



Positive Behaviour Framework

Restrictive Practice(s) Issues Paper

Report on consultations held in Perth, Bunbury and Albany

Behaviour Support Consultation Team
Disability Services Commission

Project Consultant: Peter Millier

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Executive summary

In April 2011, a series of consultations were held with people with a disability, their families and carers, peak body organisations, disability sector organisations and other interested people. Respondents in all groups agreed that people with a disability, not just those who have behaviour considered challenging, are more likely to lead restricted lives. Further, that while restrictive practices are more likely to occur as a response to 'challenging' behaviour, it was recognised that challenging behaviour(s) might well arise as a consequence of carers, families, workers and services imposing restrictive practice(s).

For the most part, there was agreement as to what constitutes restrictive practice(s) and those circumstances where their use might be justified, albeit with clear guidelines and safeguards. There was broad agreement about practices that were considered not acceptable. Respondents were also able to identify many of the drivers that led to others making decisions about, and for, people with disability. These included low expectations by families, services and society of the competence and capacity of people with a disability. Some respondents found it rather ironic that, in an era where the mantra has been 'freedom of choice', many people with a disability had not been that free to choose. Respondents also found that on those occasions when people made inappropriate choices, they were either constrained or allowed to exercise those choice(s) to their detriment.

Respondents also identified many of what Tumienki ¹(2005) calls the 'door openers' to restrictive practice including:

- Separating people from typical social and physical contexts.
- The increased likelihood of restricting people with whom we are not in typical relationships, or people whom we do not see as 'like us'.
- People being physically or socially isolated or 'hidden in plain sight' – it is happening but we do not see it.
- Service workers feeling restrained by rules/regulations and so tending to feel frustrated. Their frustration might get taken out on those who do not have any power. It is often expressed by practices such as neglect, hands-off or alternatively, imposing unnecessary restrictions on the people they support.
- The mentality that new laws, policies and therapies will 'fix the problem'.

Restrictive, and sometimes abusive, practices are more likely to occur when a particular program takes priority over the people it serves or supports. The program can also take precedence over service workers, in situations where:

¹ Tumienki, M. (2005) Adopting a Personalist Response within Impersonal Service Structures. Paper presented at the "Many Faces of Abuse" Conference, Auckland, NZ.

- Direction and guidance is imposed from above – policies, practice guidelines and the like.
- There is increasing formalisation/bureaucratisation/objectification – the bigger and more stratified, the more it tends to drive out thinking about the typical community resources the rest of us use.
- Paperwork takes precedence over people.

The consultations have identified the following principles and issues in relation to the use of restrictive practices in Western Australia:

1. Preventing, limiting and eliminating the use of restrictive practices are consistent with the United Nations Convention on the Rights of Persons with Disabilities aim of protecting the rights, freedoms and inherent dignity of people with disabilities (see Appendix One).
2. There needs to be clarity and agreement as to what constitutes restrictive practice(s); eg physical restraints, particular medications, locked buildings/doors, restrictive routines that limit freedom of expression or movement.
3. The assumptions underpinning the use of restrictive practices need to be clearly spelled out. Is it to protect the person with a disability, his/her family/carer, a worker or society? Is the behaviour the cause or the consequence of restrictions placed upon a person? Is the behaviour due to the fact that the person has led an atypical life?
4. There needs to be clear understanding and agreement as to what is 'acceptable' in regard to restrictive practice(s).
5. Decisions about the use of restrictive practice(s) should involve the person who is going to be restricted, his/her advocate, family and other concerned persons. It should be collaborative, taking into account of the needs of other parties and, in some instances, require recourse to an external authority.
6. There needs to be guidelines for decision-making around restrictive practice(s) including:
 - A clear definition.
 - Policies and procedures.
 - Clear decision-making processes.
 - Safeguards eg time limits, reviews.
 - Consideration as to whether the outcome is positive, and that the least restrictive alternative is used.
 - The safety of the person.
 - It is important to know the person and their needs well. A process involving questions similar to those identified in the concomitant report "Effective Service Design" should be a prerequisite to making informed decisions regarding the use or otherwise of restrictive practice(s).

Definitions of Restrictive Practices

The consultations clearly identified the need for clarity and agreement as to what constitutes a restrictive practice. The Disability Policy and Research Working Group (DPRWG) is a standing committee of the Community and Disability Services Ministers' Advisory Council (CDSMAC) which has been considering a national definition for restrictive practices. In April 2011, the DPRWG reached agreement at a national level on the meaning and application of a set of overarching definitions, principles, resources and recommendations for capturing data on restrictive practices across jurisdictions.

National strategy on restrictive interventions Definitions of restrictive interventions proposal

Purpose

To recommend a set of standard definitions for the following restrictive interventions that will be agreed to by all states and territories.

Background

1. The proposed set of definitions builds on the discussion paper written by the New South Wales member and current definitions submitted by states and territories to the discussion paper².
2. Focusing on discrete or 'core' restrictive interventions based on the international research evidence, the proposed set of definitions are:
 - a. Seclusion
 - b. Chemical restraint
 - c. Mechanical restraint
 - d. Physical restraint
 - e. Other restrictive interventions.

The proposed definitions also include 'other' restrictive interventions, such as those broadly defined as psycho-social restraints or consequence-driven restrictive practices.³ In Tasmania, another category used is 'environmental restraint' that includes locked cupboards, locked gates and access to rooms and space.

3. The proposed set of definitions is developed based on common definitional themes across jurisdictions so as to:
 - a. Include the intent or purpose of the definition.

² As noted in the Discussion Paper, not all states have legislation on the collection and monitoring of restrictive interventions.

³ Some of these "other" restrictive interventions have been explored in Victoria, Practice Guide on "Other restrictive interventions: locked doors, cupboards, other restrictions to liberty and practice ideas to move away from these practices", January 2010, The Office of the Senior Practitioner. Other jurisdictions such as Qld have specific "other" restrictive practices such as "restricting access", SA has "suppression of a woman's menses in the absence of a diagnosed gynaecological illness..." and NSW has "exclusionary time-out".

- b. Enable collection of common data for analysis.
- c. Eliminate need for a revision of current jurisdictional definitions.

Benefits of a nationally agreed set of definitions

1. To further strengthen and protect the rights of people with a disability who are currently subject to restrictive interventions consistent with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and other international obligations.
2. Assist Australia to meet its international obligations as a signatory to the UNCRPD.
3. Consistent with the above, there is an international movement on restraint reduction and safe elimination of restraints that is occurring within disability settings and in other settings, such as within mental health, schools and in aged care.
4. A nationally agreed set of definitions will facilitate greater inter-jurisdictional collaboration on a national strategy to reduce and safely eliminate restrictive interventions.
5. The increasing importance of data-driven policies and practice informed by the research⁴.
6. A nationally agreed set of definitions might facilitate greater international collaboration on research and lead to better practice in supporting people with disability who are subjected to restrictive interventions.

Proposed definitions⁵

Note: **Words in bold and/or phrases** denote common or similar terms (or intent) used across jurisdictions.

1. Restrictive intervention

A restrictive intervention is defined as any intervention and/or practice that is used to restrict the rights or freedom of movement of a person with a disability including -

2. Seclusion

Seclusion means the **sole confinement** of a **person** with a disability in a **room or physical space** at **any hour of the day or night** where **voluntary exit is prevented**.

⁴ The notion of nationally agreed definitions is common in settings other than disability, such as population health, mental health etc where agreed definitions play a critical role in national strategies.

⁵ The definition of “disability” is applied broadly to reflect variations of different jurisdictional legislative definition, for example, the Qld legislation on restrictive interventions pertain to adults with intellectual disability and the Victorian legislation refers to persons with disability in receipt of a disability service. The variations need to be noted when collecting and analysing data.

3. Chemical restraint

Chemical restraint means the use of **medication** or chemical **substance** for the primary **purpose of controlling a person's behaviour**. 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 illness**, a physical illness or physical condition⁶.

4. Mechanical restraint⁷

A mechanical restraint means the use of a **device**⁸ to **prevent, restrict** or **subdue a person's movement** or to **control a person's behaviour** but does not include the use of devices for **therapeutic purposes**.⁹

5. Physical restraint

Physical restraint means the **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 controlling a person's behaviour**.

Physical restraint does not include physical assistance or support related to duty of care or in activities of daily living.

6. Other restrictive interventions

This includes 'other' restrictive interventions to those defined above, such as those broadly defined as psycho-social restraints or consequence-driven restrictive practices.¹⁰ For example, in Tasmania another category used is environmental restraint that includes locked cupboards, locked gates and access to rooms and space.

⁶ To differentiate therapeutic vs non therapeutic purposes, not inclusive of "body suits" issue.

⁷ To be consistent with the international research evidence it is important to differentiate mechanical vs physical restraints.

⁸ A device may include any mechanical material, appliance or equipment.

⁹ Therapeutic purposes may include safe travel such as seat belts during transportation or arm splints as part of occupational therapy etc.

¹⁰ Some of these "other" restrictive interventions have been explored in Victoria, Practice Guide on "Other restrictive interventions: locked doors, cupboards, other restrictions to liberty and practice ideas to move away from these practices", January 2010, The Office of the Senior Practitioner. Other jurisdictions such as Qld have specific "other" restrictive practices such as "restricting access"; SA has "suppression of a woman's menses in the absence of a diagnosed gynaecological illness..."; and NSW has "exclusionary time-out".

Introduction

One of the major findings in the National Disability Services (NDS) report Towards Responsive Services for All (2009)¹¹ related to the use of **restrictive practices** in disability sector organisations. The report suggested, on the basis of information provided to it, that there appeared to be a lack of consistent policy and practice in this area. Some respondents reported they did not have any policy or practice guidelines in regards to restrictive practices. Feedback from other respondents indicated that there were differing levels of understanding about what types of behaviour actually constituted 'challenging behaviour(s)' and what was considered an appropriate response in relation to restrictive practices across the disability sector in Western Australia.

The NDS report proposed:

'that future directions for the Commission in partnership with disability sector organisations involve development and promotion of guidelines to facilitate better standards and consistent practice in such areas as restrictive practices, medications policies, organisations' behaviour policy and positive behaviour support practices'. (NDS. 2009:7)

In April 2011, as part of a consultation process to ascertain what people in the disability sector considered to be the essential elements of best practice(s) in relation to positive behaviour support, participants were also asked to respond to a series of questions in relation to restrictive practice. This enquiry was to assist in the development of a Policy Framework to guide the disability sector in the reduction/elimination of restrictive practices.

The consultation process was statewide and involved 140 participants in a World Café event in Perth. Meetings were also held with relevant groups in Bunbury and Albany, and there were some individual consultations with providers and families.

The process built upon, and also took account of, responses generated at a World Café event held in November 2010. This event was part of the Living in the West Conference in Perth. Subsequent seminars were also held in November 2010 involving Jim Mansell, Professor of Learning Disability in the Tizard Centre at the University of Kent, United Kingdom, and Adjunct Professor at the School of Social Work and Social Policy, La Trobe University, Melbourne.

The questions asked during the various country/metropolitan meetings were as follows:

1. What do you understand to be restrictive practices and why do these occur?
2. In terms of practices that restrict peoples' human rights (such as locking cupboards, restraints) is there ever a place for restrictive

¹¹ National Disability Services (2009) Towards Responsive Services For All" Perth (DSC webpage)

practices? What should be the agreed 'line in the sand'? What's OK and not OK?

3. Who should decide what is and isn't restrictive practice, and when such practices can be used?
4. What processes or systems –formal and/or informal – might be put in place to oversee the application/implementation of restrictive practices which support people with challenging behaviour in the least restrictive way?

Responses to these questions have been collated and incorporated into the following document.

1. What do we understand to be restrictive practice(s)?

Many types of restrictive practices were identified, including such measures as:

- Use of physical restraints.
- Use of medication - chemical /pharmaceutical to control behaviour.
- Restrictive clothing/items/equipment / restraint (eg splinting as a restraint).
- Locked buildings –denial of access or egress.
- Locking doors, cupboards pantry/kitchen, bedrooms – restrictive access.
- Use of devices of control – wheelchair, clothes, communication, time out.
- Restrictive routines eg inflexible meal times - routines need flexibility to cater for individual choices such as when and where people eat/drink/do things
- Inhibiting or suppressing human rights:
 - forbidding association/communication
 - ignoring physical wants/needs
 - repressing self-expression.
- Taking away peoples' rights to be involved/included in the decision-making.
- Moving a person against his/her will.
- Socially isolating a person.
- Taking away a person's right to choose.
- Denying a person access to a community service.
- Not supporting a person to access typical community services (eg banks).
- Financial restrictions – not allowing person to spend on what they want.
- Limiting freedom of expression/movement.
- Restricting independence.
- Inhibiting choice eg lack of choice as to who can/can't visit the person.
- Taking away communication device(s).
- Denying a person the opportunity to have a holiday or a job.
- Denying an individual the opportunity to have/develop a sexual relationship.
- Ignoring what people are really communicating.
- Use of nappies instead of toilet training.
- Psychological 'restraints', eg 'punishment' procedures; removal of desired things, restricting choice and comfort, food/treats and/or possession.
 - Physical punishment - adverse consequences for 'bad' behaviour
 - Emotional punishment (deny social activities/access to community)
 - Withholding rewards – such as cigarettes or food
 - Planning for group rather than individual.

2. The likely origins of restrictive practices

People with a disability are much more likely to lead restricted lives.

Restrictions might be imposed as a result of assumptions which are not developmental. For instance, that people with a disability will not be able to learn and grow or contribute to society in the same way as their non-disabled peers.

Assumptions might also be made that people with a disability need to be protected from society, or society from them. Or, there might be an assumption that people need to be protected from themselves for instance, in situations where it is assumed people lack the capacity or insight to understand the consequences of their actions upon others or themselves. These assumptions are also likely to be made about people with a so-called mental illness. Indeed, they are the very basis of mental health legislation.

It is often assumed that people with a disability are restrained as a result of them exhibiting so-called 'challenging' behaviour(s), whereas in fact they might well behave in this manner as a result of having restrictions imposed upon them.

Emerson & Einfeld (2011)¹² suggest that often, such behaviours are functional and adaptive, due to the fact that people with a disability have led atypical lives. For instance, where they:

- May react to circumstances in which they are forced to do what they do not want to do.
- Cannot communicate their needs and wants effectively.
- Feel they are not listened to or heard.
- Have communication impairments, don't negotiate well and are much more likely to react in a problematic way.
- Exhibit behaviours which are caused by pain or other physiological conditions.
- Have experienced abuse – physical, emotional, sexual.
- Have been placed in a group where all, or most of the role models, exhibit inappropriate responses (school, institution, group homes).
- Have certain syndromes which lead them to self-injure.
- Are unable to 'read' (interpret) or make sense of their environment, or the mood, feelings of others, or who respond in stereotypical ways eg people with autism.

3. Why are restrictive practices commonly used?

Among the rationales for the use of restrictive practices identified by the respondents, most tended to lie 'outside' the person who was likely to be restricted or restrained.

A person's behaviour that others find challenging often has its origins (and are a consequence of), their family, community, service system and society, even though the locus of the 'problem' is usually assumed by others to lie 'within' that person.

Issues that impact on the ability of others to understand and respond effectively to a person displaying challenging behaviour include:

¹² Emerson, E. and Einfeld, S. (2011) *Challenging Behaviour*. (3rd ed) Cambridge University Press.

- Lack of knowledge of, and about the person (with disability), his/her life experiences and the impact on his/her identity.
- Failure to understand the meaning of the behaviour and what he/she might be trying to communicate.
- Lack of a functional assessment of the person's behaviour – the context in which it occurs, the antecedents and the consequences.
- Assuming the causal antecedents of the 'challenging' behaviour reside in the person, rather than the family or service environment, or in society at large.
- No proper support plan for the person – likes and dislikes, when to use what strategy or practice to deal with the 'behaviour'.
- Lack of planned safeguards due to a failure to anticipate the likelihood that there might be circumstances where a quick response is required eg in an emergency.

Also, many of the identified rationales for the use of restrictive practices were for the convenience of others – family, carers, the service system, society. The list was lengthy:

Family

- Families/carers exhausted/stressed/desperate.
- Family/cultural perceptions – feeling shame at the person's disability and/or behaviour, especially from the perspective of cultures where there are different assumptions about disability.
- Protection of person – feeling an almost instinctive desire to protect, or perhaps over-protect, especially by family members and perhaps siblings.
- People with a disability deemed not to have ability/capacity to make decisions so some restrictive practices are deemed to be in their 'best interest'.

Organisation

- Organisational/service/system convenience and comfort.
- Difficulty in sharing information eg between organisations – 'non-disclosure'
- Safety of self and others (staff and community).
- Limitations and restrictions perhaps as a result of funding framework.
- Lack of availability of resources/funds.
- Risk management or risk aversion eg OHS/DOC takes precedence over 'dignity of risk'.
- Historical practices/training/organisational culture.
- Pressure of number of clients with challenging behaviour in one setting.
- Lack of options and alternatives.
- Need to gain compliance/control.
- Lack of 'right' people – values, experience, training, empathy.
- Lack of staff skills/training/knowledge – don't know what else to do.
- Too difficult to look at options or unable to problem-solve.

Staff

- Staff frustration.
- Staff also restricted in practice as they don't have complete autonomy.
- Lack of options/support for staff – positive view/knowledge of staff.
- Staff turnover/unfamiliar staff.
- Poor match between worker and person being served.
- Staff personal history – own practices/values might differ from family culture.
- Lack of quality professional support.
- Lack of information on resources.
- Lack of time to respond more appropriately.
- Lack of concrete planning around issues such as change, choice, review.
- Lack of ability/time for self reflection, or to consider the purpose of practice.
- When 'things' are seen as out of control - desire to manage difficult circumstances.
- Failure to consider long term consequences.
- Easy option - last resort.
- Own values/preconceptions – might differ from institutional culture and community values.
- Might be influenced by other people's opinions/comfort in allowing people with disability to make their choice eg family, experts, organisation.
- Pressures to enforce socially acceptable attitude - to fit in with society's values.
- Personal vendettas among staff or between staff and recipients.
- Control and 'power' of staff.

Society

- Society might not understand or interpret 'behaviour' in a generous way – or not be prepared to make allowances for any perceived eccentricity or oddness.
- Fear of societal reaction or response – makes organisations/family/staff overly cautious of the person drawing negative attention to themselves.
- In some instances, services might invoke duty of care as a rationale for 'risk aversion' but in fact might be more concerned about negative societal reaction to, and perception of, their organisation.

There was also a recognition that some restrictive practices might be imposed/applied due to:

- Laws, regulations, policies eg OHS or Duty of Care.
- Legal restriction – imposed by Court or Guardianship Board.
- Prison/administration orders.

4. What is acceptable – OK or not OK?

There appeared to be a lot of agreement about what was acceptable or OK.

Examples of the use of restrictive practices included:

- Locked bedroom door by choice, or for privacy.
- If for comfort, that is, their choice – how people dress themselves.
- Locked doors, cupboards for safety if someone is at risk, but need to consider alternatives eg fridge locked - put in a second fridge with safe items that are accessible.
- Use of evidence-based recordings eg prescription medication.
- Harness – safety in travel, seat belts.
- To ensure safety, security, duty of care eg for people who self-harm.
- To ensure safety of the person, staff, family, community.
- Practices that are imposed in consultation with stakeholders and professionals, and that are documented and reviewed.
- If it's the least restrictive practice.
- If individually tailored to meet person's needs.
- If paired with skills development.
- If paired with commitment and proactive support.
- As long as it is underpinned by the right values.
- As a last resort.

Respondents also seemed to have a clear sense of what was not acceptable:

- Physical restraint/manhandling.
- Strapping person in chair/left in place so they are not a 'problem'.
- Engaging the person in inappropriate activities – which s/he doesn't like.
- Use of seclusion 'time out' for the person.
- Locked bedroom doors for consequence.
- Physical/verbal/emotional/financial abuse.
- Refusal of food/drink.
- Refusal to meet basic needs.
- Denying a person choice.
- Denying/ignoring a person's cultural/religious beliefs.
- Chemical restraint.
- Using medication to control behaviour due to lack of staff or resources.
- If detrimental to person's health and well-being or causing pain.
- Any procedure or process where there are no developmental goals or good assessment.
- Any procedure/process which is not carefully documented or monitored and regularly reviewed.
- Any procedure which meets other people's needs, not the person of interest or concern.
- If the procedure limits or restricts other people as well.
- If the procedure doesn't meet the UN Charter of Human rights.
- If other methods haven't been tried or tested.

5. Who should make decisions about the use of restrictive practice(s)?

Respondents generally agreed that it depends on the context, including the type of restriction(s) which is/are under consideration. However, it was likely to involve/include a number of people at different levels. For example:

- The person who is going to be restricted should be involved regardless of whether others think s/he understands the implications, or not.
- The person should be at the centre of the process – the process should be explained to the person and his/her degree of understanding taken into account.
- There should be an independent advocate to stand alongside the person if required, to ensure his/her interests/needs are fairly represented.
- Families need to be involved – it should not be assumed that families will choose the wrong thing. There needs to be sensitivity in dealing with families – services/workers can't just say to a family 'don't lock him/her in a room' without providing an alternative.
- It should be collaborative and include others involved in the person's life together with the support worker.
- The process will need to take account of the rights of others eg locking a door to restrict/restrain one person will have implications for other service recipients.
- Sometimes staff need to be able to choose restraint for safety but it should be right for the person, not just for the service/worker.
- In some instances there will probably be a need for recourse to some sort of centralised approval and review process eg as part of a funding and service agreement.
- There might also need to be recourse to an external authority eg the Guardianship Board or Public Advocate, but it should be recognised that there are dangers in using decision processes too far removed from the person concerned.

6. Need for guidelines:

A number of guidelines for decision-making around restrictive practices were identified, including:

- Requires a clear definition; what is/is not restrictive practice eg locking doors, medication, time out, saying 'no'.
- Policies and procedures should be clearly set out.
- Some questions which might be asked include the following; is there a positive outcome? Does this suit the individual? Are we using minimum restriction? Under what circumstances might we do this?
- A clear decision-making process needs to be put in place within/between agencies. These are the steps; you need to show/prove you have gone through them.

- Memorandum of understanding between/among agencies might be required so as to be able to carry consistency in supporting people with a dual diagnosis – especially important.
- For people from different cultural backgrounds, service practice(s) might require interpretation to ensure the person and their families understand the complexities surrounding the use of restrictive practices.
- People who have intimate knowledge of who the person is should be making the decisions and if this knowledge isn't there, then a proper process should be followed to obtain it.
- Safety considerations – person, family, staff, and community members need to be carefully considered.
- There need to be safeguards, including:
 - There should be someone to advocate for the person who is independent of family and the service system
 - There should also be independent advocacy for the interests of families
 - A clearly set out approval and appeal process
 - A process will also be required when someone sees poor practice around the use of restrictive practice(s).

There was also recognition that:

- What is restrictive isn't objective – it is dependent on the perception of the person being subjected to the practice.
- There may be levels/layers of restriction/restraint eg driving, diet, mobility, hidden restrictions.
- Everybody should have a right to comment on this – the wider community included.
- These are issues everywhere in the world – it is not just disability-related.
- Underpinning this, there needs to be evidence-based practice informed by research – families need to be aware/informed as well as professionals, perhaps a case law approach to establish precedents.
- We should understand that people with a disability might sometimes make poor decisions. Do we just say 'it's their choice' or do we offer them guidance? Some guidance or direction by one party might be interpreted as 'restrictive practice' by another.
- It comes back to knowing the person – well.
- The challenging behaviour might not arise from within the person; look at environment and how it is designed. The environment, rather than the person might require alteration/modification.

7. The importance of knowing the person well

Respondents stressed the importance of knowing the person and their needs intimately. This should be based on a good understanding of their life experiences and how these have shaped their identity and reputation. How the person is perceived by their family, services, workers, peers and society at large. Thus, a number of the respondents identified the need to ask questions similar to those considered important to developing effective service design for a positive behaviour

framework. Some suggested this approach might reduce or prevent the need for restrictive practices.

- What is important to the person?
- What are his/her aspirations?
- What makes the person feel safe?
- What makes the person anxious?
- How much control does the person have over their environment, situation, and routine?
- How is the person's general health and wellbeing such as sleep, exercise, relaxation, diet and spiritual practice?
- Is the person in pain?
- Are the person's health issues adequately monitored and supported including mental health?
- What is the role of medication and is this adequately managed across health professionals and pharmacists?
- How does the person use their time (are they challenged, actively engaged, working, learning)?
- What relationships matter to the person?
- Is the person satisfied with their level of social connection and support?
- What environments does the person feel safest in?
- What matters to the person about their environment?
- What assumptions have been made about the person's competencies and capacities to learn, grow and develop into a contributing member of society?
- What sorts of restrictions – thoughts and actions – has the person been subjected to?
- What sorts of role models have been most influential in the person's life and on their behaviour?
- Is there a vision for what might constitute a 'better' life for the person?

Questions such as these might well form part of a checklist for families, carers, workers and services to use in developing a support plan for a person whose behaviour is considered challenging.

References:

Emerson, E. and Einfeld, S. L. (2011). **Challenging Behaviour** (Third Edition). Cambridge University Press.

Tumienski, M. (2005). **Door openers to restrictive practices**. Plenary presentation at Many Faces of Abuse Conference, Auckland. NZ.

Appendix One

United Nations Convention on the Rights of Persons with Disabilities

May 2008

Overview: Articles 12 to 19

State Parties to this Convention protect persons with disabilities and recognise that every person with a disability has an equal right to:

- **Equal recognition before the law**....enjoy legal capacity and support to be able to exercise it (Article 12).
- **Liberty and security of person**.... and that the existence of a disability shall in no case justify a deprivation of liberty (Article 14).
- **Be free from torture or cruel, inhuman or degrading treatment or punishment**... in particular, no one shall be subjected without his or her free consent to medical or scientific experimentation. (Article 15).
- **Be free from exploitation, violence and abuse** (Article 16).
- **Respect for his or her physical and mental integrity** on an equal basis with others (Article 17).
- **Live independently and be included in the community** (Article 19) and have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement. Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community and to prevent isolation or segregation from the community.