physical Restraint

in South Australian Residential Facilities for Children and Young People

Report for the Guardian for Children and Young People, South Australia

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and

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Foreword

Physically restraining a child is commonly justified as fulfilling an adult's protective duty to the child. And so it is, when a child is plucked from danger. The rights and wrongs become murkier though at every point beyond 'plucking from danger'. If you are responsible for making a safe home for a number of unrelated children and teenagers who have high needs and challenging behaviours the decisions about how best to manage that behaviour are complicated indeed.

Two quotes in this report from the interviews with young people illustrate this well. 'I wouldn't have felt safe, because they are just psycho…I think there is a need for them to be restrained sometimes.' And, 'I've seen one kid get restrained and it messed up his life. He just thinks that nobody loves him, nobody cares about him.'

It was comments like these made during our visits to residential facilities that prompted us to look more closely at what was happening to children and young people who are restrained, or who witness restraint, in their residences. We were also aware that the practices varied from one residence to another which was very confusing to the young people who moved between them, as most do.

In April 2009 I commenced a formal inquiry into the use of physical restraint in South Australian children's residential facilities. I engaged Associate Professor Andrew Day and Dr Michal Daffern who have specific expertise in this area to conduct the inquiry on my behalf. I thank them for applying their skill and knowledge so thoughtfully to this inquiry and for their commitment to the young residents and workers which went well beyond what was required or expected. I also thank Ms Emily Rozee who joined them as the young researcher and applied her skills to engaging the young people so well.

I am mindful of the gravity of the inquiry topic and the significance for children and adults of getting it right. And that means getting it right in every incident of high emotion and in the guidance of when to physically restrain. Using physical restraint is dangerous. The decision is complicated and made in highly charged conditions.

Complicated, difficult and risky decisions should not be made in the heat of a moment and yet the only circumstances where restraint is considered will be heated. That is why guidance, training, reflection and consistency are so important, for workers and residents alike.

People hold strong views on whether restraint is ever justified. I held strong views prior to this inquiry but, with the benefit of learning as the inquiry progressed, I now understand under what limited conditions it can be justified. I think you will find the same deeper understanding on reading this report, though you may not change your point of view.

One young interviewee said, 'I know it takes a lot out of them emotionally,' referring to youth workers. Compassion and understanding is a good place to start. I look forward to working with agencies to provide the very best and safest residential care and that young people experience as a good and restful place to be.

Pam Simmons – Guardian

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We would like to thank Ms Emily Rozee for facilitating the interviews with young people – her contribution and professionalism was greatly appreciated. We would also like to make special reference to all of those who freely gave their time to be interviewed about the use of restraint, and participants in the roundtable on restraint. Their experiences and insights were invaluable.

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1 Executive summary

The physical restraint of children and young people by residential care staff is a topic that arouses considerable emotion. There are those who are concerned about the potentially adverse effects of restraint on the well-being of children and young people and threats to their human rights, whilst others draw attention to the need to safely manage behaviour that is extremely challenging and potentially places either the child or young person or those around him or her at imminent risk of harm. Although there are some who would regard physically restraining children and young people as inappropriate under all circumstances, the findings of this inquiry suggest that many acts of restraint are likely to be lawful, and that the practice is supported by the policies and procedures of most residential care providers in South Australia. There would appear to be widespread agreement, however, that restraining children and young people is a potentially dangerous practice, that only the safest methods should be used, and that physical restraint should only occur in circumstances when it is absolutely necessary.

This inquiry, conducted on behalf of the Guardian for Children and Young People, arose as a result of visits to residential care conducted in the course of monitoring services offered to children and young people. In these visits some youth workers and residents expressed concern about the frequent use of physical restraint, and whilst restraint appeared to be commonplace in some residential facilities, in others it appeared to not be considered as necessary, or used much less frequently. The Guardian is a statutory position to advocate for the best interests and rights of children and young people under the guardianship, or in the custody of, the Minister. One of the functions of the Office is to investigate matters of concern and to provide advice to the Minister. The purpose of this inquiry, then, is to examine current policy and practices in South Australia, and, where appropriate, make recommendations for reform.

The inquiry considered restraint in residential care, as discussed in the professional literature, by those agencies that provide residential care to children and young people, and from the perspectives of a range of stakeholders in South Australia including those of young people who have been in care. The inquiry found that the rates of restraint appear to have decreased substantially over the last three years, and that there is a high level of commitment amongst service providers to work with children and young people in ways that are proactive, rather than reactive or punitive in nature. Nonetheless, practices across the residential care sector in South Australia are inconsistent, and some confusion and disagreement exists about what should be considered to be appropriate behaviour management. There is a need to revise and update policies and procedures relevant to the use of restraint across all South Australian residential care settings

to ensure greater levels of transparency, consistency and accountability across the system. Regular reviews of current policies and practices in relation to the physical restraint of children are not only necessary, but an important part of the process of ensuring that children are kept safe from harm and cared for in ways that allow them to reach their full potential. In addition, there is a consensus that those staff members who are involved in restraining children must be appropriately trained, that alternative interventions should be exhausted prior to using restraint, and that restraint must be limited to the act of holding the child or young person for the shortest necessary time. A number of specific recommendations are offered in the light of these findings.

1.1 Summary of findings

- Restraining children is a dangerous practice that can cause significant injury and even death to children and young people.
- At least since 2007 there have been no incidents of serious injury to children and young people that occurred as a result of a restraint in residential care in South Australia.
- Significant reductions have occurred in the use of restraint in recent years, and that there was now much greater awareness, training and accountability in the use of restraint than there had been previously.
- Ongoing review of incidents is important given that there is typically a reduction in the use of restraints when behaviour management practices come under scrutiny.
- There is a general consensus that restraint should be used as an intervention of last resort and in a planned fashion that minimises the risk of harm and maintains the dignity of the child. Notwithstanding this consensus there is also a need to reinforce the use of approaches to the management of challenging behaviour that do not involve direct physical intervention.
- There is no evidence to suggest that restraint effectively reduces either the frequency or intensity of challenging behaviours. The only rationale for restraining a child relates to actions that are required to protect the child or young person, or others around him or her, from immediate and serious harm.
- Restraint is most commonly used in Community Residential Care settings, although also regularly occurs in Transitional Accommodation and Secure Care units. Non-government providers have generally much lower levels of restraint, with some not using restraint at all.

- The introduction of the non-violent crisis intervention training package appears to have significantly reduced the number of reported restraints across the Community Residential Care and Transitional Accommodation units.
- Young people expressed concern about the use of restraint, and described instances when, in their experience, it had been used to secure compliance or as a punishment.
- Concern was expressed by residential care staff and managers about the high rate of restraint in some settings, and the difficulties in engendering organisational and cultural change amongst some groups of staff. Ongoing work is required to monitor and review such practices.
- Residential care staff and managers believed that much more rigorous training was required in the area of both restraint and behaviour management.
- The size and design of residential units can exert a profound influence on the use of restraint, and there is a need to develop purpose built facilities that are, informed by contemporary principles and approaches to residential care for children.
- There is little empirical basis to determine the psychological impact of restraint, and consequently there is the need for systematic research into the effects of restraint and behaviour management practices on both the levels of challenging behaviour and the social and emotional well-being of children and young people.

1.2 Recommendations

1: That the *Family and Community Services Act Regulations 1996* are amended such that use of force is not permitted to ensure that the resident complies with a reasonable direction given by an employee of the centre.

2: That a common policy on the use of physical restraint is developed by Families SA and shared with all residential care providers. It is further recommended that:

   a. This complements the development of evidence based practice guidelines (by Families SA), and be informed by a set of principles of behaviour management developed in agreement with all residential care providers.

   b. This includes provision for the separate monitoring and review of the use of mechanical restraints in secure care training centres.

   c. Debriefing with staff members, staff teams, and the young person who has been restrained is mandated, such that it occurs routinely and as part of standard practice.

   d. Care plans be reviewed and revised after each incident of restraint to include comment on how to respond to similar behaviour without the use of physical restraint.

   e. Restraint is never sanctioned to secure compliance or to punish children and young people.

   f. Physical restraint should not be done by a single staff member for children over 10 years of age.

3: That a system for the external monitoring of physical restraints is set up to:

   a. Receive all data and records of use of restraint so that there is systematic mapping of use.

   b. Review those units with apparently high levels of restraint.

   c. Provide advice on occasions when a young person has been restrained more than once over a one week period.

   e. Ensure that multi-disciplinary team services and support is sought where a young person is repeatedly restrained.

4: That residential care, is offered to groups of up to four children and young people, with an absolute maximum of six where children have low need or are sibling groups, and that residential care facilities are designed or re-designed for appropriate withdrawal spaces for residents.

5: That all residential care staff be required to receive training in both crisis intervention and behaviour management prior to working in residential care facilities, receive on-site training and supervision of their practices, and are expected to attend ongoing updates and refresher courses.

2 Introduction

> *Residential child care practitioners are often doing the most difficult jobs: they work closely with children and young people who face significant challenges and express intense emotional reactions, and in this environment their patience, skills and personal strength are regularly tested. And yet the children under their care can also be creative, caring and capable, and practitioners must engage with them in ways that help them grow to their full potential. The weight of these responsibilities is heaviest when a child or young person is most distraught and violent, and if they cannot be calmed, staff must be prepared to intervene effectively and safely. Employers and managers are responsible to ensure that they are indeed prepared, through training, advice and supervision, to undertake this aspect of their demanding work. Yet despite the level of these responsibilities, there is a general absence of recent good practice guidance on the topic of physically restraining children and young people.*
>
> (Jennifer Davidson, Director, Scottish Institute for Residential Child Care. Foreword to the *Holding Safely* report, Davidson, McCullough, Steckley, & Warren, 2005).

In 2005, Lord Carlile of Berriew QC was asked by the Howard League for Penal Reform to lead an independent inquiry into the use of restraint, solitary confinement, and strip searching of children in prisons, secure training centres, and local authority secure children's homes in England and Wales. The inquiry, triggered by the death of Gareth Myatt (a 15-year-old boy who died while being restrained in a Secure Training Centre), considered the various ways that children are treated in residential care which could, in any other circumstance, trigger a child protection investigation, and even result in criminal charges. The inquiry team visited prison service establishments, secure training centres, and local authority secure children's homes, reviewing both policy documents and data provided by the Youth Justice Board on the use of restraint in each facility. The final report contained a total of 45 recommendations, the majority of which related to changes in the use of physical restraint with children, and included the development and implementation of policies to ensure that restraint was never used as a punishment or to secure compliance (see Crook, 2006).

Concerns about the inappropriate use of restraint procedures are, however, not limited to the UK, or to the care and management of young people, with much of the research and scholarly activity in this area focussing on the care of adults involuntarily detained in psychiatric hospitals. There are, however, a number of reviews of the practice of restraint with children and young people. Ferleger (2008), for example, has described some recent examples from the US where restraint has led to tragic outcomes for children and their families (see Table 1). Whilst Ferleger notes that the vast majority of cases of restraint do not result in physical harm, these examples clearly illustrate the considerable risks that are associated with any attempt to forcibly restrain children and young people.

Table - 1 Worst-case stories from the USA (adapted from Ferleger, 2008)

Isaiah Simmons died January 23, 2007, at the Bowling Brook Preparatory School in Maryland. He allegedly acted out in the dinner line and was restrained. Four youths who witnessed the incident said staff sat on him for three hours until he passed out and died. The school has closed, the death was ruled a homicide, and indicted staff were charged with waiting 41 minutes before calling 911 about the unresponsive boy; they were later cleared of criminal charges.
Cedric Napoleon, a 14-year-old special education student died March 7, 2002, after a teacher and a classroom aide restrained him in Killeen, Texas. He suffocated due to pressure on his chest. The school said he was disruptive. His foster parents said that when the restraint happened, their son was attempting to leave the classroom to look for food because school officials had limited his food ration as punishment. The boy was not fighting or involved in any violent act at the time of the restraint.
On February 15, 2007, Jonathan Carey, a boy with autism who was a resident at the O.D. Heck Developmental Center in New York was restrained in a van while staff were running errands for 1.5 hours. He could not be revived. Two staff are being charged.
On June 3, 2007, Omega Leach, Age 17, died at the Chad Youth Enhancement Center in Tennessee, a day after being restrained for seven to eight minutes for attacking a staff member. At the end of those minutes, staff could not find a pulse. The state found that the facility violated restraint policies.
Angelikka Arndt was seven years old when she died in May 2006 while being restrained at the Northwest Counseling and Guidance Clinic in Wisconsin. She had been restrained nine times over a month. She died of ‘‘complications from chest compression asphyxiation’’ after being held face down on the floor by two staff. The restraint was due to her ‘‘gargling milk’’.
In Ephrata, Pennsylvania, Giovanni Aletriz of Allentown, was 16 when he died on February 4, 2006, the second death in two months at SummitQuest Academy, a program for boys with mental health and sex offender problems. An independent forensic pathologist found that the death most likely resulted from being held face-down forcefully. SummitQuest officials said the staff follows a crisis management procedure developed by the University of Pittsburgh Medical Center’s West Psychiatric Institute. No charges were filed because he had an undiagnosed heart condition. The Department of Public Welfare put the facility on a six-month provisional licence.

Mikie Garcia died on December 4, 2005, in Texas of ‘‘suffocation during physical restraint,’’ according to the medical examiner. He had been placed in ‘‘time out’’ for refusing to obey orders, and he started banging his head against concrete, so staff restrained him until he stopped breathing. Staff restrained the boy with his arms across his chest and his hands held behind him, in what is called a ‘‘basket hold.’’ He was 12 years old.

Examples such as these, although rare, focus attention on whether the physical restraint of children in care is ever justified or appropriate, and if alternative methods of behaviour management might have been used. It has been suggested that the practice of restraining children is counter-productive in so far as it has the potential to reinforce aggressive behaviour, counter-therapeutic and re-traumatising, and can be used inappropriately for discipline, coercion, and convenience purposes. It may also be both unethical and illegal (Kennedy & Mohr, 2001). Conversely, proponents argue that, in the face of limited alternatives, it is necessary to protect staff and other young people from aggressive behaviour, and to protect young people from deliberate self-harm, property damage and/or reckless behaviour. Davidson et al. (2005) have argued that although physically restraining children causes many staff (and children) anxiety, it may be more dangerous to not restrain a child when it is needed. It has also been suggested that restraint can, under certain circumstances, be therapeutic, in that it may assist young people who do not have the capacity to regulate their own emotions and behaviour (for a description of co-regulation see Bath, 2008).

Underpinning many of the concerns about physical restraint is the perception that in some settings it is used unnecessarily, with practices simply becoming accepted and institutionalised over time. There is widespread agreement that the restraint of children should only occur as a last resort (Mohr, 2006) The Carlile Inquiry (2006), for example, which occurred at a time of growing international concern about coercive practices used in the care and management of both adults and children in care, received evidence that restraint was used by staff simply to secure compliance. Both staff and children reported that disobedience or refusal to comply with an instruction often resulted in a restraint. This allegation was most often made about regimes in the secure training centres. Also in the UK, Moss et al. (1990, cited by Steckley & Kendrick, 2008) reported that 80 per cent of complaints by young people to the National Association of Young People in Care (NAYPIC) related to forcible restraint that they considered was unnecessary.

In Australia, attention was drawn to the use of restraint in care and supported accommodation services for children and young people by the New South Wales Community Services Commission in 2001. This report, commissioned in response to changes in State law which allowed for the use of physical restraint of children and young people in out-of-home care, called for the development of centralised

policy guidance and practice guidelines for service providers on how and when to use restraint. The authors felt that the new legislation said little about other forms of behaviour intervention, creating the potential for the rights of children and young people to be abused. There have been no comparable reviews conducted in South Australia, and relatively few previous attempts to collate and synthesise previous thinking and practice in this area.

The questions that this inquiry seeks to explore are how to determine when, and if, restraint is required, and how to balance this against the potential for harm to be caused to the young person and those involved in the restraint. These are questions that those involved in the delivery of residential services face almost every day, and it is important that practitioners have access to information that will assist in the development of good practices in working with children and young people in residential care settings. The inquiry received information from a number of different sources, including: a review of the international literature on the use of restraint; interviews with service managers and youth workers; interviews with young people who had lived in residential care settings; policies, procedures and data from provider agencies in South Australia; data on child abuse reports made pertaining to the use of restraint in residential care; a round table meeting hosted by the Guardian for Children and Young People; and written submissions made to the Guardian.

2.1 Definitional problems

One of the initial difficulties in reviewing the practice of physical restraint arises from the lack of clarity about the behaviours that are actually being referred to. Typically the term is not clearly defined either in legislation or behaviour management policy, and can carry a markedly different meaning according to the context in which it is used. This makes it difficult to make any meaningful comparisons between settings and jurisdictions and for care staff to recognise when their standard operating practices may have become coercive.

Davidson et al. (2005) define ‘physical restraint’ simply, as holding a child to restrict their movement to prevent harm, but distinguish it from ‘physical intervention’ which they regard as a broader term that includes other methods where holding is not used; this may include guiding a child away from a harmful situation or blocking his or her path. Swett, Michaels, and Coles (1989) define physical restraint as the use of bodily force for greater than five minutes to restrain the person, which is interesting in so far as this definition introduces the notion that ‘holding’ becomes ‘restraint’ only after a certain period of time. Jeffrey (2002) introduces the idea that the intention behind the restraint is important. Writing from a paediatric nursing perspective, she defines restraint as ‘the positive application of force with the intention of overpowering the child, applied without the child’s consent’ (p.20), a definition which was developed from the UK’s Department of

Health (1993) and Royal College of Nursing (1999) guidelines. She thus suggests that the difference between 'holding' and 'restraining' a child lies in the degree of force required and the intended purpose, something which may be difficult to establish, particularly in circumstances when complaints are made about the inappropriate use of restraint.

Ferleger (2008), writing in the context of the management of children with disabilities, defines restraint as the use of force to limit another person's movement which may occur by physical contact among individuals, mechanically by devices to limit movement[1], or chemically by the use of drugs. He prefers the term 'human service restraint' which encompasses both restraints and seclusion (defined as the involuntary placement of a person in a room, exit from which is not permitted). In his words: 'It refers to restraint of a client under the mandate of a program or agency, public or private, by staff who are taught specific restraint techniques' (p.156). Ferleger thus distinguishes this type of restraint from that carried out by parents, friends, and others in 'freely given relationships'. He thus proposes that human services restraint is that which is used 'in response to, or to control, injury to others, self-injury, property damage, resistance to behavior control, inappropriate behavior, rule-breaking, and the like' (p.156), a definition that is independent of the situation in which restraint is used, whether restraint is used therapeutically, as a punishment, or as part of an intervention that is pre-determined.

An important finding of the Carlile inquiry was the number of different methods of restraint they encountered across different establishments (a consequence of different definitions and preferred methods of restraint) – a total of six different approaches were endorsed for use in only eleven different settings. These methods ranged from those that involved compliance through pain (for example, 'Control and Restraint' – a procedure that immobilises the arms through joint locks using wrist inflexion), through to those that involved holding and breakaway skills (methods used to separate clients from aggressively holding staff). Lord Carlile

[1] Fryer, Beech, and Byrne (2004), writing from an Australian psychiatric perspective, note that much of the literature on seclusion and restraint use arises from North America, where certain practices such as mechanical restraint, are used more commonly than in Australia and New Zealand. Fryer et al. define mechanical restraint as 'mechanical devices such as camisoles, restraining sheets, leather restraints, and chairs that restrict or confine movement' (p.27), a definition developed by the American Medical Association Council on Scientific Affairs. This is similar to the definition of restraint used by Mayton and Fernandez (1991) as the 'direct restriction through mechanical means or personal force of the limbs, head, or body of a recipient' (cited by Allan, 2000 p.33).

made particular comment about the lack of consistency in practice across the various institutions and, how this impacted on the experience of children who (often) moved between different institutions. For the inquiry team this highlighted the need for different institutions and care providers to work to common criteria in defining (and recording) incidents of restraint.

In this inquiry we chose to adopt the broad definition of restraint adopted by Community Residential Care (in Operating Procedure Number 8). This defines physical restraint as occurring 'when a staff member uses force to hold, immobilise, or move a young person. This includes pushing, pulling, and lifting' (p.6). This definition is consistent with others, such as that of Mohr (2006) who defines restraint simply as the 'physical restriction of movement' (p.1329). However, our particular interest is in the use of restraint by human service workers (in line with Ferleger's distinction), and particularly with those methods of restraint that are considered to be most dangerous to the physical and psychological well-being of children and young people.

2.2 The risks of restraining

Although it is difficult to compare the risks of one form of physical restraint to another, and to those associated with alternative interventions (such as seclusion, mechanical restraint, or medication), some methods of restraint do appear to be more dangerous than others, particularly when they involve neck holds, obstruction of the nose or mouth, or 'prone tying', where the wrists are secured behind the back and tied to the ankles. Davidson et al. (2005) have argued that there is 'well founded' and 'widespread' concern about certain methods of restraint, which are listed in Table 2 (below).

Table - 2 Types of Restraint that Cause Concern (adapted from Davidson et al., 2005).

Neck holds	Holding a child by the neck risks asphyxiation (suffocation) or restricting the blood flow to the brain. It carries the risk of death.
Obstructing Mouth or Nose	Children spitting or biting while being restrained are legitimate concerns for staff. While staff may wish to cover the child's mouth to protect themselves from spitting or biting, the risks of asphyxiation are great.
Prone restraint	The term prone restraint simply means to hold a child face down, when on the ground, usually with their head to one side. There are many versions of this procedure. The procedure may carry unacceptable risks if pressure is placed on the child's torso or hips or the health of a child gives cause for concern. Health concerns may include obesity, asthma or other respiratory problems. It is more likely than other forms, such as standing or seated restraints, to be seen by them as a punishment or as abuse.

Seated holds	There are many seated holds with different names in different systems and approaches to restraint. Hyperflexion, where the individual is bent forward at the waist while seated, can severely restrict breathing. It is also dangerous if it happens in a kneeling position.
Supine restraint	Supine simply means face up when on the ground, and there are again many varieties of this procedure. It carries the risk of choking or inhaling vomit.
Basket holds	Basket holds again exist in several versions involving combinations of one or two people with the staff and children involved variously standing or sitting. Two variations give cause for concern. Firstly, bending the child forward in a seated position will interfere with breathing. Secondly, staff can fall accidentally across a child's back (into a prone position) but continue to hold on.
Pain compliance	Getting a child to comply by inflicting pain exists in a number of forms. These include, for example, deliberately using pressure across a joint or the use of pressure points. Pain also increases the power professionals have over vulnerable people and so the possibility of abuse.
Medication	Children may be receiving medication for a range of physical or psychological disorders. Some forms of medication may increase the risk of a child experiencing problems after a restraint. All risk assessments should take account of the possible side effects of medication both generally and in the context of restraint.

Other, less medically serious injuries, may of course occur more frequently in the course of a restraint. These include bruising, cuts, and psychological distress, and highlight the need to employ methods of restraint that are least restrictive. The UK's Mental Health Act Commission (2009) report raised concerns about the potential damage that could be caused during a restraint from jewellery, recommending that staff do not wear jewellery on their hands or wrists whilst on duty. They also pointed to the association between levels of staff training in restraint and the occurrence of injury. It is less easy to assess the risk of psychological damage, but the following account offers some insight into the potential risks of using restraint (provided by a Families SA staff member[2]):

> *A child (aged 8 years) who was in commercial care was to be moved to another unit. He had experienced chronic physical and emotional abuse at the hand of his mother and was extremely hypervigilant and*

[2] Reproduced with permission.

> *acted out with physical aggression when he felt threatened (which was often). The primary way he was physically assaulted was by his mother restraining him or pinning him to the ground and beating him repeatedly. I was extremely concerned that the use of physical restraint with this child would be a significant trigger and be re-traumatising. We saw an example of this when his mother attempted to grab hold of him and remove him from some play equipment during an access visit, which resulted in a significant deterioration in his emotional and behavioural functioning.*

It is easy to imagine how this particular child might be adversely affected, and even traumatised, if he were to be restrained by professional care givers. Given the care and protection histories of many of those children and young people who are in residential care it is also to possible to see how restraint, even when used appropriately and in line with organisational policy and procedure, can have adverse effects on the well-being of children and young people.

For the purposes of this inquiry, the Special Investigation Unit (Department for Families and Communities, South Australia) was asked to report the number of child abuse notifications from January 2007 to March 2009 (a period of 27 months) which involved the use of physical restraint in secure and non-secure residential facilities[3] and resulted in injury to the restrained child. A total of 25 such notifications were identified as within the parameters of this request. An additional five cases were reported following concerns raised in Critical Incident Reports. All of the alleged perpetrators were youth workers, with the exception of one report in which it was alleged that the social worker and police were responsible for the injuries. Notifications are classified by the Special Investigations Unit (SIU) according to degree of concern, and 15 of the 25 were considered to be of 'serious concern' which required investigation. The SIU then determines whether a 'deficit in the quality of care' has occurred, or if 'abuse' has taken place and in cases where an allegation is confirmed makes recommendations to agencies. A summary of the 19 confirmed cases is contained in Table 3 (below).

[3] Residences that are predominantly homelessness services (that is, funded through the Supported Accommodation and Assistance Program) were specifically *excluded* from the Inquiry.

Table 3 - SIU confirmed cases of physical restraint of children living in residential care which resulted in serious injury, January 2007 to March 2009 (Information provided 16 June 2009).

Location	Injury	Allegation
TA	Carpet burns on back	Dragged across carpet during restraint
CRC	Carpet burns on shoulder	Dragged across carpet during restraint
CRC	Bruise on left eye	Twisted left arm behind head. Pushed to the ground
CRC	Bruising on left arm	Restrained by two workers on each arm resulting in bruising
Secure Care	Mark on left shoulder, bruise on left upper arm, scratches on wrist	Restraint with cuffs
CRC	Superficial head injury	Worker placed hands on young person's shoulders causing him to drop to the ground. Young person alleged punched in the head
TA	Pain where hair had been pulled	Goose neck wrist hold, hair pulled, jumped on top of young person. Young person stated he felt violated. No actual sexual assault.
Secure Care	Abrasion to shoulder, hip and knees.	Held upside down. Hit head on side of table
CRC	Headache	Pushed into the wall during restraint
TA	Swollen ear with large gash inside ear. Bruise on arm	Restraint. No further information on Notification
Secure Care	Pain in arms	Grabbed by the arm twisting it behind back. Lifted up and thrown into table.
Secure Care	Reddened area on neck. Difficulty breathing	Grabbed by the neck and pushed against wall. Choked
TA	Sore shoulder	Pulled arm too far back whilst trying to restrain. Also pulled around the neck
Secure Care	Sore head	Restrained by arm around neck. Knocked head on table. Pinned to the floor face down and handcuffed.
CRC	Sprained right shoulder and numb fingers	Escorted to room. Young person pulled arm free
CRC	Graze on right side of face and shoulders	Restraint on ground holding arms behind back with Supervisor holding legs
CRC	Bruising on each upper arm	Injury suspected to have occurred during restraint of child during child's out of control behaviour
CRC	Bruise on left arm. Old wound break down	Grabbed by the arm and dragged into car
CRC	Bruising on each upper arm	'Man handled' and pushed to the ground by staff following an assault

Note: TA – Transitional Accommodation; CRC – Community Residential Care.

These cases suggest that, in South Australia, the injuries that have resulted from restraint in recent years have, on the whole, been medically minor (bruising, swelling, soreness, abrasions), but that complaints about the use of restraint are reasonably commonplace (19 confirmed in a 27 month period), and possibly indicative of the scope that exists to manage behaviour problems in ways that do not risk such injury or do not constitute a deficit in the quality of care offered.

2.3 The legal grounds for restraining a child

There are a number of laws, policies and practice principles which reflect current international thinking about the care, treatment, and rights of all people, and children in particular. The rationale for the UK Carlile Inquiry, for example, was that the rule of law and the protection of human rights should apply to all children equally, regardless of whether they are detained or in the community. It was based on the understanding that children in custody should expect the same treatment, protection and standards before, during and after detention. Also relevant, however, is health and safety legislation relating to the need to provide a safe working environment for staff (Hart & Howell, 2004).

The United Nations Convention on the Rights of the Child (which was adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990), contains a number of relevant clauses such as 'no child shall be subjected to torture or other cruel, inhuman, or degrading punishment' (Article 37), and 'every child alleged as, accused of, or recognized as having infringed the penal law to be treated in a manner consistent with the promotion of the child's sense of dignity and worth' (Article 40). A UN Committee Report on the Rights of the Child (2002)[4] reviewing UK compliance with Article 44 of the Convention also expressed concern at the numbers of children who had sustained injuries as a result of restraints and measures of control applied in prison, and at the frequent use of physical restraint in residential institutions and in custody. The Committee urged for a review of the use of restraints and solitary confinement to ensure compliance with the Convention (cited by Steckley & Kenyon, 2008, p.553).

The Children's Rights Alliance for England (CRAE) has actively campaigned for the abolition of physical restraint, arguing that it represents a human rights violation. Carolyne Willow, CRAE's national co-ordinator was quoted in the press following changes in the English law in 2007 to suspend the use of two restraint

[4] Consideration of Reports Submitted by States Parties under Article 44 of the Convention. Concluding Observations of the Committee on the Rights of the Child: United Kingdom of Great Britain and Northern Ireland.

techniques used on children in custody (which resulted from the death of Gareth Myatt and others, and prompted the Carlile inquiry). She said that: 'At last ministers seem to have accepted that children in prison are entitled to the same level of human rights protection as children in families and other settings' and that 'Ministers and staff in these centres have tried to hide behind euphemisms, but hitting children on the nose to get them to comply with instructions is a form of torture which is in clear breach of human rights, not to mention child cruelty and assault laws' (Willow, 2007).

In relation to South Australian legislation, the *Children's Protection Act 1993* makes explicit reference to the need to keep children safe from harm, and for agencies to provide child safe environments for children. This is relevant given the potential of restraint to cause harm (see above). The Act established powers for three separate bodies to monitor and act when instances of children not being cared for safely come to light (52C—The Guardian; 52J—The Council for the Care of Children; 52S—The Child Death and Serious Injury Review Committee), and a number of special investigations have taken place in South Australia in recent years in relation to the use of restraint in residential care (see above). *The Family and Community Services Act Regulations 1996*[5] are also directly relevant to the use of restraint in both training centres and residential care facilities in so far as they make specific reference to the circumstances in which force might be used (Part 3 Section 8(1) and (2) Use of Force and Part 4, Section 14 (1) and (2) Use of Force) (see Table 4).

[5] These regulations are currently under review.

Table 4 - ***The Family and Community Services Act regulations 1996***

8—Use of force

(1) Subject to any general directions of the Chief Executive Officer as to the use of force against residents of **training centres**, an employee in a training centre may use such force against a resident of the centre as is reasonably necessary in any particular case—

(a) to prevent the resident from harming himself or herself or another person or from causing significant damage to property; or

(b) to ensure that the resident complies with a reasonable direction given by an employee of the centre; or

(c) to maintain order in the centre; or

(d) to preserve the security of the centre.

(2) If force is used against a resident of a training centre, the employees involved must ensure that a written report is provided to the manager of the centre containing the following particulars:

(a) the resident's name;

(b) the names of all employees who were involved in or witnessed the use of force;

(c) the date, time and location in the centre where the use of force took place;

(d) the nature of the force used and the purpose for which, or circumstances in which, the force was used.

14—Use of force

(1) Subject to any general directions of the Chief Executive Officer as to the use of force against children placed in **residential care facilities**, an employee in a facility may use such force against a child placed in the facility as is reasonably necessary in any particular case—

(a) to prevent the child from harming himself or herself or another person or from causing significant damage to property; or

(b) to ensure that the child complies with a reasonable direction given by an employee of the facility; or

(c) to maintain order in the facility.

(2) If force is used against a child placed in a residential care facility, the employees involved must ensure that a written report is provided to the supervisor of the facility containing the following particulars:

(a) the child's name;

(b) the names of all employees who were involved in or witnessed the use of force;

(c) the date, time and location in the facility where the use of force took place;

(d) the nature of the force used and the purpose for which, or circumstances in which, the force was used.

Other states also have legislation that is relevant to the use of physical restraint. In New South Wales, for example, the *Children and Young Persons (Care and Protection) Act 1988* gives authorised carers the legal right to physically restrain a child in circumstances where there are risks of harm either to him or herself or to others, although this is for a temporary period and only to the extent necessary to prevent injury. The legislation, however, offers no guidance in relation to the definition of restraint (see page 16 above), the appropriate time period of restraint, or indeed what constitutes reasonable force. In relation to the appropriate length of a restraint, Luiselli, Pace, and Dunn (2006) investigated the effects changing from a process where the restraint was released following a specified period of calm behaviour to when a predetermined duration elapsed, independent of behaviour. For all three students who participated in this study (one child and two adolescents with acquired brain injury and difficult-to-manage behaviours), the duration of time they were exposed to therapeutic restraint decreased when the period for release was pre-determined, whereas the frequency of restraint did not change.

Ferleger (2008) has observed that much contemporary discussion on the use of human services restraint focuses on legal liability. One effect of the NSW Children and Young Persons (Care and Protection) Act 1988, according to the Community Service Commission (2001) report, is that it protects from civil or criminal liability those persons with parental responsibility who use physical restraint. Our searches failed to locate any Australian case law which resulted from the use of restraint on children, or any coroner's reports directly relevant to this topic.

A recently released report by the US Government Accountability Office (Kutz, 2009) found that there were no US federal laws restricting the use of seclusion and restraint in public and private schools and widely divergent laws at the state level. They identified 'hundreds of cases of alleged abuse and death related to the use of these methods on school children during the past two decades. Examples of these cases include a seven year old purportedly dying after being held face down for hours by school staff, five year olds allegedly being tied to chairs with bungee cords and duct tape by their teacher and suffering broken arms and bloody noses, and a 13 year old reportedly hanging himself in a seclusion room after prolonged confinement' (preface). In this report, Kutz (2009) examined 10 restraint and seclusion cases which resulted in either a criminal conviction, a finding of civil or administrative liability, or a large financial settlement. He observed that these cases typically involved children with disabilities, often in circumstances where they were not physically aggressive and in which their parents did not give consent. They mostly involved restraints that blocked air to the lungs, applied by untrained teachers and care workers. Significantly, those involved in at least half of these cases continued to be employed.

In discussing issues of legal liability, Ferleger (2008) suggests that, in the US at least, courts have 'generally been supportive of restraint use and have not

established significant barriers to the use of programmatic restraint' (p.160), despite the government guidelines, professional wisdom and practice principles that generally prohibit its use. Ferleger concludes that even severe and injurious actions have not been condemned by the courts (see Table 5), and that the current legal standard in the US is to tolerate the use of restraint when it is used by professionals, particularly for 'safety or behavior control purposes, and the action is taken in at least arguable good faith' (p.160). He does, however, cite the findings handed down by a Minnesota federal court (Nicolaison v Brown, 2007) that ''constitutionally infirm practices are those that are punitive in intent, those that are not rationally related to a legitimate purpose or those that are rationally related but are excessive in light of their purpose'' (p.160). This does suggest that any extreme behaviour carried out under the auspices of restraint may be considered unlawful. It would appear likely in the context of the New South Wales legislation that a similar position would be adopted by many Australian courts, including those in South Australia.

Table 5 - US case law regarding restraint (adapted from Ferleger, 2008).

In a 2002 decision, a 14-year-old public school student (''M.H.'') with Down syndrome sued for damages (*M.H. ex. Rel. Mr. H. v Bristol Board of Education*, 2002). M.H. misbehaved and a special education teacher spat water into his face, saying, 'This is spitting.' The incident was not reported to school supervisors, and the staff who were present later falsely told the parents, who noticed M.H.'s soaked hair, that they had been 'playing hairdresser.' On another day, a special education teacher held both the boy's arms forcibly behind his back and directed him to a task. During a fire alarm, M.H.'s arms were bruised when staff physically removed him from the building. Teachers also used a chair restraint, which was written into a behavior plan. The court concluded that (a) the two incidents of physical restraint and the incident of spitting by a teacher did not rise to the level of constitutional violations, and (b) the defendants' use of a chair restraint on the plaintiff did not violate the plaintiff's substantive due process rights because the defendants exercised professional judgment.
A 16-year-old public school student with Down syndrome was subjected to restraint and isolation for behavioral outbursts. The appeals court held that there was no violation of the Individuals With Disabilities Education Act (IDEA) or her individualized education program (IEP), as she was not treated differently from other students with behavioral outbursts (*Melissa S. v School District of Pittsburgh,* 2006).
A third-grade public school special education student with behavioral issues, including kicking and hitting others and striking his head on walls, was put in time-out and restrained repeatedly. The court noted that there was 'an increased amount of restraint in his third-grade year, but that fact alone does not make his education inappropriate within the meaning of the IDEA' (*CJN v Minneapolis Public Schools*, 2003).
A Texas court held that the wrapping of a first grade student in sheet or blanket, adding tape to secure it, and on occasions taping the wrapped student to a cot, to prevent the student from harming herself or others while 'raging,' did not violate any clearly established Fourth Amendment right to be free from such restraint *(Doe v S & S Consol. I.S.D*, 2001).

In a case involving a nine-year-old girl with severe intellectual disability, who was a student in a public school, the therapist recommended a 'blanket wrap.' The court held this restraint to be ''within the realm of professionally acceptable choices' (*Heidemann v Roether*, 1996).
A court upheld placing a second-grade student in restraints to stop him from sliding on table tops (even though his parents had withdrawn consent to the use of restraints), concluding that restraints were needed for physical safety (*Alex G. ex rel. Dr.Steven G. v Bd. of Trustees of Davis Joint Unified School District,* 2005).

2.4 Public policy

It is clear from examples in other parts of the world (see above) that incidents of restraint which cause serious adverse outcomes, including death, can lead to significant policy reform. David Ferleger (Ferleger, 2008) has suggested that two considerations are most likely to influence governmental, agency, and judicial decisions on the use of restraint. First, is the issue of efficacy (the extent to which restraint is effective and necessary) which is particularly important in circumstances in which there is a need to protect someone from immediate harm. One particular issue here is how efficacy might be conceptualised, and whether restraint is considered to have been efficacious because it resulted in the acquisition of new coping skills, or prevented harm. It is apparent that the overwhelming majority of staff do not enjoy restraining young people and perhaps, as a consequence, tend to view any decision to restrain as both necessary and justifiable. However, Ferleger (2008) suggests that restraint and other coercive practices may not, therefore, be as necessary as some staff believe and similar outcomes can be accomplished without coercive action. In other words, it may be that those involved in restraints are not always in the best position to assess whether restraint was required, and that independent review is warranted. In relation to efficacy, Ferleger (2008) argues that the existing evidence base is both 'sketchy' and 'inconclusive'. He cites Day's (2000) review of 109 articles spanning 35 years on restraints and seclusion of children and adolescents which concludes that the techniques used to date have only ''questionable efficacy'' (p. 28). Indeed there is little evidence to suggest that coercive practices assist young people to acquire strategies for self-regulation or teach them how to relate to others more pro-socially when distressed. The second consideration relates to the likely risks of harm, which is discussed above.

Sailas and Fenton (2000) have published a systematic (Cochrane) review of randomised controlled trials that focused on the use and effects of seclusion and restraint in psychiatric settings (compared to the alternatives) and, importantly for our purposes, of strategies to prevent seclusion and restraint. The search for literature on the effects of seclusion and restraint yielded a total of 2,155 citations but of these, no studies met the methodological standard required for inclusion in a Cochrane review and no data had been synthesised in systematic reviews. They

concluded that ‘no controlled studies exist that evaluate the value of seclusion or restraint in those with serious mental illness’ (p.1). They noted, however, frequent reports of serious adverse effects for these techniques in qualitative reviews and concluded that the continuing use of seclusion or restraint should therefore be questioned.

Such reviews highlight the need for governments, agencies and practitioners to develop methods of managing challenging behaviour that are safe, effective, and informed by the research evidence (even if they are unlikely to be evidence-based). The absence of empirical evidence also highlights the need to be clear about those methods that are particularly harmful and, given the risks of harm, whether there is any value in restraining young people. A number of different policies and standards have been developed that relate specifically to the use of restraint with children, most notably in relation to physical and mental health care services. Fryer, Beech, and Byrne (2004), for example, have noted that a number of policy statements are available for those working in North America, including the Joint Commission on Accreditation of Health Care Facilities and Health Care Financing Authority guidelines for the use of seclusion and restraint, the Children's Health Act 2000 (which established national standards for the use of seclusion and restraint with children in psychiatric treatment facilities), and the International Society of Psychiatric-Mental Health Nurses, which has published a Position Statement on the Use of Restraint and Seclusion. The American Academy of Child and Adolescent Psychiatry have also published Practice Parameters for the management of aggressive behaviour, with specific reference to seclusion and restraint.

In Australia, the Victorian Child Safety Commissioner has developed placement management standards for children in care which call for appropriate responses when managing a child or young person in crisis and risk minimisation strategies when caring for a child or young person with a history of, or vulnerability to displaying, challenging, risk taking, sexual offending or violent behaviours. These strategies should include behaviour management strategies aimed at preventing the recurrence or escalation of challenging behaviours; and positive approaches to behaviour management of children and young people (2.4.2). The Queensland Department of Child Safety has also recently developed a Positive Behaviour Support policy (604-1, 2009) which defines the term ‘reactive responses’. These are: “immediate responses where reasonable force is necessary to respond to a child or young person’s behaviour to ensure the safety of those involved while avoiding potential escalation of the behaviour” (p.2). This policy states that physical restraint is the holding of any body part and should only continue so long as it is necessary for the child or young person to no longer be at risk of significant immediate harm to themselves or others.

The National Standards for Juvenile Custodial Facilities (1999, due for revision in 2009) gives guidance on behaviour management which includes the specification of standards and sample indicators for practice. A number of these are relevant to the practice of restraint. For example, Section 7.7 on Use of Force offers the following Standard: ‘Force or instruments of restraint are used only in response to unacceptable risk of escape, immediate harm to the young person or to others, and are used for the shortest possible period of time, and in such a way as to avoid or minimise feelings of humiliation or degradation’.

In South Australia, this inquiry received approximately 14 different policies, 19 different operating procedures, and a number of other documents (for example, fact sheets) that were considered relevant to the practice of restraint in residential settings. These are summarised in Appendix 1. Whilst some of these documents cover broader issues of behaviour management, and share a number of common features (drawing on Families SA documents), the inconsistencies between some aspects of these documents was evident, and at times conflicting views were expressed. Some of these are described below to illustrate the need for policy reform:

- In some policies there is mention that physical restraint probably has no therapeutic value, models aggressive behaviour, and potentially re-traumatises young people. In other documents there is the view that restraint is necessary to co-regulate behaviour.
- There is a lack of clarity around when restraint is appropriate – the term 'last resort' is mentioned often, but not always defined or described in relation to examples of particular behaviours that would be considered indicative of when this point had been reached . Some policies sanction the use of restraint for 'out of control behaviour', but this is not defined or operationalised.
- There is no mention in any of the policies of organisations that allow restraint of how many people should be involved in a restraint.
- In some policies that contain warnings about not using restraint to punish, there is no mention of whether it is permissible to use restraint to secure compliance.
- The issue of planning for restraint comes up repeatedly, and is inconsistently described (that is, you shouldn't plan restraint versus you can).
- One policy suggested that a discussion should take place at the point of intake about the expectations for behaviour, including when restraint will be used, and what will work for the individual if they become agitated or angry. Other policies gave no direction about informing the resident.

- There is little guidance in some policies in relation to how long restraint should last for, and when it should be terminated.
- There is reference in most policies to the need for a debrief to take place following a restraint, but no link between this and the care plan.
- There is no policy that says professional advice must be sought when a young person is repeatedly restrained.

Given the apparent inconsistencies in practice around different residential care services (see pp.34-35, below), it is recommended that these policies and procedures are revised and integrated into a single policy to inform the practices of all providers across the residential care sector. It is particularly important here, though, to note the need to develop an evidence base for these policies in light of Ferleger's (2008) observation that 'there are volumes on proper procedures and criteria, mini-volumes on documentation, and innumerable dollars spent annually on programs for staff training in techniques that have not been found to be effective' (p.157). It is therefore recommended that practice guidelines, informed by the available research and developed in line with NHMRC guidelines, are written specifically in relation to physical restraint. Clinical practice guidelines are 'systematically developed statements formulated to assist health practitioners, consumers and policy makers to make appropriate decisions about health care. Such statements of 'best practice' are based on a thorough evaluation of the evidence from published research studies on the outcomes of treatment or other health care procedures' (NHMRC, 2000). In essence, these are a set of practice based action statements based on the results of systematic literature reviews. Practice guidelines thus use explicit, systematic methods to review the literature underpinning a specific clinical query. Such reviews are characterised by:

- the development and statement of a specific research question or hypothesis
- a transparent methodological process defined a priori
- an exhaustive search for relevant primary (and secondary) research
- application of inclusion criteria and critical appraisal of research
- an attempt to answer the research question(s) and resolve conflicts in the literature
- identification of issues central to future research on the topic and the practical application of results
- the development of guidelines or recommendations that are based on this evidence (research) and are applicable to the target population or patient group.

In relation to policy, it would also seem important to develop systems whereby incidents of restraint are routinely monitored and reviewed. A number of authors have noted an apparently extraordinary reduction in the use of restraints when behaviour management practices come under scrutiny. This is likely to occur as a natural consequence of training initiatives, as well as more formal audit and review processes. For instance, Crosland and colleagues (Crosland et al., 2008a) have examined the effects of staff training to reduce the use of restrictive procedures for foster care children in two US residential facilities (a children's shelter and a locked residential treatment facility). They provide competency based behavioural parent training to carers based on the Behavior Analysis Services Program (BASP) comprising 15 hours classroom based instruction of numerous behavioural procedures (such as staying close, using reinforcement, redirecting, pivots, setting expectations, and contracting), and ongoing coaching for staff in the locked facility. Training led to a 70 per cent reduction in reported restrictive procedures in the locked residential setting, and a 47 per cent reduction in the children's shelter. A second study by the same research team (Crosland et al., 2008b) showed an increase in the quality of interaction for foster care providers who were trained in similar methods (see also Delaney & Fogg, 2005).

3 The use of restraint in South Australia

As at June 2009 there were 177 children and young people in residential care and 67 in secure care, a total of 244 children. Of the 177 children in residential care, 54 were in the six Families SA community residential care units, another 54 in the 11 Families SA transitional accommodation houses and three in Marni Wodli, also operated by Families SA. The other children were accommodated in non-government residential facilities. Their length of stay in residential care (secure and non-secure) will vary from overnight to several years. The resident to staff ratios vary from agency to agency and type of facility. A description of the different residential care facilities operating in South Australia can be found in Appendix 4. Data were requested from each agency that provides residential services to these children and young people regarding the staff and resident profile of the units, number of restraints, gender of those restrained, and the day and time of day of the restraint.

3.1 Occurrence of restraint

In South Australia, the data submitted to the inquiry by residential care providers shows that the frequency with which restraint is used varies widely both between different services, and within services across different units. In settings that operate to broadly similar policies and procedures, considerable variation exists. In addition, some agencies in the non-government sector have policies of 'no restraint', and report no incidents of restraint. Whilst it is clear that the vast majority of incidents do not result in a physical restraint[6], this data shows that restraint is an everyday occurrence in South Australian residential care settings, occurring on average at least once a day. Although there are many difficulties in making cross-jurisdictional comparisons of the frequency with which restraint is used (due to different practices, methods of recording and reporting, age groups etc.), it is possible to make comparisons between South Australian residential care units.

Over the period of review, January 2007 to March 2009, there were a total of 944 recorded incidents of physical restraint in Community Residential Care (CRC),

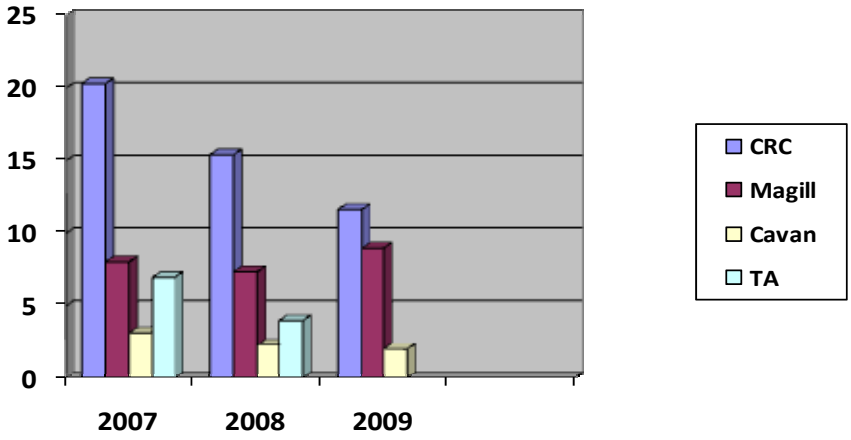
[6] For example, in Southern Junction services, a total of 43 Critical Incidents were reported over the timeframe for the Inquiry, none of which resulted in a restraint, although police officers restrained children or young people on three occasions. Across the secure care centres, 46 Critical Incidents resulted in 24 restraints or use of force (Jan-Mar 2009).

Transitional Accommodation (TA), and Secure Care (youth training centres) units. This equates to approximately 36 restraints occurring every month, or (on average) just over one per day. Of these, almost half (464) of all reported restraints occurred in Community Residential Care units, just under one third (300) in Secure Care centres, and the remainder (180) in Transitional Accommodation Units[7]. When considered in relation to the numbers of residents in each type of service, there were proportionately more recorded restraints in Community Residential Care units, followed by Transitional Accommodation, and then Secure Care. Marni Wodli have not used restraint since January 2007 (the period of review), although the policies and procedures used in this service are the same as those used in Community Residential Care. In houses operated by the non-government sector, restraint was less commonplace, although the number of children and young people in each residential unit are considerably smaller. Southern Junction Community Services, Salvation Army, and Baptist Care reported no incidents of staff restraining children and young people over the reporting period[8], Anglican Community Care reported a total of 12 restraints[9], Aboriginal Family Support Services reported nine incidents of restraint/use of force at one unit, 25 at another and 27 at a third, with all of these occurring between January to March 2009. These higher numbers of restraints are related to the younger ages of children at the houses over this period of time. It was suggested that younger children often require more physical intervention (for example, moving them away from dangerous situations), and when this occurs this is recorded and reported as involving the 'use of force'.

There is some evidence to suggest that restraint is less frequently used now than in 2007 at the start of the reporting period, particularly in Community Residential Care (CRC) units. There was a total of 464 restraints in CRC units over the reporting period (244 in 2007, 185 in 2008, and 35 to March in 2009). The average number of incidents over this time frame thus reduced from 20.3 per month in 2007 to 15.4 per month in 2008 (data for 2009 shows an average of 11.6 restraints per month). Closer examination of this data shows that these reductions are most evident in three of the six CRC units, although approximately half of all restraints occur in one of the units. Figure 1 (below) shows the average number of restraints per month by type of residential unit.

[7] There were no restraints reported at Marni Wodli in this time period.
[8] Leveda have a no restraint policy and no incidents of restraint were reported to the Inquiry.
[9] Of these five involved the restraint of an eight year old boy with a 'comfort blanket' following self-harming behaviour, and one involved rescuing a six year old from a swimming pool. There were a further five to six incidents of restraint using a comfort blanket involving a five year old male who was self-harming.

Figure 1 - Average number of restraints per month by residential unit



Note: CRC – Community Residential Care; TA – Transitional Accommodation. Cavan and Magill are secure care training centres. Non-government facilities not included due to low base-rate of restraint. 2009 data available for first quarter only and pro-rated to provide an estimate of the 2009 rates. TA data not available by year, but figures for 07-08 and 08-09 were included in a written submission. No data on the first quarter of 2009 available.

It is also important to note the number of incidents that do not lead to physical restraint. A summary of Critical Incidents was provided by the youth training centres, community residential care units and transitional accommodation houses for the period 01/01/09 to 31/03/09. This showed that over this period only a small proportion of incidents resulted in the use of physical restraint. This data is summarised in Table 6 below.

Table 6 - Frequency of incidents and use of restraint in Youth Training Centres, Community Residential Care, and Transitional Accommodation (01/01/09 to 31/03/09).

	Unit	Critical incident reports	Recording restraints
Youth Training Centres	A	29	18
	B	17	6
TOTAL		**46**	**24**
		Incidents recorded in observation log books January-March 2009	
Community Residential Care	A	127	7
	B	251	15
	C	198	4
	D	240	10
	E	121	2
	F	469	20
TOTAL		**1406**	**58**
		Incidents of problem behaviours	
Transitional Accommodation	A	349	1
	B	150	0
	C	120	0
	D	130	1
	E	211	0
	F	84	1
	G	75	2
	H	68	0
	I	165	2
	J	40	0
	K	380	1
TOTAL		**1174**	**8**

3.2 Time and duration of restraint

There is some evidence from other settings, such as psychiatric hospitals, that restraints occurring after acts of aggressive behaviour are more likely to occur at certain times of the day, and on certain days of the week (Daffern, Mayer, & Martin, 2003), although no clear pattern emerged from the data received in this inquiry. In 2007, for example, most of the CRC restraints occurred on weekdays, with most of these between 6 pm and 10 pm (100 out of 244, 40%), although in 2008 most occurred between 9 am and 6 pm (108 out of 185, 54%). There were, however, proportionally more restraints on weekends than weekdays (3.5 per day on average at weekends, compared with 1.8 per day on weekdays). In other settings, such as psychiatric wards, reductions in aggression towards staff and reduced restraints and seclusions can be observed on weekends. This is primarily because staff members do not make the same demands of patients on the weekend. Yet, this data suggests that more restraints occur on the weekends, perhaps as a result of the increased amount of time spent in the units (that is, residents are not at school).

In Transitional Accommodation units incidents occurred across the day, with 17 between 10 pm and 7 am, 22 between 7 am and 9 am, 48 from 9 am to 3 pm, 39 from 3 pm to 6 pm, and 50 from 6 pm to 10 pm. They appeared to be distributed across the week fairly evenly. In secure care, in one centre (Cavan) half (36 out of 72) of all restraints occurred between 9 am and 3 pm, with most others (24, 33%) occurring between 6 pm and 10 pm, whereas at the other (Magill), 59 (out of 228, 25%) were recorded as occurring between 9 am and 3 pm, and 85 (37%) as between 6 pm and 10 pm.

No data was provided in relation to the type of restraint used or the length of restraint, although this information is recorded in the observation log books and critical incident forms. In Community Residential Care settings, data provided to the inquiry showed that the longest restraint recorded lasted 15 minutes, whilst others were recorded as lasting between 5-10 seconds. It is unclear how this relates to policy and procedure, but difficult to imagine that a young person can be at imminent risk to other people and settle (to a ‘relaxed state’ as suggested in some policies) within such a short period.

3.3 Profile of residents restrained

Most of those restrained were male (for CRC data 2007 – 193 out of 244, 79%; 2008 – 149 out of 185, 80%). Data on the age of residents restrained across CRC, TA, and secure care was collated and showed that children and young people between the ages of six and nineteen had been restrained over the period of reporting. The most common ages for young people to be restrained were broadly consistent with the age profile of residents in the different services (Transitional

Accommodation was 11 years, in Community Residential Care, 12 years, Secure Care, 15-17 years).

One important finding to emerge from the data is that a large number of restraints are carried out on a small number of residents. That is to say that whilst many, if not most, residents never experience a restraint, some are repeatedly restrained, often over the course of a short period of time. Data provided by Transitional Accommodation (see Table 7) illustrates this.

Table 7: Number of restraints by Transitional Accommodation unit

Unit	No. of Incidents	Comments
A	8	All incidents involved two female residents (four each)
B	5	--
C	10	Ten incidents involved three residents.
D	25	Twenty one incidents involved the same person.
E	16	One person involved in eight incidents.
F	12	All involved the same person.
G	4	Two young people involved.
H	27	Only two residents involved in all incidents.
I	13	Two residents involved.
J	9	-
K	44	One girl was involved in 19 incidents, one boy in 12.
L	7	-

3.4 Stakeholder perspectives on the use of restraint

Whilst this report has thus far considered some professional, legal, and policy perspectives on the use of restraint, another important source of information comes from those who are involved either in restraining children in the course of their duties or from those young people who have themselves been restrained or witnessed it in others. There is a limited research literature on this topic, but the work that has been conducted reveals that both groups are likely to adopt a range of positions on the use of restraint. In a forum convened in Sydney in 2000 by the Community Services Commission (2001), many speakers believed that restraint could never be used safely and should be avoided at all costs, with only a small number seeing it as an appropriate response, and then only in response to

situations of serious self-harm or violence towards other residents or staff. In contrast, Lindsay and Hosie (2001) found the majority (69% of their sample) of residential care workers felt that physical restraint was an acceptable response to managing challenging behaviour, with a minority (22 per cent) reporting doubts about the need of restraint or believing that it is unacceptable.

There has been some work conducted in other settings. A postal survey of staff members from 13 child and adolescent psychiatric hospitals by Fryer et al. (2004), found that staff in these services rated seclusion and restraint as 'seldom' or 'only occasionally' having a positive effect, although they generally supported the continued use of these interventions, despite a lack of belief in their efficacy. They found that 'there was 70 per cent agreement that seclusion and restraint were appropriate responses to physical aggression, and 90 per cent agreement that they were inappropriate responses to non-compliance, hallucinations or hyperactivity' (p.29). Half of all respondents expressed their approval for the use of seclusion and restraint following self-injury, and nearly one third following threats of violence.

In contrast to the Carlile Inquiry, which found evidence that some children 'actively courted restraint as a kind of badge of honour' (p. 47), Delaney (2002) documents the 'horror, trauma, fright and alienation from staff, their intended caregivers' (p.128) of hospitalised children who are restrained. In an invited commentary for the prestigious journal *Child Abuse and Neglect*, Mohr (2006) makes the following observation: 'Indeed, the act of restraint may, in fact, constitute an event that appears to the child very much like an instance of physical or even sexual abuse. In highly emotional situations, the child's perceptual field may narrow, an especially critical phenomenon, in a child who already has difficulties in verbal receptive skills. Given this perceptual narrowing, judgment is diminished further and when coupled with pre-existing impaired verbal competence, actions that lead to restraint could be as damaging to the child from a physiological standpoint as other noxious events' (p.1329). Mohr concludes that 'the act of forcible restraint becomes one more layer of trauma on top of an already wounded psyche' (p.1329).

Steckley and Kendrick (2008) have recently published a survey of the views and experiences of children, young people and staff in a range of residential establishments in Scotland. They reported some consensus between staff and young people in how they viewed restraints, identifying a number of common themes (described in Table 8, below). They concluded that: 'Neither children and young people nor staff rejected the use of physical restraint outright, and there was near unanimity on this issue. They asserted that in certain situations it is the most appropriate intervention to ensure the safety of young people, and made distinct connections between the two. Both also spoke about the importance of less

intrusive efforts at de-escalating situations, and both questioned poor practice related to physical restraint not being used as a last resort' (p.566).

Table 8: The views of staff and young people (adapted from Steckley & Kendrick, 2008).

Necessity of physically restraining	Participants consistently connected the appropriate use of restraint with issues of protection, safety, harm, risk, danger and/or destruction: They also place importance on attempting, when practicable, less intrusive interventions before resorting to physically restraining young people.
Dilemmas and complexities in physically restraining	While there tended to be clear agreement around a general principle of restraining as a last resort and only for the purpose of securing safety when imminent or actual harm was taking place, both staff and young people still conveyed ambiguity as to what constituted the degree of harm necessary to warrant a physical restraint. This ambiguity often arose when discussing the situations related to property destruction and absconding.
Concerns about physical restraint	Both young people and staff in this study voiced concerns about inadequate reasons for being restrained.
Experiences and emotions	The young people's descriptions of being physically restrained covered a broad range of experiences. Some claimed to have no feelings about, or memories of, the actual restraint. Most staff and young people described their experiences of restraint in negative terms.
Relationships and physical restraint	For some young people, the existence of strong, positive relationships seemed to impact their experience of restraints.

3.4.1 Interviews with youth workers and managers

The interviews conducted with youth workers and service managers in South Australia residential care services revealed that a range of opinions exist about a number of issues that are relevant to this inquiry. Each interview was semi-structured, following the set of questions listed in Appendix 2[10]. The account of the interviews presented here is intended to illustrate some general themes that are relevant to the use of restraint in South Australian residential care facilities and have been used to inform the conclusions and recommendations of this inquiry.

[10] All interviews were confidential, and participants are not identified in this report. The project received ethical approval from the Deakin University Human Research Ethics Committee EC74-2009.

However, it is important to note that a relatively small number of people were interviewed, and as such it is not possible to make any assessment of the extent to which the views expressed here are reflective of others in the services in which they work. It is also particularly important to recognise that significant differences exist across the residential care sector (for example, from secure care to community based care), and that different views, practices, and procedures have developed to meet the needs of each part of the system.

Definitions

Each of the interviews began by asking the participants to talk about their understanding of the meaning of the term 'physical restraint'. Generally, and as might be expected, restraint was defined primarily in terms of physical contact with children and young people, although some also spoke about the use of mechanical restraints (that is, handcuffs) in the secure care system. For example, one person defined restraint as follows: 'I call "hands on" physical restraint. Hands on restricting movement in any way' Another as 'anything that restricts their movement.' Others did, however, offer definitions that inferred something about the purpose of restraint ('To gain control of someone using minimal force to avoid them hurting themselves, other people, and so on'; 'Where force is applied to a person who doesn't want to comply with the instructions that have been given in terms of stopping what they are doing or to escort them to another location').

Use of restraint

There was universal acceptance of the view that restraint should only be used as a 'last resort', and never to secure compliance or as a punishment. As one person put this: 'One of the things that needs to be said right up front is that restraint is the last resort. There's the whole process that we expect staff to go through, starting with chatting to the boys.... goes through the warning stage..., then a low grade consequence...'; Another felt that: 'It should never be used as a punishment or as a control exercise. And staff are very accountable through their reporting mechanisms [about this]'. However, there were conflicting views about whether this actually happens in practice. One person commented: 'From my own observation it's not always the case. It's open to too much interpretation as a last resort. I do believe some staff still do it [use restraint as a means of securing compliance or punishment]'. Another said that it was 'not very often here that it [non-compliance] ends up in restraint. They might get an early bed or a consequence'. One person made a specific observation about one of the secure care training centres that there: 'Could be more consistency across the centre. Unit supervisors have had a free rein to run a unit their particular way'. Such differences of view are most likely to reflect real differences in practice both between and within services.

In Community Residential Care units, there was a belief that restraints were more likely to occur around transition times (meal times, getting up, bedtimes, movements between things), in the mixed units ('boy-girl units are invariably where we have a higher number of restraints'), and for children and young people who present with more complex needs. It was also noted that substance use often has a major influence on the use of restraint in these units ('Sometimes drug and alcohol is a big player – very often a key feature of us having to use restraint').

One interviewee from secure care identified three main circumstances in which restraint was likely to occur. First, in response to violence between young people ('These are strong, fit young men and are often very hard to separate and control when they are already in a violent fight'). Second, in relation to young people losing their tempers and acting out, often in response to clear triggers (for example, upsetting phone calls from family, not agreeing with staff decisions, or getting upset at other residents). Finally, restraints were thought to occur when young people refused to follow direction (for example, move from a specified area to another, refusing direction – 'This often occurs when a young person is acting out and is directed by staff to take time out in their room, or when staff wish to address their behaviour in private away from other young people. Young people become defiant and refuse all direction to save face in front of their peers'). The view was expressed that the last of these circumstances was probably the least common, but the one that had the potential to be much better managed, and without the use of physical intervention.

Most of those interviewed felt that they had a responsibility, if not an obligation, to intervene physically when fights broke out. One stated that 'If there's a fight, they've [residential care workers] got to protect the young people', another that fights 'occur often, and often the only option staff have available to separate the fighting residents is physical intervention'. In the words of another person: 'You've got to get in and stop it'. In Community Residential Care settings the view was presented that it is appropriate to intervene and manage situations without calling the police: 'Part of the design is to avoid calling the police, because there is a high risk of kids being criminalised and over-criminalised in the youth justice system because of their behaviour. Part of our philosophy with the use of force and physical restraint is that if we can prevent a kid from hurting someone... ...then we avoid them getting entrenched in the justice system'. This is in the context of high rates of difficult and dangerous behaviour ('Our threshold is high. Our staff get assaulted all of the time. What our staff endure the general public wouldn't tolerate').

The view was expressed that Transitional Accommodation could not work under a 'no restraint' policy on the following grounds: 'At times, physical intervention is necessary to prevent children and young people from harming themselves or others. If a no restraint policy were to be implemented, we would no doubt see an

increase of children and young people in the juvenile justice system. I say this because at times, children and young people require physical intervention as they are unable to regulate their own emotions, self sooth or control their actions. By educating children and young people to be aware of their fears and anxieties, and behaviours relating to these, we are able to prevent potentially violent situations. But, for some highly damaged children and young people this process can take years'. This comment introduces the idea that restraint may in some circumstances be regarded as therapeutic, or part of an educative process.

There was one notable exception to the view that restraint was necessary under certain circumstances. Whilst accepting that there may be extreme circumstances when restraint is required, this person's view was that: 'Restraint is basically another form of bullying, [of] exercising power', and that it was not within the role of residential care workers to intervene. In one of the non-government residential services the following policy is in place: 'We will call the police, we won't do the job, we want a relationship afterwards'. In relation to fights, the approach advocated (and identified as successful) was to: 'Wait until there is a break in the fight and put yourself between people, but we don't take sides. Wouldn't pull someone off, because you are almost taking sides by doing that', although this particular agency mostly only works with young people outside of congregate care settings and has a 'no restraint' policy in place.

All of those interviewed were asked to complete a brief survey, asking questions about when restraint was likely to occur in the units in which they worked, and whether they thought that was a valid reason for restraining someone or not (see Appendix 3). Whilst it can be difficult to answer questions such as these without any context to the behaviours under consideration, the survey was included to provide an indication of the circumstances in which restraint might be considered valid, and how often it typically occurred. The responses show that most respondents felt that restraint was valid in three circumstances: When a young person had struck another young person; struck a staff member; or was trying to hurt him or herself. There were differing views expressed about whether restraint was valid when the young person was trying to abscond, exhibiting inappropriate sexual behaviour, was breaking furniture, or annoying and disturbing other people. In relation to the likelihood of a young person being restrained, there was a widely held view that this would never or rarely happen if the person was demanding to go to bed, demanding extra food, or demanding to speak to a staff member. It was considered most likely to occur if the young person had struck a staff member.

Policy and procedures

Each of the agencies had some policy framework in place (see p.23, above) and interviewees were generally aware of these. However, some identified the need for review and revision of Families SA policies. One noted that policies were: 'In three

different formats. We've got some that date back to 1994, some that are a couple of years old, and some that have just been changed into the e-reference format. They should all be in the same format and we shouldn't have to go hunting for them'. Another felt that behaviour management policies were 'non-existent [at a secure care centre]. It's fragmented across the units. Every unit, at this point in time, does their own thing and has their own interpretation in relation to behaviour management', although evidently some steps have been taken recently to address this. There was also the view that policies were not always consistently applied (for example, 'It's not consistent in the way it's carried out'), and that there was a lack of clarity about roles and responsibilities ('When I'm on duty as a supervisor I want to be the first port of call, but that doesn't always happen').

One submission to the inquiry commented specifically on practices in Community Residential Care, suggesting that current policies and procedures were not being followed. It was stated that staff are encouraged to put the young person to the floor 'at the first sign of trouble', and that the 'Figure 4 wrap' (where the legs are wrapped across each other) was commonly used. The recommended non-violent crisis intervention method was described as being ignored by staff in preference to the use of physical restraint, with records being falsified to reflect a non-violent approach. Whilst it is difficult to know whether such views are based on the experiences in one unit, or over a particular period of time, they are both troubling and concerning. It is clear that such behaviour would not be supported by the manager of this service who spoke of restraint in this way: 'I wouldn't support a pain approach to managing kids and staff should be very clear about that.... ...does it happen? – possibly. Often a kid who is out of control might have their legs up behind their back and arms up behind their back, but not to a pain threshold'. The policy position put forward by this person was very clear – 'the first feature of when we use a restraint is about safety', and there was a strong commitment to monitoring this and investigating instances when restraint may not have been used for safety purposes. Indeed the use of critical incident reporting across the system was seen as an important way of maintaining accountability: 'Staff are very aware of the expectation that they complete critical incident reports... ...the expectation that you would write a critical incident report reduced the number of restraints immediately'.

There was general agreement that policies and procedures needed to be re-visited and revised, although some more structural organisational issues were also identified as important to the use of restraint: '[It is] very timely that we need to review that and get more sophistication around our behaviour management guidelines. That's one part of it. I think getting a lot more rigour around our placement matching and our case management around kids and our design of the non-family based care system [is also very important]. A lot of the time kids [in CRC] shouldn't be there, are poorly matched and poorly placed'. This point was

elaborated: ‘Through that lack of capacity and our inability to move kids through the system kids can demonstrate frustration and see that if they act out or damage themselves then that is a ticket out of here. So the system has to be a lot more robust’.

Debriefing following incidents

Some observations about the need for training are reported below (see page 41), but there does appear to be a need to develop and monitor processes for reviewing incidents and offering debriefing after a restraint to those involved, particularly at Magill: ‘There is not a debrief after every restraint. The young people get spoken to by the supervisor. Ninety-five per cent of the [critical incident] forms say debriefing was not made available. There’s nobody to debrief. We have a situation up there. Every unit has a supervisor - those supervisors don’t directly involve themselves with those incidents... ...they don’t see it as their role. Their part in every incident is to interview the kid afterwards and to put together the paperwork.... you would never find a debrief come out of it. What’s most likely to happen is that it jumps immediately from an incident to an investigation’. Another interviewee agreed: ‘Not always a debrief, but there should be... ...It’s not done as routine. It might come up in a supervision with a staff member... ...It probably doesn’t happen as much as it should do after an individual incident’ – in this person’s view ‘Eighty per cent of the staff in the centre don’t have performance plans or supervision’.

It seemed that more consistent and thorough processes were in place at the Cavan centre, where all of the interviewees felt that debriefing was a routine event after a restraint (‘If there was a concern it would be part of the critical incident and relayed to the manager straight away. When we have a major incident there is always a debrief afterwards, because there is always something that you can learn’). Nonetheless, expanding the type of debriefing offered was something that was suggested: ‘I’d like to see some formal de-briefing processes after a restraint. That it be mandatory - as a team, and as an individual, and with the young person. After a restraint I think a young person should have access to a nurse or health care worker so that injuries are reported and that allegations about injuries can’t be made at a later date’. In addition, there was a view that team debriefing was an important part of staff training and development: ‘My tolerance level may not be someone else’s and we all have our personal boundaries and that is what debrief is for. My role as supervisor is to make sure that after an incident debrief happens and I think that has been a really big tool in the learning process for staff... ...But also running through scenarios at team meetings... it’s amazing how you can get different opinions’. The notion of routine debriefing was also something that is being developed in Community Residential Care – ‘What we are trying to drive is our senior youth work staff bringing a reflective practice approach to working with staff’.

Use of handcuffs

Specific comment was made about the use of handcuffs, particularly at the Magill Training Centre as it was reported that handcuffs are less frequently used at Cavan. In part this difference was attributed to the physical design of the building and the need to move children and young people along a corridor to an area where they could be safely contained. Generally, those who worked in secure care felt that handcuffs were an appropriate form of restraint – 'I think there is propensity for more injury if you don't use them', 'For a safety measure and a protective measure they are better', 'When lads are waving their arms around and trying to kick staff I think containing them is a safer option. Normally handcuffs are only used for the minimum time required'. Concerns were, however, expressed at the use of handcuffs with younger children ('We do have policies and procedures but they don't go far enough. Certainly around escorts external to the centre... kids under 12 cannot be placed into a cabin area, an isolated area, and yet the same age group kids can be handcuffed.. ..and exposed in a public manner. I don't think kids under 12 should be handcuffed at all. I don't think the majority should be handcuffed... ...We're certainly behind the eight-ball in that regard'), and outside of the Centres where there was apparently little discretion allowed on the use of handcuffs ('Our policy is that residents are double cuffed when outside of the centre. Cuffed hands together and to a youth worker... ...I guess it depends on the young person's risk category and at the moment they are all categorised the same. At the moment our policy determines that this is how they will be escorted'). There was also a view that handcuffs were often incorrectly applied, causing pain and distress ('Often, the cuffs are applied too tightly resulting in large welts being left on the youth's wrists'). The same person also recommended that the use of leg cuffs (sometimes used in hospital escorts) should be prohibited, and that a register of the use of mechanical restraints (handcuffs) should be set up to examine the reasons why such restraints are applied. Given these conflicting views, it would seem reasonable to suggest that the secure care training centres monitor and review the use of handcuffs (and leg cuffs) on an ongoing basis to ensure that they are only used in circumstances in which they are considered absolutely necessary.

Building design, resident numbers, and staff and resident ratios

The effects of both building design and staffing ratios were often noted to have a profound influence on behaviour management and the possibilities for intervening in ways that were non-physical in nature. As one person put it: 'The mere fact that boys can go to their rooms and watch TV. Give them a toilet in their room, then you don't have to let them out in the middle of the night'. At the Magill centre in particular it was felt that 'young people don't have a lot of options – they can't say I want to go to my room to lay down for a while. A lot of fights happen in the toilet area – at Cavan the boys have their own toilets and showers. Very, very hard for them to avoid each other' whereas at Cavan: 'We have individual bedrooms for

boys which have toilets, TVs, showers and radios. We establish it as their space. We don't establish it as a punishment room. The boys can go there any time they want... ... we have different areas in which the boys can lose themselves in their bedrooms to get away from their group'. This was summarised by one person in the following way: 'We can't underestimate [the value of] a person being able to go his room'.

Similar views were offered by those working outside of the secure care system: 'the design is pretty critical. Existing designs ... to move away from large groups of kids sharing the same communal living places. Kids having to interact en masse... very much contributes to [restraint]. The numbers of kids in the facilities contributes to it as well... ...The higher number of kids the less chance you have of more appropriate placement matching so you are putting kids who are likely to clash or excite each other or assault each other [together]'.

Another interviewee stated that: 'I do agree about having no more than six kids to a unit... there is less dynamics for young people who are easily aroused... ...they feel safer, there is less power games, better relationships with staff, they get more attention. It is easier on everybody'. Indeed, the numbers of residents, and their individual needs was also consistently identified as an important determinant of the use of restraint: 'It depends on the amount of kids in the centre and the dynamics of those groups of kids. You get low numbers in a unit, [for example], six kids, and you virtually eliminate fights from happening'. Staff numbers were also considered critical: 'Absolutely staffing ratios are important and in my opinion to properly restrain someone you can't do it on your own.. ...otherwise you do resort to your own techniques'. Another person commented: 'the more staff you've got to manage a situation, the less likely you are to use restraint'.

At the same time the view was expressed that the use of restraint as much about people, if not more so, than about the facilities. As one person put it: 'if you had the right people there would be less restraint... ...You put three people in a unit lined up against the window watching the kids locked in the lounge room watching TV – what's that achieving? That's not youth work, but that's what we've got'. Another comment was that 'Unless you change the culture it doesn't matter if you have a swimming pool in every bedroom it will stay the same'. Nonetheless, the size and design of residential care facilities does appear to be an important determinant of the use of restraint. This is a particular issue in both the Magill Training Centre (which is due to be replaced with a purpose built centre), and the Community Residential Care Units. It is apparent that one way of significantly reducing the rates of restraint in these units would be to reduce the numbers of residents to a maximum of six, and to develop purpose built accommodation with appropriate spaces for withdrawal and time out following behaviour that required staff intervention. In addition, there would appear to be a need to introduce more flexibility over how available placements are utilised, such that service managers

have more control over decision to place children and young people into units that are appropriate to their needs.

Staff culture

A number of particularly strong comments were made about the use of restraint in the Magill Centre in particular ('From my own experience it is my perception that the use of "restraints" here at the Magill Training Centre should be seriously reviewed'), although there was a view that restraint is used much less regularly now than previously. One person felt that in the past 'Staff were encouraged to be hard and restraint was common place for minor behavioural issues such as disrespecting staff... ...I have seen a great improvement in the way in which we work with young people and the reduced use of force. There are better processes in place to ensure young people's rights are being adhered to and staff are better educated and trained'. Nonetheless the view was expressed that there is 'Definitely a different culture [from Magill] at Cavan with regards to restraint. I think that every effort is made at Cavan to avoid restraint... sometimes at Magill other options could possibly be used prior to restraint.. ..better interpersonal skills from staff...'.

One person felt that 'There is generally a culture where someone rings a bell [duress alarm] and everyone converges. I didn't think that that ever has to occur and I actually think that there is a natural selection in long term staff teams that have actually evolved to a point where there are people who love the hype. I do think it's there'. Another stated that 'We have clear evidence that if particular staff teams are on then restraints are high', and the general view that certain staff members have practices that are inconsistent with current thinking about behaviour management in youth justice. One person stated that at Magill, 'most of the restraints happen at night between six and eight, so obviously the place does operate differently. You can look at the roster and look at the names and there is a pattern there. It's the same people and the same times... ...They are the people who have never changed and never will who will antagonise people until they go off', and another that 'It's part of an attitude where they think these kids need to be punished'. There was a lack of confidence in the ability for this culture to be changed or for these staff members to be performance managed. This pessimism is encapsulated in the following quotes: 'Nothing will change that... ...as long as they are here we will keep having incidents, we'll keep having reports, special investigations, we'll have the recommendations, and then we will do it all again next week' and that 'Some of the staff think they are bullet proof – very hard to make changes in the environment where nobody can get sacked.... you can performance manage someone for five years, and if anything you have more of a damaged employee than when you started out because you are actually documenting stuff'. Another interviewee made a similar observation: 'There is a big mix of staff members there. Some of the staff have been there over 20 years and

are reluctant to change or to take responsibility for change. My personal belief is that they should be re-trained.... ... they don't know what the Department's expectations are in terms of our obligations to communities and to families, that sort of stuff... ...You can't expect a staff member who has operated one way for so long to change without training'. There was a similar sense of powerlessness to change practice in such individuals ('I can't watch them 24 hours a day', and 'In other cases the reports go in and you just know there are going to be questions asked'), although it was felt that more stringent selection processes could help in the longer term ('if the process was more stringent and highlighted some skills sets – it's too easy to get a job. We select people too easily and by getting the right people in the right places we can make some big changes').

These cultural issues appeared to be specific to the Magill Training Centre. Similar comments were not made about the Cavan centre. In Community Residential Care, one interviewee suggested that 'It's unacceptable that we would have an old culture of restraint in place. It has shifted significantly in recent times. I think there have probably been elements of that, but those people are far and few between these days because the critical mass of staff is working in a different way'. Rather the use of restraint was seen as a function of individual behaviour rather than systemic or cultural issues ('I see it very much related to individual kids. Staff really don't enjoy it, it's not a very nice part of the job. I'll see some trends in individual kids, for seven days straight one kid is required to be restrained every day'). Nonetheless, there are differences in the use of restraint between the CRC units, with a large proportion of restraints occurring in one particular unit. This suggests that there are grounds for additional scrutiny of units in which high levels of restraint occur, and that processes are put in place to monitor the use of restraint closely, and enact changes if necessary.

The Carlile Inquiry team observed a culture in UK facilities where dissent was not tolerated and physical restraint was used to secure conformity. In their words: 'Whilst firm boundaries and consistency of response by adults in authority are essential, these have to be balanced against a tolerance and appreciation that normal teenage behaviour is testing. Over-reaction, especially if capricious and sudden, can be counter-productive and even dangerous. The supervisory relationship should be used as an opportunity for staff to model and reinforce desired pro-social attitudes and behaviours' (p.48). Whilst it would not appear that restraint is as endemic in South Australia as in some of the units reviewed as part of the Carlile inquiry, some of the comments from both youth workers and young people (see p.46 below) resonate with these sentiments. Delaney's (2002) framework for reducing restraint in child and adolescent in-patient treatment to the residential care environment is relevant here as it highlights the role of four components in reducing restraints – organisations, staff, transactions, and client. The organisational component of Delaney's (2002) framework is particularly

relevant to understanding the culture of different units and how staff members see their role. The following quote from one interviewee highlights the role that organisations can play in shaping the culture of different services: 'I think the biggest issue is to actually go back to saying why have we got this facility. What are the objectives of this facility? And once you have that clear then saying how do we actually design and select and train people to best bring about these outcomes? And I think that you actually tackle it from that approach then rarely is physical restraint going to be seen as a positive option – it's going to be something that you are trying to design out. I think the biggest problem is that most residential care in its design doesn't go much further than shelter and some degree of order'.

Staff training

Returning to the observation that 'The threshold [for restraint] has certainly come down and that's been a result of the training', most of those interviewed from secure care were strongly supportive of the training efforts. All secure care youth workers currently receive training in restraint from SAPOL – 'Youth workers are taught various holds in order to manipulate body parts for compliance. They call them straight arm bars or arm bars or figure four locks on legs, escort holds, wrist locks... ...we don't teach youth workers anything to do with pressure points... ...Has to be a minimum of two (people)', but receive no ongoing training in broader issues relevant to behaviour management. There was a view that more training was needed, and that training needed to be developed in a number of different areas. The following comments offer examples of some of these suggestions:

> *We barely scratch the service we give them basic skills to come in and then they are on the floor and that's basically it other than the mandatory stuff we have to provide*.
>
> *That's where I believe we fall down a lot in the management of our people. They know that people need training, but that doesn't seem to happen*.
>
> *Staff are asking for more training around mental health issues... the staff are not properly trained for looking at that.... mental health training is the number one issue. When the staff have a better understanding of what is happening for the child, they have a less punitive attitude*.
>
> *I wouldn't say that the standard of training is comparable with that* [in other countries]'.
>
> *I feel sorry that staff don't have training. I take real pride in de-escalating an incident... I also take pride in that when we have to use a restraint... ...that we do it humanely, with minimal force and we avoid injury. It is done in a professional manner. I don't think the training allows us to do this.*

> *It's a shame we don't have our own in-house trainers* [who understand the environment].
>
> *We train with passive* [that is. not re-enacted actual incidents], *not about doing it as a team, knowing their role, having faith in everyone to know what they are doing*.
>
> *In my opinion one of the places we fall down is that we look at CRC TA and secure care in the same light* [in training] *whereas secure care is a lot different to CRC and TA*.
>
> *Somewhere else we fall down is that we don't train for cell extractions... for planned interventions in particular training is important*.
>
> *It is my understanding currently that Cavan have access to riot gear with jackets and shields and helmets... ...we don't need it, we're dealing with children. There is no training in and around the use of shields. I don't think it is warranted at all*.

Those in other parts of the system shared the view that training was critical: 'It is paramount that the team shares a consistent and collaborative determination to resist restraining. In this way one can hope to manage significant violence and aggression in a far more creative and skilful manner bringing far greater outcomes to the client, worker and program'. The non-violent crisis intervention (NVCI) training package has been delivered across both Community Residential Care (where almost 75 per cent of staff have been trained) and Transitional Accommodation. This approach recommends physically holding a child to immobilise, but not any pain compliance methods, or locks ('Arm locks and so on have historically been an approach, but with the introduction of NVCI we have introduced a whole range of new holds around this. Arm locks and those sorts of things haven't been in place for many years [in CRC]'). Throughout the training it is reiterated that physical intervention is only to be used as a 'last resort' and alternatives are strongly promoted. One respondent wrote that all staff in Transitional Accommodation are trained in pin-pointing a child or young person's crisis development/behavioural levels – and matching these with certain staff attitudes/approaches[11].

[11] For example; if a young person appears anxious the staff are required to be supportive; if the young person appears defensive the staff are required to be directive; if the young person appears to be acting out the staff are required to progress into 'non-violent physical crisis intervention' - described as safe, non-harmful control techniques used calmly to control an individual until he/she can gain control; if the young person appears to be moving into the 'tension reduction' stage (decrease in physical and emotional energy),

The NVCI model has been introduced as high priority by managers in a number of residential care services. Baptist Care (SA) reported that the introduction of the non-violent crisis intervention method (the 'child-safe hold') 'almost immediately reduced their need to 'hold' or 'restrain' from an average of 10 times per shift (three shifts per day) to one or two a shift (by January '09). Further training in the NVCI preventative techniques has now reduced 'holds' to an average of two per month and they are no longer of significant "violence"' (written submission to the inquiry).

Secure Care staff members are currently trained in a different form of restraint training called Use of Force, which places greater emphasis on breakaways, holds, and other restraints, and less on using other approaches to behaviour management. There was no evidence received that the non-violent crisis intervention training package would not be appropriate for use in secure care, and given the view offered by many that this approach has significantly reduced the need for physical intervention, it is recommended that it is considered as the basis for behaviour management in secure care. It was apparent that training in behaviour management is not consistently offered, and not updated or reviewed, and generally that this area should have a much higher priority in the training of all residential care workers.

Behaviour management

A number of practical suggestions were made in relation to diffusing situations and avoiding the need for restraint. Some interviewees were keen to make the point that the focus of much of their work was about pre-empting incidents that required restraint ('We had tried all other avenues prior to restraint. Giving plenty of opportunity to avoid a situation where restraint might occur'; 'In my time here I would say that staff generally use as many other techniques as possible to avoid a restraint'). Interviewees spoke of the value in:

- locking down units ('creates a hell of a lot of peer pressure'),
- removing the person involved from the scene ('During an incident I've always found that if a young person has a problem with me.... if I arrive on the scene in charge of that incident I'd be looking to remove the person who the young person is angry at straight away. They may well be the catalyst to the argument. What happens too often is that that person who

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the staff are then required to match their approach by using 'therapeutic rapport' (attempt to re-establish communication with young person).

may have had the initial interaction with the young person remains throughout the event'),

- calling the police or Star Force ('Highly appropriate [following a mini-riot] to call the police due to the lack of training that we have'),
- making sure that behaviour management plans were in place,
- backing off and calling for a senior staff member to attend,
- using other measures before a duress alarm is sounded such as whistles.

One interviewee drew attention back to the very purpose and philosophy of residential services for children in the following way: 'I think the biggest issue is to actually go back to saying why have we got this facility. What are the objectives of this facility? And once you have that clear then saying how do we actually design and select and train people to best bring about these outcomes? And I think that you actually tackle it from that approach then rarely is physical restraint going to be seen as a positive option – it's going to be something that you are trying to design out as a matter of efficiency let alone anything else. I think the biggest problem is that most residential care in its design doesn't go much further than shelter and some degree of order'. The service this person works in does not use restraint, and has a strong belief in the need to provide consistent, supportive care. It was described in the following way: 'A small tight cohesive and capable team of adults who will work very closely with you doesn't matter what we go through together we won't abandon each other. You will never ever have to go through crisis care into something else'.

Multidisciplinary approaches

There was a view that a multi-disciplinary approach to behaviour management would help residential staff to respond more effectively to challenging behaviour. For example, the development of mental health service (CAMHS) support and access to an Aboriginal consultant were seen as valuable initiatives in secure care, and this model could be extended to other parts of the residential care system. One person stated that: 'I think we should have permanent psychologists on the premises. We call on them and they come when we want them, but MDT [a multi-disciplinary team] could assist in diffusing situations on the spot'. At present, though, there is no real structure for MDT working: 'If there seems to be a bit of a pattern of behaviour then a behaviour management plan is worked out'. This involves the supervisor, Families SA psychologist, and mental health nurse meeting to develop a plan. A MDT approach has also been developed in Transitional Accommodation North, where each child and young person has a 'Behaviours Displayed during Crisis Record' and a 'Crisis Response Record' to ensure that he or she is provided with individualised care. A number of people are involved in developing these plans, including house staff, key workers, senior

youth workers, psychologists/counsellors and social workers. In the recent past, psychologists had been working closely with each of the Community Residential Care units ('they would write an individual development management plan for every kid and many of those would contain a Use of Force strategy to support co-regulation of kid's behaviour'). This is something that evidently no longer occurs and was missed. It was felt that it potentially helped behaviour to be managed without the use of restraint ('We found a 0.5 [half time] psychologist attached would give us a lot more repertoire to deal with a kid's behaviour... ...It actually gave staff a lot more, with some kids, how to predict certain behaviour, to prevent them escalating and so on....').

3.4.2 Interviews with young people

A small number of young people were invited to participate in the inquiry. They were recruited through the Create Foundation and the Office of the Guardian, and were all young adults who had previous experiences of residential care, although this may not have been recent (in the last year[12]). The interviews were facilitated by Emily Rozee from the Create Foundation. Although the quotes below are from young people, whose experiences may or may not represent others in residential care, they illustrate how restraint is, or has been, experienced by young people. They provide an important perspective; one that differs from that offered by youth workers and managers. Each of the young people who participated was also invited to complete the questionnaire on the use of restraint (see Appendix 3), generally appearing to hold similar views on these questions to the staff members.

All of the people interviewed had a clear sense of the meaning of the term restraint (for example, 'holding someone against their own will', 'when someone makes it so you can't move to hurt yourself or others'), although each had different experiences of how and when restraint was used in the units in which they had lived. For example, one person who lived in Transitional Accommodation said that although staff can restrain, 'we haven't really had any here... ...I've only ever seen two', another that 'I only seen it a couple of times in the years I was there, and when I did it was an extreme happening- like someone would be raging for hours. It was definitely something that was used as a last resort'. For another young person, however, restraint was equated with immobilising the young person ('It's like a physical term of putting someone down when there is violent behaviour') and for this person it occurred frequently in some units, often without sufficient reason. Consider the following quotes from this interview:

[12] Note: there is evidence that practices have changed over the last year in some parts of the residential care system.

> *It can start from saying go to your room and then if the kid refuses it goes to arm twisted behind your back, and then you're going to start kicking your feet, another staff member could come in and hold your legs down. What I've seen, I've seen worse, both arms get back behind the back and then both legs like a little ball. He was screaming his lungs out because he's in pain and staff were just so angry using physical emotions. They're not really listening to the child screaming, they think he's still retaliating. And one time it's gone to the point where pretty much a kids arms popped out of his shoulder. And that wasn't very good and all of us kids were what the hell and we started acting up obviously and yeah, just not very goo*d.
>
> *Just say a kid's had a bad day at school. Comes home, says can you do the dishes please or something like that. Kid says piss off I'm not in the mood right now and if they continue... says you can't tell me what to do, then staff use the physical restraint. That's how it normally happens*.

All of those interviewed felt that there were circumstances in which it was appropriate to restrain young people (see also Appendix 3). One commented that 'You have to protect the other people that are in the house as well' and the need to restrain so that other residents were protected: 'I wouldn't have felt safe, because they are just psycho.. ...I think in some situations where people are totally out of control..... ....where people aren't safe or that person isn't safe then I think there is a need for them to be restrained sometimes'. Another commented that the 'only time they should ever use it is endangering themselves' and that 'you have to protect the child from getting hurt'. At the same time, there was a view that restraint could be very harmful, both for those who were restrained and those who witnessed it: 'I've seen one kid get restrained and its messed up his life. He just thinks that nobody loves him nobody cares about him - all I do is get hurt, I don't know what to do. And he's still getting into trouble to this day. It depends on the person – you get kids who come in and they think they're tough and staff can't touch them and they get restrained', 'Just watching I found it very upsetting, because I don't like seeing that sort of thing happening'.

Concerns were also expressed about both the over-use of restraint and occasions when it was used inappropriately. The following comment was made about the Magill Training Centre: 'They don't take shit. You say F you, or anything at them, you get locked in your cell and if you keep going they just put you on your arse. They don't take nothing, it's like the army... ...I realised that all the kids that were messing around, they just get put on the ground pretty hard straight away, they all start crying and then get put in their cells. Not good'. Another person talked about the force with which restraint was applied in Community Residential Care in the

following way: ‘They use the same strength on the little kids and the older kids. When they restrain me it doesn’t hurt even when I struggle, but the little kids scream ‘stop hurting me’, so they are getting hurt’. Another comment was made about the type of restraint being used: ‘The one they should get rid of is the twisting the arm behind the back. You only have to hold them or put them in their room’.

Each of the interviewees spoke about how restraints could be avoided. One commented on what he felt was good practice at one of the Community Residential Care units where ‘They would sit them in the office, and talk to them, get them help’. Another person talked about ‘Intervening before it ever reaches that point really... ...like having an understanding about young people’s moods’, although pointed to some organisational problems that stopped this from occurring: ‘it’s hard when you’re working on shift... in the two years I was there I had over 60 youth workers come through my youth home and they were working on three shifts a day and how are you supposed to understand what a young person is like, if they flip out’. This person added: ‘How are you supposed to understand the build up, if there was better relationship with young people in care then it wouldn’t ever reach a point like that ‘cause you would have an understanding of where the young person is at.... ...that leads to heaps of blow ups when you have so many people walking through and they have no idea what is going on’. Another felt that: ‘I reckon they should choose the kids that they put in the units better’.

A set of comments related to the culture of particular units, or particular groups of staff (‘There are some that have just been youth workers forever and are just gross, disgusting’; ‘We had youth workers that came from [a CRC unit] and.. ...they were arseholes. As soon as they came in they had to be told that they weren’t allowed to touch you. They would just grab you and rip you away for no reason. Just had heaps of aggression and stuff like they, I don’t know if they do it all the time up there’, ‘They put all the hard head staff members there’).

There was a general view that restraint was used to secure compliance and as a means of punishment or teaching young people a lesson: ‘Should be allowed if absolutely necessary, but not for stupid stuff like yelling or trying to run away’, ‘I reckon the older kids will get it more, because we are more responsible and should know better. I heard that a lot’. When describing particular instances, two people talked about restraints that went on for long periods of time: ‘With [name] she was way too out of control to even give a shit that she was being restrained. When she used to get restrained, she would be restrained for hours, like hours and hours, because she totally lost control.... ...with workers holding her on the floor... just sit with her for hours’. The other stated that in one unit: ‘they just restrain you straight away, put you in your room. And it can go on for hours... I’ve seen a kid, he got restrained really hard, and he almost went to the point where three hours went

past. ‘Cause he was still swearing and mouthing off. And they don’t have to, the rooms are brick and they got cages on the window.’

When asked to comment on no-restraint policies, one person felt that these were a good idea, but only if they were supported by a range of services that allowed units to be more ‘therapeutic’: ‘One of the homes my friends was in they weren’t allowed to get touched at all.. .. they used to go psycho... ....as soon as they did anything it was just calling the police. [Question: Is that a good idea?] The therapeutic approach is good if its set up in the right way.... ..but in this house it was done for all of the wrong reasons.. ... they didn’t have the people there to support that house. So they basically have this therapeutic approach.. but all it was a house with young workers who weren’t allowed to do anything’.

Generally these young people felt that incidents were recorded, although one said: ‘I’m not supposed to say this but I actually got hold of one of their log books one day, sometimes it’s not [recorded] but other times it is. Some of the stuff they say in their log books isn’t true as well’. Debriefing was not something that happened routinely: ‘They don’t do anything after. They never say have you learned from it or anything like that. It’s if you keep going this is what’s going to happen’. Another talked about being asked to write a letter instead of being restrained, considering this to be a constructive response (‘they just want us to learn the easy way. I reckon that’s way much better’).

There was also an appreciation of how difficult it is for staff to work in residential care: ‘A kid will try to set up a staff member to get him charged, because he hates him.... ...the only way they can do that is by saying to the police that he hurt. I’ve heard that lots of times... ...that’s the way it normally goes... ... and I’ve seen staff members lose their jobs because of it’. Another said that: ‘I used to slam doors so they would yell at me and break stuff because they used to ignore me to punish me’, ‘I know it takes a lot out of them emotionally [youth workers who restrain].’

In summary, these young people provided some vivid illustrations of what restraint has meant to them in their time in residential care. As stated above, these accounts may not be representative of the current climate in residential care units, or indeed of the experiences of other young people. Nonetheless, they do offer some important perspectives on the use of restraint which can be summarised as follows:

- Young people held broadly similar views of staff on when restraint would be used and its appropriateness.
- Young people had different experiences of how and when it was used.
- All felt that restraint was appropriate in some circumstances – for safety – but recognised that restraint itself was harmful.

- All could relate experiences of over-use or inappropriate use, including its use for compliance or punishment purposes.
- Most referred to the culture of particular places or particular staff groups.
- Debriefing was not always practiced with residents.
- Young people had empathy for the staff working in residential care and the sometimes volatile nature of the relationships that exist between some residents and staff.

Whilst all of the young people interviewed felt that there was a role for restraint 'as a last resort', these comments suggest that much more can be done to ensure that restraint is only used in this way, and safely and appropriately. It is well documented that those who are involved in service delivery often modify their practice and interpret policy and regulations in ways that exert their autonomy, or minimise stress on the job. There is always a gap between the intention behind policy and procedures and how they are implemented in practice. The experiences of these young people offer some insight into this issue, and some useful points of contrast with the views of those who have the responsibility for managing residential care services.

4 Conclusion and recommendations

This inquiry found that restraining children is a potentially dangerous practice that can cause significant injury and even death to children and young people. It is also often stressful, and can be dangerous, for those residential care staff members who are involved in restraints. Although there have been no medically serious incidents of injury to children and young people that have occurred as a result of a restraint in South Australia over the period of review (since 2007), physical injuries to children and young people do occur regularly when restraint is used. A total of 25 notifications of incidents involving physical restraint were made to the Special Investigations Unit over this period, with an additional five cases also reported following concerns raised in Critical Incident Reports. In the vast majority of these notifications children and young people were injured by youth workers, and 15 of the 25 were considered to be of 'serious concern' and required further investigation. The psychological harms associated with restraint are less easy to establish, but the inquiry received evidence that these can be profound and potentially long-lasting, at least for some individuals.

Given the lack of evidence to suggest that restraint effectively reduces either the frequency or intensity of challenging behaviours, it is apparent that the only rationale for restraint is to protect the child or young person, or others around him or her, from immediate and serious harm. There was a consensus from those interviewed that restraint should be used as an intervention of last resort, in a planned fashion, in ways that minimise the risk of harm, and that maintain the dignity of the child or young person. There was also general agreement that many youth workers and residential care workers are in need of further training and support if they are to manage challenging behaviour in ways that do not involve direct physical intervention. Most of those interviewed could describe instances where restraint had, in their view, been used either unnecessarily or inappropriately and saw opportunities for the incidence of restraint to be reduced. This included situations in which physical restraint had been used, not as a last resort, but as a means of securing compliance or punishing young people.

This inquiry found that significant advances have been made in recent years in relation to the level of awareness about the need to minimise the use of physical restraint procedures. Evidence was received which suggests that restraint is less frequently used now than it was in 2007 at the start of the reporting period, particularly in Community Residential Care and Transitional Accommodation units. It is relevant to observe that these services have, in recent years, made an explicit

commitment to reducing the need for physical restraint, and offered staff training in how to manage difficult and challenging behaviours in ways that do not involve physical restraint. Improvements have also been made in the processes for consulting with children and young people, providing independent advocacy and support, and ensuring that complaints are heard and responded to. Nonetheless, restraint remains a common, if not everyday, occurrence in South Australian residential care facilities. Over the period of review (January 2007 to March 2009), there were a total of 944 recorded incidents of physical restraint in Families SA facilities[13] alone. In houses operated by the non-government sector restraint was less commonplace, although there are some units in which high rates of restraint have been reported.

The most striking finding from this inquiry relates to the differing use of restraint across the residential care sector. Whereas restraint is a common, if not everyday, occurrence in some parts of the system, in others it occurs rarely, if at all. In settings that operate to broadly similar policies and procedures, considerable variation in practice appears to exist. In addition, some agencies in the non-government sector have policies that prohibit the use of restraint under all circumstances, and report that they are able to successfully care for and manage the behaviour of children and young people without physically restraining them. Such discrepancies might in part be explained by a number of factors, including differences in the profile of residents, the purpose of the facility, whether there is an option of withdrawing the service (or not), staff to resident ratios, and the physical environment in which children and young people are housed. They might also arise as a result of the values and philosophies of particular care settings, and the range of behaviour management strategies that are available to staff. They do illustrate, however, that restraint is neither an inevitable or perhaps even necessary part of providing residential care. It is also particularly important that both staff and residents are aware of what is expected of them, regardless of the part of the sector in which they live or work, and as such there is a need for much greater consistency in relation to both policy and practice. To assist in achieving this we have made a number of recommendations across the areas described below.

This inquiry makes no comment about the implementation of the following recommendations. This is a matter for the provider agencies, although one would hope that there is the capacity for the different services to work together, such that

[13] Community Residential Care (CRC), Transitional Accommodation (TA), and Secure Care (youth training centres) units.

young people who move from one part of the residential care system to another can expect to receive behaviour management services that are broadly consistent, wherever they live. In our view, the extent to which each service is able, and willing, to act upon these recommendations relates as much to the priorities of the organisation as to the constraints, financial or otherwise, that they may feel are placed upon them. The extent to which physical restraint is regarded as an inevitable feature of caring for children and young people speaks to the very purpose and philosophy of these services.

4.1 Policies and procedures

The inquiry found that, although each agency was able to provide examples of written policies and procedures relevant to the use of restraint, there are significant differences in these across the residential care sector. Although there was general agreement that physical restraint, if it is to be used at all, should only ever occur as a last resort and involve the minimal use of force, many of the policies and procedures were in draft form, contained inconsistencies, and/or a lack of clarity about how the term physical restraint should be operationalised, and what terms such as 'last resort' or 'significant harm' might mean in practice. This left their implementation up to the interpretation of individuals or staff groups, resulting in inconsistent practice and some degree of confusion for both residents and staff. In particular there were inconsistencies between some of the views expressed in relation to how physical restraint should be understood in relation to the broader purposes of residential care and its place in the broader care and protection and youth justice system[14].

4.2 Training and advice

Much has been written on how to manage behaviour effectively, on how to train staff to intervene proactively, and how to document service responses to challenging behaviour. It was not within the terms of reference of this inquiry to recommend particular approaches to behaviour management. However, the use of restraint cannot be considered in isolation from the ways in which challenging behaviour is managed. It was apparent, across the residential care sector, that there is a need to further develop positive approaches to managing individual behaviour, to develop coherent and fair systems of rewards and sanctions, processes for diversion, de-escalation and defusion, and safe ways of removing children and young people from locations where they present a risk to others. The

[14] Clarity about purpose is considered a hallmark of quality services - see 'What Works Best in Residential Care' (OGCYP, 2008).

introduction of a system for restrictive physical intervention (non-violent crisis intervention) across Community Residential Care and Transitional Accommodation provides an example of one approach that has been considered to be successful in improving practice in these areas. Nonetheless, the focus in some parts of the residential care sector is on managing negative behaviour (through the use of 'consequences'), and such approaches are more likely to be associated with the increased and inappropriate use of restraint (for compliance or punishment purposes).

There is a need to further strengthen the support and training offered to staff in how to actually implement physical restraint procedures within the particular environments in which they work. This includes ensuring that regular and refresher training takes place, that there is clarity about the roles and responsibilities of all those who are present during an incident, that individual debriefing takes place, and that incidents of restraint are always reviewed by staff groups such that personal and organisational learning can occur.

4.3 Accountability

There is evidence to suggest that a reduction in the use of restraints will occur when behaviour management practices come under scrutiny. In practice this not only involves the development of clearer and more consistent policies and procedures and training programs, but an ongoing commitment to the review, monitoring, and audit of every incident of physical restraint. Systems are currently in place across the sector to ensure that incidents of restraint are reported, and it appears that generally these are working well; that incidents are reviewed and that concerns are followed up by service managers. Those reviewing the incidents, however, are often also responsible for the running of the units in which they occur, as well as the management of the staff who are involved. Two issues arise here, the first relates to the independence of the review process, and in particular the potential conflict that arises between the need to support staff members and to promote cultural change in units which consistently have high rates of restraint. The second relates to the extent to which managers believe that they can effectively performance manage those who, in their view, use restraint in circumstances when other approaches might have been possible or appropriate. Both of these issues suggest the need for external and independent review.

In addition, it is apparent that debriefing following an incident of restraint does not always occur, and that there are no consistent processes in place to review circumstances when a young person has been repeatedly restrained within a short period of time, or to review or revise the care plan under such circumstances. These are considered important processes, if ways of working that do not involve physical intervention are to be developed.

4.4 Physical and social environment

The effects of both building design and staffing ratios were often identified as having a profound influence on the extent to which restraint was considered necessary. In particular, interviewees commented on the need for facilities to have spaces that allow withdrawal from others, privacy, and reflection, as well as to be located in places in which safety concerns are minimised (for example, away from busy roads). The physical design and location of facilities can clearly play an important role in assisting residential care staff to manage behaviour in ways that do not involve physical restraint.

The social environment, however, is equally if not more important than the physical environment. This can be understood in relation to the dynamics that emerge in caring for groups of young people of differing sizes, with differing ages, and mixed genders. It was the view of many of those interviewed that restraint is much less likely to occur when young people are cared for either individually or in small groups (less than six residents in a unit or home), and when staff-resident ratios are high. At the same time, it also would appear to be the case that practices within particular staff groups develop and become entrenched over time, and that a culture in which restraint is more likely to be used does exist in certain settings and units. Such views are consistent with those reported in an Information Paper entitled ‘What Works Best in Residential Care’ (OGCYP, 2008) which commented that the best residential care occurs when the environment is most like a young person’s own home. In practice, this means that:

- facilities and care promote inclusion, safety, comfort, wellbeing, security, belonging, respect for diversity and for individual space;
- residents have recreational equipment and opportunities;
- important events in children’s lives are celebrated;
- the needs of the whole resident group influence prospective admissions;
- a maximum of six residents are co-located;
- an optimum staff/resident ratio of 2:5 is maintained.

4.5 Recommendations

1: That the *Family and Community Services Act Regulations 1996* are amended such that use of force is not permitted to ensure that the resident complies with a reasonable direction given by an employee of the centre.

2: That a common policy on the use of physical restraint is developed by Families SA and shared with all residential care providers. It is further recommended that:

   a. This complements the development of evidence based practice guidelines (by Families SA), and be informed by a set of principles of behaviour management developed in agreement with all residential care providers.

   b. This includes provision for the separate monitoring and review of the use of mechanical restraints in secure care training centres.

   c. Debriefing with staff members, staff teams, and the young person who has been restrained is mandated, such that it occurs routinely and as part of standard practice.

   d. Care plans be reviewed and revised after each incident of restraint to include comment on how to respond to similar behaviour without the use of physical restraint.

   e. Restraint is never sanctioned to secure compliance or to punish children and young people.

   f. Physical restraint should not be done by a single staff member for children over 10 years of age.

3: That a system for the external monitoring of physical restraints is set up to:

   a. Receive all data and records of use of restraint so that there is systematic mapping of use.

   b. Review those units with apparently high levels of restraint.

   c. Provide advice on occasions when a young person has been restrained more than once over a one week period.

   e. Ensure that multi-disciplinary team services and support is sought where a young person is repeatedly restrained.

4: That residential care, is offered to groups of up to four children and young people, with an absolute maximum of six where children have low need or are sibling groups, and that residential care facilities are designed or re-designed for appropriate withdrawal spaces for residents.

5: That all residential care staff be required to receive training in both crisis intervention and behaviour management prior to working in residential care facilities, receive on-site training and supervision of their practices, and are expected to attend ongoing updates and refresher courses.

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Appendix 1

Restraint policies and procedures in SA residential care

Agency	Policy	Procedure	Other
• Families SA Community Residential Care	• Duty of Care for Children and Young People in Care Policy • Non-Family Based Care Policy	• Duty of Care for Children and Young People in Care Practice Guide • Use of Reasonable Force – Residential Care Services • No. 8: Behaviour Management & Restraint (Managing Difficult Behaviours) • No. 14: Critical Incidents & Debriefing • No. 45: Suicide and Self-Harming Behaviour	• Fact Sheet #6: Physical Restraint • Fact Sheet #10: Self-Harm
• Families SA • Transitional Accommodation		• No. 8: Behaviour Management (Consequences, Use of Reasonable Force) • No. 16: Critical Incidents (Crisis Management, Debriefing) • No. 28: Log, Diary and Running Sheets • No. 50: Suicide and Self Harming Behaviour	• Fact Sheet #1: The Iceberg Model • Fact Sheet #8: Aggression
• Families SA • Youth Training Centres	• Policy (no reference): Custodial Environments	• Secure Care Standard Procedure 13: Behaviour Management. • Families SA Procedure 2.10: Use of Reasonable Force (Custodial Environments Policy) • Procedure 4.10 Reception to a Training Centre	• Training Centre Philosophy • Training Centre Stress Screening Form • Familes SA OHS&W Management System OHPR-46-30 Working with aggressive and potentially violent clients. • Conflict Resolution Training Manual

• Department of Education and Children's Services •	• School Discipline Policy • Protective Practices for Staff in their Interactions with Students		
• Child and Adolescent Mental Health Services •		• CYWHS Nursing & Midwifery Clinical Standard on Restraint and Seclusion in Nursing Practice (draft)	• Local procedure: Managing aggressive behaviours
• Southern Junction	• Policy and Assurance Manual • Behavioural Management	• Supported Emergency Accommodation Service Procedure Manual	• Orientation Program
• Baptist Community Services	• Behaviour Management Policy (X-Tremes) • Behaviour Management (X-Cel).	• Responding to self harm (X-Tremes) • Critical Incident Management and Reporting (X-Cel)	• Powerpoint slides on logging
• Anglican Community Care	• ac.care 24/7 Residential Care Services – House Practices • ac.care – Policies and Procedures.	• Families SA Emergency Accommodation – Interim Practice Guidelines No. 7 (Behaviour Management), No.32 (Self-harm Management), No. 15 (Emergency Accommodation: Evasive and protective intervention), No. 36 (Emergency Accommodation: Workplace safety and personal welfare).	
• Leveda	• Behaviour Management Policy		• Copy of letter sent to the Office for Disability and Client Services
• AFSS	• Behaviour Management (Consequences, Use of Force) Draft Policy • Allegation of Breach of Duty of	• Crisis Accommodation Service (CAS) Incident Report Form • CAS Behaviour Management Report Form.	• YASS policies: • Use of Physical Restraint –Staff • Suicide • Suicide Prevention Addendum

	Care/Abuse in Care Draft Policy • Transporting Young People Draft Policy • Death in Care Draft Policy		• Allegations of Abuse • Behaviour Management • Conflict
Salvation Army	No policies directly related to restraint, though various other policies submitted		

Appendix 2

Interview questions

Managers and Youth Workers

These questions are designed to help us understand your knowledge and views about the use of restraint. It is important for you to know that there are no right or wrong answers and that we are not trying to test your knowledge in any way.

Descriptive questions

- I am interested in learning more about how and when physical restraint is used in your workplace. Can we start with you telling me what you understand by the term 'physical restraint'?
- What is your understanding of your agencies policies and procedures on using restraint?
- Are you aware of the policies and procedures of any other agencies? Are they better or worse? Why?
- How often, on average, would you say that restraint used in your workplace/type of care? Are there particular times or days when it is more likely? Is it used more or less than it used to be?
- Are some children more likely to be restrained? (age, gender, culture)
- When is restraint typically used (give questionnaire)?
- Do you make sure that staff who receive training do not have health problems that may prevent them from restraining children? Do new staff need to be trained before they can restrain?

Opinion

- In your opinion, how consistently is physical restraint used across each site or between staff in your organisation?
- What is your view on the relationship between staffing ratios and use of restraint?
- How important is the size and design of the residential facility?
- Tell me about the circumstances when you see physical restraint as appropriate? Why? In your view is restraint always used as a last resort? What does the term 'last resort' mean?
- Tell me about the circumstances when you see it as inappropriate? Why? Is restraint ever used to secure compliance? Or as a punishment?

- How useful are behaviour management guidelines and policies in helping staff to decide whether restraint is appropriate?
- Is there always a debrief after a restraint? How do these work? Are they useful?
- Do you believe that restraints are always recorded? What feedback to you get/give about this information? Is it helpful?
- What effect do you think being restrained has on young people?
- Do you think young people (residents) make use of review and complaints procedures? If not, what deters them?
- What alternatives are available to physical restraint?
- Does your training allow you to make good decisions about when you should restrain a child and when that restraint should end? Do you think there is a need for more staff training in this area? If yes, please describe.

Examples

- Describe to me the **last time** that you were aware that physical restraint had been used? What happened? Who was involved? What was the outcome? Were you satisfied with this?
- Tell me about a time when **you had concerns** about the use of restraint? What happened? Who was involved? What was the outcome? Were you satisfied with this?

Conclusion

- Overall, how do you feel about the use of restraint in your unit(s)/home(s)?
- Would most other people in your agency share your view on this? Why?
- We have focused on use of physical restraint in this inquiry, but are there other practices that you are concerned about?
- Is there anything else that you feel would be relevant that we have not touched on?

Ex-Residents

- What do you understand by the term restraint?
- Where were you living while in residential care and how old were you?
- Did you ever see restraint used in residential care? How often did it occur?
- When is restraint used (give questionnaire – verbal administration - and discuss)? Do different units/places work in similar ways?
- Do you believe that restraints are always recorded?
- How do you think young people usually feel when they are restrained? How easy is it to make a complaint?

- How do you think youth workers usually feel when they restrain a young person?
- Are there times when you feel that being restrained is a good thing?
- When restraints happen, does anyone (like the supervisor or manager), ask the young person for his or her views about the incident?
- What would work better than restraint?
- Are there other things you are concerned about for the residents now in residential care?
- What would you like to come out of the Inquiry?

Appendix 3

Survey on the use of restraint

(adapted from Heyman, 1987)

SUPPOSE A YOUNG PERSON IN YOUR UNIT/HOME WAS ACTING IN ONE OF THE FOLLOWING WAYS, DO YOU THINK HE/SHE WOULD BE RESTRAINED?

	PROBLEM	WOULD THE YOUNG PERSON BE RESTRAINED? Tick one of these 5 boxes for each row					IS THIS A VALID REASON? Tick one here	
Q		1 Never	2 Rarely-	3 Some times	4 Often	5 Always	1 YES	0 NO
1	The young person is becoming excited and out of control	**3 (2,1)**	**5 (4,1)**	**4 (3,1)**	**1 (0,1)**		**2 (1,1)**	**10 (7, 3)**
2	The young person has struck another young person	**1 (1,0)**	**3 (2,1)**	**6 (4,2)**	**3 (3,0)**	**1 (0,1)**	**11 (7, 4)**	**3 (3,0)**
3	The young person is yelling and making too much noise	**8 (6,2)**	**5 (4,1)**	**1 (0,1)**			**1 (0,1)**	**13 (10, 3)**
4	The young person has struck a staff member	**1 (1,0)**	**2 (0,2)**	**4 (3,1)**	**3 (3,0)**	**4 (3,1)**	**12 (9,3)**	**2 (1,1)**
5	There is a risk of the young person absconding	**6 (3,3)**	**1 (1,0)**	**3 (2,0)**	**2 (2,0)**	**2 (2,0)**	**7 (7, 0)**	**7 (3,4)**
6	The young person is exhibiting inappropriate sexual behaviour, such as exposing self or masturbating in front of others	**7 (5,2)**	**4 (4,0)**	**2 (1,1)**		**1 (0,1)**	**5 (2,3)**	**10 (8,2)**
7	The young person is demanding to go to bed	**10 (7,3)**	**2 (2,0)**		**1 (0,1)**		**1 (0,1)**	**12 (10,2)**
8	The young person is attempting to break unit/home furniture	**3 (2,1)**	**4(3,1)**	**5(5,0)**	**2 (0,2)**		**8 (5,3)**	**6 (5,1)**
9	The young person is cursing and	**8 (7,1)**	**6 (3,3)**				**2 (2,0)**	**12 (8,4)**

	swearing at other people							
10	The young person is annoying or disturbing other young people and/or staff	**8 (5,3)**	**5 (5,0)**	**1 (0,1)**			**5 (2,3)**	**9 (8,1)**
11	The young person is demanding extra food at mealtime	**13 (9,4)**	**1 (1,0)**				**2 (1,1)**	**10 (8,2)**
12	The young person is disturbing/waking other young people at night.	**4 (3,1)**	**4 (3,1)**	**2 (1,1)**	**1 (0,1)**		**1 (1,0)**	**11 (7,4)**
13	The young person refuses to go to school	**9 (6,3)**	**1 (1,0)**	**2 (2,0)**			**1 (1,0)**	**13 (9,4)**
14	The young person refuses to take his/her medications.	**12 (9,3)**	**2 (1,1)**	**1 (1,0)**			**2 (1,1)**	**12 (9,3)**
15	The young person is demanding to speak with a staff member	**12 (9,3)**	**2 (1,1)**				**2 (1,1)**	**11 (8,3)**
16	The young person is trying to hurt himself/herself	**2 (1,1)**	**2 (1,1)**	**2 (2,0)**	**6 (5,1)**	**1 (0,1)**	**12 (9,3)**	**2 (1,1)**

Note: numbers in brackets refer to numbers of youth workers and adults, followed by young people. For example, 12 (9,3) means that 12 people ticked this response, 9 of whom were youth workers/managers, 3 were young people. Totals are not always consistent, as some items were not applicable to some respondents.

Appendix 4

Residential care in South Australia

Facility	Purpose	Residents	Staff	Staff/resident ratio	Training
Magill Youth Training Centre, Families SA	Detention facility, 57% on remand	Maximum 49 residents Average 39 residents 5 units Girls (6-10) & boys 10 -17 years 32% Aboriginal	99.1 FTE staff 63 male, 39 female	Day: 1:4 Night: 1:10	Induction training – procedures, use of force, first aid, behaviour management, critical incidents; expected to undertake Certificate 4 in Youth Justice
Cavan Youth Training Centre, Families SA	Detention facility	Up to 39 residents Average 36 residents 3 units Boys only 15 – 20 years 50% Aboriginal	71.4 FTE staff 61 male, 19 female	Day: 1:4 Night: 1:10	Induction training – procedures, use of force, first aid, behaviour management, critical incidents; expected to undertake Certificate 4 in Youth Justice
Community Residential Care, Families SA	Residential care for children under guardianship or custody orders	Maximum 56 residents Average 52 residents 6 units Girls (11) & boys (42) 10 – 17 years 14% Aboriginal	121 staff Half male: half female 26-40 age (majority)	Day: 1:4 Night: 1:10	6 week orientation including NVCI and therapeutic care; Expected to undertake Certificate 4 in youth work
Transitional Accommodation [15], Families SA	Residential care for children under guardianship or custody orders	32 residents (May 09) 11 units Girls (19) & Boys (13) 9 -17 years	105 staff 40 male: 65 female Average age 38 years	Day & night: 1:3	6 week orientation including NVCI and therapeutic care; Expected to undertake Certificate 4 in youth work

[15] The name 'transitional accommodation' is misleading because for most residents the stay is medium to long term.

Marni Wodli, Families SA	Independent living and residential care as required for Aboriginal children under guardianship or youth justice orders	Maximum 3 residents (residential care only) Average 3 residents Girls & Boys 16 – 17 years All Aboriginal	9 staff 3 male; 6 female 26 – 45 years	Morning: 1:3 Afternoon 2:3 Night 1:3	6 week orientation including NVCI and therapeutic care; Expected to undertake Certificate 4 in youth work
Southern Junction Community Services	Residential care for children under guardianship or custody orders	18 residents (May 09) 5 units Girls (8) & Boys (10) 6 – 18 years	26 staff 8 male; 18 female	Average: 1:2	Certificate 4 in Youth or Children's Work
Baptist Care (SA)	Residential care for children under guardianship or custody orders	14 residents (May 09) 3 units Girls (5) & Boys (9) 3 – 18 years	26 (est) staff 21 – 55 years	Average Day: 1:2 Night 1:4	Certificate 3 or 4 in Youth Work or Community Development plus induction
Anglican Community Care	Residential care for children under guardianship or custody orders	10 residents 3 units Girls (7) & Boys (3) 5 -13 years	47 staff 10 male; 37 female 20 – 55 years	Day: 1.5:3 Night : 1:3	Varies with minimum certificate level plus induction
Aboriginal Family Support Services	Residential care for children under guardianship or custody orders	15 residents 4 units 0 -18 years All Aboriginal	37 staff 25 female; 12 male 21 – 51 years	Average: 1:2	Minimum certificate 3 in community services; half have certificate 4.
Salvation Army	Independent living program with residential care provided only intermittently	Girls and Boys 16 – 17 years			
Leveda	Accommodation and support service for people with disabilities				