Best Practice Guidelines for Occupational Therapists: Restrictive Practices and People with Intellectual Disabilities

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Intellectual Disability Advisory Group

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Working Group

This document has been prepared by the Restrictive Practices Working Group, a working group of members of the Intellectual Disability Advisory Group (IDAG) of the Association of Occupational Therapists of Ireland (AOTI). The aim of this working group was to complete the specific project of producing a set of best practice guidelines around the use of restrictive practices for occupational therapists working with people with intellectual disabilities in Ireland. The working group met and conducted its business between February 2009 and March 2010. There were some changes in the membership of the working group throughout this period, due to changes in members' work and personal circumstances. The following IDAG members contributed time and energy to the working group at various stages throughout the period of the lifetime of the working group:

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Definition of Key Terms

The following definitions have been drawn from literature and guidance documents relating to restrictive practices. Various differing terms are used interchangeably in this area of practice, which can, at times, lead to confusion among professionals when dealing with restrictive practice issues. For this reason, it was considered important in this document to adopt and adhere to one set of key terms and to provide clear definitions for each.

Restrictive Practices refer to the use of mechanical restraint, physical restraint, psychotropic medication as restraint and seclusion (MHC, 2008, p.5) for the purpose of behavioural control to prevent, restrict or subdue a person's movement (MHC, 2008, p.5)

Mechanical Restraint: The application and use of materials or therapeutic aids such as: belts, helmets, clothing, straps, cuffs, splints, specialised equipment designed to significantly restrict the free movement of an individual (Paley, 2008, p.6). This does not include the use of devices for therapeutic purposes relating to postural and orthopaedic needs (DHS, 2007, p.3).

Physical Restraint: The use of physical intervention (by one or more persons) for the purpose of preventing the free movement of a person's body (MHC, 2008, p.5).

Environmental Restraint: A number of environmental or mechanical devices may be used to restrict movement. These include but are not limited to bed rails, recliner chairs, locked doors or locked facilities (NMBWA, p.3).

Seclusion is defined as the placing or leaving of a person in any room alone, at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving (MHC, 2008, p.5).

Psychotropic medication as Restraint is the use of sedative or tranquilising drugs for the treatment of problem behaviours. Medication treatments for medical or

psychiatric conditions which underlie the disturbance are not included (MHC, 2008, p.5).

Emotional or Psychological Restraint: Verbal, non-verbal or physical intimidation that is purposefully used to alter or restrict a person's choice of behaviour or to actively encourage or discourage particular behaviour (NMBWA, 2009, p.3).

Least Restrictive: Any intervention should be the least restrictive to the person's freedom while remaining appropriate to the person's needs and the need to protect the safety of himself/herself and others (MHC, 2008, p.9).

Challenging Behaviours may be defined as "behaviours of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy or behaviours which are likely to seriously limit or delay access to and use of ordinary community facilities." (Emerson et al., 1988).

Risk Assessment is a process by which all the factors in a particular situation are considered, identifying the hazards, the potential degree and nature of any risk (COT, 2006).

Risk Management is a process whereby identified risks are either removed completely, or reduced to an acceptable level, which is then closely monitored and periodically reviewed. The aim is primarily to protect people from harm. (COT, 2006).

Capacity means the ability to understand the nature and consequences of a decision in the context of available choices at the time the decision is to be made. There is currently no legislative definition of capacity in Ireland. Where a decision requires the act of a third party in order to be implemented, a person is to be treated as not having capacity if he or she is unable to communicate by any means. Any question as to whether a person has capacity shall be decided on the balance of probabilities. (LRC, 2006, cited in MHC, 2008, p.4&9).

Introduction

Best practice promotes the use of least restrictive approaches when working with people with Intellectual Disability and/or Autism Spectrum Disorders who exhibit challenging behaviour (DOH (UK), 2008; MHC, 2008; Paley, 2008). Restrictive Practices refer to the use of mechanical restraint, physical restraint, psychotropic medication as restraint and seclusion (MHC, 2008, p.5) for the purpose of behavioural control to prevent, restrict or subdue a person's movement (MHC, 2008, p.5)

The purpose of this professional practice guideline is to act as a reference tool for occupational therapists working in Intellectual Disability and or Autism Spectrum Disorder in Ireland. As employees occupational therapists must familiarise themselves with all policies and procedures including those of the employing organisation, national policies, guidelines from regulatory bodies, ethical guidance and legislation relevant to the issue of restrictive practices. Organisations should have policies and procedures covering: risk assessment, challenging behaviour, person-centred planning, adult/child protection and abuse prevention and rights (Paley, 2008). This practice guideline provides a summary of background information and best practice guidance relating to the use of restrictive practice with this service user population and is relevant to both children and adults. The guidelines should be used mindful of other material relating to restrictive practices.

Occupational therapists are often called upon to fit straps or harnesses on wheelchairs and other chairs, on buses or taxis. This can constitute a mechanical restraint when the purpose is for behavioural control to prevent, restrict or subdue a person's movement. It is hoped that this practice guideline will empower occupational therapists with additional knowledge and understanding in this challenging and often uncomfortable area of practice, thereby enabling them to communicate with professional colleagues, plan interventions and contribute to team decisions in a confident and informed manner.

Context of Occupational Therapy Practice

Occupational therapists and other professionals practice against a backdrop of ethics, best practice guidance and legislation. In discussing restrictive practices, it is important to consider how this backdrop or context impacts on the processes, decisions and interventions employed in this area of practice.

Occupational therapists are committed to promoting participation in everyday life activities and roles of those they work with. Clinicians experience ethical dilemmas around the use of restrictive interventions which limit the rights and dignity of individuals. Ethical action by an occupational therapist is defined as a commitment to beneficence; concern for the safety and well-being of the recipients of their services (AOTA, 2005, p.639).

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. Occupational therapists' prime concern is for the welfare and rights of the users of their services (AOTI, 2007). Therefore, interventions should be designed and administered so as to be as free as possible from restrictive treatment practices. Restrictive practices 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. The guiding principle of this best practice guidance document is that each individual's rights and dignity must be respected and therefore a restriction-free environment must be promoted at all times (DOH (UK), 2008) The right of any individual to be treated with dignity and respect and to be free from harm is affirmed in global charters (UN, 2006), European and national laws (Mental Health Act 2008 (Ireland); Human Rights Act 1998 (UK)). Whenever restrictive practices are included as strategies within an individual's behaviour management programme, it is important to note that this involves a serious deprivation of that individual's freedom and rights (MHC, 2008, p.6).

The Mental Health Act 2008 (Ireland) provides for the use of seclusion and/or mechanical means of bodily restraint in approved centres for the purposes of

treatment or to prevent the patient from injuring him/herself or others. An approved centre is a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness (MHC, 2006a & 2006b). Some people with intellectual disability receive services in approved centres and may present with challenging behaviours that necessitate the use of restrictive practices.

The Mental Health Commission has issued a Code of Practice specifically directed at persons working in the delivery of mental health service to people with mental illness and intellectual disabilities (MHC 2010). This Code of Practice states that the delivery of a mental health service regardless of the setting should always be in accordance with mental health legislation and the Guidance of the Mental Health Commission (MHC 2010, p11)

It is expected that the Inspectorate of Mental Health Services will use this Code of Practice as its main tool for assessing compliance when visits to intellectual disability services are commenced.

When considering the use of restrictive interventions, 'duty of care' issues also need to be considered. A duty of care is a duty to take reasonable care of a person (COT, 2005; AOTI, 2008). The behaviour of some individuals can pose a threat to their own well-being or the well-being of others. Such behaviours can seriously affect the person's quality of life and may also result in harm to the individual and /or others, therefore their management or control may become a duty of care issue. Organisations or services where occupational therapists are employed can face ethical dilemmas posed by the need to balance a service's duty of care obligations with the rights of a person with a disability, where the behaviour of the person has the potential to cause harm to him/herself or to others. Services also have an obligation to consider staff members' rights, as they are entitled to work in a safe environment (Safety, Health and Welfare at Work Act 2005 (Ireland)).

Best practice around decision making suggests that, unless contrary evidence exists, every adult be assumed to have the capacity to make a decisions relating to him/herself (MHC, 2008). The issue of capacity is particularly pertinent to adults with intellectual disabilities, many of whom do have reduced capacity to make decisions about their care, including the use of restrictive practices. People with an intellectual disability are vulnerable, not only because of diminished capacity to make decisions

for themselves, but also because there are limited legal safeguards in Ireland to protect individuals with limited capacity in the process of decision making and consent (MHC, 2008, p6.) The Law Reform Commission aims to develop a legislative framework to address this lack of mental capacity legislation (LRC, 2006) and the Mental Health Commission (MHC, 2008, p.21-24) proposes practice guidelines to enhance decision making involving those with reduced capacity to consent.

Developments in mental health legislation and practice relating to use of restrictive practices are welcome and provide useful guidance to practice. However significant gaps still exist relating to many service standards for individuals with Intellectual Disability and or Autism Spectrum Disorder. These deficits are particularly relevant on issues of capacity to consent and human rights. All those involved in the use of restrictive practices must understand that rights, legislation, consideration of capacity issues and duty care considerations make it imperative that the individual be kept at the heart of any decision-making process.

All occupational therapists working with individuals who exhibit challenging behaviour should continue to consider the use of restrictive practices only as a last resort. They should never allow themselves to view decision-making in this area as straightforward or routine. Occupational therapists should at all times advocate for person-centred strategies which promote positive behaviour support and lifestyle choices to enable individuals exhibiting socially invalid or challenging behaviour to live a full life and reach their potential (Paley, 2008). Maintaining this focus on the person should result in decisions that better protect the interests of service users, staff and carers.

Scope of Occupational Therapy Practice in Relation to Restrictive Practices

The term scope of practice refers to the range of roles, functions, responsibilities and activities, in which a professional is educated, competent, and has the authority to perform (An Bord Altranais, 2000).

In the context of these practice guidelines scope of practice relates to occupational therapists working in Ireland with persons with an intellectual disability and or Autism Spectrum Disorders, where issues of restrictive practice arise. This scope of practice has been drafted on the basis of understanding reached following reference to a range of different sources, including: The Code of Ethics and Professional Conduct of the Association of Occupational Therapists of Ireland (AOTI, 2007); Occupational Therapy Competencies ,Therapy Project Office (2008); guidance provided by the Mental Health Commission (MHC, 2008); guidance from the Irish Medicines Board on the intended purpose of medical devices (IMB, 2009); and discussions of the core competencies of occupational therapists found in Occupational Therapy literature (AOTA, 2008).

Four main areas warrant discussion in this section. Occupational therapy core competencies are discussed in relation to knowledge and skills relevant in the management of challenging behaviour in people with Intellectual Disabilities and or Autism Spectrum Disorder. Additionally specific practice issues relating to restrictive practice in transport and the supply of mechanical devices by occupational therapists are presented. The final part of this section examines the role of the occupational therapist within the multi-disciplinary team supporting challenging behaviour.

Occupational Therapy Core Competencies

The main concern of occupational therapists is enabling the restoration, maintenance, and promotion of meaningful occupation (Hagedorn, 2001; Christiansen & Matuska, 2004; Manville Baum & Christiansen, 2005). In order to address this main concern, occupational therapists have developed knowledge and skills in a range of areas known to pose barriers or provide solutions to individuals' occupational performance. In the field of intellectual disabilities, these skill areas include: occupational analysis,

skills training, postural management, sensory processing, risk assessment, environmental evaluation (transport, housing), adaptive equipment prescription; as well as education of staff and carers. It is the occupational therapist's knowledge and skills in these particular areas which equips him/her to play a role within the team in addressing issues related to individuals' challenging behaviours.

Mechanical Restraint and Transport

Current Irish regulations relating to safety for travelling in a moving vehicle make no reference to the responsibility and potential liability of the driver of a vehicle whose passengers, who due to an intellectual disability and or Autism Spectrum Disorder, are not capable of understanding and complying with seat belt wear. In such instances, the occupational therapist, as part of a multi-disciplinary team risk assessment process, must balance the risks and rights of the individual, when considering the provision of any mechanical restraint (e.g. a restrictive harness) that would prevent the person from leaving their seat on a vehicle. Due consideration must be given to the safety and rights of the individual as well, the safety of others travelling on the vehicle; which may be jeopardised should the vehicle be involved in a collision or have to brake suddenly.

Supply of Mechanical Restraints

The occupational therapist is often the team member with greatest knowledge and experience of the range of medical devices and adaptive equipment including harnesses, to compensate for physical limitations. They are usually the team member with most experience in the prescription of these items. This does not necessarily mean however that the occupational therapist is the team member best placed to source, supply and fit such devices which are to be used solely as mechanical restraint. Services differ in relation to who takes responsibility to research, source, order and fit mechanical restraint devices. The occupational therapist should clarify their role and the role of others on this issue, including those on the MDT team and others such as technicians employed by external agencies.

The Irish Medicines Board (IMB, 2009) which has a role in relation to the manufacture and use of medical devices in Ireland stresses the importance that devices are used for the purpose for which they were designed and produced.

Mechanical devices should be fit for purpose, in good working order, and be applied in accordance with manufacturer's instructions. Additionally if a product is modified by persons other than the original manufacturer responsibility for the product passes to the persons undertaking the modification (IMB, 2009).
Occupational therapists are cautioned against modifying any medical devices or adaptive equipment as it is outside their scope of practice, competence and training to do so.

The Team and restrictive practice

On receiving any referral for an issue that may give rise to the consideration of restrictive practices, best practice dictates that the occupational therapist does not act in isolation, but rather that the referral is treated as a referral to the wider multi-disciplinary team, whose involvement will be necessary throughout the assessment and intervention process to ensure that restrictive practice is used as a last resort and is the least restrictive possible. This requirement for a team-based approach in considering restrictive practise is well-established in the literature (e.g. MHC, 2008; Paley, 2008).

In many circumstances there is a clear team structure in place around a referred service user. Where the referral originates from a setting where a clearly-defined team structure is absent, the team member responsible for initiating the referral or the occupational therapist should contact those health professionals most closely involved with the person in order to form an ad hoc team around the person. Potential team members might include, but are not limited to professionals from disciplines such as: Speech and Language Therapy, Physiotherapy, Psychology, Social Work, Nursing, Behaviour Specialists, Medicine or General Practice, Psychiatry, school, day, residential or respite service staff/ key workers, as well as advocates on behalf of the person.

Guiding Principles

Consensus in the research and practice literature relating to restrictive practices and people with intellectual disabilities and or Autism Spectrum Disorder leads to the emergence of several key guiding principles. Currently there is little to guide occupational therapy best practice in this area at national and local levels. The guiding principles are presented below and serve to inform and guide the occupational therapist in situations where restrictive practices are being considered. With the overarching aim being to facilitate occupational therapy practice which focuses on supporting optimal outcomes for each individual treated.

Person Centred Approach

Person-centeredness is defined as having an appreciation of the person as a unique individual, requiring that all planning is based on supporting each individual to lead his or her life as and how he or she wishes. In practical terms this means that all planning around the design, development and delivery of all services for people with disabilities should actively involve the individuals availing of these services and should take into account those individuals' unique characteristics, capabilities, needs and wishes (NDA, 2004, p.11).

Best Interest

The best interest of the person is the most fundamental consideration in providing a service to those with an intellectual disability (MHC, 2008). In deciding what constitutes the person's best interest, it must be recognised that a certain level of risk is essential in order for a person to exercise autonomy and freedom of choice and achieve quality of life. This concept is commonly referred to as the 'dignity of risk'. A balance must be struck between the dignity of risk and the duty of care for the person that staff members hold (HIQA, 2009; MWCS, 2006). When restrictive practice use is being considered, the positive and negative consequences for the person and others must be carefully measured and monitored (Paley, 2008). The level of risk to which the person is exposed by his/her problem behaviours must clearly exceed any and all negative effects or risks of the use the restrictive practices being considered (MWCS, 2006). Using a restrictive practice as an organisational convenience or to compensate for limited staff resources or inappropriate

environments does not constitute 'the best interest of the person' (Queensland Government, 2008).

Involvement of the Person

The person exhibiting challenging behaviours, as well as family members and/or a relevant advocate should always be included as part of the team whenever restrictive practises are being considered, and their involvement in decisions encouraged and facilitated. This should be ensured as a matter of course, regardless of the person's level of disability (MWCS, 2006).

Identifying and Understanding Underlying Causes of Behaviour

Restrictive practices must not be used in an ad hoc way, except in cases of serious risk and with short-term approval given by appropriately qualified persons (Queensland Government, 2008). Behaviour that elicits the consideration of the use of restrictive practices should, in the first instance, before any course of action or intervention is agreed, prompt an investigation and treatment aimed at understanding and eliminating the cause of the behaviour (HIQA, 2009; Paley, 2008). This assessment should be clearly documented (HIQA, 2009) and comprehensive.

Team Responsibility

Given the multiple and interacting causal and maintaining factors for behaviours that trigger consideration of restrictive practices, it is recommended that decision making on this issue should always be a collaborative and multi-disciplinary process (Danquah et al., 2009).

Last Resort and Least Restrictive

Restrictive practices should always be considered by the multi-disciplinary team as a measure of last resort when significant risk is present and for the purpose of promoting and maintaining a person's health and well being, or, in the short term, the health and well being of others (MWCS, 2006; MHC, 2008).

Proportionality is a key principle. The level of restraint applied should always be in proportion to the risk posed and be the least restrictive possible (CSCI, 2007). Restrictive practices must not be designed as a long-term or permanent strategy for a person (Paley, 2008). Where a mechanical restraint is used with a person, thorough

planning is required to ensure that the device is worn for the shortest duration possible for it to achieve the required effect (HIQA, 2009). Consideration should also be given when the mechanical restraint is first supplied, as to how it can be faded out over time (Jones et al., 2007). A plan for regular review should also be set in place (Paley 2008).

Restrictive Practices and Occupational Therapy

Occupational therapists should consider the issue of restrictive practices on a continuum from alternative non-restrictive practices in the management of challenging behaviour at one end of the spectrum to the application of restraint at the other.

When a restraint is indicated the MDT often look to the profession concerning mechanical or environmental restraints. As some individuals present with both physical support needs and behavioural support needs, the occupational therapist needs to 'separate out' these two sets of needs so that there is clarity regarding what supports are recommended to meet postural and orthopaedic needs, separate to the behavioural support needs of the individual.

Alternative Non-Restrictive Practices

In order to ensure that restraint is only used as a last resort and is the least restrictive possible means of managing challenging behaviour, occupational therapists should consider all alternative non-restrictive practices first.

A range of alternative strategies that should be considered prior to the multi disciplinary team decision to employ a mechanical or any other form of restraint is given in **Table 1** below.

Table 1: Alternative Non-Restrictive Practices

Good environmental design e.g. points of interest provided in the building, natural flow through the building, avoidance of 'dead ends', use of colour/surface treatments to designate areas, use of visual symbols, open access to safe outdoor space (MWCS, 2007), clear line of vision for staff in communal areas (MWCS, 2006).
Padding the environment e.g. furniture, doorways, walls (Jones et al., 2007).
Temperature, light and noise levels monitored and controlled (DOH, 2002; MWCS, 2006).
Overcrowding avoided (MWCS, 2006).
Use of calm or relaxing environments (e.g. quiet room, multi-sensory room) (MWCS, 2006).
Subjective barriers instead of locked-off areas e.g. cloth panels/covers to camouflage doors or door knobs (MWCS, 2007).
Mattress on the floor or a low-to-floor bed (MWCS, 2006).
Purposeful activity that is meaningful for the individual and provides the appropriate level of stimulation (DOH, 2002; MWCS, 2006; MWCS, 2007).
Opportunity for physical exercise (MWCS, 2006; MWCS, 2007).

Table 1 Cont. Exploration of the person's sleeping and rest patterns (e.g. amount of sleep; too little or too much, timing of sleep; day/night, level of physical activity; active/inactive) (MWCS, 2006).
A communication strategy e.g. objects of reference, PECS, visual timetables.
Psychological strategies e.g. social stories, transitional objects.
Table 1 Cont. Sensory strategies e.g. sensory diets etc. (Mansell, 1992; Soper & Thorley, 1996)
High densities of social reinforcement delivered non-contingently throughout the person's day (Jones et al., 2007).
Avoidance of situations known to provoke behavioural issues for an individual (DOH, 2002).
Positive behavioural support plans and care plans kept up-to-date and containing current risk assessments (DOH, 2002).
Service user, family and advocates involved in discussions about the ways in which he/she prefers to be managed in instances when he/she poses a significant risk to self or others (DOH, 2002).
Early stages of behavioural sequences that are likely to escalate are recognised and diffusion techniques are employed (DOH, 2002).
Staff observation levels are adapted to take account of differing needs and levels of risk at different times of day/night (MWCS, 2006; MWCS, 2007).
Staff are provided with adequate training in challenging behaviour and positive behavioural support strategies (DOH, 2002; Jones et al., 2007).
The number and skill level of staff corresponds to the needs of the service users and the likelihood of behavioural issues arising (DOH, 2002).
Padded clothing to reduce risk of injury from falls or self-injury e.g. knee pads, hip protectors, helmets. Although not restrictive practices, the social stigma that can result from the use of protective clothing or helmets should be considered and balanced against the frequency of falls/self-injury and the seriousness of the injury risk (DOH, 2002; MWCS, 2006).

Mechanical Restraints

Defined as the application and use of materials or therapeutic aids such as: belts, helmets, clothing, straps, cuffs, splints, specialised equipment designed to significantly restrict the free movement of an individual (Paley, 2008, p.6). This does not include the use of devices for therapeutic purposes relating to postural and orthopaedic needs (DHS, 2007, p.3).

Mechanical restraint should only be considered if following a thorough exploration of alternative non-restrictive practices an effective and safe solution has not been identified. Whenever mechanical restraint is included in a person's positive behavioural support plan, the strategy and device used must be the least restrictive

type necessary to achieve the aim of defusing/controlling challenging behaviour and it must be used under supervision and for the shortest period of time possible (MHC, 2008; Paley, 2008).

Details of mechanical restraints in use listed from least restrictive to most restrictive, are presented in **Table 2**.

Environmental Restraint

Defined as the use of environmental or mechanical devices used to restrict movement, these include but are not limited to bed rails, recliner chairs, locked doors or locked facilities (NMBWA, p.3). A key issue that must be assessed before considering environmental restraint is the level of risk caused to the person by wandering or entering/leaving specific areas. Monitoring technologies can be a useful alternative to environmental restraint, but they should never be used unless there is significant risk of falls, injury or persons absenting themselves. They may be a positive strategy if used to maintain independent mobility, physical activity, dignity and a perception of freedom and if they prevent recourse to more restrictive strategies (e.g. locked-off areas or chair straps/trays). Some of the drawbacks of such technologies are that they can give a false sense of security to staff (e.g. the person may come to harm before staff have time to respond to the alert); that they can raise the person's distress levels e.g. if the alarm sounds frequently, necessitating frequent interventions by staff; and that they can be used to justify lower than desirable staffing levels (MWCS, 2006; MWCS, 2007). A common form of environmental restraint/barrier used in care settings is bed cot sides. If considering the use of high sides or side rails on a cot/bed, assessment should first be completed to determine whether there is any underlying physical or mental health issue causing restlessness or night-wandering. The effects of the rails/sides on the person must also be assessed/monitored e.g. Do they help the person to feel secure, or do they increase his/her anxiety? Does the person try to climb over the sides, thereby leading to an increased risk of falls? (MWCS, 2006).

Details of mechanical and environmental restraints in use, listed from least restrictive to most restrictive, are presented in **Table 2**.

Table 2: Environmental & Mechanical Restraints

A Practices that track or limit free mobility (Environmental Restraints):
Monitoring technologies e.g. personal movement sensors (within a specific area or GPS); surveillance (CCTV, baby monitors); boundary-crossing alarms fitted to doorways, windows or corridors; bed-leaving alarms and floor sensor pads.
Locked cupboards/drawers.
Delayed door opening systems.
Furniture arrangement to impede mobility.
Gates across entry points or stairs.
Locked doors e.g. keypads, double handles, high handles on doors.
B Practices that restrict or prevent movement or part(s) of the body:
Modified clothing e.g. clothing designed to be difficult to remove or to prevent access to particular body parts.
Tied/restrictive clothing i.e. clothing designed to limit movement.
Hand/finger restraints e.g. gloves, mitts.
Elbow/wrist restraints e.g. splints, gaiters, wrist cuffs.
C Practices that restrict or prevent mobility and/or restrain the whole body:
Transfer belts or child reins.
Removal of footwear, walking aid or wheelchair. Turning off powered wheelchair.
Removal of aids required for communication e.g. glasses, hearing aids, communication aid. Switching off the power on a person's alternative or augmentative communication device.
Trays/tables in front of chairs/beds (except for the period of time that they are used for purposeful activities or meals).
Chair/wheelchair tilted backwards.
Cot/bed side rails or high sides for any person over 4 years of age.
Wheelchair specifications designed to restrict independent propulsion e.g. application of attendant-controlled brakes, small transit wheels when a person has the ability to self-propel.
Bus/car harness (see discussion regarding transport in the Scope of Practice section above).
Wheelchair/buggy/armchair/shower chair/toilet/ straps & harnesses.

Negative Side Effects of Mechanical Restraint Use

In addition to the crucial issues relating to the individual's human and legal rights, dignity and consent that must be considered before embarking on any strategy involving a restrictive practice (see pages 5-7 of this document for a full discussion of these factors), it is also important to consider the psychosocial and physical side effects that may result from mechanical restraint use. In a recent review of the use of restraint with people with intellectual disabilities who engage in self-injurious

behaviour, Jones et al., (2007) summarised some of the side effects commonly reported by studies in this area:

- Increased social attention gained from the wearing of a mechanical restraint can, for some individuals, serve to reinforce behaviour, thereby maintaining/increasing rates of self-injurious behaviour.
- For some individuals, the restraint may come to be seen as an escape mechanism from compulsive self-injurious behaviour. This acts against their becoming motivated to learn more appropriate/positive strategies.
- Preventing one form of self-injurious movement pattern may lead the person to develop other alternative forms of self-injurious behaviour as a replacement.
- Mechanical restraint use can lead to disruption of opportunities to engage in purposeful everyday activities, reduced interaction with others and reduced access to community places.
- Unless adequate training and monitoring is ensured, there can be a risk of incorrect or forceful application of mechanical restraints and a resultant risk of physical injury to the individual or to staff.
- Prolonged and/or regular use of mechanical restraint can lead to:
    - muscular atrophy and shortening of tendons,
    - demineralisation of bones,
    - arrested motor development, and/or
    - disuse of limbs.

Watson (2001) has referred to some additional psychological effects that can ensue from mechanical restraint use: depression cognitive decline, emotional isolation, confusion and/or agitation.

Planning for Fading and Eventual Removal of Mechanical Restraints

Restraints should only be used as short-term strategies and planning for fading of the restraint should begin from the outset, before it is ever used with the person (Paley, 2008). It may be possible to select a mechanical restraint with design components that will enable it to be faded and the level of restriction reduced easily (e.g. elbow splints with adjustable ROM or removable/gradable padding/filling).

Differentiating between the use of mechanical device for restraint and for postural management

The definition of mechanical restraint adopted in these practice guidelines excludes the use of devices for therapeutic purposes relating to postural and orthopaedic needs. The application of a groin strap to manage extensor spasticity of an individual with cerebral palsy is not considered mechanical restraint. Whereas, the application of a groin strap to secure a client with reduced mobility in a chair to prevent them

wandering is a restrictive intervention as it limits their free movement through behavioural control (DHS, 2007, p.3). Other examples of mechanical devices used in postural management include wheelchairs and splints to prevent contractures. Understanding why a harness chair or splint is being requested for an individual will assist the occupational therapist determine whether the device is being proposed for postural management or to act as a restraint.

In some complex situations the individual may present with both physical and behavioural support needs for example someone with poor sitting balance may also engage in excessive rocking behaviour which increases their risk of toppling the wheelchair they sit in. Mechanical devices may be necessary to satisfy both the individual's postural and behavioural control needs, In such cases the occupational therapist must make every effort to 'separate out' these two distinct needs. This is important in determining the level and type of support required to meet the person's physical needs and what additional measures or level of restraint are being considered in response to his/her behavioural support needs.

The multi-disciplinary team should always be explicit and transparent regarding the purpose behind device use so that it can be appropriately managed and reviewed.

Use of Restrictive Practices: The Process

In this section, the guiding principles that should be followed whenever restrictive practice use is considered are applied to practice, through an outline process involving 4 key stages:

1. referral
2. assessment
3. plan
4. review & evaluation

Figure 1 below provides a flow chart illustration of this process and includes, for each of the 4 stages, the key principles and factors to be considered and suggested steps to be followed.

It is important to clarify that, in keeping with the guiding principles outlined above (see pages 10-12); the process illustrated in this flow chart envisages a multi-disciplinary team approach. No one discipline has all the skills and answers required to complete the process. The person with intellectual disabilities, his/her family and advocate(s) should also be included throughout all stages of the process. Occupational therapists and other team members should ensure that clear written records are kept of all assessments, plans and interventions made in relation to restrictive practice use, including keeping minutes and attendance lists for all meetings

Figure 1: Key Stages in the Process of Restrictive Practice Use

(Note: Information in this figure is drawn from 4 key sources: MWCS, 2007; MHC, 2008; Paley, 2008; and Queensland Government, 2008)

Stage 1: Referral

Issues referred to or identified by the team can generally be seen as falling into one of 3 categories:

A. Restrictive practices are being considered in advance of their use, as part of a behavioural support strategy.

B. Restrictive practice use is being considered or has already been implemented in a reactive context, as a short-term response to new or escalated behaviour patterns.

Fig. 1 (Referral) Cont.

C. Restrictive practices are in use as a long-term strategy with an individual, where the person appears to have no control over their behaviour and the risk of injury to self or others is considered significant.

At this stage, it is important to identify:

- the behaviour of concern (i.e. clearly define the behaviour, when it was first observed, the environment(s) it occurs in).
- who the most appropriately qualified professionals are in this case who will be competent to complete a comprehensive assessment.
- who the people are who should be involved throughout the assessment and any ensuing decision-making (e.g. the person him/herself, family, advocate, staff who know the person well).

Stage 2: Assessment

Assessment of Person and Behaviour:

- What is the capacity of the individual to give and communicate informed consent?
- What are the person's unique needs and strengths e.g. interests, communication, culture, social factors?
- What possible reasons are there for the person to be acting in the way that is causing concern?
- Are there any underlying physical problems? e.g.
  - Is he/she experiencing any pain?
  - Could it be caused by any side effects of medication?
  - Are there any infections?
  - Is there any constipation or urinary discomfort?
  - Is a dental check up warranted?
  - Is there any deterioration in hearing or vision?
  - Any hunger or thirst issues?
  - Poor sleep patterns?

- Are there any underlying psychological problems? e.g.
  - Mental health issues – previously diagnosed or newly-emerging?
  - Any bereavement, grief or psychological distress?
  - Any agitation or restlessness?
  - Low self-esteem?
  - Is the behaviour resulting from poor or stressful relationships?
  - Any hallucinations/delusions?
  - Does the person have adequate contact with family/friends?

Fig. 1 (Assessment) Cont.

- What information do past assessments and records provide?
- Are there service/environmental issues that may be causing or contributing to the behaviour? e.g.
  - Incompatibility between the person and his/her carers, other residents and/or environment?
  - Is the person bored or under-stimulated? Are there opportunities for engagement in meaningful activities?
  - Is the person over-stimulated or seeking to escape an unpleasant environment?
  - Is the person intimidated by others?
  - Have there been any changes to the person's daily routine
  - Does the person have an appropriate level of autonomy?
  - Does the person have adequate space and privacy to meet his/her preferences?
  - Are there any issues with high noise levels in the person's primary environments?
  - Are there sufficient staffing resources?
  - Has there been adequate and appropriate staff training?
  - Are there any issues with staff approach or communication styles?

- Does the person present with any sensory processing issues that may contribute to our understanding of the behaviour?
- Are there any patterns to the behaviour? Is the behaviour intermittent rather than constant? If so, are there any predictable signs or precursors?
- Are there any measures that, if taken early, have been found to defuse the situation, or divert the person into other activities, thereby lessening the severity or duration of the behaviours?
- How is the behaviour currently being managed?
- How is the person likely to feel/react if a restrictive practice is used?
- In the case of challenging behaviours or non-seatbelt compliance on transport:
  - Why does the person use the mode of transport in question (e.g. access to a day service)?
  - What is the duration and route of the person's regular journey(s) on this transport?
  - What is the profile of others using this transport alongside the individual?
  - What other (if any) forms of transport does the person use and how do they manage in these situations?
  - What possible explanations are there for the person's preference not to wear a seatbelt?

Assessment of Level of Risk:

- Complete a behavioural risk assessment to analyse the frequency and severity of the risk posed by the problem behaviour.

Fig. 1 (Assessment) Cont.

Consideration of Alternative Strategies:

- What, if any non-restrictive strategies have be trialled in the past? To what extent were these successful or otherwise? What is the learning from these interventions? Would it be useful to trial any of these strategies again, in the same or some modified form?
- What other non-restrictive strategies is there that should be considered? Which of these can and should be trialled?

Summarise identifying least restrictive options:

Consideration of Restrictive Practices:

- A full range of non-restrictive alternative strategies should be considered and exhausted before restrictive practice use is considered.
- Restrictive practices should not to be used to ameliorate operational difficulties such as staff shortages or inadequacies in the environment.
- Use of restrictive practices should only be considered as a last resort, where a person poses an immediate threat of serious harm to self or others.
- Positive effects of using restrictive practices must outweigh both the possible negative effects and the risk posed by the problem behaviour itself.
- The restrictive practice planned should be the least restrictive and safest possible in proportion to the situation being managed.
- Under no circumstances should restrictive practices ever be used to inflict pain or humiliation on the person or as a form of punishment.
- To what extent will the use of restraint affect the person's day-to-day life and opportunities?
- What is the risk that the application of the mechanical device will reinforce the behaviour in the context that it will be used?
- How will members of the public perceive the device? What is the comparative social validity with other methods e.g. physical restraint?
- Are there any sensory issues which may affect the person's response to the device?
- Consider from the start, how the device can be faded.

IF RESTRICTIVE PRACTICE IS NOT GOING TO BE USED: PROCESS STOPS AT THIS POINT
OR
IF RESTRICTIVE PRACTICE IS GOING TO BE USED: PROGRESS THROUGH STAGES 3 & 4

Stage 3: Plan

Compile a Comprehensive Individualised Plan, to include:

- A positive behaviour plan, which details use of the restrictive practice(s) in the context of a positive framework of other non-restrictive strategies.
- A plan for how the person will be provided with positive contacts and reinforcers at times when the device is not being used.
- Strategies that should be used to anticipate episodes of problem behaviour and defuse them, or divert the person into other activities thereby avoiding the need for employing restrictive practices.
- Reason for restrictive practice.
- Specific type and duration of restraint.
- Alternatives considered.
- Application procedures/guidelines.
- Guidelines for appropriate observation of the person during wear/use.
- Indication for use - signs or antecedents that indicate that the restraint may be required.
- Potential long term physical or psychological effects of using mechanical restraint
- Systems for monitoring & review: both episodic (i.e. pre- and post- each use of the restraint) and overall (i.e. multi-disciplinary monitoring, safeguarding of rights through involvement of independent monitoring/ethics group).
- Review dates agreed
- Robust system for recording date, time, circumstances and outcome of each specific episode of restraint usage.
- Education and training required for staff re use of the mechanical restraint.
- How adequate support/supervision will be provided during use of restraint.
- Positive behaviour support plan (to reduce reliance on restraint).
- Plan for restrictive practice reduction (i.e. how use of the restraint will be faded, replaced with less restrictive strategies and over what timescale).
- How the plan is to be conveyed/explained to the person.

The plan should:

- Be in accordance with organisational and professional policies.
- Be in adherence to relevant legislation and guidelines.
- Identify who is responsible for each action of the plan.

AT THIS POINT, THE PLAN IS AGREED AND IMPLEMENTED
OR
IF A CLEAR PLAN CANNOT YET BE AGREED, THE TEAM UNDERTAKES FURTHER DISCUSSION AND/OR ASSESSMENT

Stage 4: Review & Evaluation

The review should explore and answer, but not be limited to, the following questions:

- Has the person with disabilities and his/her family/advocate(s) been involved throughout the assessment, planning and review stages?
- Have all relevant disciplines been involved in the team approach?
- Has the plan been followed in all respects? If no, what aspects of the implementation have differed from the plan and what were the reasons for this?
- Have all staff who need training in the correct use of the mechanical restraint received this training and been assessed as competent?
- Have all staff received training in challenging behaviour positive support strategies?
- Does the wear/use of the mechanical restraint in any way inflict pain on the person?
- Is the mechanical restraint used as or perceived as a form of punishment?
- Does use of the mechanical restraint reinforce the targeted challenging behaviour in any way?
- To what extent is use of the mechanical restraint impacting on the person's day-to-day life? How has this impact been addressed or minimised?
- Are the recording systems sufficiently robust as to allow audit of the device use?
- Have there been any changes to the person's pattern of behaviour?
- Are there any issues requiring specific re-assessment or review?
- Is the mechanical restraint device still fit for purpose?
- Is use of the restraint still warranted and proportionate?
- Can/should the mechanical restraint be faded, in terms of its duration/frequency of usage and/or its design?
- Do the guidelines need to be amended to reflect any alterations agreed as a result of the review?

Reviews should:

- Be regular and within the time scale specified in the plan.
- Include the person with disabilities and his/her family/advocate(s).
- Be conducted by or overseen by an independent monitoring group, if available.

A date should be set for the next review.

Summary

This professional practice guideline on the use of restrictive practices is intended to act as a reference tool for occupational therapists working in Intellectual Disability and or Autism Spectrum Disorder in Ireland. The guidelines have been developed in response to an unmet need which occupational therapists working in these areas have reported.

It is intended that these practice guidelines will aid occupational therapists in their clinical reasoning in the use of restrictive practices with their clients. This document reflects the current views, standards and legislation relating to the use of restrictive practices nationally and internationally.

As a professional practice guideline this document will change over time in response to feedback from clinicians, as well as reflecting changes in standards and legislation.

References

American Occupational Therapy Association (AOTA) (2005). 'Occupational therapy code of Ethics'. *American Journal of Occupational Therapy, 59,* 639–642.

American Occupational Therapy Association (AOTA) (2008). 'Occupational therapy practice framework: domain and process (2nd Edition)'. *American Journal of Occupational Therapy*. 62, 625-688.

An Bord Altranais (2000). *Scope of Nursing and Midwifery: Practice Framework.* [Internet]. Available from: http://www.nursingboard.ie/en/publications.aspx [Accessed 12 March 2010].

Association of Occupational Therapists of Ireland AOTI) (2007). *Code of Ethics and Professional Conduct for Occupational Therapists*. Dublin: AOTI.

Christiansen, C. & Matuska, K. (2004). 'The importance of everyday activities'. In C. Christiansen & K. Matuska (Eds). *Ways of Living: Adaptive Strategies for Special Need.* Bethseda, MD: American Occupational Therapy Association Inc.

College of Occupational Therapists (COT) (2005). *Code of Ethics and Professional Conduct, Revised*. London: COT.

College of Occupational Therapists (COT) (2006). *Risk Management by the College of Occupational Therapists: Guidance 1*. London: COT.

Commission for Social Care Inspection (CSCI). (2007). *Rights, Risks and Restraint: an exploration into the use of restraints in the care of older people*. UK: CSCI.

Danquah, A., Limb, K., Chapman, M., Burke, C., Flood, A., Gore, S., Greenwood, K., Healey, K., Kerr Reid, W., Kilroy, J., Lacey, H., Malone, C., Perkin, M. & Hare. D.J. (2009). 'An investigation of factors predictive of continued self-injurious behaviour in an intellectual disability service'. *Journal of Applied Research in Intellectual Disabilities*. 22, 395–399.

Department of Health (DOH) (UK) (2002). *Guidance for Restrictive Physical Interventions: how to provide safe services for people with learning disabilities and autistic spectrum disorder*. London: DOH.

Department of Health (DOH) (UK) (2008). *Human Rights in Health: a short case introduction.* London: DOH.

Department of Human Services (DHS), State Government of Victoria (Australia) (2007). *Disability Act 2006: Restrictive Interventions Implementation Guide*.

[Internet]. Available from: http://www.dhs.vic.gov.au/__data/assets/word_doc/0011/152858/osp_restrictive_interventions_2007.doc [Accessed 12 March 2010].

Emerson, E., Cummings, R., Barrett, S., Hughes, H., McCool, C. & Toogood, A. (1988). 'Challenging behaviour and community services: who are the people who challenge services?' *Mental Handicap,* 16, 16–19.

Hagedorn, R. (2001). *Foundations for Practice in Occupational Therapy.* London: Churchill Livingstone.

Health Information and Quality Authority (HIQA) (2009). *National Quality Standards for Residential Care Settings for Older People in Ireland.* Dublin: HIQA.

Irish Medicines Board (IMB) (2009). *Guide to the Classification of a Medical Device.* [Internet]. Available from: http://www.imb.ie/images/uploaded/documents/ADV-G0004_Guide_to_the_classification_of_a_medical_device_v2.pdf [Accessed 12 March 2010].

Jones, E., Allen, D., Moore, K., Phillips, B. & Lowe, K. (2007). 'Restraint and self-injury in people with intellectual disabilities: a review'. *Journal of Intellectual Disabilities*. 11 (1), 105-118.

Law Reform Commission (LRC) (2006). *Vulnerable Adults and the Law (LRC 83-2006)*. Dublin: LRC.

Mansell, J.L. (1992). *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs: report of a project group*. London: HMSO.

Manville Baum, C.M. & Christiansen, C. (2005). In C. Christiansen, C.M. Manville Baum & J. Bass-Haugen, J. (Eds). *Occupational Therapy: Performance, Participation, and Well-Being.* Thorofare, New Jersey: Slack Inc.

Mental Health Commission (MHC) (2006a). *Mental Health Commission Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint*. Dublin: MHC.

Mental Health Commission (MHC) (2006b). *Mental Health Commission Code of Practice on the Use of Physical Restraint in Approved Centres*. Dublin: MHC.

Mental Health Commission (MHC) (2008). *Consultation Document: Draft Code of Practice: guidance for persons working in mental health services with people with intellectual disabilities.* Dublin: MHC.

Mental Health Commission (MHC) (2010). *Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities.* Dublin: MHC.

Mental Welfare Commission for Scotland (MWCS). (2006). *Rights, Risks and Limits to Freedom: principles and good practice guidance for practitioners considering restraint in residential settings.* Edinburgh: MWCS.

MWCS (Mental Welfare Commission for Scotland). (2007). *Safe To Wander?: principles and guidance on good practice when considering the use of wandering technologies for people with dementia and related disorders.* Edinburgh: MWCS.

National Disability Authority (NDA) (2004). *Guidelines on person centred planning in the provision of services for people with disabilities in Ireland.* Dublin: NDA.

Nurses and Midwives Board of Western Australia (NMBWA) (2009). *Guidelines for the Use of Restraint in WA.* [Internet]. Available from: http://www.nmbwa.org.au/3/2210/50/restraint_guidelines.pm [Accessed 12 March 2010].

Paley, S. (2008). *Use of Mechanical Devices: restrictive physical intervention: principles for practice.* London: British Institute of Learning Disabilities (BILD).

Queensland Government (2008). *Positive Futures: an integrated approach to excellence. SRSI-09: mechanical restraint.* [Internet]. Available from: http://www.disability.qld.gov.au/key-projects/positive-futures/documents/mechanical-restraint.pdf [Accessed 12 March 2010).

Soper, G. & Thorley, C. (1996). 'Effectiveness of an occupational therapy programme based on sensory integration theory for adults with severe learning disabilities'. *British Journal of Occupational Therapy*. 59 (10), 475-482

Health Service Executive (HSE), Association of Occupational Therapists of Ireland (AOTI) (2008) Therapy Project Office occupational therapy competencies 2008

United Nations (UN) (2006). *Convention on the Rights of Persons with Disabilities*. New York: United Nations.

Watson, R. (2001). 'Restraint: its use and misuse in the care of older people'. *Nursing Older People*. 13 (3), 21-25.

Legislation

Road Traffic (Construction, Equipment and Use of Vehicles) (Amendment) Regulations 1971 (Ireland)

Road Traffic (Construction, Equipment and Use of Vehicles) (Amendment) Regulations 1991 (Ireland)

Human Rights Act 1998 (United Kingdom)

Safety, Health and Welfare at Work Act 2005 (Ireland)

SI 240/2006 European Communities (Compulsory Use of Safety Belts and Child Restraint Systems in Motor Vehicles) (European Union)

Mental Health Act 2008 (Ireland)

Bibliography

Murray-Slutsky, C. & Paris, B.A. (2000). *Exploring the Spectrum of Autism and Pervasive Developmental Disorders: Intervention Strategies*. USA: Academic Press.