"It's just a part of the job, Carers know what they signed up for"

Exposing the impacts of physical restraint use on Carers in the Australian out-of-home care sector.

Benjamin Jones

Introduction

The Australian Institute of Health and Welfare (2018) advised that as of June 20, 2018 over 45,000 children and young people were residing in out-of-home care in Australia primarily due to exposure to family violence, abuse, and neglect. This figure is growing and is an increase of 51% since 2002 (Australian Institute of Health and Welfare, 2019). This growth has occurred despite a 2015 independent review commissioned by the Australian Government into out-of-home care. This review declared that the out of home care system was failing in its responsibility to address the complex needs of vulnerable children in out-of-home care (Tune, 2015).

When children enter the out-of-home care sector they receive support from care staff known as carers. In Australia, Carers are often unqualified, under skilled, and inadequately trained as therapeutic practitioners (Healy, Meagher & Cullen, 2009). These Carers however are required to provide support for many of the most vulnerable, emotionally dysregulated, and at times violent, children in Australian society (NSW Government, 2018). Kim & Hopkins (2015) identified that child workers are at the highest risk of workplace violence in the entire human services sector. Violence was identified as being an immediate risk to themselves or others.

Despite a carers own ethics, values and belief systems, many Australian out-of-home care policies replicate the NSW Governments (2018) legislated 'Restricted Practice Authorisation Policy' and require care staff to be trained and use restricted practices such as physical restraints to assist with keeping identified young people safe when there is imminent risk of harm to the child, staff or others.

In context to the Australian residential out-of-home care sector, physical restraint is identified as the 'use of action or physical force to prevent, restrict or subdue movement of a person, for the primary purpose of influencing their behaviour' (Department of Health, 2018).

The decision to physically restrain a child and intervene against a person's freedom in response to behaviour is one that is ambiguous, frightening and incredibly dangerous with occurrences resulting in trauma, injuries and even death to the child or young person (Nunno, Holden and Tollar, 2006). Despite the associated risks, physical restraint is regularly applied by Carers in residential out-of-home care settings on children and young people at rates higher than adult patients in psychiatric treatment facilities (Caldwell, 2010). Ethical concerns related to professional integrity and social justice are highlighted within this confronting statement in a sector that is paramount to increasing justice and social fairness to vulnerable and high needs children and young people (Australian Community Workers Association [ACWA], 2017).

Carers have a critical role to the well-being of children and young people recovering from significant trauma. Garfat (2004) outlines that the most valuable tool care workers have in their therapeutic Interventions with children and young people is themselves. Steckley & Kendrick (2008), identified that the lasting effects of applying a physical restraint can be long-term and traumatic. Throughout the literature review and in the authord extensive experience in the out-of-home care sector training physical restraint across Australia, there is sparse information taught or available that identifies the impacts that physical restraint has on those applying these high risk interventions.

Given the dangers of physical restraint, lack of literature, ethical issues and high turnover rates of carers in the out-of-home care sector, the author set out to answer the question: What are the impacts on carers using physical restraints on children and young people in residential out-of-home care?

This paper will discuss research of restraint related literature across various countries and sectors to identify the impacts restraint use has on carers through the consideration of theory, exploration of ethical principles and applying the authors practice experience. Systems and Trauma Theory will be used to examine the complex impacts and recommendations will be proposed to provide greater support to Carers working in the out-of-home care sector.

Literature Review

Despite the high frequency of restraint use in the out-of-home care sector, A literature review into the impacts of physical restraint on carers was conducted and had concerning results. Not a single article published from January 2010 and March 2020 across Australia, The United States or United Kingdom focused primarily on the impacts of restraint on Carers in the out-of-home care sector, highlighting a stark absence of research into a critical issue. Despite high prevalence and frequency, is the sector turning a blind eye?

To source relevant literature, search fields were required to be broadened to include juvenile detention centres, and psychiatric treatment facilities. An additional 11 articles were identified through consultation with professionals and searching reference lists of relevant articles outside the initial date range. A total of 14 appropriate literature items were identified in relevance to the practice question.

The articles contain a range of qualitative and quantitative research methods from programs and care facilities across Australia, United States and United Kingdom. In analysing the articles, the primary impacts were physical and psychological effects.

Physical Impacts

Physical restraint use can result in significant injuries with carers disclosing injuries ranging from cuts, scratching, biting and swelling all the way to bone fractures (Braxton, 1995; Lebel et al, 2010; Sanders, 2009). In an Australian study of over 721 child protection staff, many disclosed role related impacts of physical exhaustion, fatigue, insomnia and intestinal issues with 22% of staff interviewed advising that they had taken leave at some point in their role as a result of being injured or unwell following violent incidents (Briggs, Broadhurst, & Hawkins, 2004).

In addition to the risk of injury, additional physical impacts included high frequency to engage in negative coping mechanisms that included substance use, alcohol use, overusing prescription medications or acting irrationally by quitting employment or taking frustrations out on significant people unrelated to the incident (Briggs et al., 2004; Sequira & Holstead, 2004; Smith, 2017).

Psychological Impacts

The exposure to high risk and dynamic violent situations experienced by carers when using physical restraint has the potential to have large and lasting impacts on the psyche and emotional state of a person (Bloom, 1999). Incidents in which a young person is displaying violent behaviour by attempting to hurt themselves or others is likely to lead to carers feeling fearful (Bracha, 2004). Chronic fear is evidenced to result in severe psychological impacts including mood swings, disassociation, stress disorders, nervous system alterations, immune dysfunction, and lasting feelings of helplessness (Caldwell et al., 2010; Caringi and Pearlman 2009).

Sequeira and Halstead (2004) reported that in the nursing sector, the use of restraint in psychiatric treatment facilities has immediate psychological impacts on staff including symptoms such as anxiety, fear, anger, distress and crying. This data also outlined tendency of psychological impacts post shift once adrenaline had reduced, staff support was minimised and staff were left to return to their own families to process the psychological enormity of what they had experienced. Impacts included insomnia, inability to concentrate and regular memory loss (Cusack et al., 2018).

Smith (2017) and Steckley et al. (2008) outline similarities through the use of direct quotes from out-of-home carers during interviews on Client experiences. Carers in the UK labelled restraints as horrific and described that they often returned home stressed, numb and felt a range of emotions including impacts of guilt, shame, worry, defeat. Carers reported having significant onset of panic and confusion regarding their own decisions, ability to keep others safe and their own suitability to the industry.

Szmuckler and Appelbaum (2008) reviewed the use of restraint in mental health inpatient settings, identifying that even witnessing a physical restraint occurring could evoke strong psychological trauma, contribute to staff being fearful of future engagement with clients or lead to staff being desensitised or hardened to restraint use.

An Out-of-Home Care practice perspective

When reviewing the literature in relation to physical restraint procedures, there are many similarities between out-of-home care and juvenile justice and psychiatric treatment facilities. These similarities identify an abundance of similar physical and psychological impacts that are transferable regardless of industry. The author however identifies that when considering his knowledge and experience in the out-of-home care sector, the absence of Australian out-of-home care literature results in a number of unique and significant differences not being considered throughout the literature that would be likely to contribute to additional significant impacts on carers in the Australian out-of-home care sector.

Out-of-Home Care therapeutic expectations and Staff Ratios

Unlike juvenile justice centres and psychiatric treatment facilities, and despite misconceptions, the children and young people are in care primarily due to being victims of abuse or neglect and not behaviour (NSW Government, 2018). Children are not living in institutionalised locked buildings with multiple qualified staff. Children in out-of-home care reside in homes in the community whilst receiving 24/7 trauma informed care. This care is often provided by one Carer

who is responsible for up to four children and young people. If a physical restraint occurs in out-of-home care, staff are often isolated, unable to access immediate support or debrief and heavily rely on phone calls or 000 emergency responders. Carers engaging in a high-risk restraint with a young person at 6pm, may not even see another staff member until the following day.

Carers that are frightened or fearful of children disclosed hesitation to continue meeting requirements of the role and even reported minimising their engagement and responsibilities to supporting children whilst on shift to reduce the likelihood of further challenging behaviour (Lebel et al., 2010). Unlike other sectors, they are unable to render assistance or finish the remainder of the shift in another support wing. Common roster and staff shortages witnessed in the sector has even result in the carer unable to leave shift despite requesting to do so.

Carers who have used physical restraint on children have reported fractures and distrust in their relationship post restraint which had lasting effects on the ability to reconnect with the child (Braxton, 1995; Smith, 2017; Steckley et al,, 2008). Braxton (1995) identifies that when fear impacts a carer, the carer often engages in survival techniques described as being erratic, irrational, and punitive as opposed to therapeutic interventions. Not only does this impede a carers sector requirement to provide trauma informed care, it also fails to meet Australian ethical practice guidelines that promote that individuals have a human right to appropriate supports (ACWA, 2017).

Restraint responsibility, ambiguity and impacts on carers decision making

What defines violence and when to use physical restraint remain a subject of interpretation, ambiguity, and confusion. (Nunno et al., 2006). An individual's interpretation of violence is often the root cause of fear, uncertainty and hesitation (Caldwell et al., 2010). In the out-of-home care sector, this is a decision that is often being made by a carer under immense pressure with dynamics that are constantly changing and limited formal training or on the job support (LeBel et al., 2010).

Observations by the author during the facilitation of physical restraint training across Australia over an eight year period has identified a regular theme of carers own perceptions of what constitutes violence being subjective and heavily influenced by their previous experiences, clients, training, personality and length of time In the role.

A fatality study by Nunno and Holden (2006) conducted research of restraint related deaths in out-of-home care across a 10-year period in the United States. A total of 23 cases were researched through coroner's reports and court findings. Of the 23 deaths, zero restraints were recognised as meeting the imminent risk to themselves or others threshold. These figures should bear a striking concern to current practices.

Consideration of Theory

Caring for vulnerable children who have experienced trauma, often results in carers supporting children who are displaying pain-based behaviours (Anglin, 2014). In a practical sense, these types of behaviours experienced by carers regularly include loud and frequent emotional outbursts, threats, property damage and even violent behaviour (Tune, 2015). Although goodwill and empathy are strong traits for a carer, the consideration of theory, assists in identifying that impacts of restraint on carers needs to be prioritised and is not just a short-term or isolated issue (Healy et al., 2015).

Systems Theory

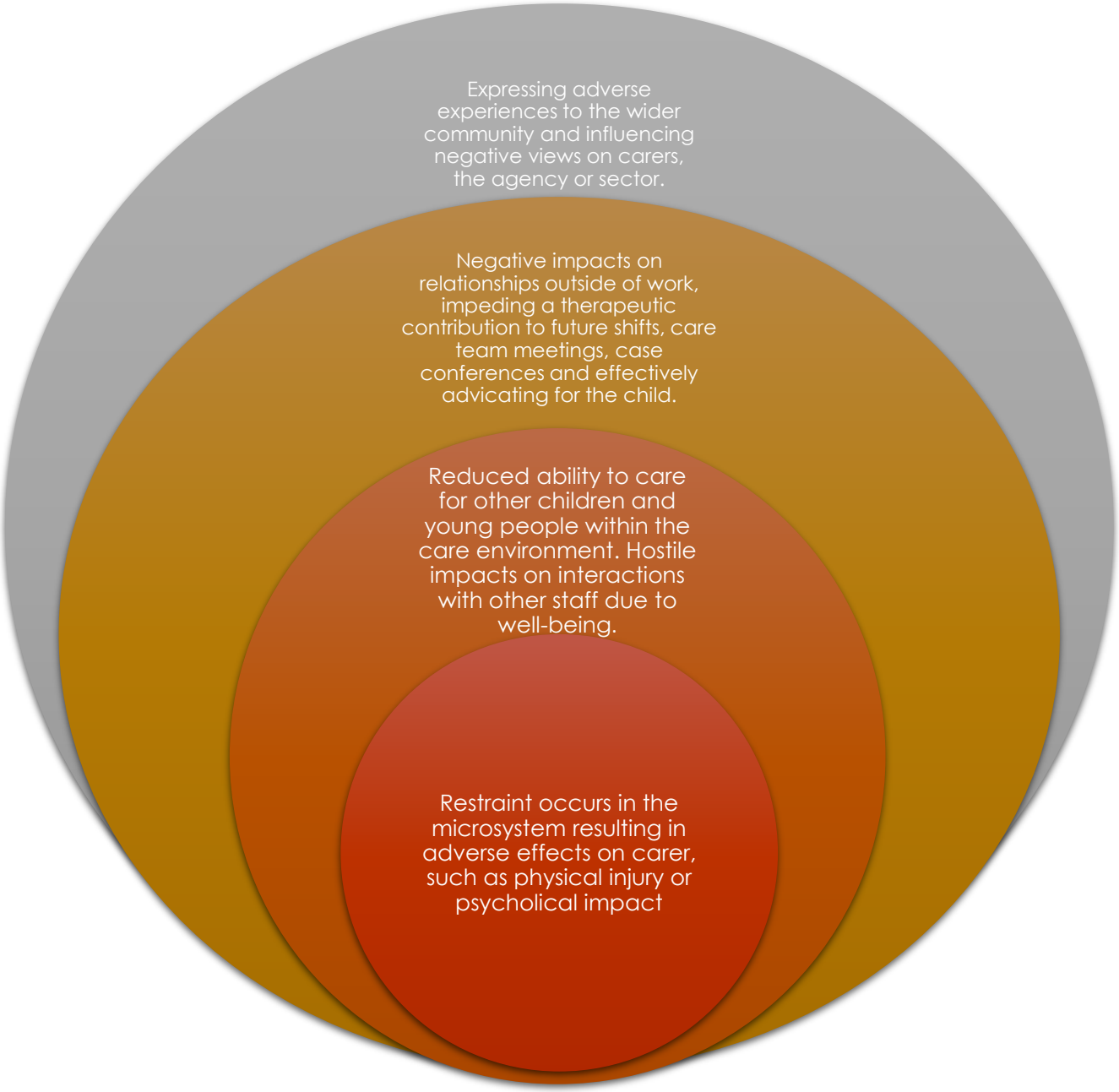
Systems theory states that human behaviour is influenced by a variety of factors that work together through multiple smaller systems. The interactions within one part of a system will have influence on other parts or the whole system. (Bronfenbrenner, 1979). This informs that a Carers microsystem or immediate environment where the workplace interactions are occurring, have a ripple effect within other ecological systems. Adverse experiences in the microsystem such as performing a physical restraint is likely to have impacts on carers and vastly influence theirs and others lives, post shift. To support others, we need to be the best version of ourselves (Garfat, 2004). Carers who are leaving work following a physical restraint and are feeling exhausted, fearful, anxious or with strong feelings of helplessness are likely to have dire effects through their interactions on many other systems.

Negative feelings, views and perceptions are likely to impede on supporting other children within the care environment or even impacting carers personal lives when returning home to resume their own relationships outside of work. Carers who are injured or feeling frustrated, dissociated or numb following experiences of using physical restraint are likely to impact indirect environments throughout the mesosystem and exosystem by having a reduced cognitive ability to think and respond effectively due to the state of their own wellbeing (Bloom, 2019). These effects could occur during significant future supports and planning moments for children they care for. Outcomes for children could be influenced, such as the ability to provide adequate therapeutic care during future shifts or even impacted the ability to advocate sufficiently with best intentions for the child throughout upcoming care team meetings or case conferences.

The impacts of physical restraint on carers can even have larger societal impacts throughout engagement with the wider community known as the macrosystem. A carer discussing their negative experiences and perceptions on the sector

following the use of physical restraint may impact the way other carers, agencies or the sector as a whole are viewed by society in how they are supporting or resolving conflict for many of our most vulnerable children in society. This is also creates further ethical challenges in which the sectors support of an individual's inherent dignity, worth and social justice may be regarded as questionable.

Fig. 1. This depicts the possible impacts on various systems when considering Ecological Systems theory



Trauma Theory

With evidence that performing a physical restraint can be traumatic for a Carer, considering trauma theory is important. Sustained traumatic experiences can impact the way Carers feel, think, and sense threat (Bloom, 1999). Perry (1999) states that traumatic experiences can impact the brain permanently and alter an individual's ability to manage pressures and external threats. As a carer to children and young people, the ability to cope and respond effectively under pressure is a critical skill and might result in harm to others, especially if a Carer is the only support person during a 12 hour shift. Qu and Lim (2016) detailed the significance of an adult's influence on a child's feelings, confidence, and psychological functions, declaring that a healthy engagement between adult and child is critical to children's healthy development.

Trauma theory is an innate link to human being's mammalian heritage. In modern practice, this concept is often referred to as the fight, flight and freeze response (Van der Kolk, 2017). This theory identifies that when carers are involved in a traumatic event such as physical restraint, an acute stress response occurs within the body producing hormones that are released to the brain. If there are sustained levels and frequencies of overwhelming emotions for a carer, significant damage to an individual's physical body and psyche can oocur (Bloom, 1999). If Carers are exposed to physical restraints in high frequencies, Bloom (1999) outlines that the hormones can alter the brain resulting in increases to an individual's perception of even minor threats being highly sensitive. This response will be an automatic biological response resulting in often irreparable damage to carers.

In the authors experience, the supervisors responsible in providing this support to Carers are often unaware of these impacts and prioritise the needs of children and young people. This often results in blame on the carers ability to effectively manage the crisis or meet the expectations of the role. This is supported in a 2004 Australian study of child protection staff that identified that organisational responses to violence often resulted in blaming the worker or normalising the violence as just a part of the job (Briggs et al., 2004). Not everyone is appropriate for youth and childcare work, but exposure to violence having an impact on you, does not mean a person is unqualified to do the role. This attitude not only discourages staff members from working with young people in care, it places unrealistic expectations on carers.

The consideration of trauma theory and impacts of restraints on carers is an evident contributor to the high staff stress, turnover, increased training and recruitment costs, medical expenses, mental health compensation claims, poor service reputation amongst the Community and poor support to those individuals living in the out-of-home care sector (LeBel, 2010; Steckley & Kendrick, 2008; Kim & Hopkins, 2015).

Recommendations

The total Government expenditure in 2017-2018 on all child welfare programs nationally in Australia was a massive $5.8 billion in $3.4 billion specifically for out-of-home care services (Australian Government, 2019). It is evident that allocating funds is not influencing the increasing numbers of children entering out-of-home care and is not providing support or awareness to staff about the impacts that physical restraint can have on their well-being.

Anyone who has directly experienced a crisis that culminated in restraint, can attest to the severity of the experience. Despite this, there is no mandated training or formally recognised debriefing procedures in place to support out-of-home care supervisory staff. Incidents such as physical restraint need to be identified as a considerable support need; it should not be just another part of the day or role.

Procedures to assist in supporting the well-being of carers or assisting them to learn from the adverse experiences to reduce the reoccurrence, severity and frequency should be a necessity. The identified impacts listed within this paper outline that carers would benefit from an effective, consistent and importantly mandated post-crisis response procedure between supervisors and carers. This would allow the opportunity for carers to debrief, access support as close to the incident as possible, learn from the experience and importantly reduce the psychological impacts of physical restraint on carers.

Research into the benefits of debriefing can be identified outside of the out of home care sector. Research by Barnett-Queen and Bergman (1990) reviewed the effectiveness of debriefing with police, firefighters and other emergency service staff identifying that debrief reduces impacts of psychological impacts following traumatic incidents.

A clinical practice study of Hospital staff in the United Kingdom, reviewed the benefits of debriefing following adverse incidents. This was completed with Doctors and nurses that had experienced highly traumatic incidents as significant as losing patients during surgeries. This research concluded that; debriefing increases staff support, well-being and can influence a positive change in an institutional attitude from one of blame to one of processing and learning (Vaithilingam et al., 2008). Australian child protection staff data identified that only 18% of 721 child protection staff surveyed felt as though they had received adequate levels of support following incidents of violence (Briggs et al., 2004).

Supporting Carers effectively places a heavy responsibility on supervisors. In the authors experience, those in supervisor roles throughout the out-of-home care sector have had no formal training in assisting carers to adequately debrief. High support and high accountability is necessary by a Supervisor (Holden et al., 2009).

A mandatory competency-based training for supervisors should be implemented sector wide identifying strategies to

support supervisors to assist carers following all significant incidents, especially following restraint use. A supervisor should have the skills to assess whether a staff member is able to continue to perform duties or a robust referral system to a well-being role for additional support. Carers, supervisors, and agencies should be looking at any restraints, questioning why and how they happened, and making sure that they are reviewed supportively and constructively with the Carer as soon as possible and at minimum; before the carer's next shift.

A culture of a learning organisation where incidents are supportively deconstructed and reviewed through reflective practices with staff can ensure that everyone can learn and adjust strategies to improve outcomes for both children and importantly- the carers supporting them.

Conclusion

To truly explore the impacts of physical restraint on carers, further exploration with consideration to the specific requirements and uniqueness of working in the out-of-home care sector is required. This paper has identified genuine and significant impacts that physical restraint has on carers using practice observations and application of theory. The absence of relevant literature exposes that this is an area that is not receiving adequate priority despite the potential for devastating impacts on carers and the vulnerable population they are required to support.

This paper identifies a gross oversight of efficient post-crisis support to carers that creates conflict with many ethical practices identified throughout the Australian Community Workers Association as well as the United Nations fundamental human rights that are required to be universally protected (Cohen, 1989). Recommendations to support supervisors to implement effective debrief procedures influencing organisational change have been illustrated with evidence of success from other sectors.

Exposure into this systematic issue reveals grave practice issues and ethical concerns for the responsibility of supervisors to adequately support carers following the use of physical restraint in direct care roles. US Judge Potter Stewart once stated that "Ethics is knowing the difference between what you have a right to do and what is right to do" (Marsel, 1987). A question lingers to our sector, is our support of carers ethically right? Are we caring about our carers?

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