Finding a better way: Research informing policy and practice reform to reduce and eliminate physical restraints in disability services.

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Acknowledgement of Country & Commitment to Reconciliation

Let us acknowledge the First Nations Peoples on whose unceded land we meet

Let us give respect to their wisdom and

to the elders

Let us reflect on why a disproportionate number of First Nations Peoples experience disability

Let us commit ourselves to incorporating

First Nations ways of being, knowing, and doing into our PBS

Waldo (Palawa) '*Help Me Find My Way*'

Regulated Restrictive Practices

Practices that have the effect of restricting rights or freedom of movement of a person with disability.

There are generally five categories of regulated restrictive practices recognised in state and Commonwealth regulations:

- Seclusion
- Chemical restraint
- Environmental restraint
- Mechanical restraint
- Physical restraint

We have come a long way ?

Quality & Safeguards Commission Annual Report 2024-25 (tabled 5th November)

2024–25: nationally the total number of restrictive practices reported increased by 5.9% compared to the 2023–24.

2024–25: nationally 1,081 more participants were subject to unauthorised restrictive practices, representing a 9.5% increase compared to the 2023–24.

Physical Restraints authorised in participants' most recent plans:

- 2023–24: 2,969
- 2024–25: 3,100

(NB – *increases in size of the scheme and BSPs reported*?)

Background to our project

- Commissioned by the Victorian Senior Practitioner.
- To investigate and propose policy and practice solutions to build on work originally undertaken by Victorian Senior Practitioner in 2009 and to address emergent concerns:
  - ❑ the misuse of physical restraints and the subsequent adverse impact on people with disability;
  - ❑ confusion about the use of physical restraint in the exercise of a person's duty of care to safeguard people with disability and;
  - ❑ possible effects on the frequency of the use of physical restraint arising from changes to the regulatory framework associated with the transition of oversight to the NDIS Quality and Safeguards Commission.

Two Phases x Five Projects

Five research questions.

Q	Question	Method
1	What has been occurring in Victoria with respect to the reporting of physical restraints over the past 10 years, and what might account for any such trends?	Analysis of RIDS data over ten years
2	What is considered to be contemporary good practice in policy concerning the use of physical restraints in disability and related services (e.g., mental health & aged care) and what evidence exists for the successful reduction and / or elimination of such practices?	Formal academic and grey literature review
3	What are the experiences and major concerns among *disability service providers* with respect to the implementation of policy and subsequent practices designed to reduce and wherever possible eliminate the use of restrictive practices, including concerns about occupational violence, and the understanding (and potential confusion) with respect to issues of the physical restraint of clients in the exercise of an organisation's '*duty of care*'?	Survey behaviour support practitioners, interviews with managers and APOs
4	What are the *experiences and major concerns among people with disability and their families* with respect to the implementation of policy and subsequent practices designed to reduce and wherever possible eliminate the use of restrictive practices?	Focus groups with people with disability and family carers
5	How might what we have learnt about the reduction and elimination of physical restraints be translated into a stronger policy and practice framework that can be agreed upon and implemented safely and successfully in the disability sector?	Integration of all data and an inclusive codesign workshop

Research Question 1 – Reflections

What has been occurring in Victoria with respect to the reporting of physical restraints over the past 10 years, and what might account for any such trends?

1. Are our data fit for purpose?
2. How might we bring about greater transparency in data reporting and harmonise the work of state and Commonwealth agencies?
3. Are we collecting the right data – if our aim is to reduce and where possible eliminate restrictive practices, why don't our data collection processes focus on these issues: step-downs, reductions in use, and fade-outs?
4. Do we track and monitor success (*appreciative inquiry*)?

Research Question 2 – Reflections

What is considered to be contemporary good practice in policy concerning the use of physical restraints in disability and related services (e.g., mental health & aged care) and what evidence exists for the successful reduction and / or elimination of such practices?

The literature review identified 23 studies relating to reducing the use of physical restraints each of which had evidence of success that can be added to future best practice guides.

Evidence of what works included:

1. A number of multicomponent models: *No Force First*, *Safewards*, *ReSTRAIN*, *SAMSHA*
2. Single intervention studies: Mindfulness techniques; reflective practice; fixed-time release reductions, and step downs of physical holds

But:

- Generally, the research had been conducted in non-controlled / non-experimental settings
- Longitudinal monitoring of innovative interventions had not been undertaken
- **Are these frameworks and practices well known and adopted in every-day service provision (do Behaviour Support Practitioners and service providers have access to the literature?)**

Research question 3 - Reflections

What are the experiences and major concerns among *disability service providers* with respect to the implementation of policy and subsequent practices designed to reduce and wherever possible eliminate the use of restrictive practices, including concerns about occupational violence, and the understanding (and potential confusion) with respect to issues of the physical restraint of clients in the exercise of an organisation's '*duty of care*'?

1. 77% of respondents reported hearing about unauthorised use of physical restraint
2. Physical restraint (authorised or unauthorised) was reported to be used in response to concerns about: *safety of the person*, *safety to others* (staff, family, members of the public), *road/traffic safety*, *resident-to-resident assaults*, and to facilitate *access to medical care* and in support during *personal care*
3. Organisational systems for monitoring and reducing physical restraint were not perceived as being well established
4. General consensus that systems that fine organisations and people do not work. We need systems that lead to openness and positive change through learning
5. The level of bureaucracy needs to be addressed now there are two reporting frameworks (state and Commonwealth).

Research question 3 – Reflections con..

Why physical restraint continues to be used:

- *lack of training and skills* (32%);
- *attitudinal barriers* (37%),
- *belief physical restraint is necessary* (34%),
- *lack of resources* (21%),
- *wanting a quick fix* (19%),
- *organisational culture* (15%),
- *lack of awareness of alternatives* (11%),
- *inadequate oversight* (6%)

Emerging themes on *what works* for reduction:

- training (esp. practitioners)
- positive behaviour support
- better regulatory information and support
- practice oversight ensuring plans are implemented by staff and families

Research question 4

What are the *experiences and major concerns among people with disability and their families* with respect to the implementation of policy and subsequent practices designed to reduce and wherever possible eliminate the use of restrictive practices?

1. Many people simply did not know enough about what a physical restraint was, and that some restraints were banned.
2. The groups emphasised what needed to happen after an emergency restraint, so it doesn't happen again.
3. Many people observed cultures of micro-aggression and micro-control (*psycho-social restraint*)

- **McVilly, K. (2019). Psycho-social restraint: An unacknowledged cruel, inhuman and degrading restrictive practice in disability services. *International Journal of Positive Behavioural Support, 9(2)*, 41-45.**

Research question 4 – Reflections con…

- **Choice, control and communication** are at the very heart of all disability supports, and need to feature in BSPs and staff training
- People with disability and family carers **need to know more** about physical restraint – what is banned and circumstances relating to what is allowed
- Working with people with behaviours of concern take ***time*** and ***teamwork***
- The BSP development process needs to be **inclusive** and not dominated by professionals.
- People with disability and family carers are willing and able to provide training and be part of the policy making process (**co-design** as key to the way forward)
- **Systems of complaint** need to be of equal strength to the organisations against whom complaints are made.

Research question 5 - Reflections

How might what we have learnt about the reduction and elimination of physical restraints be translated into a stronger policy and practice framework that can be agreed upon and implemented safely and successfully in the disability sector?

- Need to ensure we collect the right data to inform what we do
- We need rules and guidance
- We need training
- But if we train in physical restraint this becomes the default position; need to 'train to the alternatives'
- Regular staff – know the client well; understand triggers and what settles clients
- Know the person, understand needs and build relationships of trust
- Balance risks – to the person or to property …. Staff need training and line management support
- Staff need to be able to make decisions in the moment – supported by ethics training
- Clearly written plans to help new and existing staff know the options
- People need a sanctuary place – somewhere safe to go; a known place with a known person
- Consider people's & backgrounds – history, culture, religion, values

Findings informing a way forward in policy & practice

- Re-think **data** collection & reporting
- Draw on a broad range of **practice models**
- Disseminate models, educate, coach and support service providers in implementing **evidence-informed practice frameworks**
- Apply the principles and practices of **co-design and co-production** to behaviour support
- Elevate the **voice of people with disability** in behaviour support (and counter professional / service dominance)
- Explicitly address **fear** among families and service providers about '*what might happen*'
- Progress conversations, education and training to address issues of

our Duty *of* Care *vs* our Duty *to* Care

Three new PBS Resources

The Right Direction: https://therightdirectionpbs.com/

Promoting PBS Practice: https://www.promotingpbspractice.com/

Deciding with Support: https://decidingwithsupport.flinders.edu.au/

A new publication - Key areas of *knowledge, skill, and capability:*
A Blueprint for the PBS Workforce & Workplace

1. Upholding **human rights** and dignity;

2. Formulating **goals** for behaviour support;

3. **Planning and implementing** behaviour support and intervention;

4. **Monitoring and evaluating** the implementation of behaviour support;

5. Addressing **environmental** issues;

6. Promoting **skill development**;

7. **Empowering people and their families** through education and support;

8. **Empowering staff** through education and professional development; and

9. **Augmenting behaviour support** with evidence-informed practice.

(McVilly, et al., in press. Using Expert Voices to Determine the Key Components of Positive Behaviour Support for the Development of a National Professional Development & Training Curriculum. *Journal of Policy & Practice in Intellectual Disabilities*)

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Thank you

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