Reduction of Physical Restraint in Victoria

March 2024

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VICTORIA State Government | Families, Fairness and Housing

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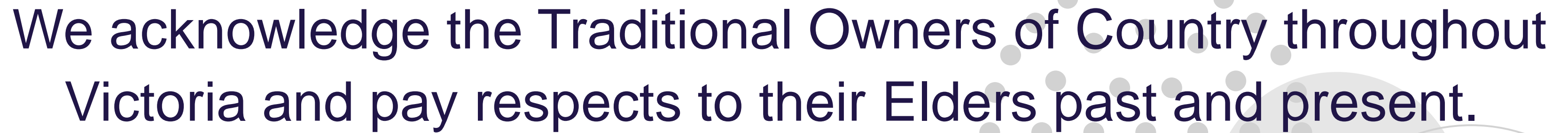
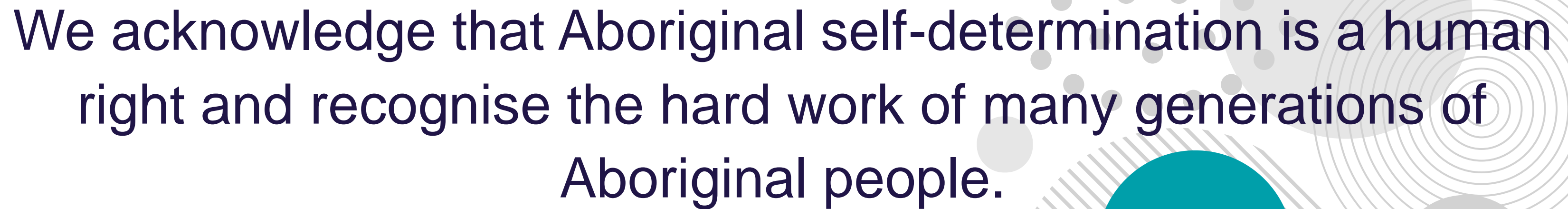


We acknowledge the Traditional Owners of Country throughout Victoria and pay respects to their Elders past and present.



We acknowledge that Aboriginal self-determination is a human right and recognise the hard work of many generations of Aboriginal people.

Disability Act 2006
The main purposes of this Act are-

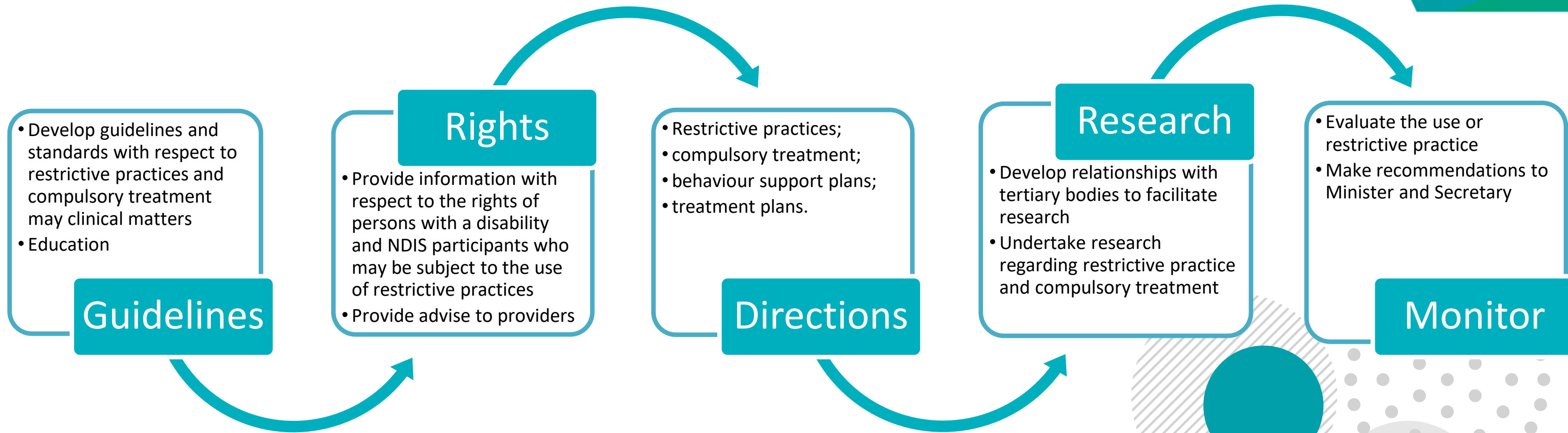
a)

- to provide a legislative scheme for persons with a disability which affirms and strengthens their rights and responsibilities and which is based on the recognition this requires support across the government sector and within the community; and

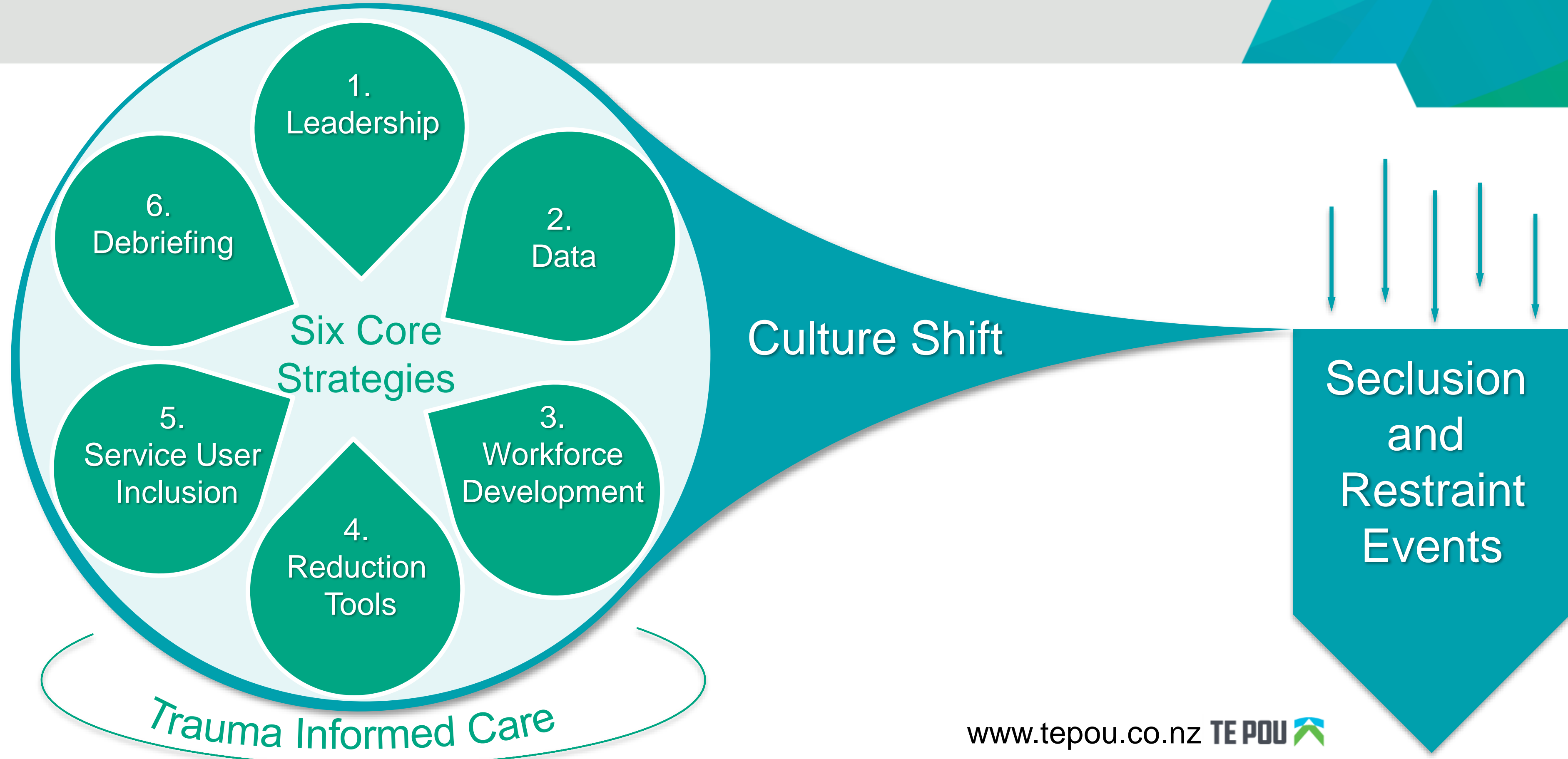
b)

- to provide a mechanism by which NDIS participants' rights are protected in relation to the use of restrictive practices and compulsory treatment.

s24 Functions of the Senior Practitioner



Huckshorne - Six Core Strategies (2005)



Is physical restraint effective?

- Questionable efficacy (Duxbury, 2015; Ferleger, 2008)
- *Despite the absence of evidence of efficacy, there are volumes of proper procedures, criteria and documentation. Innumerable dollars spent annually on staff training in techniques that have not been found to be effective* (Ferleger, 2008)
- How is efficacy conceptualised?
- *There is no research evidence to suggest that coercive practices assist young people to acquire strategies for self-regulation or teach them to relate to others more pro-socially when distressed* (Day et al., 2010)
- Restraint does not decrease aggression (Crocker et al., 2010)
- No controlled studies exist that evaluate the value of seclusion or restraint in those with serious mental illness (Sailas & Fenton, 2000)
- Schools that do not regulate restraint experience more restraint use (Barnard-Brak et al., 2014)

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Party yacht death a result of restraint (New Zealand Herald, 28/9/2011)

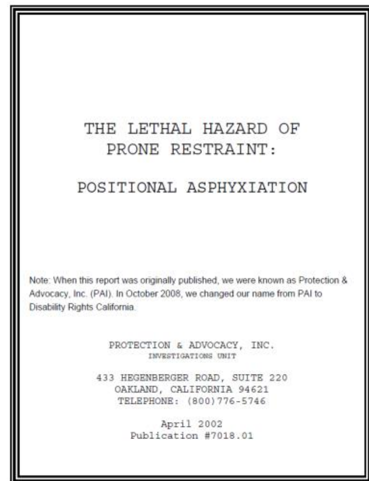
Guards restrained casino patron with 'shut down' tactic (The Age, 20/6/2012)

Excessive force in Sunshine Coast citizen's arrest factor in Amit Kuma's death (Brisbane Times, 11/03/2015)

Hartford Courant

Thomas Jefferson sued us for libel ... and lost

Weiss EM, et al. (1998) Deadly restraint: a Hartford Courant investigative report. *Hartford Courant,* October 11 – 15.



THE LETHAL HAZARD OF PRONE RESTRAINT:

POSITIONAL ASPHYXIATION

Note: When this report was originally published, we were known as Protection & Advocacy, Inc. (PAI). In October 2008, we changed our name from PAI to Disability Rights California.

PROTECTION & ADVOCACY, INC.
INVESTIGATIONS UNIT

433 HEGENBERGER ROAD, SUITE 220
OAKLAND, CALIFORNIA 94621
TELEPHONE: (800)776-5746

April 2002
Publication #7018.01

(Morrison et al., 2002)

Investigating physical restraint in mental health services

- **Experiences of negative psychological impact, re-traumatisation, perception of unethical practice and broken spirit** (Strout, 2012)
- **Injury to staff** (Hollins & Stubbs, 2011; Lancaster et al., 2008; Lee et al., 2001; Leggett & Silvester, 2003)
- **The use of physical restraint should be viewed as an adverse outcome of treatment** (Gerolamo, 2006)
- **Trauma and developmentally-informed perspectives as utilised in CAMHS units** (Azeem et al., 2011; Stewart et al., 2012)
- **Outcomes following physical restraint of older people are significantly worse** (Castle & Engberg, 2009; Engberg et al., 2008; Stubbs & Hollins, 2011)
- **Those with hearing impairments and those with ID are at greater risk of restraint** (Diaz & Landsberger, 2010; Hartman & Blalock, 2011)
- **A greater accountability of trainers** (Hollins & Paterson, 2009)

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Development of the Senior Practitioner's Direction on Physical Restraint

Victorian
Law Reform
Commission

People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care
Report

Victorian Law Reform Commission

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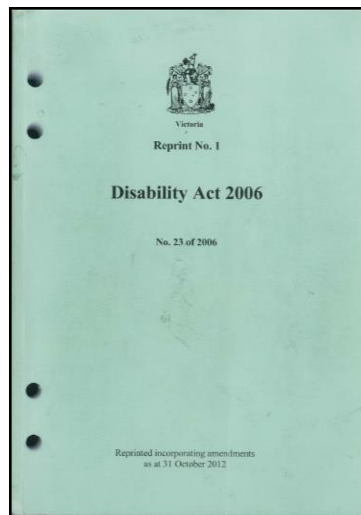

Victoria
Reprint No. 1
Disability Act 2006
No. 23 of 2006
Reprinted incorporating amendments as at 31 October 2012

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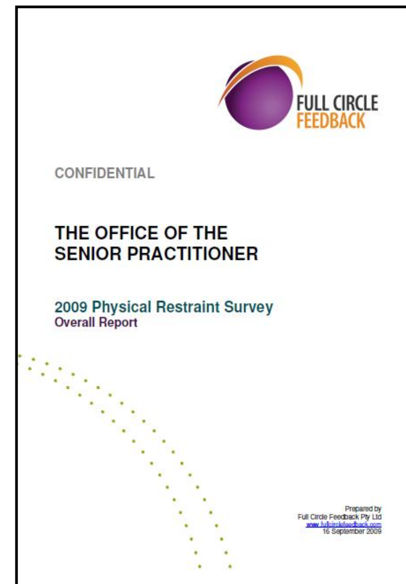

FULL CIRCLE FEEDBACK

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THE OFFICE OF THE SENIOR PRACTITIONER

2009 Physical Restraint Survey
Overall Report

Prepared by
Full Circle Feedback Pty Ltd
www.fullcirclefeedback.com
16 September 2009

2004

2006

2007

2009

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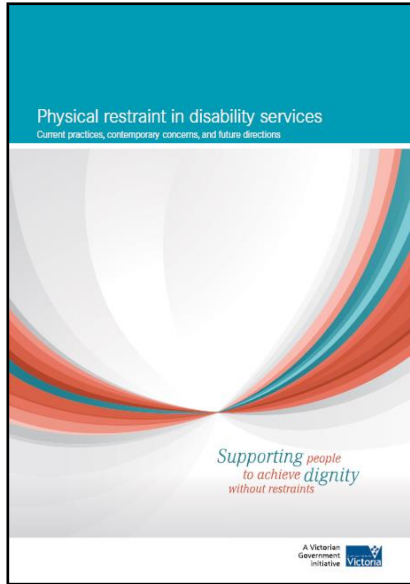
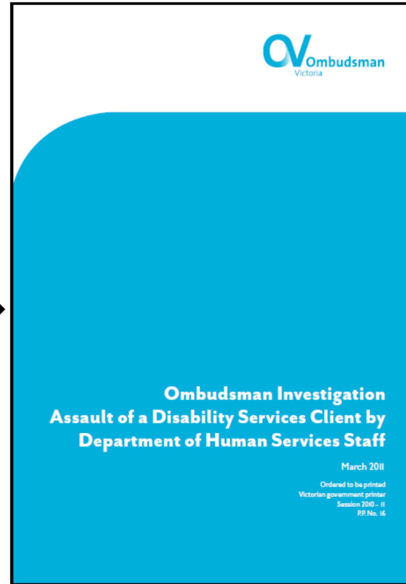
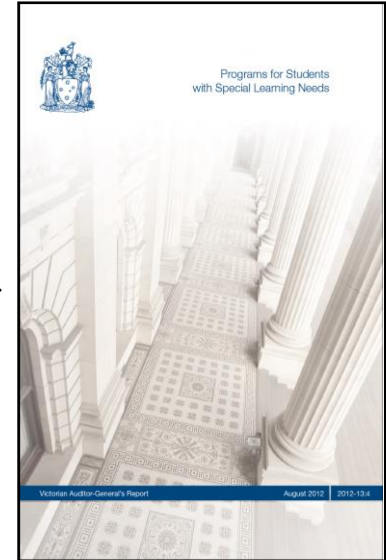
Events leading to development of the *Direction on Physical Restraint*







2009

March 2011

May 2011

August 2012

Events following development of the *Direction on Physical Restraint*

Victorian Equal Opportunity & Human Rights Commission

Held back

> The experiences of students with disabilities in Victorian schools

humanrightscommission.vic.gov.au

September 2012

2011

Review of the Medical Theories and Research Relating to Restraint Related Deaths

uclan

Caring Solutions (UK)
University of Central Lancashire

2011*

Department of Health

health

A new Mental Health Act for Victoria

Summary of proposed reforms

Victoria

October 2012

Practice of Prone Restraint

Chief Psychiatrist Clinical Practice Advisory Notice

health

21 June 2013

The Chief Psychiatrist has statutory functions under the *Mental Health Act 1986*. A primary responsibility of the Chief Psychiatrist is for the medical care and welfare of persons receiving treatment or care for a mental illness. This includes monitoring mental health treatment and care provided to individuals and implicit is the improvement of clinical practice. This includes the development of clinical guidelines and providing education and advice to ensure best practice.

This Clinical Practice Advice Notice is to support clinical services in the development of procedures to ensure the appropriate care and treatment of people being physically restrained in mental health services.

Of particular concern is the practice of **PRONE RESTRAINT**. The use of **PRONE RESTRAINT** is to be avoided. If in the course of a restraint a person is put in a prone position then this must cease as soon as practical and is not to exceed 3 minutes.

Background

The physiology of restraint related deaths is difficult to determine as the actual numbers are small and classifications of deaths vary from place to place. Factors include:

- The position a person is held in and in particular use of the prone position
- Acute behavioural disturbance and excited delirium
- Stress related cardiomyopathy
- Alcohol and drug use.

A recent review by Duxbury et al (2011) found that out of 38 restraint related deaths, 26 deaths were associated with positional asphyxia. Positional asphyxia occurs when a person being restrained is placed in a position that compromises their breathing and as a result does not get enough oxygen. When there is a lack of oxygen, this can lead to disturbance in cardiac rhythm and death may result.

Recommendations

1. All restraints are high risk to the people involved. Restraint (particularly prone restraint) has been identified as a significant risk and so health services are recommended to have strategies to minimise the use of all restraints and the risks associated with restraint.
2. Health services should ensure executive oversight is present over all restraint practice and policy development.
3. **PRONE RESTRAINT** should not be used. If in the course of a restraint a person is put in a prone position then this must cease as soon as practical and is not to exceed 3 minutes.
4. In clinical health settings, it is recommended that a registered nurse is required to be responsible for monitoring of the vital signs and ensure the chest area of a person is not compressed. If prone restraint is used, the registered nurse will ensure the person is not in a prone position for longer than 3 minutes.
5. All staff should be educated in the use of restraint and the risks associated with restraints.
6. A suitably qualified health professional should be in charge of the restraint process.
7. All restraints should be treated as an incident, reviewed and documented accordingly.

References:
Tasmanian Government, (May 2012) Safer Practice Notice : No: 02 / 20120814 – Prone Restraint & the Risk of Positional Asphyxia
New South Wales, (June 2012) Policy Directive: Aggression, Seclusion & Restraint in Mental Health Facilities in NSW Caring Solutions
United Kingdom: University of Central Lancashire, (2011), Review of the medical theories and research relating to restraint related deaths

Victoria

Department of Health

June 2013

Implementation of the *Direction on Physical Restraint*

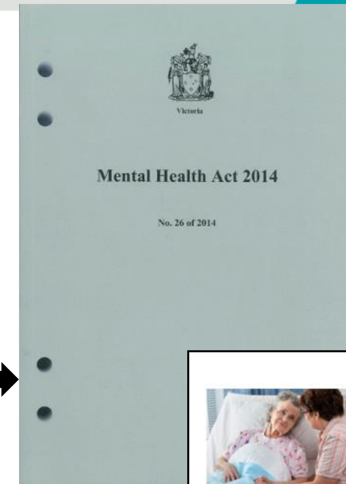
Launch
Roll-out
Assessments
Case consultation

June – Dec 2011

Case consultation & ongoing dissemination

January 2012 onwards

July 2013



2014

NDIS Rules 2018

Rectangular Snip

National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018

made under the

National Disability Insurance Scheme Act 2013

Compilation No. 1

Compilation date:	1 December 2020
Includes amendments up to:	F2020L01512
Registered:	14 December 2020

About this compilation

This compilation

This is a compilation of the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* that shows the text of the law as amended and in force on 1 December 2020 (the ***compilation date***).

The notes at the end of this compilation (the ***endnotes***) include information about amending laws and the amendment history of provisions of the compiled law.

Uncommenced amendments

The effect of uncommenced amendments is not shown in the text of the compiled law. Any uncommenced amendments affecting the law are accessible on the Legislation Register (www.legislation.gov.au). The details of amendments made up to, but not commenced at, the compilation date are underlined in the endnotes. For more information on any uncommenced amendments, see the series page on the Legislation Register for the compiled law.

6 Rules apply only to specified kinds of restrictive practices

A restrictive practice is a ***regulated restrictive practice*** if it is or involves any of the following:

(a) seclusion, (b) chemical restraint, (c) mechanical restraint,

(d) physical restraint, which is the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.

(e) environmental restraint,

Updated July 2023

Position Statement

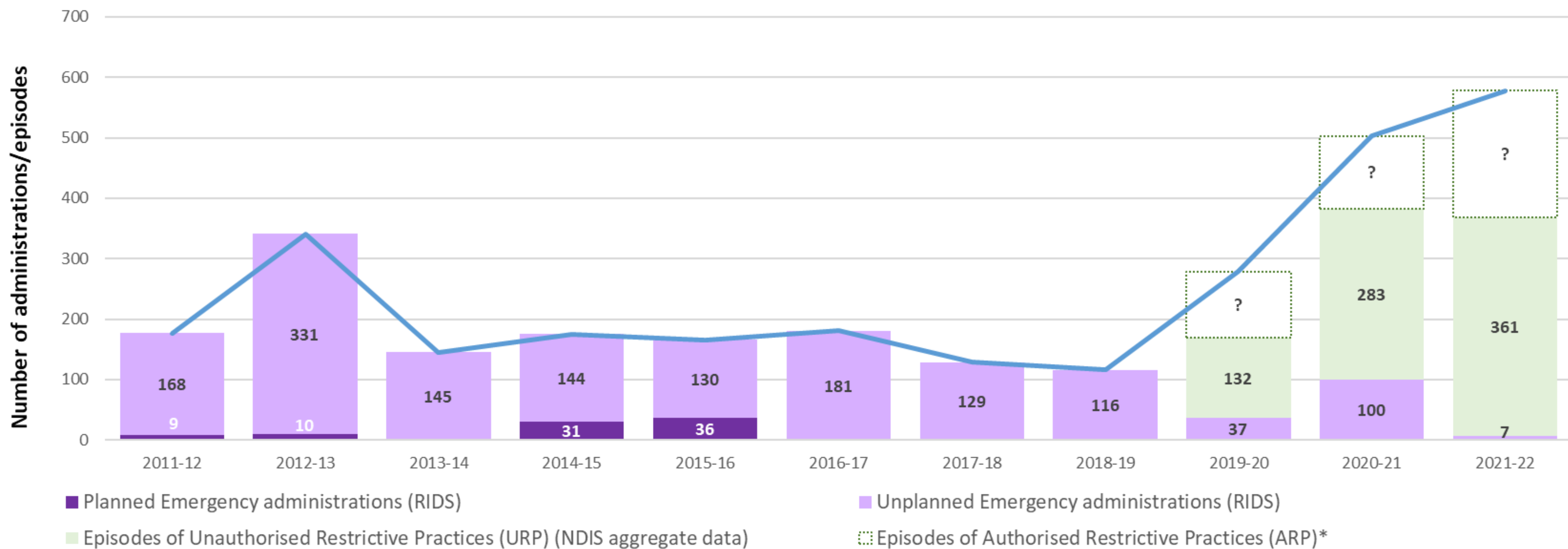
Practices that present high risk of harm to NDIS participants

Updated July 2023

1. Key points

- Certain practices place NDIS participants at high risk of harm and are associated with adverse and catastrophic outcomes such as long-term psychological or physical injury and death.
- The use of some of these practices may constitute abuse and/or neglect of an NDIS participant. These include specific forms of physical restraint and punitive approaches.
- Some of these practices are also prohibited by law in some states and territories.
- The NDIS Commission is concerned about the use of practices that present a high and unacceptable risk of harm to NDIS participants.
- The NDIS Commission's position on these practices is clear, that is, they should **not** be used.
- Use of these practices by NDIS providers, both registered and unregistered, constitutes a serious breach of the NDIS Code of Conduct.
- The NDIS Commission will take strong action against any provider and individuals that engage in these practices.
- Any practice that presents a high risk of harm to NDIS participants must be **immediately** ceased and appropriate action taken to ensure participant safety, health and well-being.
- The practice should be replaced with proactive and evidence-informed alternatives that have been based on a risk assessment.

Reported use of physical restraint (NDIS Proda ARP2 data TBC) by Victorian disability providers 2011-12 to 2021-22 by financial year of administration and type of approval/authorisation



* Column heights for episodes of authorised restrictive practices are not indicative of actual numbers because NDIS data on these episodes have not been made available.

The Senior Practitioner's Direction on Physical Restraint 2011

Physical restraint means the use, for the primary purpose of the behavioural control of a person with a disability, of physical force to prevent, restrict or subdue movement of that person's body or part of their body, and which is not physical assistance or physical guidance.

What is physical assistance or physical guidance?

a) Physical assistance or physical guidance is *not* physical restraint as defined in the direction.

b) Physical assistance or physical guidance means the use, for the purpose of the wellbeing and support of a person with a disability, of non-coercive physical contact to enable activities of daily living or for therapeutic purposes.

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Why particular physical restraint types are prohibited in Victorian disability services

Asphyxia; restraint & positional

Prone

Supine

Basket-hold

Hobble-tying or holding

Neck

Obstructing the mouth or nose

Hyperflexion at the waist; seated or kneeling

Blunt trauma to the chest, catecholamine rush, alcohol use, acidosis, psychotropic drug use leading to cardiac arrhythmia

Hyperpyrexia

Rhabdomyolysis

Thromboembolic disease

Aiken et al. (2011). *Review of the Medical Theories and Research Relating to Restraint Related Deaths*, Caring Solutions (UK) & University of Central Lancashire.

Day et al. (2010). Use of restraint in residential care settings for children and young people, *Psychiatry, Psychology and the Law, 17*(2): 230-244.

Ferleger, D. (2008). Human services restraint: its past and future, *Intellectual and Developmental Disabilities, 46*(2): 154-165.

Mohr, W.K. & Mohr, B.D. (2000). Mechanisms of injury and death proximal to restraint use, *Archives of Psychiatric Nursing, XIV*(6): 285-295.

Nadler-Moodie, M. (2009). Clinical practice guideline: 1-hour face-to-face assessment of a patient in a mechanical restraint, *Journal of Psychosocial Nursing, 47*(6): 37-43.

O'Halloran, R.L. (2004). Re-enactment of circumstances in deaths related to restraint, *The American Journal of Forensic Medicine and Pathology, 25*(3): 190-193.

Parkes et al. (2011). Effect of seated restraint and body size on lung function, *Medicine, Science and the Law, 51*: 177-181.

Paterson et al. (2003). Deaths associated with restraint use in health and social care in the UK. The results of a preliminary survey, *Journal of Psychiatric and Mental Health Nursing, 10*: 3-15.

Paterson et al. (2003a). Restraint-related deaths in health and social care in the UK: learning the lessons, *Mental Health Practice, 6*: 11-17.

Prohibited Physical Restraint Types

(a) the use of **prone restraint** (subduing a person by forcing them into a facedown position)

(b) the use of **supine restraint** (subduing a person by forcing them into a face-up position)

(c) **pin downs** (subduing a person by holding down their limbs or any part of the body, such as their arms or legs)

(d) **basket holds** (subduing a person by wrapping your arm/s around their upper and or lower body)

(e) **takedown techniques** (subduing a person by forcing them to free-fall to the floor or by forcing them to fall to the floor with support)

(f) any physical restraint that has the **purpose or effect of restraining or inhibiting a person's respiratory or digestive functioning**

(g) any physical restraint that has the **effect of pushing the person's head forward onto their chest**

(h) any physical restraint that has the **purpose or effect of compelling a person's compliance through the infliction of pain, hyperextension of joints, or by applying pressure to the chest or joints.**

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Is the *Direction on Physical Restraint* consistent with the critical features of PBS?
(Carr et al., 2002)

Quality of life	Clients and staff, multiple dimensions, focus on aspects daily schedules and interactions	Attachment 1: Explanatory Note *Why has this direction been given?*	Yes
Lifespan perspective	Intervention as an ongoing process, follow-up measured over long-periods	Only for planned emergency physical restraint	?
Ecological validity	Intervention in all naturalistic community contexts, with typical intervention agents	Applies to all disability services and their staff, volunteers and practitioners etc.	Yes
Social validity	Interventions are practical, desirable, effective (behaviour reduction and improve QoL), there is goodness of fit	Sections 1.2 and 2.2 Attachment 3: Checklist for planned intervention	Yes
Stakeholder participation	All relevant stakeholders participate, partnerships in collaboration, no expert or passive roles	Medical and behavioural consultation, existing behaviour support plan (BSP) requires consultation process	Yes
Systems change	Focus on problem contexts - not behaviour, sustained organisational changes	This is not a defined goal of the Direction but there is scope for organisation change brought about by the Direction	?
Emphasis on prevention	Focus on skill building and environmental design	Required for BSP and limited emergency nature of restraint use	Yes
Practice flexibility	Variety of data collection, single and multi-component intervention	Required for BSP and further information specified for planned use	Yes

Antecedent interventions: Luiselli, J. (2009). Physical restraint of people with intellectual disability: a review of implementation reduction and elimination procedures, *Journal of Applied Research in Intellectual Disabilities, 22*: 126-134.

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It takes more than just a legal Direction…

(c.f. *the legislative driver* (Paley, 2012))

- **Staff have many false assumptions**
- **Impact on staff**
- **Organisational factors**
- **A greater accountability of trainers**

Administrative directives

Staff re-education

Positive interventions

Staff perceptions of frequencies of incidents

Staff perceptions of safety in the workplace

Effective structures

Contextual demands

Lack of alternatives

Escalatory effects of physical restraint

Perceptions of risk

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Benefits of Regulating Physical Restraint

1. **Promotes workplace culture change**
2. **Promotes transparency of practice**
3. **Acknowledges that physical restraint is not an acceptable standard intervention**
4. **Obtain data on use – using it to advantage**
5. **Reduce negative outcomes for staff and clients**
6. **Opportunity to investigate other practices**
7. **Adoption of best practice**
8. **Attend to the legal rights of clients**

The responsibility for restraint misuse lies with individuals and the systems they operate in (Clarke, 2013)

Summary

•There are international movements to limit the use of physical restraint and prohibit/ban prone restraint

•State and national inquiries in Australia regarding the welfare of people in care

•There is no evidence that physical restraint changes a person's behaviour

•There is increasing evidence that physical restraint commonly results in injury to both parties

•There is evidence that organisational and practice changes can efficaciously reduce physical restraint use and behaviours of concern

•Disability, mental health and now the education sector in Victoria are addressing physical restraint use

•Other sectors cannot afford to not address physical restraint in the same manner

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