Disability Services

Aversive, Restrictive & Intrusive Practices in Services for People with a Disability Policy & Guidelines

Subject: **Aversive, Restrictive & Intrusive Practices in Services for People with a Disability Policy and Guidelines**

Policy Number: DS 007

Related Legislation, DHHS, Group, Disability Services Policies, Standards & References:	**This policy replaces existing policy:**
• *Disability Services Act 1992* • *Commonwealth Disability Discrimination Act 1992;* • *Criminal Code Act 1924* • *Police Offences Act 1935* • *Personal Information Protection Act 2004* • *Anti-Discrimination Act 1998* • *Health Complaints Act 1995* • *Guardianship and Administration Act 1995;* • *Mental Health Act 1996;* • *Criminal Justice (Mental Impairment) Act 1999.*	Aversive, Restrictive & Intrusive Practices in Services for People with a Disability Policy and Guidelines dated 2002.
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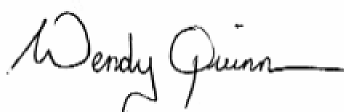
Signature: 

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1. Policy

The purpose of this policy and accompanying procedural guidelines is to ensure that people with a disability who are supported or receive services funded by Disability Services are treated with respect and dignity, and that their right to safety and privacy is maintained.

This document provides staff with a clear set of procedures for the acceptable use of practices that are, or have the potential to be, restrictive or intrusive. The guidelines establish procedures for the authorisation, reporting and monitoring of such practices within services managed or funded by Disability Services. It also ensures that aversive, restrictive and intrusive practices are monitored in accordance with the provisions of the *Disability Services Act* 1992 (the DSA).

In the past aversive, restrictive and intrusive practices were often used as methods of limiting or modifying the challenging behaviour of people with a disability, particularly where the behaviour posed a threat to the safety of the person with a disability and/or others.

In the mid to late 1980s researchers and practitioners demonstrated that aversive practices are not required to create lasting changes in behaviour.[1] Non aversive practices are at least equally effective in creating short and long term change. Staff working with clients with a disability have an ethical and moral responsibility to choose the least restrictive alternative.

Aversive practices are now prohibited within services managed or funded by Disability Services, and restrictive or intrusive practices have been limited to use only as a last resort and only when the least restrictive method available is chosen. It is important that organisations contact the Disability Services Ethics Committee to seek advice in relation to such practices.

Aversive, restrictive and intrusive practices impose limitations on the ability of an individual to exercise freedom of movement, and are potentially abusive and a denial of human rights. They therefore pose serious ethical and legal questions as to their appropriate use.

Restrictive practices rely on external controls to restrict the movement or responses of a person. They impose limitations on the ability of a person to exercise their right to freedom of movement, and can sometimes be necessary to prevent a person from harming themselves or others.

Intrusive practices are those that are forced or impinge upon another person without their permission, consent, invitation or the right to do so. As such, they also encroach upon a person's individual rights and freedoms, but can sometimes be necessary to prevent a person from harming themselves or others.

This policy and accompanying guidelines are to be followed wherever the use of such practices is being considered. This applies to all organisations managed or funded by the department to provide services to people with disabilities.

1.1 Scope

The intent of this policy and accompanying guidelines is to assist service providers to uphold the objectives, principles and standards contained within the DSA as they relate to aversive, restrictive and intrusive practices. This document provides details of the processes that should be followed by service providers when considering the use of such practices in the provision of services to people with a disability.

[1] E.g. La Vigna G.W., & Donnellan A.M. (1986). *Alternatives to Punishment: Solving Behaviour Problems with Non-Aversive Strategies*. Irvington Publishers Inc.

1.2 Application

Pursuant to the DSA, this policy applies to all

- All persons with a disability who are receiving services from an organisation(s) managed or funded by Disability Services.
- All services directly managed by Disability Services and all non-government organisations (NGOs) that provide services for people with a disability and that are funded by Disability Services. It applies to managers, and staff members.
- Forensic Disability – refer to the Restrictive Practices for People with Disabilities who are under Forensic Disability Orders – Policy and Guidelines.

1.3 Principles

The *Disability Services Act* 1992 outlines the principles and standards that persons with a disability have a right to expect from organisations providing them with services.

Rights in relation to Aversive, restrictive and intrusive practices are as follows:

- People with a disability have the same right as other members of society to receive services in a manner which results in the least reasonable restriction of their rights and opportunities. (Schedule 2, Principal 6)
- Programs and services are to be designed and administered so as to be as free as possible from Aversive, restrictive and intrusive practices. (Schedule 3, Standard 9)

Disability Services and other service providers therefore have a clear moral, professional and legal responsibility to provide an environment for its clients that is as least restrictive as possible and free from any aversive practices.

1.3.1 Limiting Intrusion upon clients

The *Disability Services Act* 1992 requires that:

- Programs and services are to be designed and administered so as to respect the rights of persons with disabilities to privacy and confidentiality (Schedule 3, Standard 16.)

1.3.2 Principles relating to limiting intrusion

Principles in relation to limiting intrusion and respecting client privacy in services for people with disabilities are as follows:

- Staff members should always recognise and respect the rights of persons with disabilities to have their own privacy.
- Staff and visitors should always knock before entering private rooms in residential services. (This does not apply in emergency circumstances when the safety of a client is at risk).
- Personal information that is given to staff members in confidence by a client should not be disclosed without their permission. (This does not include situations where staff members are obliged to divulge information to others in accordance with the policies and procedures of an organisation).
- Staff must seek consent from a person with a disability (taking into account their level of understanding) before planning or initiating any activity. This applies no matter what the activity may be, whether it is to have a shower or where to go for a holiday. For further information on consent refer to the *Consent by Clients – Policy and Guidelines (2003)*.

- The personal space of a person with a disability should be respected by staff at all times. Behaviours such as inappropriate hugging, leaning on wheelchairs and standing over clients without their approval are not an acceptable practice.
- *Challenging Behaviour Intervention Plans* that involve restrictive or intrusive practices should consider the impact that the proposed practice might have upon other clients. For example, it would be inappropriate to restrict all clients living in a residence from a favoured activity because it is a trigger for challenging behaviour for one client.

If the behaviour of one client is an intrusion to other clients or restricts their capacity to live in normal circumstances, options to develop appropriate skills should be explored and implemented. For example if a client is excessively noisy, or enters the private rooms of others, steps should be taken to develop the person's skills.

1.4 Duty of Care

In addition to the legislation listed above, the area of common law known as 'duty of care' is relevant to the use of restrictive or intrusive interventions.

Duty of care is an important component of the law of negligence. The law of negligence allows for people and organisations to be held responsible if their actions, do not meet an acceptable standard of care. To protect individuals under emergency situations this may involve the use of restrictive or intrusive practices in order to protect the person or others from harm (e.g., restraining a person from running onto a busy road.)

A duty of care may be breached if a service provider behaves unreasonably. In a particular situation failure to act may also be unreasonable. A duty of care may therefore be breached by both action and inaction.

Examples of these are as follows:-

Action: Restraining individual from running on to road.

Inaction: Not attempting to stop traffic when a client manages to run onto road.

Further detailed information regarding duty of care is contained in Disability Services' *Duty of Care* position paper.

1.5 Ethical considerations

The right of an individual to be treated with dignity and respect and to be free from harm is affirmed in global charters such as the United Nation's *Declaration on the Rights of Mentally Retarded Persons* 1971 and the United Nation's *Declaration on the Rights of Disabled Persons* 1975.

Aversive practices as a method of punitive control deprive people of basic human needs and rights. They are morally and ethically wrong and illegal.

Restrictive practices, by their very nature, rely on external controls to restrict the movement or responses of a person and therefore deny that person their fundamental rights.

Similarly, support or treatment can be considered intrusive (and unethical) if it is forced upon or impinges upon a person without their permission, consent, invitation or a right to do so.

1.6 The Disability Services Ethics Committee

The Disability Services Ethics Committee (DSEC) is established under the *Disability Services Act* 1992, and reports directly to the Minister for Health and Human Services.

The primary function of the DSEC is to monitor programs and services for persons with a disability to, '*ensure that they are designed and administered so as to be as free as possible from*

Aversive, restrictive and intrusive practices.' With few exceptions restrictive or intrusive practices should not be ordinarily used without seeking advice from the DSEC.

The DSEC provides a mechanism for all interventions that include restraint and seclusion to be discussed, monitored and reviewed by an independent statutory body.

The Committee consists of a minimum of nine members, including

- a legal practitioner;
- a medical practitioner;
- such other persons who, in the opinion of the Minister have qualifications, expertise, or experience in issues relating to disabilities.

1.7 Prohibition of Aversive Practices in Services for People with Disabilities

"Aversive therapy/treatment practices as methods of punitive control" deprive people of basic human needs or rights and are <u>not to be used under any circumstances by services managed or funded by Disability Services.</u>

Under the provisions of the *Criminal Code Act 1924* and the *Police Offences Act 1935,* certain forms of aversive (and sometimes restrictive) practices constitute an assault (e.g., physical abuse, threats, or confinement without consent) and those responsible will potentially face criminal charges and prosecution by the police. In very few situations where these practices are considered to be acceptable refer to Section 1.9.

1.7.1 Examples of Aversive Practices

Examples of aversive practices that are not to be employed in services managed or funded by Disability Services include, and are not limited to:

- physical abuse or corporal punishment (e.g., hitting, hair pulling, slapping, pushing, spitting, or pinching);
- psychological abuse (e.g., verbal abuse, ridicule, threats, put-downs, emotional manipulation);
- any practice involving the application of unpleasant conditions (e.g., cold baths, 'hosing down,' squirting liquid into a person's face, applying chilli paste to the hands to prevent biting);
- depriving people of meals, sleep, clothes, outings or personal hygiene;
- taking or withholding personal property, except to replace property intentionally damaged by the person receiving services (even this practice requires consent from the person or guardian).
- time out for managing behaviour in adults.

Further information about abusive practices is contained in Disability Services' *Guidelines Relating to the Reporting of Abuse in Services for People with Disabilities*.

1.8 Use of Restrictive & Intrusive Practices in services for people with disabilities

Most people with a disability will go about their day-to-day lives without the need for interventions to manage behaviour or risk.

Disability Services acknowledges that there may be occasions where some form of restrictive or intrusive practice may need to be employed to manage some instances of severe challenging or risk behaviour.

These should only be used as part of a Challenging Behaviour Intervention Plan which has been developed in consultation with the client, their advocate and their "significant others".

1.8.1 Conditions of use

With the exception of emergency situations, and those required by law, and adaptive equipment that improves quality of life and the restriction of environmental hazards, <u>any instance of a restrictive or intrusive practices must:</u>

- only be used as part of a *Challenging Behaviour Intervention Plan/Support Plan* that has been discussed and monitored by the Disability Services Ethics Committee;
- involve the least reasonable restriction of the person's rights;
- be used as a last resort only when all other treatment options have either been trialled and found to be ineffective or have been excluded as being inappropriate; and
- be time-limited.

It is important to remember that whenever restraint or intrusion is proposed as a strategy within a behaviour management program this will involve a serious deprivation of an individual's freedom and rights.

The implementation of restraint or intrusion in this context must also be consistent with the Principles Underlying Effective Behaviour Management (See Appendix 1.)

1.9 Situations where restrictive or intrusive practices are acceptable

Practices that are restrictive or intrusive are <u>only acceptable in the following circumstances:</u>

1.9.1 Under the supervision of the Disability Services Ethics Committee (DSEC)

When all other options have been found to be ineffective or inappropriate in preventing a challenging behaviour, it may be appropriate method to use the least restrictive method available to prevent that behaviour from occurring. Having taken that decision a referral should be made to the DSEC for advice and monitoring.

All *Challenging Behaviour Intervention Plans* which contain the use of restrictive or intrusive practices must be submitted to the DSEC for advice and monitoring on the progress of the intervention. It is important to remember that restrictive or intrusive practices are considered time-limited and that the DSEC may only advise an intervention to be used for a set period of time.

The DSEC must also be made aware of any restrictive or intrusive practices that are proposed as an interim measure to control behaviour whilst awaiting formal review of a *Challenging Behaviour Intervention Plan* by the Committee.

It is permissible to implement a behaviour intervention technique in emergency situations in order to meet duty-of-care and then apply to have it monitored by DSEC.

1.9.2 Meeting Duty of Care (Emergency Situations)

Disability Services and funded service providers, like all community members, have a duty to take reasonable care to avoid injury to people through action or inaction. These people may be clients, family members or members of the general public who may be affected by the activities of Disability Services and other service providers. The rights of staff members are also involved as they are entitled to work in a safe environment.

Emergency situations where a restrictive practice may be necessary to avoid harm are most commonly the result of challenging behaviours. When the behaviour of a person has the potential to harm themselves or others, there is a need to balance the duty of care obligations of the service against the rights of the person with a disability.

Situations where an intrusive practice is required tend to involve medical emergencies (for example where the health of a client is significantly at risk and they are refusing medication) or instances where a client is at risk of harming themselves (e.g. a client with a history of self harm who has locked themselves in their room and is not answering).

Generally speaking the use of restraint or intrusion is only acceptable where it is required to meet the provision of 'duty of care' in emergency situations (i.e., to prevent harm or injury to a person with a disability, staff or members of the public) or where it is required by law, (i.e., seat belts in moving vehicles). For example, a client may be attempting to run out onto a busy road or has suddenly and unexpectedly become violent.

Restraint can only be used if the behaviour is of such an intensity and duration that it is highly likely it will cause injury to the person, staff members or others without the use of restraint. If the challenging behaviour recurs, a *Challenging Behaviour Intervention Plan* must be developed and submitted to the DSEC.

Incidents where restrictive or intrusive practices are needed to prevent a breach of a duty of care must be documented to allow for review, planning and risk management.

For further information on the management of emergency situations refer to the accompanying guidelines.

1.9.3 Adaptive equipment to improve quality of life

The use of restraint is acceptable where the restraint is to improve the client's ability to function and is the least restrictive alternative and has been recommended by a Health Professional. Examples of adaptive equipment that improves quality of life include leg callipers, wheelchairs or other equipment that improves the comfort, mobility, or ability of a client to carry out a task independently (such as a modified feeding spoon).

Mechanical devices that prevent injury caused by involuntary movements are included in this category (e.g., a helmet to prevent injuries due to drop seizures or a seat belt used to prevent someone with severe cerebral palsy from falling out of a chair).

Bed railings used to prevent a person from falling out of bed are also acceptable after assessment of their appropriateness. For further information refer to the Disability Services *Bed Selection and Safety Features: Policy and Guidelines*.

While the use of adaptive equipment to improve quality of life does not require a referral to DSEC; provided that the least restrictive alternative is chosen after all other options have been considered, it should be discussed with the client and/or their advocate and person responsible.

1.9.4 Restricting access to environmental hazards

Environmental restraint used to restrict access to potential hazards can be carried out provided that it is for the sole purpose of preventing harm or injury to a client or others and that the least restrictive method is chosen.

Environmental restraints that are acceptable include:

- Sharp objects kept in a locked drawer in circumstances where a client has a history of being violent with knives.
- Locks on cupboards to prevent someone with an insatiable appetite from uncontrolled access to food (e.g., clients with Prader-Willi syndrome).
- Household poisons such as detergents and chemicals kept in a locked cupboard where a client is unable to distinguish between these items and consumables.
- Preventing access to other environmental hazards where a client does not have a capacity to avoid them. For example, hotplate covers to prevent burns from stoves.

All medications, regardless of whether they are administered by the client themselves or their support worker are to be kept in secure lockable storage and must conform to the pharmaceutical storage instructions given for that particular medication as indicated on the label (this applies to group home situations, respite, day options, etc, not private homes.) For further information on storing medications refer to the *Guidelines for the Administration of Medication for People with Disabilities in Community Based Disability Services.*

It is important to note that this category of restraint only applies to minor modifications to the environment of a client that would not be out of place in any normal household. This also applies to environmental modifications that meet obligations/expectations under the OH&S Act.

Any restraints that significantly restrict the freedom of client or movement such as the locking of rooms or denying access to food stores or possessions require referral to the DSEC.

All environmental restraints with the aim of preventing challenging behaviours must be the subject of monitoring; therefore a referral seeking advice from the DSEC must be made prior to implementation.

1.10 Consent

Before any restrictive and intrusive practice can be implemented and referred to DSEC the client must provide consent to such practice and understand the practice being implemented. The client's advocate should be encouraged to be involved in the process of obtaining consent.

If the client is incapable of consenting to the proposed treatment/practice, then in most cases the plan should be discussed with the 'significant others' in the clients life. The 'significant other' should be asked to give informed consent.

In situations where there is a dispute about the necessity or appropriateness of the practice the matter must be referred to the Guardianship and Administration Board.

Issues around consent pertaining to the use of aversive, restrictive and intrusive practices are as follows:

1.10.1 Emergency situations

In situations where the person with a disability is in immediate danger of harming themselves or others, staff members and service providers have a duty of care to protect the person or persons. In these exceptional circumstances consent is not required for restraint or intrusion to be able to be used lawfully. Failure to act could in fact constitute a breach of duty of care.

In certain circumstances where staff feel they themselves are at risk or feel threatened by a client, it is permissible for staff to remove themselves from the situation taking into consideration any documented behaviour support strategies/protocols within the support plan that may be in place. This would also allow clients to have the appropriate personal space they require.

1.10.2 Involvement of 'Significant Others' and the Person Responsible

Due to the nature of these practices it is important that *Challenging Behaviour Intervention Plans* are devised in consultation with the 'significant others', advocate and any other appropriate persons. Where the client is incapable of providing consent or is unable to communicate or understand the proposed treatment consultation with these key people is essential.

Where the plan involves consent for medical or dental treatment then consent must be obtained in accordance with the Guardianship and Administration Act, usually this consent will come from the person responsible.

It should be noted that there are some instances where consent or substitute consent to medical or dental treatment is not needed:

- when there is a medical or dental emergency; and
  (This means the treatment is needed to save the clients life, to prevent serious damage to the client's health or to prevent the suffering of significant pain or distress.)

- when the treatment is minor
  (For example, a visual examination of the patient's mouth, eyes, ears or throat, providing first aid or the administration of a non-prescription drug (such as painkillers or an antihistamine) within recommended dosages.)

For further information please refer to the Administration of Medication for People with Disabilities in Community Based Disability Services policy and guidelines, or to Guardianship and Administration Board.

1.10.3 The Client

In situations where a client is unable to be effectively involved in the decision-making process and has no 'significant others', the Guardianship and Administration Board would be required to appoint a legal guardian.

Again, the DSEC does require the consent of a client to advise and monitor implementing a restrictive or intrusive practice in services funded or managed by Disability Services. However, wherever possible the person for whom the restrictive or intrusive practice is proposed should be involved in the process for developing the *Challenging Behaviour Intervention Plan.* If the client is not able to do this the 'significant other' must be involved in this.

1.10.4 The Advocate

In order to support the clients with their decision making ability and to ensure that their interests are respected, advocates should be involved in the development of all Challenging Behaviour Intervention Plans/Support Plans.

The DSEC requires that any Challenging Behaviour Intervention Plans that are referred to their office have been developed in consultation with the clients advocate if applicable.

1.10.5 The Guardianship and Administration Board

Where a legal guardian has been appointed, this person must be involved in all decision making processes for developing a Challenging Behaviour Intervention Plan.

Usually there is no need for the Guardianship and Administration Board (GAB) to appoint a legal guardian for the sole purpose of providing consent for the use of a restrictive or intrusive practice. Examples of situations where a guardian may need to be appointed include a client's objection to implement the treatment practice; an unresolved dispute between interested parties or where the police or health professionals are required to return a person to their home when they are a danger to themselves and unwilling to be escorted.

1.11 Definitions/Glossary

This policy and its accompanying guidelines should be interpreted within the context of the following definitions:

1.11.1 Aversive Treatment Practices (Punitive)

An aversive practice is one that uses unpleasant physical or sensory stimuli in an attempt to reduce undesired behaviour. An aversive practice is usually one which cannot be avoided or escaped and/or is pain inducing. Aversive treatment also refers to any withholding of basic human rights or needs (e.g., food, warmth, clothing); or of a person's goods, belongings or favoured activity for the purpose of behaviour management or control. The use of aversive practices is unethical, may be in certain circumstances illegal and is prohibited in services managed or funded by Disability Services.

1.11.2 Challenging Behaviour Intervention Plan

A behaviour management plan that includes a functional assessment of behaviour using the Challenging Behaviour Workbook template or other described methodology.

1.11.3 Comprehensive IABA Plan

A Behaviour Management Plan incorporating a comprehensive functional assessment report and recommended support plan, using the IABA template.

1.11.4 Emergency situations

Situations where the safety or well-being of clients or staff is put at a significant risk are considered to be emergencies.

Examples of emergency situations would be where a client is attempting to walk onto a busy road, is in need of urgent medical assistance or has suddenly and unexpectedly exhibited a violent/aggressive outburst.

Challenging behaviours are emergencies when they occur for the first time or so infrequently that they are unpredictable.

1.11.5 Interim Support Plan

A behaviour management plan developed to support the transition of a client from one setting to another (e.g. prison to shared home). Primarily developed to reduce risk, the plan would contain initial functional and antecedent analysis, reactive strategies and focussed support strategies.

1.11.6 Intrusion and Intrusive Practices

Intrusion and intrusive practices are those approaches that are placed or forced upon an individual without their invitation, consent or the right to do so. Examples of intrusive practices include, but are not limited to:

- entering without right or welcome into a client's personal environment (e.g., bedroom, home, bathroom);
- forcing oneself upon a client or the personal space of a client unasked (e.g., hugging or standing over a client);
- impinging on the rights or freedom of a person (e.g., reading/divulging personal information without consent or making major life decisions on behalf of a client without their consent).
- Using equipment that impinges on or reduces personal privacy such as monitoring devices (including baby monitors, movement detection pads).

1.11.7 Least restrictive alternative

A practice that:-

a) is not more restrictive or intrusive than is necessary to prevent the person from inflicting harm on themselves or others; and
b) is applied no longer than necessary to prevent harm or danger.

1.11.8 Person Responsible

The concept of a 'Person Responsible' is defined in the *Guardianship and Administration Act 1995*. A 'Person Responsible' can give consent or substitute consent to medical or dental treatment when the client is unable to consent because they cannot understand the nature and effect of the proposed treatment, or cannot communicate their consent.

The client's medical and dental practitioner should determine who the Person Responsible is prior to providing non-emergency treatment.

Please refer to the *Guardianship and Administration Act (1995)* for further details relating to the Person Responsible. http://www.guardianship.tas.gov.au

1.11.9 Restrictive Practices (Restraint)

To restrain a person is to restrict, limit or prohibit their behaviour or freedom or movement or thought in some way. Restraint can be defined in a number of ways, including:

Chemical Restraint

Medication or other substances prescribed by a medical practitioner, for the sole purpose of behaviour management or control (e.g., sedation to reduce aggressive behaviour or a PRN medication to manage an outburst).

Medication prescribed by a qualified medical practitioner or psychiatrist for the primary purpose of treating a physical condition or mental illness would not be categorised as chemical restraint. When prescribing medication for mental illness the practitioner is required to do so within the requirements of the Mental Health Act. The client's advocate/person responsible should be consulted in such situations.

Examples of chemical restraint include:-

- sedating medications such as tranquillisers; antipsychotics, minor and/or major eg haloperidol, midazolam.

Environmental Restraint

Environmental restraint is the modification of the immediate environment of a client to deny access to hazards or possessions. Examples or such modifications include:

- locking cupboards, pantries or draws to limit a client's access to harmful items such as medication, sharps or chemicals;
- gates to prevent exit from a property;
- denying access to food stores, their wardrobe, or certain rooms.

Mechanical Restraint

The use of external devices, materials or equipment to prevent, restrict or subdue the voluntary movement of any part of the person's body without consent. (E.g. an arm splint to prevent someone from hitting themselves).

A mechanical device used to prevent bodily movement that is involuntary and harmful to the person does not constitute restraint. For example, a helmet to prevent injuries due to drop seizures or a seat belt used to prevent someone with severe cerebral palsy from falling out of a chair or off a commode.

Note: Although the use of bed railings does not always constitute a mechanical restraint, the use of railings to prevent a person falling out of bed should only be used as a last resort after all other options have been considered.

Examples of mechanical restraint include:-

- Restraining arms on toilets
- Seat belts on chairs
- Shackles and handcuffs
- Side rails on beds
- Posey restraints or similar products
- Helmets.

Voluntary use of bedrails is not a form of restraint. A client may request that the bed rails be raised to make them more secure or assist them with moving in the bed.

Physical Restraint

The use of manual means to prevent, restrict or subdue the movement of any part of the person's body without their consent. The use of physical restraint may be necessary in some situations. These situations would be emergency situations where the use of physical restraint is necessary for a staff member to meet a duty of care (e.g preventing a person from placing themselves in a dangerous situation or harming themselves or others).

Seclusion

Seclusion refers to the placement of a person in a room or other place from which voluntary exist is not possible, for a period of time not determined by that person for the sole purpose of behaviour management or control.

This encompasses not only confinement resulting from doors, gates and windows being locked from the outside, but also situations where an individual is unable to open a door from the inside. For example, due to the position of the door handles, or the nature of the person's disability). In addition, if the person concerned believes that the orders or verbal statements made by the

person imposing the seclusion that they cannot leave a room or place, then a state of seclusion would be deemed to exist.

Note that the definitions of restraint provided do not apply to the application of restraints required by law (i.e., the wearing of a seat belt in moving vehicles.)

1.11.10 Significant Others

A person(s) such as a family members or close friends, who are important or influential in one's life. This term is similar to person responsible, but used in a broader context to describe all those who should be consulted about the persons lifestyle, where as person responsible is a legal term used to describe the person with the authority to consent to medical or dental treatment.

1.11.11 Severe Challenging Behaviour

"Behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which seriously limits the persons access to ordinary settings, activities, services and experiences". Radler 1991

1.12 Relevant Legislation

Other legislation which is relevant to Aversive, restrictive and intrusive practices includes:

- *Disability Services Act 1992*
- *Commonwealth Disability Discrimination Act 1992;*
- *Criminal Code Act 1924*
- *Police Offences Act 1935*
- *Personal Information Protection Act 2004*
- *Anti-Discrimination Act 1998*
- *Health Complaints Act 1995*
- *Guardianship and Administration Act 1995;*
- *Mental Health Act 1996;*
- *Criminal Justice (Mental Impairment) Act 1999;*

2. Guidelines

2.1 Responding to Challenging Behaviour

If the use of restraint or intrusion is proposed as a behaviour management strategy in a service managed or funded by Disability Services, the following process should always be followed:

2.1.1 Steps to follow

1. Deal with the Immediate Risk

When a challenging behaviour occurs for the first time it may be necessary to use restraint or intrusion to prevent harm without first gaining consent.

2. Explore all Non-Restrictive and Non-Intrusive Options Available

If the challenging behaviour reoccurs it is the responsibility of a supervisor/house manager to develop a strategy to handle the behaviour in the long term.

The supervisor/house manager should first attempt to address the behaviour by using non-restrictive and non-intrusive strategies. Options might include educating the client around why the behaviour is inappropriate or avoiding triggers to the behaviour.

The Service Coordination and Resource Teams (Disability Services) are available to assist both non-government service providers and departmental staff in the development of such strategies.

Challenging Behaviour Intervention Plans will initially be developed using non-aversive and non-intrusive strategies. All Challenging Behaviour Intervention Plans must outline how, when, where and why the non-aversive strategies are applied. Challenging Behaviour Intervention Plans must be regularly monitored and reviewed to ensure their ongoing relevance to supporting the person. For further information on devising a *Challenging Behaviour Intervention Plan* refer to *Appendix Three.*

Exploring the cause of the behaviour can often be helpful in preventing it. For further information refer to *Appendix 1: Principles Underlying Effective Behaviour Management.*

It is important that each attempt at resolving the behaviour through non-restrictive or non-intrusive means is monitored and that its effectiveness is documented in writing.

3. Develop a Challenging Behaviour Intervention Plan

When all non-restrictive and non-intrusive options have been trialled and documented as being ineffective, restrictive or intrusive treatment practices can be proposed as part of a *Challenging Behaviour Intervention Plan.*

In extraordinary circumstances where the risk to the person with a disability is assessed as being a high risk for harm to self or others restrictive/intrusive practices may be proposed as part of a *Challenging Behaviour Intervention Plan* without first trialling other options.

The *Challenging Behaviour Intervention Plan* should be devised through consultation with family, guardians, direct support providers, service managers and other appropriate persons. Service Coordination and Resource Teams of Disability Services are available to assist both Non-Government Service Providers and Departmental Staff in the development of plans.

Wherever possible, the person for whom the restraint or seclusion is proposed should be involved in the process of developing the program.

4. Make a Referral to the Disability Services Ethics Committee (DSEC)

All *Challenging Behaviour Intervention Plans* involving restrictive or intrusive treatment practices must be forwarded to the DSEC for review together with a completed *DSEC Referral Form*. For further information on the DSEC process refer to *Section 3.15*. A copy of the DSEC Referral Form is attached at *Appendix Three*.

The referral should include the details of any interim strategies involving restrictive or intrusive practices planned to manage the challenging behaviour while awaiting the formal advice of the DSEC.

5. Implement and Monitor the Restrictive or Intrusive Practice

Once advice has been received from the DSEC, implementation of the restrictive or intrusive practice may proceed under the condition that it is monitored. All instances of monitoring must be documented in writing.

If the restraint used is manual or mechanical, a system of monitoring must be devised and its correct use explained by an appropriately qualified health care professional. All staff members must adhere to this and every incident of monitoring must be recorded in writing.

Staff members must be appropriately trained in the proper application of the restraint or intrusion and the monitoring procedures; this is to be outlined as part of the *Challenging Behaviour Intervention Plan*.

6. Report against the Challenging Behaviour Intervention Plan

The majority of restrictive or intrusive treatment practices will be time limited. That is, they may only be used for as long as is necessary to address the behaviour and must be regularly reviewed. Regular written reports on the progress of the client will need to be produced in accordance with any timeframes set by the DSEC. The DSEC will review these reports and advise whether the restrictive or intrusive practice may continue. The level of restriction should be sought to be reduced over time.

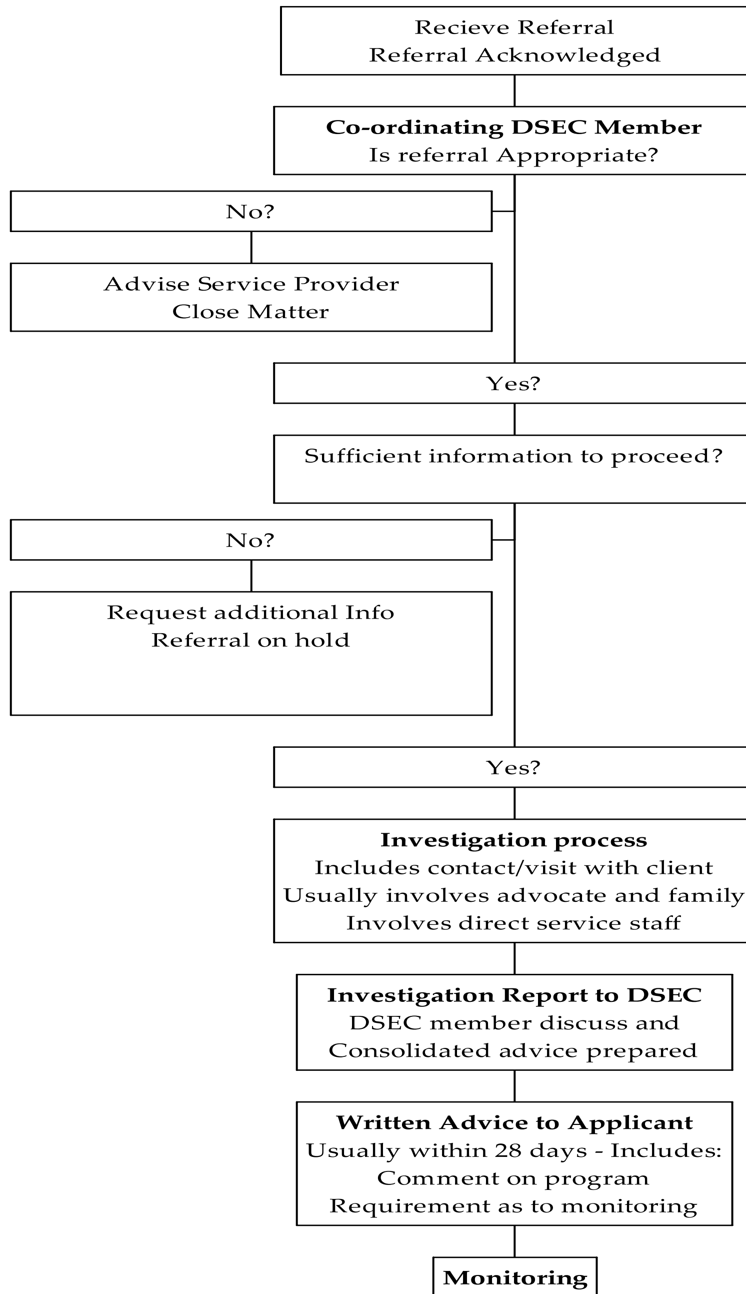
2.2 The DSEC process

Each *Challenging Behaviour Intervention Plan* referred to the Committee must be accompanied by a completed *DSEC Referral Form*. Once this form is received the case is registered and allocated a year and case number.

The DSEC will provide advice on the practices in writing to the person/service making the referral. The Investigation Officer will contact the person/service shortly after the referral has been received.

2.2.1 DSEC Flow Chart

The DSEC has developed a flow chart that demonstrates the advice and monitoring process.


Recieve Referral
Referral Acknowledged
Co-ordinating DSEC Member
Is referral Appropriate?
No?
Advise Service Provider
Close Matter
Yes?
Sufficient information to proceed?
No?
Request additional Info
Referral on hold
Yes?
Investigation process
Includes contact/visit with client
Usually involves advocate and family
Involves direct service staff
Investigation Report to DSEC
DSEC member discuss and
Consolidated advice prepared
Written Advice to Applicant
Usually within 28 days - Includes:
Comment on program
Requirement as to monitoring
Monitoring

2.2.2 Contacting the Committee

For advice or to make a referral contact the DSEC on:

Email: dsec@justice.tas.gov.au

Phone: (03) 6230 7745 (voice mail)

Write to: Disability Services Ethics Committee
GPO Box 826
Hobart TAS 7001

Application forms can be downloaded from the following website address.

www.dsec.justice.tas.gov.au

2.3 Legal responsibility

Apart from the monitoring and review processes outlined above, it is crucial that staff devising *Challenging Behaviour Intervention Plans* containing restrictive or intrusive practices seek and receive appropriate advice on relevant legal issues.

Advice may be obtained from a number of sources depending on the specific issue in question and may include:

- Disability Services Ethics Committee (DSEC);
- Guardianship and Administration Board (GAB);
- Office of the Solicitor General (Departmental staff only – referrals via Deputy Secretary).

2.4 Responding to emergency situations

2.4.1 Challenging Behaviours

- When responding to a potentially emergency situation, staff members are expected to protect themselves from injury but are limited by using ‘reasonable force.’
- A reasonable amount of force is just enough force for effective protection of self and others and no more than is absolutely necessary. The force used should be directed at deflecting the person and should not be aimed at causing pain.
- Staff members in a work setting cannot resort to the use of traditional self-defence techniques as they are obligated to protect not only themselves from avoidable injury but also the people they are supporting.
- The response of a staff member to a person who is threatening or attempting to injure should reflect the seriousness of the incident i.e.

  A. Crisis Communication

  Will the person stop the dangerous behaviour when encouraged to do so (eg distracted by preferred activity, active listening, asked to stop).

B. Evasion

If the person will not stop, can harm be avoided by evasion?

C. Restraint

If the person is not restrained will he/she or someone else be seriously injured?

- All emergency instances whereby a restrictive or intrusive treatment practice is implemented must be reported to a supervisor/manager of the service provider.
- It is the responsibility of the supervisor/house manager of the organisation to ensure that the details of the emergency are documented in writing.
- For behaviour that is 'recurring,' either in the short or long term, a *Challenging Behaviour Intervention Plan* will need to be developed as outlined in the Operational Guidelines.

2.5 Medical and other emergency situations

- When responding to medical and other emergencies, duty of care dictates that staff must act reasonably.
- Therefore in emergency situations where the life or health of a client is placed significantly at risk, staff may proceed with providing medical assistance without obtaining consent. This may also involve the use of restrictive or intrusive practices in order to protect the client from harm.
- Again, all emergency instances whereby a restrictive or intrusive practice is implemented must be reported to a supervisor/manager of the service provider.
- It is the responsibility of the supervisor/house manager to ensure that the details of the emergency are documented in writing. This documentation should cover what practices were implemented, who they were implemented by, why they were implemented, when they were implemented and for how long.

Further information can be located at the following website address: http/www.guardianship.tas.gov.

3. Appendices

3.1 Appendix One: Principles Underlying Effective Behaviour Intervention

1. Separate the Behaviour and the Person

   Our capacity to understand the behaviour and to develop appropriate strategies will be greatly enhanced if we remember that independent of the behaviour, no matter how challenging, is a person whose basic human needs are no different from our own.

2. Look at the situation from the point of view of the person with the disability

   To effectively understand the situation we need to 'step inside the shoes' of the person.

3. How you perceive a behaviour determines how you feel and how you respond

   We need to consider our own beliefs, values and expectations and how they influence our interaction with the person; understanding ourselves is part of the challenge.

4. Behaviour serves a purpose for the person or communicates a message

   We need to work out what the person is trying to achieve or communicate by their use of the challenging behaviour and then try to develop alternative ways that they can achieve their purpose. There is no use simply trying to punish or eliminate the behaviour.

5. Challenging behaviours have causes

   Behaviours do not simply emerge 'out of the blue.' They either currently serve a purpose or have in the past served a legitimate purpose for the person.

6. To effectively manage challenging behaviour, base strategies upon causes

   Strategies are most effective when they have meaning for the person and when they are based on the needs and aspirations of the person.

7. Effective management promotes quality of life issues and is non-aversive

   Aversive management techniques (i.e. punishment) lay the foundations for further challenging behaviours; we may suppress one behaviour and in turn give rise to an equally undesirable behaviour. We may teach the person that the only effective way to meet their needs is to interact with others in an aversive way. Also, aversive techniques such as 'time out,' restricting movement or access to personal possessions, etc are unethical and illegal. Alternatively, promoting the person's quality of life by enhancing their environment and skills significantly lessens the likelihood that they will have to use challenging behaviour to meet their needs. Non-aversive strategies provide long-term and lasting solutions.

8. Family and Support Workers are the key in managing challenging behaviour

Effective strategies are based on both formal assessment and an intimate understanding of the person's everyday life. Strategies are most effective when implemented on a consistent basis, where the person lives and works, and by people who the person already trusts and with whom they already have a close working relationship.

3.2 Appendix Two: Disability Services Ethics Committee Referral From

DISABILITY SERVICES ETHICS COMMITTEE
REFERRAL FORM

P.O. Box 826 Hobart, Tasmania 7001
Ph: (03) 6230 7745
E-mail: dsec@justice.tas.gov.au
Website: www.dsec.justice.tas.gov.au

All information received by DSEC is held in confidence in accordance with the DHHS confidentiality policy and the legal requirements of the Privacy Act.

Contact person: **Phone No:**

Address: **Postcode:**

Date of Referral: **Person Referring:**

Service or Program:

Address (please provide street address): **Postcode:**

Name of Client: **Date of Birth:**

Permission from client: (please circle)

Yes: **No:**

Name of Person Responsible, Advocate Guardian: (if appropriate)

Reason for the Referral

(attach additional pages if insufficient space)

Name of Client

Ethical issues that gave rise to the referral:

1.

2.

3.

(attach additional pages if insufficient space)

IF RELEVANT TO THE REFERRAL PLEASE PROVIDE INFORMATION ON THE FOLLOWING:

1. What does the behaviour suggest?

___

___

___

___

___

___

2. What has been tried with what results?

___

___

___

___

___

(attach additional pages if insufficient space)

Name of Client

ACTIONS TAKEN BY DSEC:

Referral Acknowledged – Date:

___

Appropriate Referral – Yes No – letter advising sent – Date:

___

Investigation Officer:

___

Investigation Report prepared – Date:

___

Sent to DSEC – Date:

___

Advice Provided – Date (should be within 28 days of receipt)

___

Co-ordinating Member Comments:

Summary of Advice:

3.3 Appendix Three: What to include in a Challenging Behaviour Intervention Plan

Points to consider when devising a *Challenging Behaviour Intervention Plan* include the following:

1. **General Criteria**

   a. *Format***.** Report is properly titled, is on formal letterhead stationery, uses appropriate type style, heading and margins, includes date of report (i.e., date final typed) and referral date (i.e., date referral was made from the referring agency). Period of service should also be shown incorporating the date the referral was given to the Resource Team member and the date the report was submitted for typing. The end of the report should indicate the name, title and affiliation of the author.

   b. *Identifying Information*. This section includes the person's name, date of birth, ID# (if any), present address, and referral source. Optional information includes the names and relationships of the people the client is living with and an indication of the client's program settings.

2. **Reason(s) for Referral**

   a. This should be a brief statement identifying the source of the referral and the specific behaviours precipitating it. Note should also be made of any special considerations regarding the motivation of the key social agendas and how these relate to the referral problems. Additionally, any negative consequences threatened as a result of the behaviour, e.g., physical damage to the learner and/or others, placement in a more restrictive setting, etc., should be noted.

   b. This should be a brief statement of the key social reasons for requesting the services by the social agent. If the referral was made by an agency separate from the key social agent, some determination should be made concerning the agreement between them as to the reasons for the referral.

3. *Data Source.* This section should identify and list the methods used in conducting the assessment. This could include direct observation, interviews, questionnaires, review of evaluation reports prepared by other professionals, previous program data, etc.

4. *Description of Services*. This section should list the settings in which the assessment was carried out. Times and dates should be indicated. Also included should be telephone conferences, program development and report writing time.

5. **Background Information**

   a. *Brief Learner Description.* This should be a brief narrative description of client-identifying information such as age, sex, diagnosis, ability to comprehend and produce language, and any relevant results of formal or informal testing that may have been reported by other professionals. Concrete descriptions and examples should be provided of client abilities and functioning level.

   b. *Living Arrangement.* This should be a brief description of the current living arrangement indicating who he/she lives with, by name and relationship, the type of residence and the name, age and contact of any (other) family members who may have regular contact with the learner.

   c. *Program Placement.* This should be a brief description of the present program placement(s) including location, name, type of program, evaluation of program, staff contact person, address, and phone number.

d. *Health and Medical Status.* This section should describe the general health of the learner, recent illnesses, operations, seizure activity, type of seizure, blank or staring spells, etc. It should also indicate frequency of seizures, most recent seizures, treatment for seizures, what medication or drugs the learner is presently taking and for what purpose.

e. *Previous or Current Treatment.* This section should describe any previous attempts to treat the current problems and the outcome of those efforts. This should include, for example, information concerning where, whom, and for what reason there were any in-patient referrals, and a brief description of previous behavioural intervention programs. Previous interventions should be described in sufficient detail as to allow for an evaluation of design and an evaluation of procedural reliability.

6. **Functional Analysis of Presenting Problem(s).**

a. *Description of Referral Problems.* Each behaviour should be defined to include topography, cycle course and measures of severity. Present rate and severity measures or best estimates should be reported.

b. *History of the Problem.* The onset and duration of the current problems should be indicated. Any recent increases or decreases in the behaviour should be indicated. In addition, indications and/or speculations should be reported regarding any events that may have contributed to an exacerbation of the problem(s).

c. *Ecological Analysis.* This section should describe the system that surrounds the target behaviour, including the physical characteristics of the environment, the social system and opportunities for interpersonal interactions, and program characteristics.

Factors to consider when conducting an ecological analysis should include, but are not necessarily limited to:

- The expectations of the client about the environment.
- The expectations of others in the environment concerning the learner.
- The nature of the materials and physical objects available to the learner.
- The reinforcement and preference value of the materials/objects available.
- The nature of the activities in which the learner is engaged in terms of difficulty, interest level, etc.
- The number of people present in the client's environment.
- The behaviour of other people in the client's environment.
- Environmental pollutants such as noise, crowding, etc.
- Sudden changes in the learner's life, environment or reinforcement schedule.
- Individual abilities such as general skills, communication skills, and adaptive ability, as they relate to the demands of the environment.
- The level of program difficulty.
- The effectiveness of available reinforcers.
- The variety of materials/activities available.
- The variety of grouping arrangements used.

- The opportunities for interaction with others, including individuals who are not disabled.
- The variety and nature of settings to which the learner has regular access.
- The nature of instructional strategies used in programming.

d. *Antecedent Events.* Specific antecedents which typically precede the problem behaviours should be described. This should include consideration of specific activities, time of day, location, people, task and other (e.g., social demands), etc. In addition, the conditions associated with low probabilities of target behaviour should be clearly identified. Finally, hypotheses that target behaviour could be an elicited response should be considered and discussed.

e. *Consequent Events.* The reactions of others to the behaviour should be described. Past methods used to manage the problem, and the results of those efforts, should be described with appropriate cross references to previous and current treatment section. Finally, events that may act to maintain or reinforce the current problems should be described.

f. *Impressions and Analysis of Meaning.* Hypotheses concerning what function and/or communicative role the behaviour may be serving for the learner should be indicated in this section. In addition, these hypotheses should suggest some general strategies for intervention which should be described in this section of the report.

7. **Motivational Analysis**.
This section should identify and prioritize potential positive reinforcers for the learner. Included should be predictably occurring behaviours, likes and dislikes, and verbal requests. Satiation level should be indicated and/or further assessment in this area should be described and recommended.

8. **Mediator Analysis.**
This section should describe the parents, teachers and other key social agents who would act or who may act as mediators of the programs. Their strengths and weaknesses should be described as well as the potential effects of these on the course of intervention. A realistic estimate should be made of the ability of the mediator to carry out programs given the demands on time, energy, emotions, and the constraints imposed by the specific program_settings. If different or additional resources are needed in this area, they should be described.

9. **Recommended Intervention Program**.

a. Long-Range Goals. This section should describe the long-range goals for intervention in terms of clinical outcome, i.e., quality of life measures.

b. Short-Term Behaviour Objectives. This section should indicate time limited measurable objectives for each of the referral problems and targets of the intervention and positive program. Specifically, in regard to the referral problems, this should indicate in quantitative terms the changes that are being targeted in comparison to baseline levels and when those targets are expected to be reached. Measurable objectives should also be established for durability, generalisation, side effects and social validity.

c. Data Collection**.** The procedures and forms to be used for data collection should be described for each of the short-term objectives. The methods used to ensure the reliability of observations should also be described, if applicable.

d. Intervention Procedures.

1. Ecological Manipulations. Specific recommendations should be made for alterations to the learner's physical, programmatic and/or interpersonal environments for the purpose of providing the most support for achieving the overall treatment goals and objectives.

2. Positive Programming. Specific and systemic instructional programs should be described to develop:

   a. *General Skills*. In the areas of domestic, vocational and general community functioning. The tasks and activities should be directly functional, chronologically age-appropriate and performed in socially integrated community settings.

   b. *Functionally Equivalent Skills.* In an effort to give the learner more effective and socially acceptable ways of addressing the functions identified for the targeted problem behaviours.

   c. *Functionally Related Skills*. In an effort to provide the learner with those critical skills that are related to but that do not directly serve the same functions identified for the problem behaviours.

   d. *Coping Skills*. To increase the learner's ability to tolerate unavoidable, naturally occurring aversive events, particularly those identified as discriminative for problem behaviour.

3. Direct Treatment. Specific intervention strategies should be prescribed with the objective of producing the most rapid reduction in problem behaviour, in a manner consistent with the overall treatment goals and objectives.

4. Reactive Strategies. Specific recommendations should be made for the situational management of behavioural episodes in a manner consistent with IABA's Emergency Management Guidelines.

5. Staff Development. This section should describe any possible staff training that would facilitate the delivery of the program described above.

10. **Comments and Recommendations**.

   a. Any difficulties that may be anticipated in the proposed intervention should be described.

   b. Additional resources or services that may be available and helpful to the key social agents in carrying out the program should be specified. If services are being recommended, the number of hours should be specified as well as specific expectations concerning the future fading of these services.

   c. Strategies for evaluating treatment outcome should be described (e.g., quarterly), progress reports, individual team meetings, etc.