

AVERSIVE, RESTRICTIVE AND INTRUSIVE TREATMENT PRACTICES

Policy and Guidelines

Policy Statement

In accordance with the Principles and Standards of the *Tasmanian Disability Services Act (1992)*:-

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

Disability Services acknowledges that there may be occasions where some form of restrictive practice may need to be employed to manage some instances of challenging behaviour. Except in emergency situations, (see ***Definitions***, p4) such practices:

- should only be used as part of a challenging behaviour intervention plan;
- should involve the least reasonable restriction of the person's rights;
- should be used only when all other options have been explored and
- should be time-limited.

All Challenging Behaviour Intervention plans which contain the use of restrictive practices must be submitted to the Disability Services Ethics Committee (DSEC) for endorsement.

Restrictive practices should not be used without appropriate authorisation, reporting and monitoring except where duty of care provisions apply (see ***Duty of Care***, p5).

Rationale

In the past, aversive, restrictive and intrusive practices have been used in attempts to modify the challenging behaviour of some people with a disability particularly where the behaviour posed a threat to the safety of the person with a disability and/or others. The very nature of this type of intervention is contentious. Practices such as restraint and seclusion impose limitations on the ability of an individual to exercise freedom of movement, are potentially abusive and a denial of human rights and therefore pose both ethical and legal questions as to their validity.

More importantly, researchers and practitioners in the mid-to-late 1980's demonstrated quite conclusively that punishment (aversive practices) does not create lasting changes in behaviour¹. Aversive practices are usually only effective in the short term, whereas long term sustainable change in behaviour is achieved through positive, individualised environmental adaptations and the provision of skill development opportunities.

However there are times (e.g. protecting someone from harm) when it may be necessary to use some form of restrictive practice in response to challenging behaviour. In such instances the *Tasmanian Disability Services Act (1992)* offers only general guidance (e.g. 'as free as possible', 'the least reasonable restriction') as to what is and what is not an acceptable intervention.

This policy and guidelines have therefore been developed to clarify the Department's position with regard to aversive, restrictive and intrusive practices and to establish acceptable practices and provisions in relation to the authorisation, reporting and monitoring of interventions that are or have the potential to be aversive, restrictive or intrusive.

Scope

This policy and its guidelines apply to all services directly managed by Disability Services and all non-government organisations that provide services for people with a disability and which are funded by Disability Services. It applies to managers, staff members and volunteers.

¹ For example, La Vigna G. W., Donnellan A. M. (1986); *Alternatives to Punishment. Solving behaviour problems with non-aversive strategies.* Irvington Publishers Inc.

Definitions

The following definitions will apply: -

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

This definition encompasses not only confinement resulting from doors and windows being locked from the outside, but also situations where an individual is unable to open a door from the inside (e.g. due to the position of the door handles, or the nature of the person's disability).

Restraint

The definitions provided below do not apply to the application of restraints required by law (ie. the wearing of a seat belt in moving vehicles).

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).

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. mittens to prevent someone biting their hand, an arm splint to prevent someone from hitting their head, a helmet to prevent someone from hitting themselves).

Mechanical devices which are used to prevent bodily movement that is *involuntary* and harmful to the person does not constitute restraint (e.g. a helmet to prevent injuries due to drop seizures, a seat belt used to prevent someone with severe cerebral palsy from falling out of a chair).

N.B. Although the use of bed railings does not 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.

Chemical Restraint

- the use of medication, or other substances, which may or may not be prescribed by a medical practitioner, for the *sole purpose* of behaviour management or control.

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.

Aversive Treatment Practices/Punishment

- an aversive practice is one that uses unpleasant physical or sensory stimuli in an attempt to reduce undesired behaviour. An aversive intervention 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 a person's goods/ belongings or of a favoured activity for the purpose of behaviour management or control.

Examples of aversive practices or punishment include:-

- physical abuse (e.g. pinching, pushing and hitting);
- psychological abuse (e.g. ridicule, threats, put-downs, emotional manipulation);
- any practice involving the application of unpleasant conditions (e.g. cold bath, squirting liquid into a person's face, applying chilli paste to the hands to prevent biting);
- the cancellation of an evening activity as 'punishment' for challenging behaviour which occurred earlier in the day.

Least Reasonable Restriction

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

Emergency situations

Situations where challenging behaviour occurs for the first time or so infrequently that it is unpredictable. The challenging behaviour must be 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 or seclusion. If the behaviour recurs a Challenging Behaviour Intervention plan **must** be developed. Guidelines for the management of emergency situations are contained in **Appendix 2**.

Legal Issues

Legislation

Legislation which is relevant to the use of aversive, restrictive and intrusive practices includes: -

Tasmanian Disability Services Act (1992)

Tasmanian Criminal Code Act (1924)

Tasmanian Police Offences Act (1935)

Tasmanian Anti-Discrimination Act (1998)

Commonwealth Disability Discrimination Act (1992)

Under the provisions of the *Criminal Code Act (1924)* and the *Police Offences Act (1935)*, certain forms of restrictive and/or aversive practices (e.g. physical abuse, threats or confinement without consent) would constitute an assault and those responsible may face criminal charges and prosecution by the police.

Other forms of aversive, restrictive and intrusive practices, whilst of a non-criminal nature are still illegal and legal redress can be pursued through the Anti-Discrimination Commission, the Disability Discrimination Solicitor, or through civil action. Examples include any form of aversive treatment (with the exception of physical abuse).

Behaviour management practices which are abusive are totally unacceptable and may be illegal. Further information about abusive practices is contained in Disability Services' *Guidelines Relating to the Reporting of Abuse in Services for People with Disabilities (November 2000)*.

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 interventions.

Duty of Care is a component of the law of negligence. The law of negligence sets as a minimum acceptable standard a requirement for Disability Services and the organisations which it funds to act reasonably. In considering the use of restrictive interventions, 'duty of care' issues need to be considered. A duty of care is a duty to take reasonable care of a person. Under emergency situations (see ***Definitions*** p4) this may involve the use of restrictive practices in order to protect the person or others from harm (e.g. restraining a person from running onto a busy road).

Disability Services and funded service providers, like all community members, have a duty to take reasonable care to avoid injury to other 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.

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 action or inaction.

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

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

Consent and the role of the Guardianship and Administration Board

Using a restraint or seclusion as described under Definitions without the consent of the person with a disability would, under ordinary circumstances constitute an assault and the perpetrator may be charged with a criminal offence. However 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 seclusion to be able to be used lawfully. Failure to act could in fact constitute a breach of duty of care (see above).

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 practise. Examples of situations where a guardian may need to be appointed include 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 they are unwilling to be escorted.

Ethical Issues

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

These rights are also reflected in the *Tasmanian Disability Services Act (1992)*, which specifies the use of the least restrictive alternative in service provision.

Ethical dilemmas occur when there is a need to balance a service's duty of care obligations against the rights of a person with a disability; a person whose behaviour has the potential for self harm or of harming others. Staff members' rights are also involved as they are entitled to work in a safe environment.

Aversive, restrictive and intrusive 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. However, emergency situations (see p4) may occur where the use of restrictive practises may be required in order to prevent a person harming themselves or others.

The role of the Disability Services' Ethics Committee

The *Tasmanian Disability Services Act (1992)* acknowledges the ethical difficulties inherent in the situation described above by providing for the establishment of a Disability Services Ethics Committee (DSEC).

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 treatment practices.’

The DSEC provides a mechanism for ethically contentious interventions to be discussed, authorised, monitored, and reviewed by an independent statutory body. In this way the rights of people with a disability are safeguarded as much as possible whilst also allowing for a response to the challenging behaviour which is positive and part of a holistic support program.

Use of Restraint, Seclusion and Aversive Therapy/Treatment Practices

The following provisions relate to programs and services funded and/or provided by the Department of Health and Human Services, Community and Rural Health Division, Disability Services.

- Aversive therapy/treatment practices as defined in this document deprive people of basic human needs or rights and are **not** to be used under any circumstances.
- Restraint and seclusion as defined in this document may be used in specific circumstances only and under specific conditions as a strategy of last resort if it is implemented in accordance with the operational guidelines outlined in the following pages.

Disability Services' Operational Guidelines

Use of Restraint or Seclusion

Generally speaking the use of restraint is acceptable where it is required by law, (i.e. seat belts in moving vehicles), where it is required to meet the provisions of '*duty of care*' (see p5) or in emergency situations, (i.e. to prevent harm or injury to a person with a disability or members of the public) (see p4).

The use of restraint is also acceptable where the restraint is used to improve the client's ability to function (i.e. an adaptive piece of equipment) provided it is the least restrictive alternative.

When restraint or seclusion is proposed as a strategy within a behaviour management program it is important to note that this involves a serious deprivation of an individual's freedom and rights.

Operational procedures for the use of restraint or seclusion in this context must be consistent with the principles underlying effective behaviour management as used by Disability Services (see *Appendix 1*).

Operational Procedures

If restraint or seclusion is to be used as part of a behaviour management strategy, the following requirements must be met:

- it must be demonstrated that all non-restrictive options have been tried, including strategies developed in conjunction with the Service Coordination and Resource Teams of Disability Services;
- trials of alternatives must be documented and verified as having been ineffective or that the risk to the person with disabilities is assessed as great enough to warrant the immediate use of restraint or seclusion before other options have been trialed;
- the use of restraint or seclusion must form part of a Challenging Behaviour Intervention plan outlining how, when, where and why the restrictive practice is applied. The plan must include monitoring and review provisions ensuring the clients continued safety and well being;
- restraint or seclusion should not be part of a Challenging Behaviour Intervention plan unless it can be demonstrated that without it the person with disabilities or others will be in imminent danger or there is a likelihood of damage to property;
- the Challenging Behaviour Intervention plan should be devised through consultation with family, guardians, direct support providers, service managers, Disability Services' Resource Team and any other appropriate persons;

- wherever possible, the person for whom the restraint or seclusion is proposed should be involved in the process of developing the program;
- a copy of the plan must be forwarded to the DSEC for endorsement;
- restrictive practises should not be used at meal-times unless authorised by the DSEC;
- staff members must be appropriately trained in the proper application of the restraint or seclusion and the monitoring procedures, this is to be achieved as part of the behaviour management plan. All instances of monitoring must be documented;
- if the restraint used is a chemical restraint a system of monitoring must be devised, explained and written by the prescribing medical practitioner. Staff members must adhere to this and every incident of monitoring must be recorded in writing, and
- 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. Staff members must adhere to this and every incident of monitoring must be recorded in writing.

Legal/Ethical Advice

Apart from the monitoring and review processes outlined above it is crucial that staff involved in devising behaviour management programs that include restrictive interventions seek and receive appropriate advice on relevant legal and ethical 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 Divisional Director)

Regardless of whether or not advice is required from the DSEC a copy of all Challenging Behaviour Intervention plans which involve restrictive practices must be forwarded to the DSEC for **information**. This will formalise the DSEC's monitoring role under the *Disability Services Act (1992)* and provide an automatic safeguard for staff members involved in the devising and implementation of behaviour management programs.

Appendix One

PRINCIPLES UNDERLYING EFFECTIVE BEHAVIOUR MANAGEMENT

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 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 from ‘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.

Appendix Two

GUIDELINES FOR MANAGING EMERGENCY SITUATIONS

- ❖ When responding to a potentially **emergency situation**, staff members are expected to protect themselves from injury but are limited to 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.
- ❖ A staff member’s response to a person who is threatening or attempting to injure should **reflect the seriousness of the incident** i.e. :-
 - A) **Crisis Communication**
 - ❖ Can the person be talked into stopping the dangerous behaviour ?
 - B) **Evasion**
 - ❖ If the person won’t stop, can harm be avoided by evasion ?
 - C) **Restraint**
 - ❖ If the person is not restrained will he/she or someone else be seriously injured?
- ❖ For behaviour that is “recurring”, either in the short or long term, a **Behaviour Intervention Management Plan** will need to be developed as outlined in the Policy Statement and guidelines, pp 1, 4, 8, 9 and Appendix 1.