ORANGA TAMARIKI
Ministry for Children

EVIDENCE CENTRE
TE POKAPŪ TAUNAKITANGA

New Zealand Government

Physical restraint and de-escalation

Best international practice as applicable to secure youth justice residences

Evidence brief

March 2023

EVIDENCE CENTRE
TE POKAPŪ TAUNAKITANGA

The Oranga Tamariki Evidence Centre works to build the evidence base that helps us better understand wellbeing and what works to improve outcomes for New Zealand's children, young people and their whānau.

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Introduction

> Too many organizations providing residential care services to children and youth continue to believe that their violence and restraint levels are at the lowest that can be achieved and that their current strategies…represent an acceptable response (Paterson et al., 2008).

This evidence brief addresses physical restraint and de-escalation best international practice. In particular, the following questions are addressed:

1. What are the leading established (and any emerging) international de-escalation and(or) restraint training (and system) models, to what extent are they evidence-based, and what are their respective strengths, weaknesses, and applicability to the Oranga Tamariki youth justice residence context?
2. How do the de-escalation and restraint policies, training course, systems and practices in Oranga Tamariki residences compare to overseas youth justice or similar residential care settings?
3. What are important considerations on de-escalation and restraint with Indigenous young people?
4. What are the key requirements for effective and ongoing implementation of an approach to de-escalation and restraint?
5. How should a de-escalation and restraint model optimally interface with an effective residences' care model and practice framework and associated organisational policies, training and systems, and better prevent the need for de-escalation in the first place while also lifting quality and outcomes?

In terms of report structure, following a background section that discusses the context for Oranga Tamariki youth justice residences, and a section outlining the evidence brief's methodology and limitations, most of the report is given over to the findings from the literature. Findings are presented in relation to the following:

- Leading international programmes
- Prevalence of physical restraint
- Consequences of physical restraint
- Children's experience of physical restraint
- Physical restraint and Māori
- Reducing use of physical restraint
- Physical restraint and care model or practice framework interface.

A brief discussion and conclusion then follows highlighting some possible implications for Oranga Tamariki youth justice residences.

Terminology

As for terminology, there is a widely cited US definition of restraint from the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (2010): "Restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a person to move his or her arms, legs, body, or head freely" (p. 7). This definition serves to highlight that legally, conceptually and practically, restraint can take many forms and in some jurisdictions, settings or organisations, restraint may include use of seclusion, medication, handcuffs, cable ties, ankle cuffs, waist belts, and spit-hoods.

In the New Zealand context, the Ministry of Health Ngā paerewa Health and disability services standard (Standards New Zealand, 2021, page 9) defines restraint as "the use of any intervention by a service provider that limits a person's normal freedom of movement". De-escalation refers to "processes in which a highly aroused person is redirected from an unsafe course of action towards a supported and calmer emotional state. This usually occurs through timely, appropriate, and effective interventions and is achieved by service providers using skills and practical alternatives". (Standards New Zealand, 2021, page 5).

The term *physical restraint* is widely used in the international literature to differentiate it from other possible forms of restraint. Defined as "an intervention in which staff hold a child to restrict his or her movement and should only be used to prevent harm" (Davidson et al, 2005, p. vii), unless the context suggests otherwise, generally *physical restraint* is the term used in this report.

Legislation and international instruments

Within the context of *Te Tiriti o Waitangi*, "an obvious touchstone against which all Crown actions including law, policy and practice in Aotearoa New Zealand should be evaluated" (Lynch, 2019), Oranga Tamariki and its youth justice residences are expected to comply with:

- United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules), 1985
- Oranga Tamariki Act, 1989
- United Nations Convention on the Rights of the Child, 1989
- United Nations Guidelines for the Prevention of Juvenile Delinquency (the Riyadh Guidelines), 1990
- United Nations Rules for the Protection of Juveniles Deprived of their Liberty, (the Havana Rules), 1990
- Oranga Tamariki (Residential Care) Regulations, 1996
- Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), 2002)
- United Nations Convention on the Rights of Persons with Disabilities, 2006

- United Nations Guidelines for the Alternative Care of Children, 2010
- Oranga Tamariki (National Care Standards and Related Matters) Regulations, 2018.

Background

Introduced in 2019, the Oranga Tamariki Youth Justice Residences' model of physical restraint is called Safe Tactical Approach and Response (STAR). This bespoke model was designed and developed by Oranga Tamariki in consultation with the New Zealand Police Tactical Training Wing; as such it draws on some elements of the New Zealand Police's approach to physical restraint. According to a report to the Oranga Tamariki leadership team Health, Safety and Security Governance Committee (Oranga Tamariki Youth Justice Residences, 2019), there had long been concerns about the previous programme Managing Actual and Potential Aggression (MAPA) (Crisis Prevention Institute, n.d.-a). and the extent to which it met the safety needs of either young people or staff. In particular, and with the then impending legislative extension for youth justice residences to accommodate 17 year olds, it was deemed that the existing MAPA programme did not provide a sufficient level of response to safely resolve higher level aggressive and assaultive behaviours.

In late December 2020, eight young people, made serious allegations of cruel, inhuman and degrading treatment or punishment at Te Au rere a te Tonga youth justice residence in Palmerston North. The allegations were made to representatives of the Office of the Children's Commissioner (2021) as they were carrying out an unannounced monitoring visit as part of the National Preventive Mechanism (NPM) under the Crimes of Torture Act (1989). As well as the use of disproportionate and excessive force during physical restraints, young people also alleged that staff:[1]

- incited young people to fight with staff members
- bullied young people
- swore and yelled at young people
- humiliated young people
- hit young people in the secure unit and in their bedrooms; and
- supplied cannabis to young people (Office of the Children's Commissioner, 2021 p. 6).

In their report, the Office of the Children's Commissioner (2021) went on to state that they had been advised that following investigations, the police had deemed that there was insufficient evidence to lay charges, and that Oranga Tamariki Human Resources processes in relation to named individuals found no evidence of misconduct.

[1] There was also an allegation that one individual member of staff watched a young person while they were changing and asked for massages.

However, the Office of the Children's Commissioner (2021) report did find that "staff use of force is inappropriate and harmful, as an area for development" (p. 12). Furthermore, the report's first recommendation was that the Deputy Chief Executive Youth Justice Services "continues to carry out a [national] review of the STAR youth justice physical restraint training to identify national trends regarding the number and nature of physical restraints, including those that have resulted in injury to young people and/or staff" (p. 8). With specific reference to Te Au rere a te Tonga youth justice residence, recommendations 11 and 12 also related to physical restraint.

Over 2021 there were media reports on, and related to, the above, as well as others about Korowai Manaaki youth justice residence in South Auckland. These have prompted the need for evidence to support how Oranga Tamariki addresses current issues across their Youth Justice residences. On the back of this reporting in June 2021 came the video footage of a 'physical restraint' at Te Oranga Care and Protection residence in Christchurch being published by the media outlet Newsroom; this led to several internal and external reviews being commissioned.

Since this evidence brief was commissioned, the latest Oranga Tamariki (2022) *Safety of Children in Car*e annual report has been published. This report, specifically in relation to both youth justice and care and protection secure residences, found that:

> Of significance is the increase [over the previous year] in physical harm caused by staff which most often occurred in the context of the young person being physically restrained. Physical harm occurred in the following context:
>
> – when there was no mandate to use force often reflecting a reactive response to verbal abuse by a young person,
> – the holds were applied incorrectly, and the young person was harmed as a result, or
> – when unlawful physical actions were used by the staff member.
>
> Some of the responses to young people reflected an inappropriate emotional and professionally immature response by the adults involved and on occasion this could reflect an instinctive response to trauma experienced (p. 19).

In a press release on publication of the report, the Commissioner for Children (2022) expressed particular concern about the physical restraint of children in residences.

Notwithstanding these reports (i.e. Office of the Children's Commissioner, 2021; Oranga Tamariki, 2022) and others (Shalev, 2017, 2020), no research on the physical restraint of children in New Zealand youth justice residences has been identified.

Methodology and limitations

Academic and professional journal articles, as well as some book chapters were identified using EBSCO and Google Scholar. In instances where no content, or only abstracts, were available, alternative sources were used where possible to access material e.g. the MSD library service and inter-library loan access, Google, ResearchGate, and DeepDyve.com.

Although most of the literature for the review comes from academic journal articles, using Google the review also encompassed:

– grey literature from government and other agencies and organisations; and
– select evidence-based and organisational websites.

As terminology varies across countries, the use of search terms and search strategies were generally iterative rather than pre-determined.

This evidence brief has some limitations:

1. As an evidence brief rather than a full literature review, this report aims to represent a good, but not necessarily an entirely comprehensive, summary of existing literature.
2. This report focuses on physically restraining children (and the much more limited research on de-escalation). However, the way individual researchers and jurisdictions define and frame physical restraint, and the extent to which they conceptually link its use with forms of seclusion, varies widely. As such, wherever identified or not, some researcher's published findings may go beyond physical restraint.
3. There has been some recent growth internationally in the available empirical and theoretical literature on the use of physical restraint with children in residential care. However, this mostly comes from the US, Canada and the UK; while no comparative international studies have been identified, some anecdotal evidence would suggest that the use of physical restraint in residential childcare may be much less widespread in non-Anglo-American countries.
4. The topic generally remains under-researched. Most of the empirical research is relatively small-scale, and since 2002 only two relevant systematic reviews (i.e. Roy et al., 2021; Slaatto et al., 2021) by Canadian and Norwegian researchers respectively, appear to have been published.
5. As most research studies occur in a national or state/province context that reflects particular legal, policy and practice approaches and orientations to child welfare and mental health in particular, there are limitations on the extent to which overseas findings can be applied to New Zealand.
6. While perhaps understandable, it is worth noting that across the literature there is generally little differentiation between the use of 'appropriate' and 'inappropriate' physical restraint i.e. 'appropriate' as a last resort and for the shortest period

possible by well-trained and supported staff that fully complies with the law and organisational policy, and 'inappropriate' where that is not the case and may be a breach of criminal law or the *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (Association for the Prevention of Torture, n.d.; United Nations Human Rights Office of the High Commissioner, n.d.).

7. There is no New Zealand research on the use of physical restraint with children in statutory care. Furthermore no New Zealand studies on the physical restraint of children in Education or Corrections settings has been identified either, although there has been one recent New Zealand study in a child and adolescent mental health inpatient unit (Black et al., 2020).
8. No studies have been identified on the use of restraint and Indigenous children.

Findings

Leading international programmes

In youth justice residences, Oranga Tamariki uses its own bespoke physical restraint model – Safe Tactical Approach and Response (STAR). In England and Wales the Managing and Minimising Physical Restraint programme used in specialist Young Offenders Institutions and Secure Training Centres since 2012, is also a bespoke model (House of Commons House of Lords Joint Committee on Human Rights, 2019) and across the United Kingdom some other physical restraint and de-escalation models in use would be deemed to be in-house or localised (BILD Association of Certified Training, n.d.).

However, most Anglo-American secure youth justice facilities appear to use one of the commercially available stand-alone de-escalation and physical restraint training programmes. While there are similarities, content across programmes can vary significantly (Coulson, 2019). Four leading international physical restraint and de-escalation programmes are shown in Table 1.

Table 1: Four leading international physical restraint and de-escalation programmes

	Non-violent Crisis Intervention	Management of Actual or Potential Aggression	Therapeutic Crisis Intervention	Safe Crisis Management
Organisation	Crisis Prevention Institute	Crisis Prevention Institute	Cornell University's Residential Child Care Project	JKM Training
Location	US (own Australasian office in NSW[2])	US (own Australasian office in NSW)	US (Australasian licensee NSW-based TACT/Allambi)[3]	US (Australasian licensee NZ-based PsychAssure)[4]
Courses	Train the trainer	Train the trainer (foundation & advanced courses)	Train the trainer (TACT, 2022)	Train the trainer Theory, physical restraint, & specialist
Advantages	California Evidence-Based Clearinghouse for Child Welfare (CEBC) (2016b) listed (but research evidence not able to be rated); & Crisis Prevention	Large provider. Reasonable evidence base' Crisis Prevention Institute BILD (n.d.) certified	CEBC (2020b) listed (but research evidence not able to be rated); Therapeutic Crisis Intervention BILD (n.d.) certified; Specific to residential	CEBC (2017) listed (but research evidence not able to be rated); BILD (n.d.) certified; Robust instructor assessment; & System-wide approach

[2] At time of writing NVCI is not offered in Australasia.
[3] TACT Training is part of Allambi Care, a major Australian OOHC and child and family services provider.
[4] Christchurch-based PsychAssure is an education consultancy. Kibble Education and Care, Scotland, the organisation in one of the five cases studies in the main report and provider of various forms of OOHC, is the Safe Crisis Management Licensee for Europe.

	Non-violent Crisis Intervention	Management of Actual or Potential Aggression	Therapeutic Crisis Intervention	Safe Crisis Management
	Institute BILD (n.d.) certified[5]		childcare; More integrated and system-wide approach; & own reasonable evidence base	
Disadvantages	Wide range of sectors and less de-escalation focus	Wide range of sectors	No listing identified on evidence-based websites	Low international presence
Websites	www.crisisprevention.com/Our-Programs/Nonviolent-Crisis-Intervention	www.crisisprevention.com/en-NZ/Our-Programs/MAPA-Management-of-Actual-or-Potential-Aggression	https://rccp.cornell.edu/TCI_LevelOne.html www.tacttraining.org.au	https://safecrisismanagement.com/

Both the Non-violent Crisis Intervention (NVCI) and Management of Actual or Potential Aggression (MAPA) programmes are Crisis Prevention Institute (n.d-a, n.d.-b) training and certification courses. Established in 1980, this US-headquartered company has 38,000 certified instructors across their various programmes. It operates in a wide variety of sectors and industries including healthcare, behavioural health, long-term care, human services, social care, education, security, corrections, corporate, and retail. NVCI was used for many years across youth justice residences (Lambie, 2016). MAPA is currently used by care and protection residences as well as youth justice supervised community homes. Therapeutic Crisis Intervention was developed, and is operated by, Cornell University's Residential Child Care Project (2021) in the US. First developed in the early 1980s, worldwide the programme currently has over 3,000 professionals certified as Therapeutic Crisis Intervention trainers (Matheson, 2021).

Although much less well-known across New Zealand and Australia, JKM Training's (n.d.) Safe Crisis Management programme has an associate programme that is not offered by any of the other leading providers; the European licensee is the high profile Kibble Education and Care.

[5] More information on BILD certification on page 22.

The following table also identifies a range of complementary or other relevant widely-used alternative programmes.

Table 2: Complementary or relevant alternative programmes

Programme	Focus	Inclusion reason
ALERT (TherapyWorks, n.d.)	Making self-regulation easier for children (young people & adults)	Introduced at Kaahui Whetuu
Behavioural Support Strategies (Voluntary Services Aberdeen, n.d.)	Physical restraint & de-escalation	BILD (n.d.) certified; Example of smaller local programme
Collaborative Problem Solving® (Think:Kids, n.d.)	Structured problem solving process	CEBC (2020a) listed (rated as promising research evidence) and used in a New Zealand child and adolescent mental health inpatient unit (Black et al., 2020)
Handle With Care® Behavior Management System, n.d.)	Verbal de-escalation and patented physical restraint technique	CEBC (2016a) listed (but research evidence not able to be rated)
Six Core Strategies for Reducing Seclusion and Restraint Use® (National Association of State Mental Health Program Directors, 2006)	Service review tool that aims to support leaders and managers in reducing the use of seclusion and physical restraint.	US evidence-informed adult mental health service assessment tool used internationally including New Zealand (Te Pou, 2013, 2020); also increasingly used with other groups including youth detention (e.g. Restraint Reduction Network, n.d.-a)
SPEC (Safe Practice Effective Communication) (Te Pou, n.d.)	National four-day training programme on best and least restrictive practice for DHB staff working in mental health inpatient units	New Zealand DHB programme supported by Te Pou.
The Mandt System® (Mandt System, 2018, n.d.)	“In this place, and with these people, I feel safe™”	CEBC (2015) listed (but research evidence not able to be rated)
Trauma Systems Therapy (New York University Department of Child & Adolescent Psychiatry, n.d.)	Stabilisation of child’s environment while enhancing ability to regulate emotions	CEBC (2020c) listed (but research evidence not able to be rated); & client-level &/or system-level

Prevalence of physical restraint

As previously stated, internationally the use of physical restraint with children in youth detention centres and other residential settings for children is under-researched (Roy et al., 2021; Slaatto et al., 2021; Steckley & Kendrick, 2007). While most Anglo-American jurisdictions, whether national, state, provincial or territorial, appear to collect physical restraint data for monitoring purposes, few choose to publish it. Also in relation to England and Wales, but possibly also applicable elsewhere, the House of Commons House of Lords Joint Committee on Human Rights (2019) has stated that the data that is published on physical restraint across their custodial settings and hospitals is incomplete and hard to interpret.

Any such challenges are further compounded when comparing the frequency and nature of the use of physical restraint across jurisdictions, due to different practices, methods of recording and reporting, and use of age groups etc. (Day & Daffern, 2009).

However, examples of governments which have published physical restraint data do include the UK (in relation to England and Wales) and South Australia. In England and Wales (population approximately 58m) citing annually published Youth Justice Board and Ministry of Justice statistics, the House of Commons House of Lords Joint Committee on Human Rights (2019) reported that force was used 6,600 times over 2017/18 with children in their specialist Young Offenders Institutions and Secure Training Centres (i.e. these figures exclude youth justice places in Secure Children's Homes which form the third part of what is referred to there as the *Secure Estate*); of these 6,600 instances, 4,200 involved the use of *Managing and Minimising Physical Restraint* programme techniques. In South Australia (population of around 2m), in a research report prepared for the Guardian for Children and Young People (Day & Daffern, 2009) it was reported that one child in residential care (including but not limited to youth detention centres) was being restrained each day; of these, two youth a week[6] on average were restrained across their two youth detention centres.[7][8]

While no US research on the prevalence of physical restraint specifically in youth detention centres has been identified, Green-Hennessy and Hennessy (2015) found that 82% of surveyed licensed and/or accredited (non-secure and secure) residential treatment centers (n=693) for children and youth had used seclusion and/or physical restraint practices during the preceding 12 months. This is similar to a finding from Brown and colleagues (2012) who found that 76% of residential treatment centers reported having secluded or restrained youth in the previous year.

In terms of individuals, most children in youth detention centres or residential care will have experienced or witnessed the use of physical restraint (Independent Restraint Advisory Panel, 2014; Shenton & Smith, 2021; Steckley & Kendrick, 2008). For example, while the sample was small (n = 58) the Independent Restraint Advisory Panel (2014) prepared for the English and Welsh governments, did find that the majority of interviewed children in Secure Children Homes had been subject to physical restraint whether in their current or a previous placement.

[6] 24 physical restraints over the three month observation period.
[7] As at June 2009 there were 67 youth in the Cavan and Magill Youth Training Centres (88 places available in total).
[8] At the time the Cavan [now Adelaide) Youth Training Centre accommodated some youth up to the age of 19 in certain circumstances and their figures include some 18 and 19 year olds. However over the observation period, most of those restrained in these youth detention centres were aged 15-17.

As for staff, their use and experience of physical restraint can vary widely (Geoffrion et al., 2021), with a new Canadian study (Mathieu & Geoffrion, 2022) finding some significant differences between those who they called 'super users' and 'normal' users (n=198) of physical restraint:

> The results showed very strong evidence that super users have a greater fear of violence…indeed strong evidence that they perceive more verbal aggression…very strong evidence that they witness more aggression against themselves…and extremely strong evidence that they perceive themselves to be more often victims of physical aggression…than normal users. Moderate evidence also revealed that super users experienced a higher level of traumatic stress and perceived a better work climate than normal users (p. 1).

Consequences of physical restraint

While there have long been concerns about the use of physical restraint with children, there are circumstances where its use as a last resort and for the shortest period possible, can and does prevent harm, whether that be harm to children themselves, other children, staff, or other people (Fraser et al., 2016; Independent Restraint Advisory Panel, 2014; Nunno et al., 2007, 2021; Smith, 2020). For example in England, the Independent Restraint Advisory Panel (2014) found that breaking up fights between children was cited as the main reason for using physical restraint, followed by preventing self-harm and staff assaults. There is also some Scottish qualitative research evidence that for some children in some contexts, there are circumstances where the appropriate use of physical restraint by a member of staff who the child has a trusting relationship with, may potentially be experienced as a caring act (Steckley & Kendrick, 2008).

However, across the literature the use of physical restraint is primarily associated with a range of adverse risks and consequences:

- child deaths (Bryson et al., 2017; Nunno et al., 2007, 2021; Smallridge & Williamson, 2008, 2011; Steckley & Kendrick, 2008)
- child injuries (Bryson et al., 2017; LeBel et al., 2010; Roy et al., 2021; Steckley & Kendrick, 2008)
- children being (re-)traumatised (Bryson et al., 2017; Steckley & Kendrick, 2008)
- damaged relationships with staff and poorer quality of care (De Hert et al., 2011; LeBel et al., 2010; Pollastri et al. 2016;)
- potential escalation of individual physical conflicts (De Hert et al., 2011)
- an ongoing climate of violence (Slaatto et al., 2021) and
- staff injuries and sick leave (Smith et al., 2017; Slaatto et al., 2021; Zelnick, 2013).

In relation to fatalities, research has found that between 1993 and 2018 there were 79 restraint fatalities amongst children in residential care across the US (Nunno et al., 2007; 2021) as described in Table 3 below:

Table 3: US residential childcare restraint fatalities 1993-2018

Type of residential facility or programme	Total	1993-05	2006-18
Children within the child welfare system	27	21	6
Psychiatric centers	22	19	3
Agencies for children with disability or developmental delay	14	8	6
Juvenile corrections facilities	13	8	5
Community school programmes	2	2	0
Wilderness camps	1	1	0
Total	**79**	**59**	**20**

Note. Reproduced from ”A 26-year study of restraint fatalities among children and adolescents in the United States: A failure of organizational structures and processes”, by M. Nunno et al., 2021, p. 665. Copyright Springer.

As this research study is largely based upon available internet search systems, some US fatalities may not have been included here (this method was used as according to the researchers there is no reliable administrative data source in the US at the federal level on children in residential care restraint fatalities). Approximately half of these US deaths were in secure and non-secure child welfare and youth justice-type facilities. Beyond the sheer scale of fatalities, three other findings from the study were particularly noteworthy.

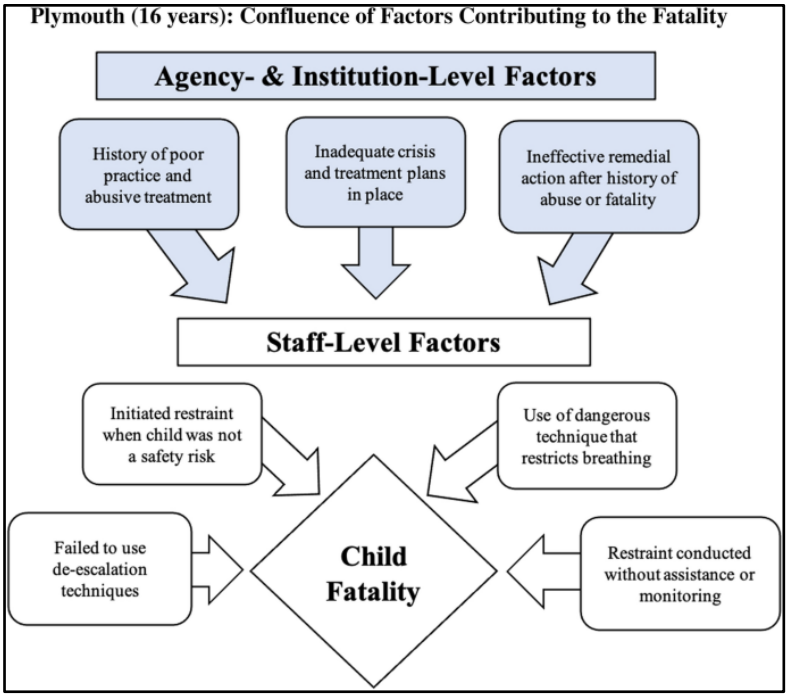
Firstly, for almost half of the children, the reported cause of death was asphyxia (38 children). Other causes of death included cardiac arrhythmia (12 children), suffocation (three children), exertion (three children), sudden death (two children), and aspiration (two children).

Secondly, the events leading up to many of these 79 restraint fatalities, were triggered by relatively benign behaviours that do not appear to have been either threatening or dangerous.

> These events involved non-compliance with staff demands or program requirements, such as remaining quiet or sitting properly without wiggling. In other examples, the precipitating event involved children refusing to give up a ball, accept exercise willingly as a punishment, put on shoes, take off a hoodie, or leave or return to a cottage, a classroom, or a gym (Nunno et al., 2021, p. 8).

Thirdly, the researchers found that death was usually associated with a number of, and the interplay between, different agency, institution and staff-level factors, rather than one single factor. The researchers illustrated some of these factors with the following figure on why 16 year old 'Plymouth' (composite case) died:

Figure 1: Confluence of factors contributing to the fatality of Plymouth (composite case)



Note. Reproduced from "A 26-year study of restraint fatalities among children and adolescents in the United States: A failure of organizational structures and processes", by M. Nunno et al., 2021, p. 671. Copyright Springer.

Elsewhere in other Anglo-American jurisdictions and Europe, children in residential care dying as a result of being physically restrained seems by contrast to be very rare; reasons for this difference have not been specifically identified from the literature. However, the 2004 death of 15 year old Gareth Myatt during a physical restraint at the G4S-run Rainsbrook Secure Training Centre and the 2004 suicide of 14 year old Adam Rickwood following his being restrained at the Serco-run Hassockfield Secure Training Centre, (Smallridge & Williamson, 2008; Steckley & Kendrick, 2007, 2008) have helped drive many of the policy and practice changes in the UK, and in particular England and Wales, over the last decade.

Children's experience of physical restraint

Internationally, there is little research on children in residential care's experience of physical restraint (Slaatto et al., 2021). This limits our understanding of not only how children view physical restraint, but also on how physical restraint is directly and indirectly experienced. However, a small body of UK research and related evidence on children's experiences of physical restraint in residential care has emerged over recent years.

Children in residential care in the UK generally accept that physical restraint may sometimes be justified in order to protect them, other children and staff from harm (Independent Restraint Advisory Panel, 2014; Morgan, 2005; Shenton & Smith, 2021; Steckley & Kendrick, 2008). For example in the previously mentioned Steckley and Kendrick (2008) Scottish study in which 37 children in residential care (including secure care) were interviewed, children (and workers) "consistently connected the appropriate use of restraint with issues of protection, safety, harm, risk, danger and/or destruction" (p. 9).

Furthermore, in a consultation with children in English Secure Children's Homes (Independent Restraint Advisory Panel, 2014), a small number of children reported feeling safe or protected in these or other residential settings when witnessing others being physically restrained. According to the UK children's rights charity Article 39 (n.d.) some children also report that "being held by staff helps them feel protected and safe" (para 2) and as previously mentioned this was also found in Steckley and Kendrick's (2008) Scottish research.

However, children also consistently report that the use of physical restraint is frequently unfair or unwarranted (Independent Restraint Advisory Panel, 2014; Morgan, 2005; Shenton & Smith, 2021; Steckley & Kendrick, 2008; Who Cares? Scotland, n.d.). For example in Scotland, Who Cares? Scotland, the advocacy organisation for children in care, reported that children were particularly concerned about how physical restraint was being used:

> They say it is used too often, and too soon. Young people often end up with bruises, sore (sometimes broken) limbs and carpet burns. Restraint should be a last resort, and done safely. Some young people say they have experienced restraint that has been little more than physical abuse (Who Cares? Scotland, n.d., p. 18).

Similarly, in a more recent English study specifically with children in care or custody across their secure estate (Secure Children's Homes, Secure Training Centres and specialist Young Offender Institutions), it was cited that even in instances where it might be warranted, "restraint is often chaotic, traumatic and harmful; it can trigger complex and problematic responses" (Shenton & Smith, 2021, p. 60).

Across these research studies, children also had expectations that:

- staff need to be able to spot potential problems and identify when individual children are getting distressed and/or angry, effectively deal with situations early on and so avoid the need for physical restraint altogether (Independent Restraint Advisory Panel, 2014; Morgan, 2005; Steckley & Kendrick, 2008)
- staff are proactive and attempt, where practical, other measures before resorting to physical restraint (Independent Restraint Advisory Panel, 2014; Steckley & Kendrick, 2008)
- staff adhere to individual care plans in relation to methods of physical restraint which should or should not be used on them (Independent Restraint Advisory Panel, 2014)
- physical restraint should never involve pain with staff being trained so that they do not hurt children (Morgan, 2015; Steckley & Kendrick, 2008).

In terms of how children experience physical restraint, in the Independent Restraint Advisory Panel's (2014) interviews in England, many children experienced or witnessed both injuries (usually minor) and feeling unwell during a physical restraint:

> Children described experiencing or witnessing others feeling breathless, nauseous, sweating and anxious. The most significant finding is that almost universally the children do not tell staff at the time. Reasons for this are varied: 'too angry'; 'too breathless'; 'there's no point'; 'when you can't breathe staff didn't notice' p. 50).

Overall, the predominant feeling children reported about being restrained was that of anger, with some saying that the use of physical restraint also damaged their relationships with individual members of staff. However, for some others, a trusted member of staff carrying out an appropriate physical restraint could be experienced as a caring act of care; something also echoed by Steckley (2015).

Physical restraint and Māori

While the challenging history of New Zealand's residences (e.g. Abuse in Care Royal Commission of Inquiry, 2020; Confidential Listening and Assistance Service, 2015; Human Rights Commission, 1982; Stanley, 2016) would suggest that Indigenous young people may well have been disproportionately restrained in the past, no specific national or indeed international evidence has been identified in relation to Indigenous children and the use of physical restraint in youth detention centres or indeed any other settings. Also, according to the recent New Zealand Human Rights Commission follow up report (Shalev, 2020), Oranga Tamariki does not collect physical restraint ethnicity data in youth justice residences for either management or reporting purposes.

However, given that Indigenous youth are so significantly over-represented in youth detention centres across Australia, Canada, the United States and New Zealand, perhaps this is a moot point. For example in New Zealand 80% of young people in youth justice residences identify as Māori (67% as Māori and 13% as both Māori and Pacific[9]) (Oranga Tamariki, 2021). As such, it could be said that in Oranga Tamariki physical restraint is indeed disproportionally used on Indigenous youth, simply by virtue of the fact that Indigenous youth are so significantly overrepresented in New Zealand and other relevant Anglo-American youth dentation centres (Australian Children's Commissioners and Guardians, 2016, 2017; Cunneen et al., 2016; Statistics Canada, 2022; The Sentencing Project, 2021). Or in other words in New Zealand, Australia and Canada's youth justice systems' youth detention centres, whether by design or practice, are principally used for Indigenous youth.

While not limited to just physical restraint as framed in this report, some relevant New Zealand research has been identified in relation to Māori adults and mental health services. One small-scale study (Kumar et al., 2008), using administrative data from one psychiatric inpatient unit in Rotorua, found that Māori were generally no more likely than non-Māori to experience *restrictive care*; this term includes physical restraint, seclusion, and other related psychiatric practices that "reduce the autonomy and choice of the individual" (p. 387). However, three other New Zealand

[9] A further 7% identify exclusively as Pacific.

adult mental health studies solely on the use of seclusion paint a somewhat different picture for Māori. El-Badri and Mellsop's (2002) small-scale study on the use of seclusion in Waikato acute general adult psychiatric wards found that "Male, *non-European* [emphasis added] patients and patients with certain diagnoses were at particular risk for seclusion" (p. 399). In another of these authors' studies, again in the Waikato but this time on patient and staff perspectives rather than prevalence, El-Badri & Mellsop (2008) found that 17 of the 21 (81%) participating psychiatric out-patients who were Māori reported that they had previously been secluded, whereas the corresponding figures for Europeans was 34 out of 78 (44%). A larger and more recent study on seclusion (McLeod et al., 2017) reached a similar conclusion; analysing the Programme for the Integration of Mental Health Data (PRIMHD) national dataset for nine of the country's 21 District Health Boards, Māori[10] adults admitted as inpatients to a psychiatric unit had a 39% higher rate of seclusion than non-Māori non-Pacific.[11]

In relation to children, a seclusion and restraint study was recently carried out in a New Zealand child and adolescent mental health inpatient unit (Black et al., 2020). The aim of the study "was to determine whether implementation of a Collaborative Problem Solving approach (Think:Kids, n.d.) would be associated with a decrease in seclusion and restraint" (p. 578). While ethnicity is not discussed, the study found reductions in the use of the following:

- 33% reduction in *partial restraint events* (from 338 during 2016 to 226 during 2018)
- 60% reduction in *full restraint events* (from 202 during 2016 to 80 during 2018)
- 79% reduction in *locked doors (*from 283 during 2016 which increased further in 2017 to 59 during 2018) and
- 98% reduction in the use of *seclusions* (from 102 during 2016 to 2 during 2018). Another feature of the study was that as well as the analysis of a range of administrative data including occurrences of seclusion and restraint, a pre-post staff survey was also carried out; "despite some initial scepticism the staff found this approach useful" (Black et al., 2020, p. 578).

While the above study is about implementation of the Collaborative Problem Solving approach (Think:Kids, n.d.), the Te Pou (2013, 2020) adaptation of the US Six Core Strategies for Reducing Seclusion and Restraint Use© (National Association of State Mental Health Program Directors, 2006) organisational assessment tool for use in New Zealand's mental health services[12], had also been adopted early on in the life of the project. The second edition (Te Pou, 2020) of this adaptation cites the incorporation of the context of Te Tiriti o Waitangi and responsiveness to Māori, and has a "strengthened emphasis on the role of people who access services, and of whānau and Māori as partners in care" (p. 4). With a stated goal of eventually eliminating the use of seclusion and restraint, it is acknowledged that inpatient mental health services "continue to seclude Māori and Pacific peoples at disproportionately higher rates" (p. 4). SPEC (Safe Practice Effective

[10] This study took a prioritised ethnicity approach if more than one ethnicity was recorded.
[11] "18 Pacific peoples not included in the prioritised Māori group were excluded from the non-Māori (largely New Zealand European) comparator group, as Pacific peoples had similar proportions of seclusion to Māori and could obscure comparisons with majority New Zealand European ethnicity" (para 11).
[12] Discussed further in later section on Taking an organisation-wide systems approach

Communication) (Te Pou, n.d.), a national DHB four day training course for DHB staff working in mental health inpatient units, is also in place. SPEC training focuses on de-escalation techniques, therapeutic engagement, trauma informed care principles, cultural engagement as preventative strategies, and teaches the safe use of personal restraint as a last resort. Research on the use of SPEC in one DHB identified that improving cultural safety and responsiveness for Māori was vital to effect better health outcomes for Māori, and an emphasis on safety signifies a substantial practice change (Brebner, 2022).

As well as mental health, in New Zealand physical restraint is also used in other areas such as emergency departments, aged care, disability, corrective services and education in (Royal Australian and New Zealand College of Psychiatrists, 2021; Ministry of Education, 2020).

Reducing use of physical restraints

Physically restraining children is a complex and increasingly contentious and controversial topic, and one that gives rise to strong professional and personal feelings on both sides of the debate (Day et al., 2010; Deveau & Leitch, 2015; Mathieu & Geoffrion, 2022; Roy et al., 2021; Steckley, 2015; Steckley & Kendrick, 2007); it is also an area that is ethically fraught (Steckley, 2015, p. 195).

Many jurisdictions and their provider, professional, and advocacy organisations are looking to address the misuse, overuse and safety of some physical restraint techniques, and more broadly reduce or even eliminate their use of physical restraint altogether (for example, Association of Children's Residential and Community Services, 2022; National Association of State Mental Health Program Directors, 2006; Restraint Reduction Network, n.d.-a; Scottish Government, 2022).

As well as some individual research studies on reducing the use of physical restraints, two systematic reviews have recently been published. The first of these reviews is *The use of restraint and seclusion in residential treatment care for youth: A systematic review of related factors and interventions* (Roy et al., 2021). This is a Canadian study that analysed 23 research studies on restraint and seclusion in (largely North American) Residential Treatment Centers (RTCs). The second is *Conflict prevention, de-escalation and restraint in children/youth inpatient and residential facilities: A systematic mapping review* (Slaatto et al., 2021). This Norwegian study analysed 14 studies undertaken in (again largely North American) residential-care and hospital/psychiatric facilities, although a small number were conducted in juvenile justice facilities.

Both reviews found that there are some studies which show that various educational and training programmes, strategies, frameworks and guidelines, may have contributed positively to a reduction in the use of physical restraint with children. Conceptually important, Slaatto et al. (2021) also found that "interventions that contributed to a reduction in episodes of R&S [Restraint & Seclusion] differed from those that led to a reduction in conflicts and aggression" (p. 1). However, the studies included in both reviews tend to be quite small-scale, have small effects sizes, and generally do not investigate why or how any such reduction came about. As such neither of these systematic reviews recommend any specific interventions beyond

the need for education and training; both reviews also outline areas where more research is needed.

A strong focus of the Roy et al. (2021) study was the identification of 61 different factors or variables associated with their use as follows:

- Personal characteristics of the youth (29 factors across nine studies): “Ethnicity, age, sex, self-harming behaviors, and medication management stood out in the literature as youth related characteristics with the use of R&S [Restraint & Seclusion] in RTCs [Residential Treatment Centers] (p. 15).
- Personal characteristics of the staff (17 factors across five studies): Generally education level and attitude, but not experiences, stress level and training which were also found to be factors in the cited Larue et al. (2009) study on the perceptions of psychiatric healthcare teams.
- Environmental characteristics (nine factors across five studies): Generally level of personal freedom, degree of intimacy, existence of meaningful activities and physical space, but not level of support, which were also found to be factors by Larue et al., 2009; Roy et al., 2020 also identified the after-school period as a possible factor.
- Different programmes for the reduction of restraint and seclusion (six programmes across six studies): While the majority of these studies evaluating the implementation of programmes reported a reduction in the use of restraint (and seclusion), we do not know why, i.e. which specific programme elements and how they worked.

However it is important to recognise that across the 23 research studies covered in this systematic review (Roy et al., 2021), 53 of these identified factors came from single research studies, with the remaining factors only being covered in two or three studies. Roy and colleagues (2021) go on to conclude that reducing the use of restraint (and seclusion) is likely as much about the often complex and dynamic interplay between the characteristics of the child, the care provider, and the environment, and the implementation of any reduction programme, than individual factors. That said, there is more of a consensus in the literature on staff safety, on the need for more and better use of de-escalation techniques, safer use of physical restraint, and only using physical restraint where it is absolutely necessary (Fraser et al., 2016; Smith, 2020).

Getting the care fundamentals right

At a basic level, we have long known what needs to be done in order to achieve or maintain safety in residential care. For example, in Often Ignored: Obvious Messages for a Safe Workforce, Lane (2000) identified 10 features required to ensure safety for both children and staff; the absence of these 10 features had all figured in major UK reports on residential child care over the previous decade including The Pin Down Experience and the Protection of Children: The Report of the Staffordshire Child Care Inquiry (Levy & Kahan, 1991); Choosing with Care: The Report of the Committee of Inquiry into the Selection, Development and Management of Staff in Children’s Homes (Warner, 1992); and The Children’s Safeguards Review (Kent, 1997). They are as follows:

1. Attracting the best people and promoting residential care as a career
2. Selecting the best people through the use of rigorous processes
3. Effective management
4. Quality supervision
5. Whistle-blowing policies
6. Support from senior leadership
7. Pay and conditions
8. High professional standards
9. Quality assurance systems
10. Training and developing the workforce.

Lane (2000) argues that while these 10 messages may seem patently obvious, in the UK they have often been ignored:

> The people who have paid the price for this failure have been primarily the children and young people in residential services, but also residential workers and, as the ripples have spread outwards, the providing agencies and the wider public. The main message is that safe services of good quality will only be provided if the workforce is of high quality (p. 15).

Sector and organisational leadership

Leadbetter (as cited by Steckley and Kendrick, 2008) suggests that historically, physical restraint has been a taboo subject in many agencies, and something that is largely left to residential staff and their immediate managers:

> The historical tendency has been to 'individualise' the question of the management of challenging behaviour. To frame it simply as a matter of individual staff competence with risk viewed as simply 'part of the job'. This perspective has effectively de-emphasised the role and responsibilities of the agency and focused the responsibility for risk assessment and intervention on the individual staff member, who inevitably remains in the frame when things go wrong (pp. 3-4).

However, with their requirements for regular refresher training, the ongoing implementation of physical restraint training models are very resource intensive. Add to that the realities of shift work and some organisations having high staff turnover, staff shortages, and/or use of casual staff, and perhaps a limited pool of trainers, ensuring that all staff have even attended basic training has regularly arisen as a key issue in a number of inquiries into excessive, inappropriate, and dangerous use of physical restraint in youth detention centres and residential childcare providers overseas (e.g., LeBel et al., 2010; Nunno et al., 2021). If an organisation's objectives are around reducing harm and improving care outcomes, as opposed to simply trying to ensure that staff operate within the law, then the organisation's commitment to the model and any underpinning change programme, needs to be all the stronger.

In England, sector and organisational leadership is currently being demonstrated with the following:

- Establishment of the Restraint Reduction Network (n.d.-a): A registered charity which brings together committed organisations providing education, health and social care services.
- Development of rights-based training standards: *The Restraint Reduction Network (RNN) Training Standards* (Ridley & Leitch, 2020) "apply to all training that has a restrictive intervention component and will provide a national and international benchmark for training in supporting people who are distressed in education, health and social care settings (p. 3).[13]
- Certification: The BILD (British Institute for Learning Disabilities) Association of Certified Training offers certification for in-house training and commercial training providers across health, education and care settings – curricula, senior trainers and affiliated organisations.
- Qualifications: A new online 12-month Practice Leadership in Reducing Restrictive Practices diploma qualification to support those committed to restraint reduction translates theory into practice and achieve their goals (Restraint Reduction Network, n.d.-b).[14]

In Scotland, the Scottish Physical Restraint Action Group (SPRAG) has been established; specifically for residential childcare organisations and practitioners. This national initiative is focused on reducing the use of physical restraint (Centre of Excellence for Children's Care and Protection. n.d.). In a similar vein in the US, the national Association of Children's Residential and Community Services (2022) held an event entitled *Relationships First: Committing to the Reduction and Elimination of Restraints* and has committed to hosting a series of follow up events.

Taking an organisation-wide systems approach

There needs to be some recognition of the limitations of training programmes. Smith and colleagues (2017) argue that the widespread funding of training in crisis management is not sufficient to mitigate staff getting assaulted. Winstanley and Hale (2008) make a similar point:

> It may also be that training is not the issue here. Research into aggression towards health care staff suggests that the aggression is more frequently about patient or victim characteristics, about environmental factors or about the interaction between those involved than about specific training (p. 108).

[13] The Standards aim to facilitate culture change, and not just technical competence. They are designed to: Protect people's fundamental human rights and promote person centred best interest and therapeutic approaches to supporting people when they are distressed; Improve the quality of life of those being restrained and those supporting them; Reduce reliance on restrictive practices by promoting positive culture and practice that focuses on prevention, de-escalation and reflective practice; Increase understanding of the root causes of behaviour and recognition that many behaviours are the result of distress due to unmet needs; Where required, focus on the safest and most dignified use of restrictive interventions including physical restraint" (Ridley & Leitch, 2020. p. 14). The scheme includes training needs analysis to ensure training is proportional to the needs of the population and setting.

[14] A six-month Certificate in Reducing Restrictive Practices is also available.

One leading international programme, Therapeutical Crisis Intervention, places a particularly strong focus on a systems approach. While arguably equally applicable to other similar programmes, the Residential Child Care Project (2021) at Cornell University make the following point in relation to organisational leadership and support:

> By providing sufficient resources including adequate and qualified staff, skilled and supportive supervisors, time for reflection and planning, support for regular external and internal monitoring, and clear rules and procedures that have safeguards against abusive practices, leadership promotes positive programming and an organizational culture to sustain the Therapeutic Crisis Intervention system (p. 21).

Figure 2: Therapeutic Crisis Intervention (TCI) system

Note. Adapted from "The Therapeutic Crisis Intervention system – information bulletin (7th ed.)" by Residential Child Care Project, 2021, p. 20. Copyright 2021 Cornell University Bronfenbrenner Center for Translational Research.

Smith (2020) argues for a systematic and holistic approach to increasing the safety of children and staff alike "that targets changes in organizational norms, values, and practices" (p. 167). Alongside issues for managers, supervisors and team leaders within residential care, in Victoria the Centre for Excellence in Child and Family Welfare (2021) identifies a particular responsibility for the senior organisational leaders to demonstrate a commitment to promoting a culture where violence and aggression is not accepted as 'part of the job' (para 4). Paterson and colleagues (2008) propose that organisations need to adopt a broader public health harm reduction approach that addresses all three dimensions of prevention as follows:

- *Primary:* action taken to prevent violence before it occurs;
- *Secondary*: action taken to prevent violence when it is perceived to be imminent; and

– *Tertiary*: action taken when violence is occurring and after it has occurred to prevent or reduce the potential for physical and psychological harm to the parties involved and to inform primary and secondary prevention strategies. (p. 128)

Deveau and Leitch (2014) make a similar point in relation to restraint reduction being multi-faceted: “Achieving restraint reduction probably requires multiple strategies including: leadership and organizational change, monitoring use of RPI [Restrictive Physical Intervention] to inform practice, workforce development, extending consumer roles/ participation, staff debriefing and external review” (p. 2).

Not specific to a single physical restraint model, the previously mentioned Six Core Strategies© (LeBel et al., 2010; National Association of State Mental Health Program Directors, 2006), and its New Zealand adaptation for use in mental health services (Te Pou, 2013, 2020) is also an example of a systems-wide holistic approach towards reducing the use of physical restraint. Increasingly used beyond the US, the Six Core Strategies© provides a comprehensive evidence-informed systems approach to support a reduction in the use of physical restraint and seclusion. The six core strategies are:

1. Leadership in organisational culture change.
2. Using data to inform practice.
3. Workforce development.
4. Inclusion of families and peers.
5. Specific reduction interventions (using risk assessment, trauma assessment, crisis planning, sensory modulation and customer services).
6. Rigorous debriefing.

Physical restraint and care model or practice framework interface

The use of physical restraint and de-escalation, cannot be viewed in isolation from other aspects of residential child care.

Compatibility and integration

Residential workers and their managers have to work with a lot of ambiguity. As individuals and teams, alongside physical restraint and de-escalation training, their daily practice is also informed by their other professional training, and use of legislation, policies, therapeutic models, practice frameworks, and theories (Halvorsen, 2018; McDonald, 2012). An English review of physical restraint training systems commissioned for use with children in Secure Children's Homes run by local authorities and community organisations (Independent Restraint Advisory Panel, 2014), identified some significant challenges for residential staff, managers and organisations relating to consistency across regulations, guidance and practice advice as follows:

- substantial variations in underpinning values
- wide variations in use of terminology and a myriad of differing definitions of restraint, serious incidents and related terms
- some degree of duplication, and occasionally, contraction, across government departments.

The panel also found no instances of structured and regular feedback on injuries to children who had been restrained or other concerns between the Secure Children's Homes, the training commissioners, and the training providers, that might have helped to address issues (including, but not limited to, compatibility and integration).

More broadly, the Independent Restraint Advisory Panel (2014), also found that that there was no universal understanding or methodology for 'accrediting' physical restraint training as well as: "a lack of clarity as to the responsibility for ensuring that any restraint system commissioned had been assessed for the safety of the package and the techniques that constitute it, and its appropriateness for the [particular] environment" (p. 62). In order to commission the most appropriate physical restraint training for their needs, the report went on to recommend that organisations should develop a single set of principles and requirements, within an ethical and values-based governance framework, to better inform and support their commissioning of such training.

Safety through relationships

One particularly important interface between the care model or practice framework and the physical restraint programme, is relationships. Writing from an attachment and trauma-informed theoretical perspective, Barton and colleagues (2012) assert that the primary determinant of the effectiveness of addressing challenging behaviour (in all of its forms) will be the stage of the relationship between the child and the residential worker:

> The more secure the attachment and the more skilled the carer is, the more able she will be in managing the behaviour. As the child develops a sense of safety and belonging, he becomes more capable of receiving feedback, and taking consequences on, with trust in the carer…the carer's ability to be attuned to the underlying needs of the child can only occur through the building of a relationship (p. 92).

Smith and colleagues (2013) make a similar point in relation to the centrality of relationships: "While structure, routine, rhythm and ritual are important, they do not exist in their own right but only when enacted through relationships" (p. 22). Also taking an attachment perspective, they go on to say that residential workers need to sensitively and consistently enable children to better manage their feelings of anxiety, and experience a sense of safety and security. Otherwise, children are likely to deploy defense mechanisms in order to protect themselves against feelings of anxiety and emotional pain. Fear, frustration and projection-related behaviours "may be described and experienced as aggression, or acting out or anger management problems" (p. 23). Therapeutic relationships require the residential worker to be able to understand the child's behaviour and help them process their feelings, whilst at the same time confidently and spontaneously respond to the child's need for these anxieties to be managed.

Steckley (2015) goes further:

> Physical restraint must be understood within the context of relationships. The relational, emotional, embedded realities of situations involving restraint are far better served by care ethics, which attends to their relevance and puts relationship at the centre of its consideration. To develop safe, ethical and developmentally rich environments, residential cultures must make space for, and effectively address related ambiguities and tensions, including those between care and control and the impact of violence on care environments (conclusion).

Trauma informed environments

Another important and promising interface between the care model or practice framework and physical restraint and de-escalation is any trauma-informed environment (Bryson et al., 2017). In quasi-experiential longitudinal research carried out over four years by Schmid and colleagues (2020), the researchers measured the effect of trauma-informed care on hair cortisol concentration, as a marker for stress, in staff from 14 residential care homes; they also measured children's physical aggression towards staff. While previous research (Salloum et al., 2015) has demonstrated that such approaches can increase compassion, satisfaction, and reduce symptoms of burnout among residential workers, this was the first study to show a decrease in physiological stress (Schmid et al., 2020). Staff from five of the homes (the intervention group) were using a trauma-informed approach (Trauma Informed Care) and those from the other nine homes (the control group) were not. By the four-year point, the intervention group reported significantly less physical aggression than the control group. They also showed significantly lower hair cortisol

concentration than those in the control group. While there may have been other variables at play, this suggests reduced physiological stress levels:

> The measured decrease in stress levels among the staff might be associated with the core principles of TIC, such as fostering and maintaining mental hygiene, coherence, mindfulness, and resilience. By implementing operational procedures that guide the staff to a better understanding of their own stress symptoms and promoting self-care, they might be better equipped to recognize and adapt to the young people's needs and to avoid traumatic re-enactment (Schmid et al., 2020, Conclusion para 1).

The researchers suggest that through the use of a trauma-sensitive lens, children's self-regulation and coping skills can be promoted by creating an atmosphere of shared decision-making. However, "the staff's ability to regulate and contain their own emotions in highly stressful interactions is of equal importance in order to recognise and adapt to the young people's needs" (Schmid et al., 2020, Discussion para 4). While promising rather than conclusive, new Canadian research (Matte-Landry & Collin-Vézina, 2022) across 44 residential units on the impact of a comprehensive trauma-informed staff development initiative (initial training, coaching and supervision, Communities of Practice, annual symposium and meetings with senior managers) also found some reductions in the use of physical restraint.

Discussion and conclusion

A key advantage of a bespoke Oranga Tamariki model is that this should avoid any ambiguity in relation to what the organisation does and does not deem to be safe. As Davidson and colleagues (2005) state: “It is service providers and not those [external organisations] who provide training in physically restraining children who are ultimately responsible for making sure that the methods used are appropriate and safe in their residential establishments” (p. 4).

Other advantages of a bespoke model are that STAR can reflect the youth justice residences’ legal and operating context and be accredited by NZQA (Oranga Tamariki Youth Justice Residences, 2019); there is also scope for better ongoing alignment between training, policy, procedures and practice (Davidson et al., 2005).

However, in comparison to the four leading international programmes previously presented, there are a number of other differences with STAR that may potentially be disadvantages:

1. STAR does not appear to have been informed by a review of national and international research evidence.
2. STAR (as reflected with its more paramilitary sounding name Safe Tactical Approach and Response), focuses primarily on physical restraint (Shalev, 2020), whereas leading international programmes are increasingly focusing more on de-escalation, and to varying degrees being trauma-informed, relational safety and/or prevention.
3. STAR may be perceived as prioritising staff safety over children’s safety.
4. STAR, along with Managing Actual and Potential Aggression (MAPA) and Non-violent Crisis Intervention (NVCI), is essentially a staff training programme, whereas both Therapeutic Crisis Intervention and Safe Crisis Management also encompass a much broader organisational systems focus.
5. Unlike some of the leading international programmes, there is no external quality monitoring, or organisational accreditation requirements.
6. The design, implementation and/or effectiveness of STAR does not appear to have yet been evaluated.

Finally, while physical restraint (and de-escalation) is important, as outlined in the main body of the report, it is only one of many elements that need to be meaningfully addressed for a youth detention centre to be both safe and effective. Indeed, while many jurisdictions and residential providers are looking to reduce or eliminate their use of physical restraint, for some youth detention centres in Europe, for example Diagrama’s facilities in Spain with their relationship-based care model and degree-qualified staff, the use of physical restraint has reportedly long been rare and when it is used it really is a last resort rather than an expected and accepted part of the culture (Matheson, in press).

That said, while overseas experiences and research can be valuable, Oranga Tamariki also needs to better understand why, who and how children in our youth justice residences are being restrained as a basis for their strengthened strategy. In reviewing the use of STAR in the context of other available models, adopting the New Zealand version of the Six Core Strategies© of (1) Leadership, (2) Using data, (3) Workforce development, (4) Inclusion of families and peers, (5) Specific reduction interventions, and (6) Rigorous debriefing (Te Pou, 2013, 2020, n.d.), would be a good place to start.

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