



## **Health and Community Services Union submission to the Office of the Senior Practitioner: 'Rethinking the use of Physical Restraint'.**

HACSU welcomes the Office of the Senior Practitioner's [OSP] review into the use of Physical Restraint within Disability Services. We believe this is a timely review that will inform future think for service provision. HACSU agrees that all efforts should be made to limit the need for the use of physical restraint within disability services and urges the development of the necessary training and support systems and the appropriate funding for the required strategies to enact this vision. Notwithstanding this support, there are a range of concerns regarding the content of the OSP's position paper that require some additional debate.

With the enacting of the Human Rights Charter and the new Disability Act there is a need to refocus service provision to one that reflects these changes. Such a shift requires significant investment in training, development of the workforce and most importantly resourcing, including additional staffing. Little attention is given to the issues of understanding the culture, analysing strategies to reorient the focus of service providers and the possible cost of the resources required to achieve this.

Reducing the use of physical restraint is complex and requires a balanced and considered approach to chart a way towards reducing its use. We believe the OSP's position paper sets a highly emotive tone, which is neither helpful nor productive towards engaging practitioners to achieve these ends. The inclusion of de-contextualised data from the United States, including details of injuries and deaths, does not provide any insight into the Victorian experience; yet, its inclusion enables the reader to draw the erroneous conclusion that it does. The failure of the OSP to caution the reader against drawing this negative inference between these two disparate service environments is concerning. Noting this silence, it is difficult to view these references as anything other than provocative and emotive; their inclusion does nothing to enhance rational dialogue about the real issues.

In our experience, rather than focussing on international service provision as the paper does, we believe it more constructive to speak of, and about, local practice. The OSPs intention to prohibit a number of practices that are not used within Victoria is indicative of this. It is unfortunate that a significant proportion of the research quoted in the paper was sourced from overseas and the lack of local research and data on the current use of physical restraint within Disability services is of concern. We believe this paucity of local data needs to be addressed and concur with Dr Keith McVilly who in his research paper *'Physical Restraint in Disability Services: Current Practices;*



*Contemporary Concerns; and Future Directions'* also calls for more locally based research to inform future practice.

The OSP's intention to prohibit the use of *all* physical restraint *except* in unforeseen emergency circumstances raises serious questions for the safety of staff, other clients and the public. We understand it is the OSP's view that such a prohibition would not allow this form of restraint to be included in a person's Behaviour Support Plan [BSP] as an emergency response of last resort. We believe there may be certain circumstances that could require some form of physical restraint to be exercised and the mandatory removal of this may place the safety and well being of staff and clients at unacceptable risk and we are therefore not able to support such a prohibition.

During HACSU's recent Rethinking Physical Restraint Forum our member's identified the following barriers to a reduction in the use of physical restraint and made a number of recommendations to overcome these barriers. We seek further dialogue with the Office to further discuss its intent and to progress these recommendations further.

## **Barriers to reducing the use of physical restraint.**

### **Barrier 1 - No definition of physical restraint:**

Our member's identified the lack of a definition of physical restraint and the lack of policy and practice guidelines within the DHS on the use of physical restraint as a barrier to its reduction.

#### ***Recommendation:***

- *That the DHS generate:*
  - *A clear definition of physical restraint;*
  - *A clear definition of what is not physical restraint;*
  - *A policy position on the use of physical restraint;*
  - *Clear and concise practice guidelines on the use of physical restraint;*
- *That training be provided to all levels of staff, including management, regarding this change in service provision;*
- *That all future new staff inductions include the above policy documents and definitions.*

### **Barrier 2 - Lack of managerial support and guidance:**

Our member's identified the systemic and ongoing failure of management to provide appropriate levels of support and guidance to staff working in more complex locations with people with behaviours of concern as a significant barrier to reducing physical restraint.

#### ***Recommendation:***

- *That appropriate senior support is made more readily available to provide timely, proactive and responsive assistance and support to*



*staff working in complex locations with people with behaviours of concern;*

- *To ensure management and house staff to have a closer working relationship management must be more supportive and attend the workplace when there is a critical incident especially for Active Night and Sleep Over staff and in such instances debriefing be provided in an appropriate and timely manner by an external agency.*
- *To address the dislocation between office based managers and the day-to-day challenges faced by house based staff, line managers should work on shift at CRUs with people with behaviours of concern to allow them to model best practice and lead by example. This would enable:*
  - o *Staff teams to have clear understanding of agreed work practices that would ensure consistent service delivery;*
  - o *Timely review of policies and procedures to meet the changing needs of people with behaviours of concern.*

### **Barrier 3 – Staffing Issues**

Our member's identified inadequate staffing issues as a significant problem. These include: insufficient staff hours on the roster, unstable staff teams, inexperienced and / or untrained staff, the high use of casuals and / or agency staff and absence of senior roster positions as barriers to reducing the use of physical restraint.

#### **Recommendation:**

- *Ensure staff working in more complex locations are highly skilled and experienced, with minimum mandatory Cert IV for all staff;*
- *Staff to receive timely in-house training in line with the support needs of the people being supported;*
- *Inexperienced staff new to the service should not be placed in more complex locations until they have undertaken mandatory training and any other training as required by the service;*
- *Improved vacancy management protocols and systems of work must be implemented to ensure staff teams are stabilised with all vacant lines advertised and appointed to, and the development of specific specialised replacement pool.*
- *This would consist of people who would become preferred casuals, with the necessary skills and knowledge, and be prioritised to work in these complex houses;*
- *Complex locations must be adequately staffed to enable the regular and ongoing provision of Person Centred Active Support;*
- *All staff, including preferred casuals, to be trained in the use of Positive Behaviour Support and Person Centred Active Support;*
- *That all casuals should have the minimum mandatory Cert IV qualification.*

#### **Barrier 4 - Inadequate skills training:**

Our member's identified a lack of skills and knowledge regarding alternate practice to enable them to better manage behaviours of concern i.e.: de-escalation, positive behaviour support and positive strategies, as a barrier to reducing the use of physical restraint.

***Recommendation:***

- *Enhance the skill set and knowledge base of all staff, including preferred casuals, by specific training provision in a range of alternative practices. This training to be delivered at the CRU where possible and to be ongoing or have follow up as required;*
- *That specialist training is delivered on a multi-level approach and not just by one service provider but through, for example: the OSP, Specialist Services and Mental Health Practitioners and that House Supervisor and Area Managers model best practice whilst working on shift;*
- *That there is the capacity to provide training on-shift with the trainer modelling the training to the team, enabling the provision of timely feedback and review to the house staff;*
- *That House Supervisors take an active lead in the provision of direct support in the absence of other senior workers;*
- *That more training in: computer use, completing administrative tasks associated with Behaviour Support Plans and Active Support and working with people who also have mental health issues be provided;*

#### **Barrier 5 - Poor physical environment:**

Many CRUs are poorly designed and fail to meet the specific needs of people with behaviours of concern. This structural inadequacy impacts on staff's ability to appropriately support people with behaviours of concern. Our member's identified the poor and inappropriate design and layout of CRUs as creating a barrier to reducing the use of physical restraint.

***Recommendation:***

- *That a focus group comprising, among others, of staff who provide a service to people with behaviours of concern be created to have input into different models and designs of future units*
- *That the current building standards be reviewed and updated;*
- *That different models of CRU be designed which better meet the specific needs of people with behaviours of concern.*

#### **Barrier 6 - No mandatory qualification:**

Our member's identified the lack of mandatory qualifications for staff working in more complex locations with people who exhibit behaviours of concern as a barrier to reducing the use of physical restraint.

***Recommendation:***

- *That a Cert IV in Disability Studies be mandatory minimum qualification for all staff working with people with behaviours of concern;*

- *That the Cert IV curriculum be updated to include modules on Positive Behaviour Support and positive strategies to enable staff to better assist people with behaviours of concern.*
- *That a greater proportion of staff working in more complex locations undertake additional senior practitioner training and be promoted into more senior worker roles.*

### **Barrier 7 - Inconsistent delivery of Professional Development and Support [PDS]:**

Our member's identified the lack of space for staff to reflect on their practice, the sporadic provision of PDS sessions and a lack of local forums or communities of practice in which house staff can discuss and understand what constitutes best practice as barriers to reducing the use of physical restraint.

#### ***Recommendation:***

- *That PDS sessions are placed at a higher priority throughout the DHS;*
- *That management ensure PDS sessions are regularly provided, at a minimum of monthly, to all levels of staff with a focus on supportive assistance and professional development;*
- *That forums are provided and communities of practice encouraged to enable house staff understand what is best practice and provide space for staff to reflect on their practice with their peers;*
- *That staff be trained in techniques to provide them with the skills to self-assess and be self-reflective.*

### **Barrier 8 - Incompatibility between people who live in CRU's:**

Our members have identified that a poor mix of people with behaviours of concern can exacerbate those people's behaviours; this impinges on staff's capacity to reduce the use of physical restraint.

#### ***Recommendation:***

- *That the complex relationship issues that can arise as a result of a poor mix be acknowledged as exacerbating behaviours of concern. In such instances management must be more proactive to establish a better mix of people to share a house;*
- *That it be considered a Human Rights issue to be able to choose with whom you live.*

### **Barrier 9 – The Blame Culture:**

Our member's identified a culture of blame and secrecy within the DHS that is endemic, which creates fear in the workforce and produces a system that is reactive rather than proactive. Staff rarely feel supported when their practice is scrutinized by parents, OSP or the media and often feel demonised for doing their job to the best of their abilities.

#### ***Recommendation:***



- *That management take an active and supportive role when practice is being scrutinized and support staff in these circumstances. It is hard enough to work in these circumstances without being demonised for doing so.*

### **Barrier 10 – Lack of monitoring of procedures and practices**

Our member's identified the current lack of monitoring of service quality as a barrier to reducing the use of physical restraint.

#### ***Recommendation:***

- *That in instances when poor practices are identified, management are proactive, not punitive, in their response to remedy the situation;*
- *To ensure that Incident Reports are not able to go 'missing' the current Incident Report system must be updated;*
- *Incident Reports are allocated a serial number or codifier to ensure they can be tracked.*

### **Barrier 11 – Invisibility of the OSP**

Our member's identified the need for the OSP to be more visible and accessible and the role of the OSP be clarified to Disability Services staff.

#### ***Recommendation:***

- *That the OSP be more accessible to Disability Services staff, ensuring staff understand the role and intent of the OSP to enable this change in service provision.*

### **Barrier 12 – Community Visitors**

Our member's identified the failure of the Disability Act 2006 to empower Community Visitors to attend ATSS's enabling independent witnesses to scrutinise this type of service provision.

## **CONCLUSION.**

Our member's are supportive of the move to reduce the use of physical restraint but not at the expense of their or other's safety. However, the clear message that came out of the forum was that to ensure these ends are achieved the following key issues need to be addressed:

- There needs to be a clear definition of what is, and what isn't, physical restraint and the DHS needs to generate clear policy and practice guidelines regarding its use.
- Management must start to provide better and more timely support and guidance to staff working in complex locations, leading by example.
- Management need to be more proactive in their response to addressing issues of staff need and more timely in the provision of support to staff.
- Ongoing staffing issues need to be addressed with an increase in staff hours.



- The current system of vacancy management needs to be improved to reduce the reliance on casuals and agency staff and stabilise staff teams.
- Cert IV needs to be the minimum mandatory qualification required to work with people with behaviours of concern along with the provision of appropriate and, if needed, ongoing skills training to staff teams through a multi-level approach.
- To enable staff to develop in their roles they need to receive ongoing and productive PDS. The issue of the poor physical environment of many SSA's needs to be addressed

These are significant issues that require genuine consideration and attention. With a commitment to reverse the current experience of both staff and people with a disability with respect to the use of physical restraint, HACSU welcomes continued dialogue with the OSP to develop strategies and systems that will make a real difference in these services and in order to achieve the ultimate aim of reducing the use of physical restraint.

**LISA Inc. Comment:** We refer to “Barrier 9” and the reference to: *“It is hard enough to work in these circumstances, without being demonised for doing so”*

Certainly this is correct - direct care staff should not be abused by stakeholders of residents. However, direct care staff need to understand and accept that vulnerable people need support independent of the service provider to address any questionable service level and quality.

Nevertheless, this support (stakeholders) should be encouraged/directed to take matters of concern to management levels above house supervisor.

The difficulty of this being effective within the public service, is that all levels of DHHS management avoid, deny, ignore and very assertively claim the claims of the complainant are just their opinion. And, DHHS management do all in their power to intimidate/punish those who complain – residents, stakeholders and direct care staff.