



Director of Forensic Disability POLICY

Title: Use of Reasonable Force

1. Policy Statement

This policy addresses the use of reasonable force via physical restraint at the Forensic Disability Service (FDS). The use of reasonable force is lawful under the *Forensic Disability Act 2011* (the Act). The use of reasonable force also raises a number of ethical dilemmas and can in some circumstances amount to a breach of a client's rights.

This policy must be read in conjunction with the *Director of Forensic Disability Policy - Regulated Behaviour Control*.

2. Purpose

This policy sets out the relevant provisions of the Act and the Director of Forensic Disability requirements regarding the use of reasonable force via physical restraint at the FDS. More specifically, it:

- defines physical restraint;
- sets out a number of prohibited techniques of physical restraint;
- states the limited circumstances in which physical restraint may be used; and
- outlines the reporting requirements for the use of physical restraint.

3. Scope

This policy applies to the FDS. The Administrator, Senior Practitioners, Authorised Practitioners, and other persons appointed under section 104 of the Act, performing a function or exercising a power under the Act must comply with this policy.

This policy does not apply to police officers exercising their powers with respect to forensic disability clients, or the use of restraint (or 'clinical holding') under other jurisdictions such as by medical professionals for the purpose of essential care, assessment and treatment of the client.

This policy is not intended and should not be read or construed in any way as attempting to describe, circumvent or limit the application of the common law or the provisions of the Criminal Code Queensland relating to the use of force in self-defence, protection of the public, and concepts of duty of care.

This policy must be implemented in a way that is consistent with the purpose and principles of the Act.

4. Authorising Legislation

Section 91 of the Act.

5. Position on use of physical restraint

The use of physical restraint raises a number of ethical dilemmas and can constitute a breach of an individual's human rights. Physical restraint is also known to cause harm, including psychological distress, trauma, physical injury and in some instances, death (Allen, 2011).

Additionally, people who have experienced physical or sexual abuse and trauma who are exposed to physical restraint are at increased risk of developing or exacerbating conditions such as anxiety, depression, or the recurrence of post-traumatic stress disorder (Cusack, Cusack, McAndrew, McKeown & Duxbury, 2018).

Staff who implement physical restraint are also at risk of being physically injured or experiencing strong emotions including fear, anger, sadness, worry, shock, frustration, and self-doubt that may influence their future interactions with forensic disability clients (Sequeira & Halstead, 2004). The use of physical intervention can damage positive relationships that have been established, and impact on the client's ability to trust staff and feel safe.

The position of the Director of Forensic Disability is to minimise, reduce and where possible, safely eliminate the use of physical restraint within the FDS. Physical restraint should be planned, used in very limited circumstances, and only as a last resort.

6. Policy

6.1 Defining physical restraint

Physical restraint is not defined under the Act. Therefore, for the purpose of this policy, physical restraint is defined as:

“any direct contact where the intervener's intention is to prevent, restrict, or subdue movement of the body of another person” (Cusack et al, 2018)

The Act only supports the use of physical restraint where it has been deemed as necessary and reasonable to intervene with a regulated behaviour control (behaviour control medication, mechanical restraint or seclusion) under section 68, or to detain the client in the FDS under section 155.

If FDS staff assess the need to use physical restraint with a forensic disability client at the FDS, it must only be used with the minimal force that is necessary and reasonable in the circumstances as stipulated in sections 68 and 155 of the Act.

The Act, sections 113(2) and (3), 151 and 155, legislates that a practitioner (as defined under the Act section 104) supporting a client absent from the FDS or on community treatment may use the reasonable force necessary where a client is under their charge, and:

- absconds from them during the absence from the FDS or community treatment; or

- the authorised period of community treatment has ended and the client is required to return to the FDS.

Section 150 stipulates that the client is lawfully detained, and under the legal custody of the Administrator. Section 155 also permits the use of the minimum force that is necessary and reasonable for the exercise of the Administrator's power to detain a client to the FDS where the client is authorised or required to be detained in the FDS.

If an FDS staff member is unsure of the legislative or policy requirements regarding the use of reasonable force, they should consult the Administrator and proceed in accordance with the Administrator's advice. Refer to Attachment 1 for further information on the relevant Act provisions.

Prior to considering the use of reasonable force it must be determined that it is the least restrictive approach. For some clients the use of reasonable force would not be deemed a safe course of action. The following considerations should be given:

- Is it the only course of action? Is it absolutely necessary?
- Are there any other strategies which could be implemented which are likely to achieve the same outcome?
- Is the use of reasonable force for physical restraint less risky than the behaviour it is being used as a response to?
- Will the potential harm caused by undertaking the physical restraint be less than the potential harm of not intervening?
- What are the risks (such as medical condition/s, physical or psychological trauma) to the person exposed to it?
- What (if any) risks or potential harm does the strategy pose to staff or other people?

6.2 Use of techniques

Staff should only physically restrain a client if they have received appropriate training while employed by the FDS. Staff must only use accredited FDS physical restraint training and must not improvise or use any other physical restraint method. The client's wellbeing and safety must be closely observed for the duration of the restraint and post-restraint.

The correct application of physical restraint should include, but is not limited to, the following:

- the head and neck are protected and not in danger;
- the airway and breathing is not compromised;
- the client's basic vital signs (e.g., skin colour) and wellbeing are able to be monitored;
- the person is standing or seated as soon as practicable (noting risk associated with seated even when the torso is kept upright); and
- appropriate aftercare strategies are implemented.

6.3 Physical restraint techniques

There is a growing body of evidence that specific techniques and practices associated with an act of physical restraint are indicated as high risk. Such techniques increase the risk to clients and staff

including risks of physical harm, psychological harm and in extreme instances, death (refer to Attachment 2 on evidence base regarding high risk techniques).

As required by the Act, a risk management plan must be part of the client's Individual Development Plan (IDP) (section 15(2)) (refer to *Director of Forensic Disability Policy and Procedure - Clinical Risk Assessment and Management*). Where physical restraint is a last resort strategy, the risk management plan must highlight any identified individual client risks and how identified risks will be reduced with the aim of avoiding the use of physical restraint (refer to Attachment 3 on planning and risk assessment).

It is crucial to understand the profound negative psychological effect that physical restraint has on people who have experienced trauma in their lives. Trauma experiences are a likely factor for many clients at the FDS (refer to *Director of Forensic Disability Policy – Trauma Informed Care*).

6.3.1 Techniques specifically prohibited for use on a client

While this is not an exhaustive list, the following physical restraint techniques or approaches are specifically **prohibited** for use on a forensic disability client as part of a physical restraint response in the FDS:

- Any restraint with the purpose of applying pressure and pain to a person;
- Basket holds (e.g., subduing a person by wrapping both arms and or legs around their upper or lower body);
- Unsupported take-down techniques (e.g., subduing a person by forcing them to free-fall to the floor or by forcing them to fall to the floor with no support);
- Any physical restraint that has the purpose or effect of restraining or inhibiting a person's respiratory or digestive functioning;
- Any physical restraint that has the effect of pushing the person's head forward onto their chest or lap so the person is bent forwards;
- Any physical restraint that has the purpose or effect of compelling a person's compliance through the infliction of pain, hyper-extension or hyper-flexion of the joints, or applying pressure to the chest, abdomen or joints;
- Any strikes or so called 'distraction techniques' which use the application of pressure or short term pain or discomfort to gain compliance of that person; and
- Any use of prone restraint (subduing a person by forcing them into a face-down position).

6.3.2 Techniques regarded as high risk

Techniques regarded as **high risk** should be avoided wherever possible on clients at FDS. While it is not an exhaustive list, the following techniques should only be employed if all other reasonable alternatives have been tried and found to fail:

- Use of supine restraint (e.g., managing a person by restraining them in a face-up position whilst on the ground); and
- Controlled techniques which assist a person's descent from standing to the ground.

In relation to the use of supine restraint, all floor restraints have an increased risk regardless of how a client is held. This is particularly so in acute settings where there is an increased risk of excited delirium occurring in the population, and complications occurring due to interactions between what people do, environmental factors, the client's medical history and prescribed medications. The Administrator and Senior Practitioner must consider an individualised approach to use of physical restraint with clients and, importantly, take into account a person's pre-existing physical/ medical condition(s) and/or prescribed medications.

Refer to Attachment 1 and 3 for further information on legislative considerations, and appropriate risk management frameworks to be applied.

6.3.3 Reporting the use of physical restraint

Any use of physical restraint must be reported immediately to the Administrator. The details of the incident and the techniques used are to be recorded in the client's records and the incident reporting process.

The Administrator must notify the Director of Forensic Disability of any use of reasonable force (refer to *Director of Forensic Disability Policy – Notification to Incidents to Director of Forensic Disability*). The Administrator must send through the incident report and provide information about how future management of the client will be undertaken with consideration to the known risks, and include a plan for reducing the use of physical restraint. The Senior Practitioner must ensure that the appropriate information is added to the client's IDP and communicated to all staff.

6.4 Recording and reporting

6.4.1 Records

A record must be made for every situation where physical restraint is used. A record is to be made in the client's file.

The Administrator is to also ensure that any use of physical restraint is recorded within the context of a Behaviour or Incident Report within the Forensic Disability Act Information System (FDAIS), and referenced accurately within the Behaviour and Incident Report Register within FDAIS. This Register will then provide a record of all use of physical restraint at the FDS.

The following information must be recorded in both the client file and Register:

- The names of staff members involved in the incident;
- A description of the situation and the behaviour that gave rise to the use of the physical restraint;
- The nature of risk that was present, including the people who were at risk;
- The least restrictive practices used prior to the physical restraint;
- A description of the physical restraint technique that was deployed by team members;
- The duration that the person was held in a physical restraint;
- Details of what occurred during and after the restraint, including after care strategies as appropriate;

- The names of any witnesses including other clients; and
- Details of any injuries and treatment given as a result of the injuries.

6.4.2 Reporting

Where required, the FDS should follow the departmental critical incident reporting process regarding any critical incident involving physical intervention. However, the Director of Forensic Disability must be notified of any use of reasonable force on a forensic disability client (refer to *Director of Forensic Disability Policy - Notification of Incidents to Director of Forensic Disability*).

7. Roles and responsibilities

Administrator

The Administrator must:

- Ensure the Director of Forensic Disability is notified of every instance of physical restraint;
- Ensure any use of physical restraint is recorded as a behaviour or incident report and within the Behaviour and Incident Report Register;
- Ensure a record is kept of all staff training; and
- Ensure staff can access relevant training in conflict management and physical intervention and have their skills refreshed at regular intervals.

Senior Practitioner

The Senior Practitioner must:

- Ensure each forensic disability client has an IDP and risk management plan which appropriately addresses alternatives to the use of physical restraint (such as defusing and redirecting behaviour) for the client's ongoing care in the FDS;
- Ensure the IDP is regularly reviewed and includes strategies to reduce, eliminate and avoid the use of physical restraint;
- Ensure systematic incident review and data analysis is undertaken after each individual incident to evaluate the level of risk presented by the use of physical restraint; and
- Ensure support mechanisms are in place for clients who were subjected to the use of physical restraint.

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Designation: Director of Forensic Disability

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Attachment 1 - Legislative Considerations¹

A.1.1. Minimum force

Physical restraint is lawful where it constitutes the use of minimum force necessary and reasonable in the circumstances under sections 68 and 155 of the Act.

Pursuant to section 68 of the Act a Senior Practitioner or Authorised Practitioner may, with the help, and using the minimum force, that is necessary and reasonable in the circumstances: (a) administer behaviour control medication; (b) use mechanical restraint; or (c) place a client in seclusion.

Section 155 permits the use of the minimum force that is necessary and reasonable for the exercise of a Practitioner's power under section 37 (taking a client to an authorised mental health service if transferred); section 113(2) or (3) (taking a client to the FDS or an authorised mental health service); or section 151 (taking a client to appear before court and return to the FDS).

Section 155 also permits the use of the minimum force that is necessary and reasonable for the exercise of the Administrator's power to detain a client in the FDS where the client is authorised or required to be detained in the FDS.

¹ This Policy should not be considered legal advice.

Attachment 2 - Evidence base regarding High Risk Techniques

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Rimland, S (2011) *Strategies and Barriers to Minimising the Use of Restrictive Practices and a Review of Initiatives across Human Services Sectors*. Centre of Excellence for Behaviour Support, Department of Communities and Multicultural Affairs, Queensland/University of Queensland.

Attachment 3 – Planning and Risk Assessment

A.3.1. Planning

For each individual client, the Senior Practitioner must consider whether physical restraint is likely to be necessary in the exercise of reasonable force under sections 68 or 155 of the Act or in the exercise of duty-of-care, and with consideration to the legislative considerations referred to in Attachment 1.

Subject to the above conditions, physical restraint may be implemented in an emergency situation or as part of a planned response.

Emergency means a sudden state of danger requiring immediate action to prevent or manage a serious and imminent risk of harm to the person or to another person or people, and where the client's behaviour/risk is not known or foreseen by FDS.

Planned use of physical restraint is:

A planned response developed when physical restraint is necessary as a last resort and is part of an agreed and planned response to a **known potential risk (foreseeable risk)**. It is a risk-assessed response to a known behaviour aimed at preventing or managing a serious risk of harm to the person or to any other person.

A.3.2. Risk Assessment for the use of physical restraint

The Senior Practitioner must ensure that management plans are developed to reduce the risks of harm from physical restraint. In developing a management plan for physical restraint, the Senior Practitioner must consider the risks associated with using physical restraint and must plan for management of these risks. The Senior Practitioner must demonstrate that they have considered and conveyed to staff specific risks such as:

- the physical health condition(s) of the person;
- the weight of the person;
- the particular syndrome of the person (as there are particular physical conditions that increase risks, such as people with Down and Turner syndromes who may have cervical spine instability or abnormality);
- current medication that may also increase the risks (for example, medication such as chlorpromazine and carbamazepine, which may affect particular heart function);
- neurological or psychological factors;
- whether the act of restraint itself may reinforce the behaviour of concern;
- the alternatives to the use of physical restraint and evidence why these are unlikely to be helpful in promoting a safe outcome;
- how the use of physical restraint will be avoided, reduced and eliminated; and
- behavioural risk and a clear rationale for managing presenting risk.

The Senior Practitioner must review the risk assessment on a regular basis. The risk assessment will inform the risk management plan and where relevant, the behaviour support plan and other planned responses. Risk management plans should indicate how identified risks will be reduced with the aim of avoiding the use of physical restraint.

With regards to the use of physical restraint the Senior Practitioner must be able to show that environmental risk assessments have been undertaken and considered prior to any use of physical restraint as a last resort.

An assessment of contra-indications for the use of physical restraints related to health will be undertaken for every client in line with the client's current health status. An assessment of other contextual and environmental risk factors that may be contra-indications of physical restraints will also be undertaken (refer to A.3.3 Contra-indications to the Use of Physical Restraint).

A.3.3. Contra-indications to the Use of Physical Restraint

The Senior Practitioner should also consider the following health contra-indications and seek medical advice before planning for the use of physical restraint:

- known history of heart or vascular problems (such as a history of arrhythmias, high blood pressure or low blood pressure);
- known history of difficulty with breathing, or a history of respiratory illness (such as asthma, sleep apnea or chronic chest illness);
- known history of musculoskeletal problems (such as abnormal curvature of the spine [scoliosis and kyphosis], neck and or back problems, arthritis, recent fractures or history of dislocated joints or osteoporosis);
- known history of neurological conditions such as epilepsy or cerebral palsy;
- known history of metabolic disorders;
- presence of any syndrome that increases risks in any of the above factors (for example, people with Down syndrome often have unstable neck joints – known as atlantoaxial instability; people with Rett syndrome are prone to scoliosis; or a person with cerebral palsy may have impaired respiratory function);
- presence of a sensory impairment (visual or hearing – the person may experience further stress from not understanding what is happening to them);
- presence of sensory integrative dysfunction which may affect how a person experiences touch sensations, pain and their sensory perception of their environment;
- presence of a communication impairment (ensure support staff know how the person communicates, such as, understanding if the person is showing visible distress and therefore is unable to respond appropriately);
- the person is elderly;
- the person is obese, underweight or has any other problems with weight that may increase risks;
- the person has a history of a mental health issue or post-traumatic stress disorder;
- the person is on current medication that increases the risks in any of the above factors; and
- conditions which may increase risk factors in the client such as sickle cell anemia.

In developing a management plan for implementing physical restraint, the Senior Practitioner should also ensure FDS staff avoid the use of physical restraint, where possible, in cases where the client:

- has recently been physically unwell;
- has experienced recent bereavement or distress;

- has experienced significant change in their daily routine and hence may be in a heightened state of anxiety;
- is having a meal or drink or has just finished eating or drinking;
- is in an environment that may increase risks to staff or the client.

A.3.4. Stopping the Physical Restraint Immediately

The Senior Practitioner should ensure staff are aware of the risks and contra-indications associated with the use of restraint. The Senior Practitioner should also ensure FDS staff are aware that they should cease physical restraint immediately, where the client being restrained shows signs of any of the following conditions:

- breathing difficulties – very rapid or slow breathing;
- fits or seizures;
- choking;
- vomiting or diarrhea;
- blue colouration of the hands, feet, lips or other parts of the body (indicating reduced oxygen circulation in the blood);
- bone fractures;
- any other signs which staff interpret or recognise as a sign of distress for the client;
- the client reports pain or show signs of being in pain.

A.3.5. References

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