Physical Restraints:

A ten-year review and future policy development.

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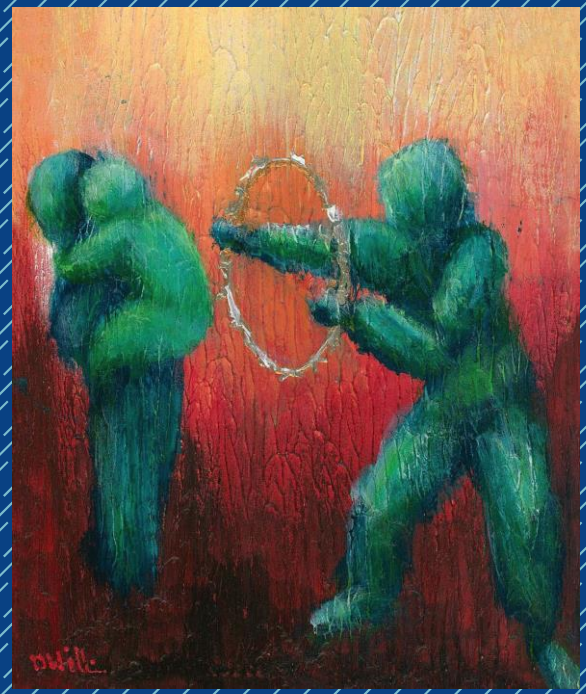

Looking Back 15 Years (McVilly, 2009)

10 areas for action > 40 recommendations

1. Defining restraint;
2. Response cost;
3. Seclusion;
4. Locking facilities;
5. Working with people with disability, their families and advocates;
6. Working with the sector to bring about a climate conducive to systemic change;
7. Staff education;
8. Regulating the use of restraint and seclusion;
9. Monitoring the use of restraint and seclusion; and
10. Research.

Looking back 15 Years (McVilly 2009; p.5)

"This review of the literature establishes that contemporary world's best practice in support of people with disability who exhibit behaviours of concern (i.e., challenging behaviours) is informed and directed by ethical, clinical and legal imperatives to at least minimise, and in many circumstances eliminate the use of restraint and seclusion.

This focus on a policy of restraint minimisation, or even the establishment of a restraint free service environment, does not of course deny the periodic necessity for staff to exercise their duty of care to protect a client from imminent danger, through their use of minimal force. Rather it focuses attention on the need to conceptualise and regulate the use of restraint as an 'exceptional circumstance', requiring a high level of ethical, clinical and legal justification, rather than as a regularly used or commonly accepted practice.

To successfully achieve this level of practice, action needs to be taken both systemically and at the point at which individuals receive support.

Failure to so act will place individuals (both people with disability and those who provide their support) at an unacceptable level of risk, physically, psychologically, legally and ethically".

Confronting questions for us all….

- Have our behaviour support policy, planning and authorisation processes deteriorated into nothing more than the licencing of ***state sanctioned violence***?

- If so, what are we going to do to reform the current policy and practice environment, to reinfuse the ***Positive*** into *Positive Behavioural Supports*?

- What are we going to do to ensure that BSPs focus on building capable environments, developing people's opportunities and skills, and improving people's quality of life?

Background Context (1)

Prior to 2019 the *Victorian Physical Restraint Direction Paper 2011*:

- prohibited the use of specific physical restraints
- did not allow physical restraints to be used in a Behaviour Support Plan (BSP)
- allowed for an 'emergency response' to be added in a BSP Appendix
- saw reporting of emergency use of physical restraint on a regular basis (RIDS)

In 2019 NDIS *Quality and Safeguards Commission* became the regulator, whilst VSP remained the authorising agency. As a consequence:

- an updated *Victorian Physical Restraint Direction Paper* was issued 2019
- physical restraint could be included in a BSP, consistent with national policy
- physical restraints could be authorised for use PRN

Background Context (2)

- There has been an increase in BSPs lodged with the VSP for authorisation that include physical restraint for authorisation.

- Data collected by the NDIS QSC on the use of physical restraint has not been available as anticipated.

- The VSP needs data and other evidence to informed and targeted policy and strategy responses to reduce and, where possible, eliminate the inappropriate use of physical restraints.

Physical Restraint: A ten Year review

The VSP has commissioned the University of Melbourne and Monash University with their partners, VALID and National Disability Services to undertake a research Project entitled:

Physical Restraint: A Ten-Year Review.

- *How best can legislation and policy governing physical restraint post 2019 provide for better levels of safeguarding and drive practice changes designed to reduce and where possible eliminate the use of physical restraint and improve the lives of people with disability subject to such restraints?*

NOTE - Our project is in the early stages - so we shall present a summary the work undertaken so far.

Physical Restraint: A Ten Year Review

Gathering Data & Building Evidence → Co-designing Policy & Supporting Practice

1. Investigating existing data and current 'good practice initiatives'	2. Investigating current Disability Service Sector responses to VSP and NDIS Policy	3. Listening to the voice of people with disability and co-designing for future physical restraint policy and practice
• Analysis of VSP RIDS data for the past 10 years • [Analysis of NDIS data] • Review of published scientific literature • Review of reputable grey literature	• Sector survey • Interviews with service providers • Focus groups with people with disability • Focus groups with family members	• A series of co-design workshops • Development of new policy • Identification of practice initiatives to support the implementation of new policy

Key Messages from the peer-reviewed literature & the grey literature

Capable Environments are critical

Legislative instruments & policy governing physical restraint and associated practices 'set the tone' – highly influential

Service leadership (from the board and throughout management) can make a BIG difference to how policy is translated into practice and if practice initiatives are implemented

Professional development + practice leadership / coaching & mentorship

Staffing arrangements -

- Quantity: Staff-Client Ratios
- Quality: Staff-Client Relationships

Informed Practice -

- Person-centred
- Data driven
- Professional development and supported practice

Risk / Safety management as an *outcome*, not as a driver or *determinant* of practice

Promising Models from the peer-reviewed literature & the grey literature

6-Core Strategies

Organisational Leadership; Lived Experience; Data; PD; Tools & Alternatives; Debriefing, support, & on-going learning

No Force First

Restraint is inconsistent with a human rights approach and detrimental to ‘recovery’; risk is understood as being shared in relationships between staff and service users; understanding what ‘last resort’ really means

Safe Wards

Recognising alienating environments; Understanding staff modifiers; Understanding client modifiers; Recognising how conflict arises; Recognising flashpoints; Containment & recovery

Promising Models from the peer-reviewed literature & the grey literature

Grafton

Integrating six principles of trauma informed practice: Evaluate the function and intent of behaviours; Promote a culture of comfort; Recognize practices that are re-traumatizing ; Reinforce training for all employees; Transform the language used; Recognize the role of the caregiver as an opportunity to heal

CALM

PBS + Trauma informed care; critical nature of staff-client relationships; integrated approaches focusing on environments, skills and personal development;

RAID Approach

PBS with a strong focus on recognising and reinforcing socially appropriate and functional behaviours; down-playing disruptive behaviours; establishing boundaries and non-physical crises intervention

Emerging experiences from (N=85) service providers

- 25% of respondents support a person who has an authorised physical restraint.
- 80% of respondents report hearing about or witnessing unauthorised physical restraint.
- Authorised physical restraints included: hand holding, response blocking, bear hugs, or redirection of movement (physical escorts).
- Unathorised physical restraints included: holding a person's arms or legs down, sitting on a person, response blocking, bear hugs, lifting a person from a seated position, or moving a person against active resistance.
- Frequently used in the absence of behaviour support plans.
- Restraint reported to be used in response to physical aggression, self-injury, or to prevent injury as a result of falls or running into traffic
- Respondents report physical restraint is used because families and staff are unaware of alternatives to physical restraint, proposed alternatives have not been effective, families and staff are burnt out and need a "quick fix," or families and staff are fearful about their safety, the safety of the individual, or the safety of others
- Respondents report that more education for families about restraint, more wrap-around family support, more education about alternatives to restraint, and more time and funding for family and staff training in PBS would help reduce the use of physical restraint

"***I worry that terms like 'zero tolerance' and the NDIS being firmer on fines will actually just make people hide it more***"

The voice of people with disability and family carers (early analysis of rich & nuanced data)

- Restraint is not often categorised (physical, mechanical, chemical, etc) but rather seen as any action that takes away peoples exercise of choice and self-determination – a human rights issue
- Restraint as a means of keeping people safe in emergencies is recognised as OK, but with reservations (and regulation over when it is to be done, and how it is to be done)
- People are at heightened risk when they are not supported by staff who know them well, and where they are supported across environments that do not communicate with each other
- Poor quality BSPs, poor training in BSP implementation, poor mentorship in BSP implementation, poor monitoring and review of BSPs: https://www.promotingpbspractice.com/
- Poor practices in engaging with the people about whom plans are being developed – the need for *supported decision making*: https://decidingwithsupport.flinders.edu.au/

The voice of people with disability and family carers (early analysis of rich & nuanced data)

- How much physical restraint is used “just in case something happens”, or to ensure support staff “are in control”
- We need more discussion about the balance between “duty of care” and “dignity of risk”
- Support work is acknowledged to be a challenging job, and support professionals need to make both practical and ethical decisions ‘in moments’
- Staff are “scared” for both their clients and for themselves – they need more support
- Need to foster person-centred approaches; but very dependent upon individual staff; culture set by the house supervisor; lack of monitoring for ‘up the chain’

Co-design of policy and strategy initiatives

- Evidence from data analysis + peer-reviewed literature + grey literature + insights from service providers, family members and people with disability to inform a co-design process

- Bring together stakeholders to reflect on the available evidence and generate policy and practice solutions that are both evidence-informed and which have ecological validity

Some Reflections to Date

- There is a paucity of data available on which to build evidence-based policy and strategy
- The data we do have has been collected in different ways at different points in time under different policy regimes ….. And consequently, poses major challenges for analysis and interpretation
- We need a well-constructed national data set that is fit for research purposes, not simply monitoring of regulatory compliance …… and which is available across all jurisdictions to inform jurisdiction-specific policy and strategies and to all ow for national benchmarking
- There is a paucity of peer-reviewed literature to inform policy development….. And as a consequence, we need to turn to related literature in the fields of mental health and aged care (but this too can be problematic)
- There are some well researched models….. But no one model need be applicable under all circumstances….. We need to take an eclectic and flexible approach to policy and practice informed by different models
- Service providers and service workers have important lived experience to contribute
- People with disability and families have important lived experience to contribute

Some Emerging Questions

- What might a good data collection process and a good data set look like to inform policy on physical restraint, and how might we generate and share such a data set across jurisdictions?

- What are the enablers (and barriers) to effectively reducing and where possible eliminating physical restraints, and how might we share these solutions across services and jurisdictions; how can we better learn from each other?

- Do physical restraints have any place in a BSP?
- Does the inclusion of physical restraints in a BSP and their subsequent authorisation simply amount to *state sanctioned violence*?
- Are we using BSPs as a mechanism to authorise, licence and legitimise *state sanctioned violence*?
- **Should physical restraints be regulated and monitored by separate means, leaving BSPs to do the work for which they were originally intended – building capable environments, developing opportunities and skills, improving people's quality of life?**

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Thank you

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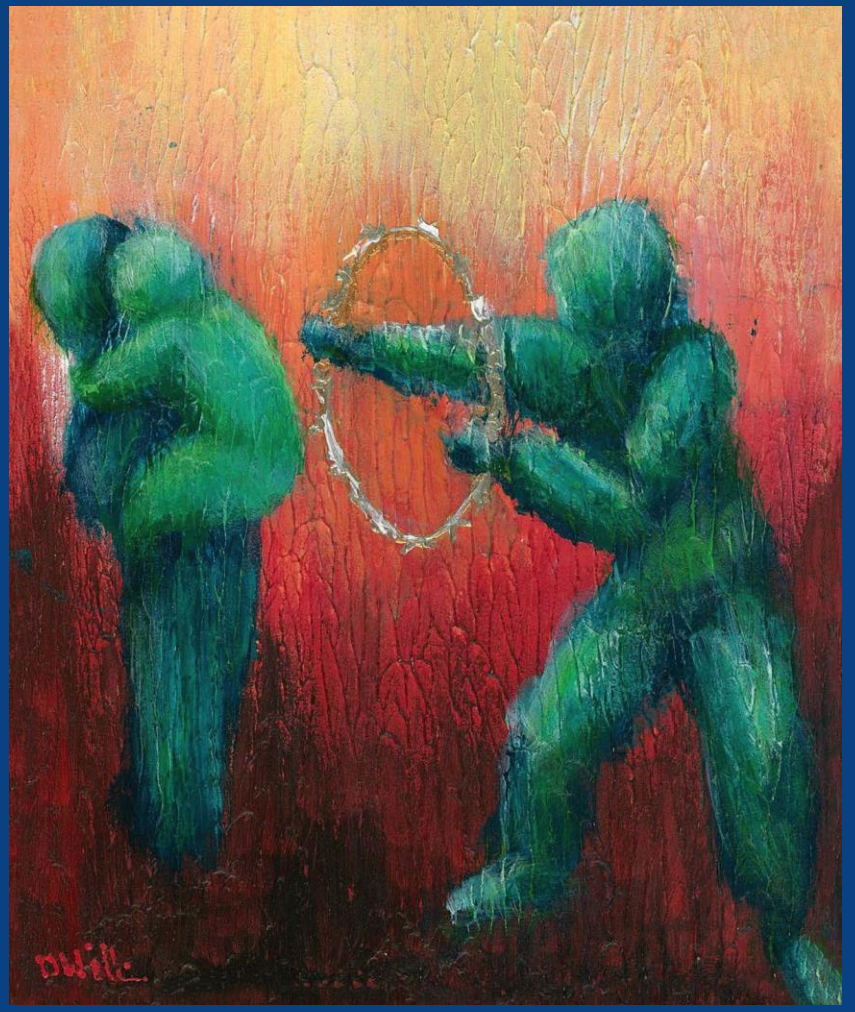

MONASH University

VALID

NDS National Disability Services