



Disability Services Commission

Code of Practice for the Elimination of Restrictive Practices

Contents

Overview	1
Part One – Overview of the purpose and context of the Code	2
1.1 Purpose	2
1.2 Accessibility.....	2
1.3 Context.....	2
1.4 Key terms	3
Part Two – Development of operational policy and guidelines to assist with service implementation	3
2.1 Positive Behaviour Support and systemic change in service delivery	3
2.2 Service Guidelines.....	4
2.3 Use of restrictive practices	5
2.4 Withdrawing restrictive practices	6
2.5 Issues to consider in defining a restrictive practice	6
2.6 Consent.....	8
2.7 Grievances	8
2.8 Code review	9
Appendices	10
1 International, national and state obligations	10
2 Definitions and key terms	12
3 Decision-making flow charts:.....	17
4 Behaviour Support Plan Quality Evaluation II (BSP-QEII).....	19

To support disability sector-wide engagement in the elimination of restrictive practices

Overview

This Code of Practice for the Elimination of Restrictive Practices is part of the Positive Behaviour Framework and should be read in conjunction with other Positive Behaviour Framework documents such as:

- Positive Behaviour Framework Effective Service Design
- Positive Behaviour Support Information for Disability Sector Organisations
- Towards Responsive Services for All!
- Positive Behaviour Framework Substantive Equality Project 4
- Evaluation of the Sector Workforce and Development Project to Promote the Use of Positive Behaviour Support in Disability Services.

This is the second edition of the Code of Practice (“the Code”) which provides the basis for the disability sector to develop operational policy and guidelines for eliminating the use of **restrictive practices** (see 1.4). It applies to all services provided and funded by the Disability Services Commission for children and adults with disability.

The first edition, released in November 2012, by a coalition of partners from across the disability sector, included a commitment to a review of the Code, 12 months after implementation. This edition is the result of that review, in which representatives from a broad range of disability sector organisations, people with disability, families, carers, advocacy organisations and other government agencies were consulted.

A significant change since the introduction of the Code in 2012, has been the launch of new National Standards for Disability Services (National Standards), which have been adopted by all States and Territories. West Australian organisations are strongly encouraged to adopt the Code as a means of demonstrating compliance with Standard 1 of the National Standards:

“The service promotes individual rights to freedom of expression, self-determination, decision-making and actively prevents abuse, harm, neglect and violence.”

The intent of National Standard 1 is to promote ethical, respectful and safe service delivery that meets, if not exceeds, legislative requirements and achieves positive outcomes for people with disability. The **human rights** (see 1.4) principles which underpin Standard 1 are relevant across all six National Standards, each of which supports and reinforces the fundamental right of people with disability to have respect and dignity. This includes the dignity of risk — the right to choose to take some risks in life.

The Standard emphasises the importance of:

- dignity and respect
- freedom of expression
- self-determination

- choice and control
- confidentiality and privacy
- freedom from discrimination, exploitation, abuse, harm, neglect and violence
- the role of families, friends, carers and advocates in the safeguarding of rights
- comprehensive systems to prevent or promptly respond to any breaches of rights.

This second edition of the Code reflects the requirements of the National Standards.

It is divided into two parts:

- part one, which provides an overview of the purpose and context for the Code
- part two, which is to inform the development of operational policy and guidelines to assist with service implementation.

Part one – overview of the purpose and context of the Code

1.1 Purpose

The purpose of the Code is to:

- raise awareness of the human rights of people with disability
- contribute to the elimination of the use of restrictive practices for people with disability who experience **challenging behaviours** (see 1.4)
- ensure safeguards are in place in exceptional circumstances where it is necessary to use restrictive practices to protect the welfare of individuals and the safety of third parties
- assist disability sector organisations to demonstrate compliance with the National Standards for Disability Services, the Commission’s Quality Management Framework and Serious Incident Reporting requirements.

1.2 Accessibility

The Code will be available in a plain English format and other formats to meet the communication and cultural needs of diverse stakeholders. This includes, but is not limited to, people with intellectual disability, people with vision impairment, Aboriginal people and people from cultural and linguistically diverse backgrounds.

1.3 Context

In WA, the Code is one of a number of related strategies implemented to support the Commission’s Positive Behaviour Framework. The Framework was guided by the ‘Towards Responsive Services for All’ report which promoted a coordinated, state-wide approach to **Positive Behaviour Support** (see 1.4).

The essential elements of Positive Behaviour Support, and its strong evidence base, were also reflected in the Effective Service Design report, which was developed after sector-wide consultations. It highlights those elements of service design and delivery that, if applied, would lead to a significant reduction or elimination in the need for use of restrictive practices. In the first edition,

the Code drew on Standard 9 of the WA Disability Services Standards, now replaced by Standard 1 of the National Standards for Disability Services 2013.

International, national and state obligations and legislation in relation to the human rights of people with disability underpin the development of the Code (refer to Appendix 1).

A key tool to support the elimination of restrictive practices, that is being supported by the Commission, is the **Behaviour Support Plan Quality Evaluation Guide II (BSP-QEII)**.

1.4 Key terms

Key terms associated with the identification, reduction and elimination of restrictive practices are defined in Appendix 2. They are identified in the body of the document in **bold** font.

Where a key term in this document is also used in the National Standards, the definition in the National Standards is used.

Part two – Development of operational policy and guidelines to assist with service implementation

2.1 Positive Behaviour Support and systemic change in service delivery

The implementation of the Code requires systemic change. The key systemic change required is the implementation of Positive Behaviour Support within organisations.

Positive Behaviour Support is a set of research-based strategies used to increase quality of life and decrease challenging behaviour by teaching new skills and making changes in a person's environment. Positive Behaviour Support strategies are considered effective when intervention results in increases in a person's success and personal satisfaction, and the enhancement of positive social interactions across work, academic, recreational and community settings. Valued outcomes include increase in quality of life as defined by the person's unique preference and needs and positive lifestyle changes that increase social belonging (source: http://www.apbs.org/new_apbs/general-introduction.html#definition).

The wellbeing and safety of people with disability, their families and/or carers and the staff who provide services, will be primary considerations as the Code is implemented and embedded.

To implement Positive Behaviour Support and eliminate restrictive practices, individual disability sector organisations and the sector collectively must plan for:

- significant organisational cultural change
- significant changes in current service design, policies, practices and tools that support person-centred practice
- increased interdisciplinary liaison and collaboration between disability sector organisations, and between the disability services sector and other sectors
- adapting the Code so that it has cultural relevance
- some new content and changed requirements for staff training
- closer and more informed relationships between service providers, people with disability, families and carers.

Operational implementation of the Code is the responsibility of each service provider and should take into account the types of service provided and the assessed needs and abilities of each person for whom the services are provided.

2.2 Service Guidelines

The following service guidelines are to be considered when delivering services to people who experience challenging behaviours. The guidelines are underpinned by recognition that people with disability are in the best position to make decisions and choices for themselves and have the **capacity** to communicate this.

- The service provider will develop services that uphold **human rights** and the wellbeing, inclusion, safety, quality of life and **substantive equality** for people with disability.
- Service providers will recognise that people with disability have the same rights as all people to equality before the law and to equal protection under the law, without discrimination.
- Service providers will have policies, procedures and tools in place to safeguard the rights of people with disability and to identify and monitor the use of restrictive practices.
- Service providers will ensure that services are person-centred, proactive and enhance the quality of life for the person.
- Service providers will adopt practices that recognise and support the person's authority in decision-making, choice and control.
- Service providers will recognise that people with disability, their families and carers are the natural authorities for their own lives and are in the best place to communicate their choices and decisions.
- Service providers will ensure whatever supports necessary are put in place to help people with disability communicate their wishes.
- Service providers will actively facilitate the person's engagement with family, carers, other friends and advocates who know them well (or if applicable, their guardian or relevant authority) to support discussion around the needs and wishes of the person with disability.
- Service providers working with people of Aboriginal or cultural and linguistically diverse backgrounds will demonstrate **cultural competence** in their governance, values, behaviours and practices.
- Cultural relevance and appropriateness of services, in a person-centred context, is an important consideration but does not over-ride the requirement for the human rights of the person with disability to be the paramount consideration.
- **Behaviour Support Plans** are key practice and accountability documents and must be in place for all people identified as experiencing challenging behaviours.
- Service providers will recognise the importance of understanding the nature and function of the person's behaviour in order to minimise the use of restrictive practices, and will seek specialist guidance (for example, from a **Behaviour Support Consultant**) to assist in developing this understanding when necessary.
- The Behaviour Support Plan Quality Evaluation Guide II (BSP-QEII) will support the development, implementation, monitoring and review of quality Behaviour Support Plans.

- Service providers will ensure Behaviour Support Plans consider the key components required by the BSP-QEII in their development (refer to Appendix 4).
- Service providers will put in place **Positive Behaviour Support Panels**.
- Service providers will develop terms of reference for such panels and ensure panels include a representative external to the disability sector organisation.
- Service providers will maintain a register of all restrictive practices in place which will include progress towards developing action plans to minimise and eliminate the use of restrictive practices.

2.3 Use of restrictive practices

- Restrictive practices will be minimised by service providers ensuring evidence-based policies and procedures are in place, along with adequate staff numbers, quality training and supervision and due care for the welfare and professional development of staff.
- Restrictive practices cannot be approved for organisational or staff convenience or to overcome a lack of staff, inadequate training, a lack of staff support and/or supervision.
- Service providers will recognise that the use of restrictive practices are not effective long-term strategies to manage risks and behaviours and can result in long-term physical and psychological harm.
- Service providers will reduce and eventually eliminate restrictive practices in place wherever possible.
- A restrictive practice may only be implemented when it is agreed to by the service provider's Positive Behaviour Support Panel as the **minimally restrictive** intervention to address the person's identified needs and risks. This agreement will be based on a written submission to the service provider's Positive Behaviour Support Panel, to confirm:
 - all less restrictive practices have been carefully evaluated and cannot be applied
 - without the intervention the person is a risk to themselves and/or to others
 - there has been consideration of the impact of the intervention on the rights and wellbeing of others who share the person's environment
 - the restrictive practices is considered in the context of a Positive Behaviour Support Plan and a **person-centred plan**
 - any other considerations the panel deems necessary.
- A restrictive practice that has been supported by the Positive Behaviour Support Panel must be implemented:
 - with the informed consent of the person involved, using the organisation's procedures in place for determining capacity to consent, or
 - when the person is determined not to be able to provide consent, the consent of the person with the authority to make decisions on behalf of the person, or from an appointed guardian with the relevant authority

- for the shortest possible time while a more appropriate arrangement for support is developed.
- A restrictive practice that has been supported by the Positive Behaviour Support Panel must be applied under the supervision of a designated, experienced staff member who is on duty at the time, and form part of a Behaviour Support Plan.
- Approved restrictive practices must be reviewed by a senior manager at intervals of no less than once every three months, and by the Positive Behaviour Support Panel, no less than once every year, from the date of the first approval.
- Restrictive practices must be recorded at each event, and reviewed by the service provider at least once every 12 months.
- A restrictive practice for which there has been no prior Behaviour Support Plan, including **seclusion** and **physical restraint**, might be necessary in an emergency, to save a person's life or to prevent them from experiencing serious physical or psychological harm, or to prevent the person causing serious physical or psychological harm to another person.
- When a restrictive practice is used that has not had prior Positive Behaviour Support Panel agreement, is not documented in the Behaviour Support Plan and for which consent has not been obtained:
 - the circumstances in which the intervention was used must be reviewed and recorded by the service provider as soon as possible to minimise the risk of a recurrence
 - the person's family or guardian must be advised as soon as possible
 - if it is a serious incident, it must be reported to the Commission as a Serious Incident Report within seven days.

2.4 Withdrawing restrictive practices

It is dangerous to withdraw existing restrictive practices before the service provider is satisfied that:

- safe and more respectful alternatives have been developed, trialled and demonstrated to be effective for the person concerned
- staff have had the appropriate training in how to apply the new practices and have demonstrated the skills required to support the person under the new arrangements
- the person has given informed consent or where they are assessed as not having the capacity to consent, a person with the relevant authority is involved, or a guardian has been appointed, and he/she has consented to the withdrawal of the existing practice.

2.5 Issues to consider in defining a restrictive practice

Use of a therapeutic device

The use of any device (eg arm splints) for the management of behaviour is a restrictive practice and the Challenging Behaviour and Restrictive Practices Decision-Making Flow Chart should be the reference (refer to Appendix 3).

The use of a **therapeutic device** does not constitute a restrictive practice when it is clinically prescribed for the purpose of:

- improving the quality of life of a person with disability, by preventing or minimising body shape distortions and the directly-related secondary complications that result in pain, discomfort and poor health, and/or
- assisting a person to participate in a desired task or activity by minimising factors that impede them and enabling their engagement in an activity which would not otherwise be possible, and/or
- providing **treatment** where, if there were no restriction of the person, an adverse health outcome would occur.

A device may be used for these purposes if its use:

- is clinically prescribed by an appropriately qualified **health professional**
- is formally and regularly reviewed
- the person has given informed consent or where they are assessed as not having the capacity to consent, a person with the relevant authority is involved, or a guardian has been appointed, and he/she has consented to the withdrawal of the existing practice.

The prescribed device must be:

- the **minimal intervention** to achieve the desired result
- based on evidence from current best practice.

Use of medication

The use of psychotropic and other drugs to reduce symptoms and behaviours associated with conditions such as anxiety, depression and other mood disorders or a psychosis, does not constitute a restrictive practice when:

- the medication is prescribed for a person who has a psychiatric condition diagnosed by a qualified psychiatrist and is reviewed at least annually or
- the medication is prescribed by a general practitioner who is treating the person as part of a Medicare-approved mental health plan and the medication is reviewed at least annually.

When the service provider is responsible for attending a mental health medical appointment with a person for whom they provide support, the person must be supported by someone who knows them well.

When medication is prescribed at the appointment, the staff member must request a written statement from the doctor to confirm the reason for the prescription, and the statement must be placed on the person's medical records held by the service provider.

When a **PRN medication** is prescribed, each occasion it is given to the person must be authorised by the most senior service staff member on duty, who must enter full details of the dose, time and circumstances leading to the decision to use it onto a PRN medication register.

Use of environmental or psycho-social restraints

Whether or not an **environmental restraint** or a **psycho-social restraint** would be considered to be a justifiable restrictive practice for the purposes of this Code requires the service provider to make a case-by-case decision which takes into account:

- the age of the person – some interventions, inappropriate for adults, might reflect acceptable community practices in relation to the protection of children
- whether the intent is to punish or overprotect or is to meet a duty of care or an occupational health and safety requirement
- the balance between the rights of the person and the rights of all others who share the person's environment.

Such practices, when agreed by a Positive Behaviour Support Panel, must be documented in the Behaviour Support Plan and be formally and regularly reviewed.

2.6 Consent

- Service providers will ensure that the person provides informed consent in relation to all matters that affect them and understands the nature and consequences of their consent. This includes understanding the impact on them of implementing or removing any restrictive practice that might result from their consent.
- The service provider will use the organisation's internal policy and procedures for determining capacity to give informed consent.
- The service provider will use whatever strategies are necessary, taking into account the person's cultural and communication needs and understanding, to facilitate the person's capacity to communicate their choice and decisions.

When:

- there is uncertainty about the person's capacity to provide informed consent, and/or
- there is an absence of engaged family, carers, other friends and advocates to assist the person to make decisions, and/or
- there are conflicts around what decisions and actions are in the person's best interests

the service provider will seek the advice and guidance of the Office of the Public Advocate for adults, and the Department for Child Protection and Family Support for children under 18 years of age, as to the correct action to take.

2.7 Grievances

When a person, or a guardian, or another person with authority to make decisions on behalf of the person, disagrees with any actions a service provider undertakes in relation to the requirements of the Code, the service provider will ensure that the person is aware of all options available to assist in the resolution of the matter. This support includes:

- ensuring the person (and/or their representative) understands how to access the service provider's internal grievance procedure, and the various external agencies with a mandate to receive and respond to a grievance from a person with a disability

- providing advice to the person of their right to external advocacy support and assistance to make contact with an advocacy organisation if they so choose.

2.8 Code review

In acknowledgment of the importance of the implementation of this Code, the Commission will initiate a further review before the end of 2016.

For further information, contact:

Jacki Hollick
Manager
Statewide Positive Behaviour Strategy
Disability Services Commission

Author:

Mike Cabbage
Manager
Behaviour Support Consultation
Disability Services Commission

Date:

November 2014

Appendix 1

International, national and state obligations

The following have informed the development of the Code:

- Universal Declaration of Human Rights.
- United Nations Convention on the Rights of Persons with Disabilities, with particular reference to:

Article 4 1(b)

To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities.

Article 4 1(c)

To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programs.

Article 4 1(d)

To refrain from engaging in any act that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention.

Article 4 1(e)

To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organisation or private enterprise.

Article 14

Liberty and Security of the person.

Article 15

Freedom from torture or cruel, inhuman and degrading treatment or punishment.

- Convention on the Rights of the Child 1990.
- Disability Discrimination Act 1992.
- National Standards for Disability Services 2013.
- National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Services Sector 2014.
- Disability Services Act 1993.
- Children and Community Services Act 2004.
- Guardianship and Administration Act 1990.

- Equal Opportunity Act 1984 (WA).
- Carers' Recognition Act 2004.
- Positive Behaviour Framework: Effective Service Design 2010.

Appendix 2

Definitions and key terms

There are various interpretations in the disability services sector of key terms associated with the identification, reduction and elimination of restrictive practices but the following definitions are adopted for the purpose of this Code.

Behaviour Support Consultant

Behaviour Support Consultants act as mentors and/or frontline coordinators to assist organisations to implement the Positive Behaviour Framework reform agenda. These positions also act as a point of contact across the sector to encourage collaboration, evidence-based practice and support transparency for organisations in the development of behavioural responses for people with disability who sometimes experience challenging behaviour. Behaviour Support Consultants play an active part in the ongoing development and planning for the Positive Behaviour Support Panel process and assessing the quality of Behaviour Support Plans.

Behaviour Support Plan

An individual/behaviour support plan is a plan developed for a person with disability which specifies a range of strategies to be used in supporting the person's behaviour, including proactive strategies to build on the person's strengths and increase their life skills. Source: <http://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/national-framework-for-reducing-and-eliminating-the-use-of-restrictive-practices-in-the-disability-service-sector>

Behaviour Support Plan Quality Evaluation Guide II (BSP-QEII)

The BSP-QEII is an evidence-based guide for assessing the quality of Behaviour Support Plans.

Capacity

The extent to which a person is capable of making reasonable judgements about their personal welfare and treatment.

(This definition is from the Office of the Public Advocate's 'A Guide to Enduring Power of Guardianship in Western Australia')

Challenging behaviour

Challenging behaviour is defined as "culturally abnormal behaviour(s) of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to the use of ordinary community facilities"

(Emerson, E, 1995. Cited in Emerson, Eric, 2001, "Challenging Behaviour: Analysis and Intervention in People with Severe Learning Disabilities", Cambridge University Press, p 3.)

Cultural competence

The specific knowledge and skills required in working with a specific community. The ability of agency staff to respond in a culturally responsive manner to culturally and linguistically diverse and Aboriginal people to whom they provide services (Equal Opportunity Commission, 2005, Understanding the Policy Framework for Substantive Equality Key Terms).

Health professional

The definition of a 'health professional' is a person registered under the "Health Practitioner Regulation National Law (Western Australia)" as set out in the Civil Liability Act, 2002, Section 5PA below.

"health professional" means –

- (a) a person registered under the Health Practitioner Regulation National Law (Western Australia) in any of the following health professions –
 - (i) chiropractic
 - (ii) dental
 - (iii) medical
 - (iv) nursing and midwifery
 - (v) optometry
 - (vi) osteopathy
 - (vii) pharmacy
 - (viii) physiotherapy
 - (ix) podiatry
 - (x) psychology

or

- (b) any of the following –
 - (i) a medical radiation technologist as defined in the Medical Radiation Technologists Act 2006 section 3
 - (ii) an occupational therapist as defined in the Occupational Therapists Act 2005 section 3
 - (iii) any other person who practices a discipline or profession in the health area that involves the application of a body of learning.

Human Rights

Human rights are rights inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. Source:

<http://www.ohchr.org/en/issues/pages/whatarehumanrights.aspx> .

Minimal restriction or minimal intervention

The term 'minimal restriction' or 'minimal intervention' recognises any restrictions on choice and control should be minimal and evidence based. Clear information should be provided to people with disability, their families and carers so that restrictions are transparent and easily understood.

Positive Behaviour Support Panel

A Positive Behaviour Support Panel is a panel to guide the development and delivery of services that are respectful of human rights of people with disability, in accordance with the Disability Services Commission's Positive Behaviour Framework and Code of Practice for the Elimination of Restrictive Practices. The Positive Behaviour Support Panel is responsible for monitoring the use of restrictive practices and reaching agreement (including interim agreement) or non-agreement of a restrictive practice to be used to support individuals accessing services.

Positive Behaviour Support

Positive Behaviour Support is a set of research-based strategies used to increase quality of life and decrease challenging behaviour by teaching new skills and making changes in a person's environment. Positive Behaviour Support strategies are considered effective when interventions result in increases in a person's success and personal satisfaction and the enhancement of positive social interactions across work, academic, recreational and community settings. Valued outcomes include increase in quality of life as defined by the person's unique preference and needs and positive lifestyle changes that increase social belonging (Association for Positive Behaviour Support, 2013).

PRN medication

Most medications are prescribed with instructions that they should be taken once in the morning, three times a day, etc. The term 'PRN' is a shortened form of the Latin phrase, which translates roughly as "as the thing is needed". PRN, therefore, means a medication that is not to be taken at regular times but only at times when it is necessary that symptoms are relieved.

Restrictive practice

The definitions for the terms 'restrictive practice', 'chemical restraint', mechanical restraint, 'physical restraint and 'seclusion' are from the 'National Framework for Reducing and Eliminating the Use of Restrictive Practices' (2014).

A 'restrictive practice' is defined as any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability, with the primary purpose of protecting the person or others from harm.

- **Chemical restraint**

A 'chemical restraint' means the use of medication or chemical substance for the primary purpose of influencing a person's behaviour or movement. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment, of a diagnosed mental disorder, a physical illness or physical condition.

- **Environmental restraint**

An 'environmental restraint' restricts a person's free access to all parts of their environment. Examples of environmental restraints include but are not limited to:

- barriers that prevent access to a kitchen, locked refrigerators and restriction of access to personal items such as a TV in a person's bedroom
- locks that are designed and placed so a person has difficulty in accessing or operating them
- restrictions to the person's capacity to engage in social activities by not providing the

necessary supports they require to do so.

- **Mechanical restraint**

To be consistent with the international research evidence, it is important to differentiate mechanical vs physical restraints. A 'mechanical restraint' means the use of a device (may include any mechanical material, appliance or equipment) to prevent, restrict or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes. For example, purposes may include the use of a device to assist a person with functional activities, as part of occupational therapy, or to allow for safe transportation.

- **Physical restraint**

A 'physical restraint' means the sustained or prolonged (eg a physical force or action lasting longer than approximately 30 seconds, that is not a reflexive manual restraint) use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing a person's behaviour. Physical restraint is distinct from the use of a hands-on technique in a reflexive (eg momentary contact to guide or redirect a person, lasting for no more than approximately 30 seconds) way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.

(McVilly, K, 2008, 'Physical restraint in disability services: current practices; contemporary concerns and future directions'. A report commissioned by the Office of the Senior Practitioner, Department of Human Service, Victoria, Australia)

- **Psycho-social restraint**

'Psycho-social restraint' is the use of 'power-control' strategies. Examples of psycho-social restraints include but are not limited to:

- requiring a person to stay in one area of the house until told they can leave
- directing a person to stay in a unlocked room, corner of an area, or stay in a specific space until requested to leave (also known as 'exclusionary time-out')
- directing a person to remain in a particular physical position (such as laying down) until told to discontinue
- 'over-correction' responses (such as requiring a person who has spilled coffee to clean up not only the spilled coffee but the entire kitchen)
- ignoring
- withdrawing 'privileges' or otherwise punishing, as a consequence of non-cooperation.

- **Seclusion**

'Seclusion' means the sole confinement of a person with disability in a room or physical space at any hour of the day or night where voluntary exit is prevented, implied, or not facilitated.

Person-centred planning

Person-centred planning may be defined as: a process of individual discovery and action that assist

the person to live the life they want to live and find their place in the community. Source: <http://www.ideaswa.net/upload/editor/files/downloads/HeatherSimmons.pdf>

Substantive equality

Substantive equality recognises that:

- rights, entitlements, opportunities and access are not necessarily distributed equally throughout society
- equal or the same application of rules to unequal groups can have unequal results
- where service delivery agencies cater to the dominant, majority group, then people who are not part of the majority group and who have different needs might miss out on essential services.

Hence, it might be necessary to provide different service types and approaches to people with disability and their families who are members of minority groups.

(Disability Services Commission Substantive Equality Statement of Commitment for People with Disabilities, 2006)

Therapeutic device

A 'therapeutic device' is primarily used to improve function (motor and bodily) and to prevent or reduce the risk of body shape distortion and their/its subsequent secondary complications. Therapeutic devices employ a variety of methods used for the purpose of restricting the movement of the person due to high or low tone and/or postural deformity and in some instances, behavioural movements. They may also be used for short periods of time to allow for wound healing/tissue repair.

The use of a therapeutic device aims to minimise the person's risk of developing physical deformity/injury that leads to the development of pressure on the soft tissues, to the development of pain or a reduction in functional capabilities.

Examples of therapeutic devices include but are not limited to:

- postural supports such as inserts
- splints to minimise contractures
- shoulder, chest and pelvic straps for optimal postural support
- helmets
- seatbelt modifications for safe transport
- night-time positioning equipment.

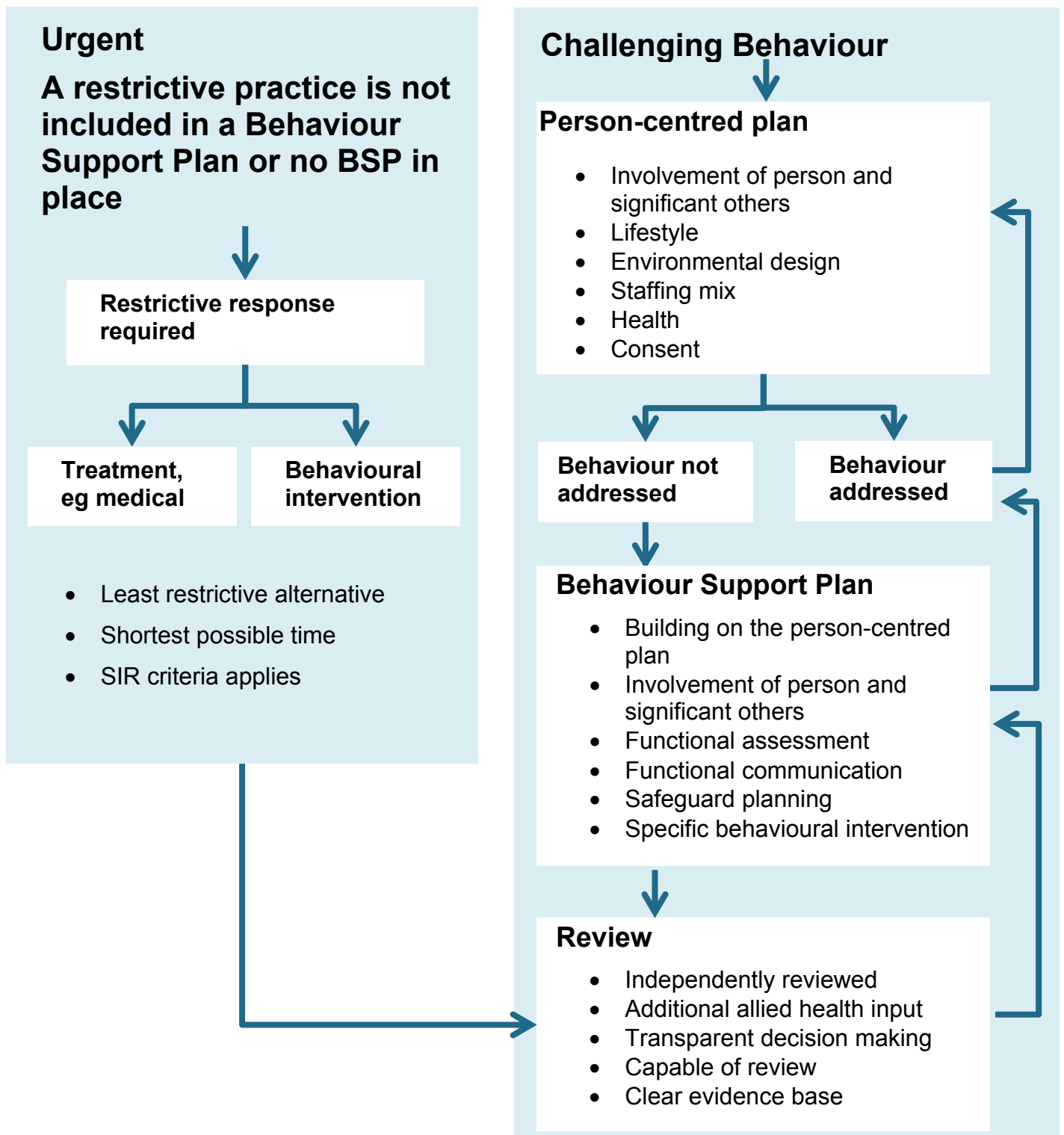
Treatment

In the Guardianship and Administration Act 1990, the term 'treatment' refers to any medical, surgical or dental treatment or other health care, including life sustaining measures and palliative care.

Appendix 3

Decision-Making Flow Chart

Challenging Behaviour and Restrictive Practices



Note: Outside of an emergency situation, with any Behaviour Support Plan (BSP), the aim is not to have a restrictive practice in place.

Decision-making Flow Chart

Therapeutic Device

Therapeutic Device

(Any device used to manage behaviour is a restrictive practice, and the Challenging Behaviour and Restrictive Practices flow chart applies)



Person-centred Assessment

- Involvement of person and significant others
- Function
- Health
- Lifestyle
- Environment
- Physical



Individualised Prescription by Allied Health Professional

Equipment to promote:

- Health
- Safety
- Mobility
- Activities of daily living
- Communication
- Posture/body shape



Review

- Successful use
- Objectives achieved
- Service and maintenance
- Least restrictive

Appendix 4

Behaviour Support Plan Quality Evaluation II (BSP-QEII)

What is the Behaviour Support Plan Quality Evaluation Guide II (BSP-QEII)?

The BSP-QEII is an evidence-based guide for assessing the quality of Behaviour Support Plans (Browning Wright, D, Cafferata, G, Keller, D, and Saren, D, 2009).

Why use the BSP-QEII?

The BSP-QEII has been well researched within and outside of Australia. Several studies show the guide is effective in assessing the quality of Behaviour Support Plans and can result in benefits for the person with a disability, the staff supporting the person and the organisation. Research shows that:

- high quality Behaviour Support Plans lead to reductions in the frequency and severity of behaviour, **reductions in the use of restrictive practices** and improvements in quality of life for people with disability (Webber, Richardson, Lambrick and Fester 2012, and Chan, LeBel and Webber 2012)
- use of the BSP-QEII increases staff ability to develop and implement Behaviour Support Plans and leads to increased theoretical knowledge of Positive Behaviour Support without specific training in Positive Behaviour Support (Browning Wright, Mayer, Cook, Crews, Kraemer and Gale 2007, and Maclean and Grey 2012).

The BSP-QEII is a way an organisation may demonstrate meeting the new National Standards for Disability Services, particularly Standard One: Rights.

How is the sector using the BSP-QEII?

The BSP-QEII can be used to assess the quality of Behaviour Support Plans, particularly plans which contain a restrictive practice and are presented to a panel for consideration. The BSP-QEII serves to provide a common language that assists disability sector organisations and their panels to discuss and address Behaviour Support Plan quality.

How does the BSP-QEII relate to Positive Behaviour Support?

The BSP-QEII covers six key elements of Positive Behaviour Support including function of behaviour, situational specificity, environmental behaviour support factors and functionally equivalent skills, reinforcement, reactive strategies, team coordination and progress review. Twelve components of a Behaviour Support Plan are assessed according to standard criteria. Each component scores 2, 1 or 0 with a maximum possible score of 24 points (Browning Wright, D, Cafferata, G, Keller, D, and Saren, D, 2009).

What elements are important to include in a Behaviour Support Plan according to the BSP-QEII?

For a Behaviour Support Plan to be considered to have reasonable quality it needs to include several components which cover the key elements of Positive Behaviour Support. These include:

1. **Function of behaviour:** This is a description of why the behaviour occurs (or what the purpose of the behaviour may be) and is usually described in terms of the person getting or avoiding something.

2. **Situational specificity:** This refers to identified factors which lead to the behaviour being more likely to happen. These factors are often described as ‘setting events’ and ‘triggers’ in a plan. These factors reflect the underlying unmet needs leading to the behaviour.
3. **Environmental behaviour support factors and functionally equivalent skills:** These are the proactive strategies put in place to reduce the likelihood of the behaviour occurring. They are preventative strategies implemented before behaviour occurs. They are developed from information regarding the situational specificity and function of the behaviour (as described above). Plans should include preventative strategies relating to changes to the environment and skill development.
4. **Reinforcement:** This is what is put in place to encourage the person to use appropriate behaviour to get their needs met instead of using challenging behaviour to get their needs met.
5. **Reactive strategies:** These are the strategies put in place to support the person during and after the behaviour of concern. It is essential that reactive strategies adequately address the safety of everyone involved.
6. **Team coordination and progress review:** This relates to the plan including clear evidence of team work/collaboration in implementing and reviewing progress of the plan. This also relates to the plan including specific goals (usually to increase positive behaviour or reduce challenging behaviour) and includes the method and timing for regular review.

Within the West Australian context several additional factors are considered important to include in a Behaviour Support Plan:

- Evidence of a person-centred approach: It is important that a culturally sensitive, holistic picture of the person is presented, rather than just a focus on the behaviours of concern.
- Evidence of involvement of the whole team supporting the person including formal and informal supports such as family/friends and carers at every stage in the development, implementation and review of the plan.
- Focus on addressing broad environmental factors to meet the person’s needs.
- Inclusion of quality of life goals which enhance the person’s independence, participation and inclusion in society.
- Attention to communication and relationship development with the goal of meeting the person’s need for belonging.

References

Browning Wright, D, Mayer, G, Cook, C, Crews, S, Rawlings Kraemer, B, Gale, B, 2007, ‘A Preliminary Study of the Effects of Training Using Behaviour Support Plan Quality Evaluation Guide (BSP-QE) to Improve Positive Behaviour Support Plans’, *Education and Treatment of Children*, Vol 30, No 3, pp 89–106

Browning Wright, D, Cafferata, G, Keller, D, and Saren, D, 2009, ‘The BSP Desk reference: A Teacher and Behaviour Support Team’s Guide to Developing and Evaluating Behaviour Support Plans for Behaviours that Interfere with the Learning of Student and/or Peers’

Chan, J, LeBel, J, and Webber, L, 2012. ‘The Dollars and Sense of Restraints and Seclusion’. *Journal of Law and Medicine*, Vol 20, No 1, pp 73-81

McClellan B and Grey I, 2012, 'A Component Analysis of Positive Behaviour Support Plans', *Journal of Intellectual and Developmental Disability*, Vol 37, No 3, pp 221-231

Webber L, Richardson B, Lambrick F, Fester T, 2012, 'The Impact of the Quality of the Behaviour Support Plans on the Use of Restraint and Seclusion in Disability Services', *International Journal of Positive Behavioural Support*, Vol 2, No 2, pp 3-11



Disability Services Commission

146-160 Colin Street, West Perth, WA 6005

PO Box 441

West Perth, WA 6872

Phone: (08) 9426 9200

Freecall (country): 1800 998 214

Fax: 9226 2306

TTY: 9426 9315

Email: dsc@dsc.wa.gov.au

Website: www.disability.wa.gov.au

© Copyright Disability Services Commission. November 2014.

This publication is available in alternate formats on request.