Government of South Australia

Office of the Guardian for Children and Young People

Summary of the Inquiry Report

Policy and Practice in the Use of Physical Restraint in SA Residential Facilities for Children and Young People

November 2009

The rights and wrongs of using physical restraint to protect children and young people from harm are far from clear cut. This inquiry explores the strongly-held views about its use in the very real and testing context of residential facilities which accommodate children with high needs. It also provides data on the use of physical restraint from January 2007 until March 2009.

The inquiry commenced in April 2009 and was conducted by Associate Professor Andrew Day and Dr Michael Daffern for the South Australian Guardian for Children and Young People. Ms Emily Rozee was engaged to assist with the interviews with young people.

The full report can be viewed at www.gcyp.sa.gov.au

The physical restraint of children and young people by residential care staff is a topic that arouses considerable emotion. There are those who are concerned about the potentially adverse effects of restraint on the well-being of children and young people and threats to their human rights, whilst others draw attention to the need to safely manage behaviour that is extremely challenging and potentially places either the child or young person or those around him or her at imminent risk of harm.

Although there are some who would regard physically restraining children and young people as inappropriate under all circumstances, the findings of this inquiry suggest that many acts of restraint are likely to be lawful, and that the practice is supported by the policies and procedures of most residential care providers in South Australia.

This inquiry found that restraining children is a potentially dangerous practice that can cause significant injury and even death to children and young people. It is also often stressful, and can be dangerous, for staff who are involved in restraints. Although there have been no medically serious incidents of injury to children and young people that have occurred as a result of a restraint in South Australia over the period of review (since 2007), physical injuries to children and young people do occur regularly when restraint is used.

Given the lack of evidence to suggest that restraint effectively reduces either the frequency or intensity of challenging behaviours, it is apparent that the only rationale for restraint is to protect the child or young person, or others around him or her, from immediate and serious harm.

To contact the Guardian:

Tel 08 8226 8570
Fax 08 8226 8577
gcyp@gcyp.sa.gov.au

Use of restraint in SA children's residential facilities

I *have seen a great improvement in the way in which we work with young people and the reduced use of force. There are better processes in place to ensure young people's rights are being adhered to and staff are better educated and trained.*

youth worker

This inquiry found that significant advances have been made in recent years in relation to the level of awareness about the need to minimise the use of physical restraint. Evidence was received which suggests that restraint is less frequently used now than it was in 2007 at the start of the reporting period. Nonetheless, restraint remains a common, if not everyday, occurrence in South Australian residential care facilities. Over the period of review (January 2007 to March 2009), there were a total of 944 recorded incidents of physical restraint in Families SA facilities alone. In houses operated by the non-government sector restraint was less commonplace, although there are some units in which high rates of restraint have been reported.

The most striking finding from this inquiry relates to the differing use of restraint across the residential care sector. Such discrepancies might in part be explained by a number of factors, including differences in the profile of residents, the purpose of the facility, whether there is an option of withdrawing the service , staff to resident ratios, and the physical environment in which children and young people live. They might also arise as a result of the values and philosophies of particular care settings, and the range of behaviour management strategies that are available to staff. They do illustrate, however, that restraint is neither an inevitable or perhaps even necessary part of providing residential care.

Policies and procedures

Every unit, at this point in time, does their own thing and has their own interpretation in relation to behaviour management

youth worker

The inquiry found that, although each agency was able to provide examples of written policies and procedures relevant to the use of restraint, there are significant differences in these across the residential care sector. Although there was general agreement that physical restraint, if it is to be used at all, should only ever occur as a last resort and involve the minimal use of force, many of the policies and procedures were in draft form, contained inconsistencies, and/or a lack of clarity about how the term physical restraint should be operationalised, and what terms such as 'last resort' or 'significant harm' might mean in practice. This left their implementation up to the interpretation of individuals or staff groups, resulting in inconsistent practice and some degree of confusion for both residents and staff.

Training and advice

Unless you change the culture it doesn't matter if you have a swimming pool in every bedroom it will stay the same.

manager

It was not within the terms of reference of this inquiry to recommend particular approaches to behaviour management. However, the use of restraint cannot be considered in isolation from the ways in which challenging behaviour is managed. It was apparent, across the residential care sector, that there is a need to further develop positive approaches to managing individual behaviour, to develop coherent and fair systems of rewards and sanctions, processes for diversion, de-escalation and defusion, and safe ways of removing children and young people from locations where they present a risk to others.

Accountability

[Restraint] should be allowed if absolutely necessary, but not for stupid stuff like yelling or trying to run away.'

young person

There is evidence to suggest that a reduction in the use of restraints will occur when behaviour management practices come under scrutiny. In practice this not only involves the development of clearer and more consistent policies and procedures and training programs, but an ongoing commitment to the review, monitoring, and audit of every incident of physical restraint. Systems are currently in place across the sector to ensure that incidents of restraint are reported, and it appears that generally these are working well; that incidents are reviewed and that concerns are followed up by service managers. Those reviewing the incidents, however, are often also responsible for the running of the units in which they occur, as well as the management of the staff who are involved.

This gives rise to potential conflict in the review process between the need to support staff and to promote change in places which have high rates of restraint. The managers also believe that they have limited power to manage performance issues when restraint is used inappropriately.

It is apparent that debriefing following an incident of restraint does not always occur, and that there are no consistent processes in place to review circumstances when a young person has been repeatedly restrained within a short period of time, or to review or revise the care plan under such circumstances.

Physical and social environment

I do agree about having no more than six kids to a unit... there is less dynamics for young people who are easily aroused... ...they feel safer, there is less power games, better relationships with staff, they get more attention. It is easier on everybody.

youth worker

Interviewees commented on the need for facilities to have spaces that allow withdrawal from others, privacy, and reflection, as well as to be located in places in which safety concerns are minimised (for example, away from busy roads). The physical design and location of facilities can clearly play an important role in assisting residential care staff to manage behaviour in ways that do not involve physical restraint.

The social environment, however, is equally if not more important than the physical environment. This can be understood in relation to the dynamics that emerge in caring for groups of young people of differing sizes, with differing ages, and mixed genders. It was the view of many of those interviewed that restraint is much less likely to occur when young people are cared for either individually or in small groups (less than six residents in a unit or home), and when staff-resident ratios are high. At the same time, it also would appear to be the case that practices within particular staff groups develop and become entrenched over time, and that a culture in which restraint is more likely to be used does exist in certain settings and units.

Recommendations

I've seen one kid get restrained and it's messed up his life. He just thinks that nobody loves him, nobody care about him – all I do is get hurt, I don't know what to do. And he's still getting into trouble to this day.

young person

1. That the *Family and Community Services Act Regulations 1996* are amended such that use of force is not permitted to ensure that the resident complies with a reasonable direction given by an employee of the centre.

2. That a common policy on the use of physical restraint is developed by Families SA and shared with all residential care providers. It is further recommended that:

   a. This complements the development of evidence based practice guidelines (by Families SA), and be informed by a set of principles of behaviour management developed in agreement with all residential care providers.

   b. This includes provision for the separate monitoring and review of the use of mechanical restraints in secure care training centres.

   c. Debriefing with staff members, staff teams, and the young person who has been restrained is mandated, such that it occurs routinely and as part of standard practice.

   d. Care plans be reviewed and revised after each incident of restraint to include comment on how to respond to similar behaviour without the use of physical restraint.

   e. Restraint is never sanctioned to secure compliance or to punish children and young people.

   f. Physical restraint should not be done by a single staff member for children over 10 years of age.

3. That a system for the external monitoring of physical restraints is set up to:

   a. Receive all data and records of use of restraint so that there is systematic mapping of use.

   b. Review those units with apparently high levels of restraint.

   c. Provide advice on occasions when a young person has been restrained more than once over a one week period.

   e. Ensure that multi-disciplinary team services and support is sought where a young person is repeatedly restrained.

4. That residential care, is offered to groups of up to four children and young people, with an absolute maximum of six where children have low need or are sibling groups, and that residential care facilities are designed or re-designed for appropriate withdrawal spaces for residents.

5. That all residential care staff be required to receive training in both crisis intervention and behaviour management prior to working in residential care facilities, receive on-site training and supervision of their practices, and are expected to attend ongoing updates and refresher courses.