Office of the Senior Practitioner

Roadmap resource for achieving dignity without restraint

For whom has this resource been written?

This resource has been written for CEOs and for senior managers in any organisation that provides services and supports to people with disabilities.

Contents

Foreword

In our work to continually improve our service to clients I am pleased that the Office of the Senior Practitioner has commissioned this resource to inform practices that minimise the use of restrictive interventions and safeguard the rights of people with a disability. This resource will shape the practice improvements of health and human service providers and support a reduction in the use of restrictive interventions and result in improved behaviour supports for clients.

Restrictive interventions such as restraint and seclusion impact directly on a person's quality of life and human rights. Chemical restraints are also sometimes used without proper consideration of alternative positive behaviour supports which may be more appropriate. Restraint and seclusion may provide a short-term solution to an individual's behaviour however they do not provide holistic solutions to resolve underlying issues over time.

Research now demonstrates that quality behaviour support plans reduce the need for practitioners to use restrictive interventions. Functional behaviour assessments and targeted replacement behaviours have also been shown to better meet peoples' support needs and to improve their quality of life.

The Roadmap was commissioned to provide human services organisations with an innovative, evidence-based practical tool for promoting dignity, self-determination and improved outcomes for clients. The application of the principles and practice in this resource will also support our obligations under the United Nations Convention on the Rights of Persons with a Disability 2008 and the Victorian Charter of Human Rights and Responsibilities 2007.

I highly commend this resource to you.

Gill Callister
Secretary

Why would you want to reduce the use of restrictive practices?

- Reducing restrictive practices is ethical and based on human rights. No person should have their personal freedoms restricted or undergo any form of physical or mechanical restraint unless all other options to manage behaviours that have the potential to harm the person, others, or their property, have been tried.
- Reducing restrictive practices is a win-win formula. It leads to better lives for the people who might otherwise be restricted and it improves the working experience of staff. It reduces the likelihood of physical harm to both staff and people with a disability.
- Reducing restrictive practices is economically beneficial. It will reduce WorkSafe costs, it will reduce staff absence and increase staff retention. Ultimately it will position your service more positively among competing provider organisations.
- Reducing restrictive practices requires your service to be in tune with contemporary disability practice and is an indicator of the quality of your service.
- Reducing restrictive practices is not aspirational. It has been achieved in other jurisdictions and can be achieved in your own organisation.
- This document will show that small changes can have a big effect, can save on costs in the long run, and improve the lives of the people your organisation provides care for.
- In developing a human rights culture, support a positive complaints resolution culture and a commitment to continuous improvement.

What does this resource hope to accomplish?

By working through this resource you will identify principles and values for achieving dignity without restraint. The resource will support you to work with staff and people who use your service to organise policy and then implement practice designed to reduce restrictive practices over time.

This resource is a companion to the Roadmap for reducing restrictive practices in Victoria, which will be referenced throughout. The roadmap can be downloaded from DHS>For Service Providers>Disability> Protecting Rights and is available on request from the Office of Senior Practitioner, telephone 9096 8427.

Positive principles for increasing choice and reducing restraint

Behaviours of concern are generally seen as behaviours of such frequency, intensity or duration that they cause harm or potential harm to the person or to others.[1] Under the *Disability Act 2006*, where such behaviours are discussed, an authorised program officer (APO) can authorise the use of 'seclusion', 'mechanical' or, on advice of a medial practitioner, a 'chemical restraint' as part of a behaviour support plan (BSP).[2] In Victoria BSPs and the use of restraints are reported to the Senior Practitioner using the Restrictive Interventions Data System (RIDS).

Outside of 'behaviours of concern' there are other behaviours that can be concerning. For example, lethargy, acquiescence and repetitive behaviours may not threaten others but they may nevertheless be concerning.

This roadmap resource offers signpost summaries and a map of how your organisation can navigate its way to better outcomes and more freedom for those

who use your service. The approach recommended is not just for clients who show behaviours of concern or concerning behaviours, but for all clients and also for staff. This resource is about a culture and way of working.

Organisations that have implemented positive behaviour support and person-centred active support approaches are using contemporary models of best practice. The roadmap and this resource widen best practices around what we term positive support.

It is not just the behaviours of the person that are important. We can change behaviours by adapting interaction and environment. That means changing how services and staff act. It also means seeing the causes of behaviour, and behaviours of concern, in a different way. Box 1 states some principles about the causes of behaviours of concern and concerning behaviours.

Box 1: The causes of behaviours of concern – statement of values

- The causes of behaviours of concern are multiple and varied.
- It is vital to address the cause(s) of any behaviour of concern.
- Behaviours may be seen as behaviours of resistance, behaviours of protest, behaviours of pain and so forth. The cause is not, per se, the person him or herself.
- The cause(s) of behaviours of concern are the same causes that would produce the same behaviours in the population as a whole. Causes relate to infringements to human rights, a response to past trauma, to an inability to express current feelings of pain, or through mental ill-health.
- It is vital that the external factors causing behaviours of concern are systematically assessed and addressed.
- Ignoring the cause of behaviours of concern does not resolve the person's issues. In addition ignoring these causes may over time accentuate and heighten the behaviours of concern.

[1] Adapted from Emerson E 1995, *Challenging behaviour: analysis and intervention with people with learning difficulties*, Cambridge University Press, Cambridge.

[2] More recently under s. 159(2)(e) of the Disability Act, the Senior Practitioner has published the *Physical restraint* direction paper (May, 2011) setting out the limited circumstances in which such restraints can be used.

Pit stop 1: Gearing up for change

Worldwide research evidence identifies six key characteristics in organisations that have been found to be successful in reducing restrictive practices:[3]

- leadership towards organisational change (by boards, CEOs and senior managers)
- using data to inform practice (through RIDs data and accurate APO reporting)
- using restraint and seclusion reduction tools (finding an alternative based on evidence)
- workforce development (accredited courses and in-service training)
- involving consumers and their advocates (individual and advocacy roles for working together)
- debriefing techniques (to determine what works and what needs to change)

.

The Office of the Senior Practitioner (OSP) aims to replicate these conditions in Victoria to enable Victorians with a disability the best chance to achieve dignity without restraint.

While the Senior Practitioner's role is to develop the standards and guidelines with respect to restrictive interventions and compulsory treatments for people with disabilities, the Senior Practitioner also recognises that each organisation must draw upon its own established expertise and on its staff strengths.

However, this cannot be achieved without leadership for change within disability service provider (DSPs) organisations (see Chapter 8 in the roadmap). An example of leadership is provided in Appendix 1.

Leadership is vital. But organisations will not be able to achieve change to reduce restrictive practices if others do not recognise leadership and good practice. Change will involve an organisational approach, consultation with staff, people who use services, families and advocates too. The move must be towards creating a human rights organisation in which dignity of risk is achieved and in which each person's chosen future is central to the organisation's efforts to support them.

So how is this done?

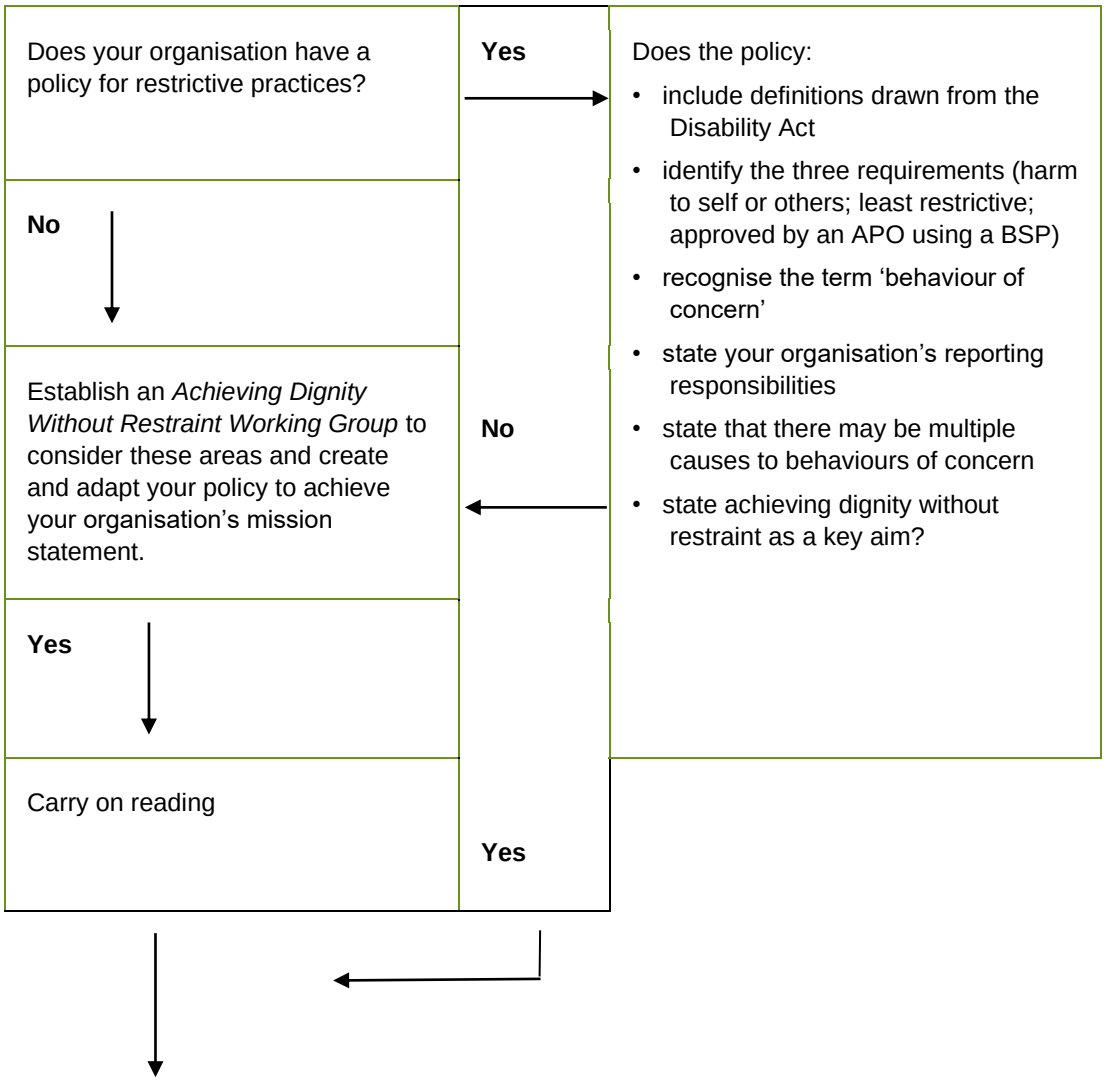
[3] Azeem M, Aujila A, Rammerth M, Binsfeld G and Jones R 2011, 'Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital', *Journal of Child and Adolescent Psychiatric Nursing*, vol. 24, pp. 11–15.

Huckshorn K 2005, *Six core strategies to reduce the use of restraint and seclusion: Planning tool (draft)*, viewed 4 March 2011, <http://www.nasmhpd.org/general_files/publications/ntac_pubs/SR%20Plan%20Template%20with%20cover%207-05.pdf>.

Pit stop 2: Set up a working group

It is a good idea to put in place a working group or equivalent for achieving dignity without restraint. That working group will be tasked with working through this document and informing or developing your organisational policies and practice (see page Chapter 5 in the roadmap). Early work for this group is set out in Figure 1.

Figure 1: Organisational guide for implementation – gearing up for change



Membership of the working group

Include in the core membership one or more of the following: senior manager, APO, a member of the direct support staff, a representative who uses the service and a family representative (NB: it should be part of the role of each member to consult with and inform those they represent). Include others who you consider may be able to contribute or co-opt at appropriate points people with an expertise in human rights, advocacy, family care or training, or members of the Behaviour Support Service (BSS)[4] team.

[4] Previously called the Behaviour Intervention Support Team (BIST).

Pit stop 3: Best practice in behaviour support

Your organisation *should* be working to achieve best practice in behaviour support using a positive behaviour support (PBS) model.[5] Appendix 2 provides a PBS case study.

PBS involves a number of components:[6]

- It requires systematic gathering of information about the person – which includes maximising communication with the person, and undertaking assessments using recognised tools.
- Make sure you and your staff are interpreting the behaviours in the same way.
- Functional behaviour assessment is important in working out the causes and function that behaviours of concern play in the person's life.
- Designing good-quality behaviour support plans to reduce, minimise or prevent a behaviour of concern can involve changing an environment, teaching the person or staff skills and having immediate response strategies in place when, and if, a behaviour occurs.
- Implementation and ongoing evaluation of the support plan is important in finding out what to do when things don't work out as planned. Debriefing with staff after an incident is important to determine how to do things differently next time.

What more will help to reduce the use of restrictive practices?

The Senior Practitioner believes that a model of prevention requires a human rights approach. It requires all those involved in planning, delivering and monitoring services to adopt human rights, to use a strengths-based model that works with the positive things in people's lives and it requires developing dignity through risk as will shortly be detailed.

Before moving on it would be useful to read the vignettes in Appendix 3. As you read the remainder of this resource ask how the resource might help the person in each of these vignettes and use the questions to support your enquiry.

[5] For a best practice guide to PBS visit the Department of Human Services website by navigating through About the Department > Documents & Resources > Reports & Publications > PBS Course

[6] Adapted from: Department of Human Services 2009, *Positive behaviour support: getting it right from the start,* pp. 7–8

Pit stop 4: Causes of behaviours of concern

The causes of behaviours of concern are multiple and varied. Figure 2 helps to identify the source of such behaviours.[7] Your working group should think about what more can be added and how to elaborate this model further for use in your organisation.

Figure 2: Identifying causes of behaviours of concern and appropriate responses

<table>
<tr>
<td rowspan="5">Establish causes of behaviour
Indicators – Institutionalised, secure environments, regimented settings, moving residence, life-threatening illness or injury, overcrowded places, boring activities, fear for safety
Personal trauma – Deaths in family or of friends, loss of close friendship, personality clashes that get out of hand, unresolved issues
Abuse – Physical, sexual, emotional, financial, victimisation, lack of care
Pain – Unmet health need
Low self-esteem – No autonomy and choices, broken into acquiescence, sees disability as producing negative self-concept, actions of others confirm the negative self-image
Witness of traumatic events
Infringement of human rights</td>
<td rowspan="3">Behaviours witnessed?
Acting out, aggression, anger, avoiding people, places and or activities, distorted beliefs, extreme risk-taking, irritability, lassitude, loss of trust, reduced emotion, reduced enjoyment of life, self-destructiveness, sleeplessness, startle responses, victimising others, violence</td>
<td colspan="2">Mental health treatment</td>
</tr>
<tr>
<td colspan="2" rowspan="2">Mental health assessment</td>
</tr>
<tr>
<td rowspan="2"></td>
</tr>
<tr>
<td>BSP</td>
</tr>
<tr>
<td>No cause identifiable</td>
<td colspan="3">Behaviour of concern</td>
</tr>
<tr>
<td>Cause identified – Address cause and not simply behaviour</td>
<td colspan="3">Not a behaviour of concern relevant to Disability Act</td>
</tr>
</table>

Read the case studies (Appendix 3) and, using the model above, identify possible sources of behaviours of concern and concerning behaviours for Maurice, Jenny and James.

Your working group will have added to the boxes. It is useful to consult and agree changes to the model within your organisation with people who use your services, family carers and advocates. Additionally:

- Ensure your APO is involved and uses the chart in their work.
- Introduce methods to ensure staff apply the content of the chart to their practice and report anomalies or concerns to the APO.
- Use the rest of this resource to identify further tools you might use. Or, develop or adapt tools the organisation is already using.

A model of prevention requires a quality service. Quality services avoid employing interventions that cause behaviours of concern or concerning behaviours and address areas that cannot be changed (for example,

[7] An alternative approach to looking at causation is provided in *Positive behaviour support: getting it right from the start*. Examine the PowerPoint on page 85 that presents the external factors, internal factors and warning signs. This can be downloaded from the Department of Human Services website by navigating through About the Department > Documents & Resources > Reports & Publications.

previous traumatic experiences).

It is vital to look at unseen causes and to consider behaviours that are concerning though not challenging. Some behaviours that should be of concern are not easily seen. Look at the case study of Jenny in Appendix 3. Jenny's passivity covers up a cauldron of emotion that she doesn't feel the power to express or trust that anything might be done about if she complains.

What does this tell you about the quality of the service you provide? Can you think of other examples where behaviours that should be concerning are not visible? Is there some other way of building a better service and assessing potential issues that would lead to concerning behaviours or behaviours of concern?

The following page provides an approach to assessing the service quality by using a human rights assessment model. Figure 3 makes some more recommendations for your working group.

Figure 3: Establishing a model of causation

<table>
<tr><td>Does your organisation have a model for identifying the causes of concerning behaviours or behaviours of concern?</td><td>No</td><td>The working group should establish a model of causation.</td></tr>
<tr><td rowspan="2">Yes</td><td rowspan="3"></td><td>The working group consults stakeholders and pilots a model with APOs.</td></tr>
<tr><td>Move to pit stop 5.</td><td rowspan="2">Does everyone in the organisation know and use the model? Do APOs and those involved in person-centred planning know the model well enough to use it in their work?</td></tr>
<tr><td></td></tr>
</table>

Pit stop 5: Understanding the relevance of trauma

People with a disability are more likely to have experienced trauma in their lives, to have been institutionalised controlled, or to have been abused. As such, they have been traumatised and have been witnesses to traumatic events (see Chapter 4 of the roadmap). People can be re-traumatised where restrictive practices or continued control are used in their lives. This breaks the trust needed for effective support relationships. Indeed, for those who are unable to communicate the damage may be irreparable as these traumas can never really be addressed.

The role of policy should therefore be: to assess and seek to address past or current trauma or abuse and the effects on behaviour and the person's everyday experience; and to create an preventive structure, environment and interactional experience so that no trauma eventuates from what is happening right now (see Appendix 4c, 4d and 4e in the roadmap for further information on trauma, assessment and service approaches).

Figure 4 presents an organisational guide that can be used by your working group.

Figure 4: Organisational guide – trauma-informed care

<table>
<tr>
<td>Has your organisation a policy for trauma-informed care and practice?</td>
<td>Yes</td>
<td rowspan="5">Ensure the policy:
• establishes principles and a definition, vision and values
• gives an explanation of why trauma is so relevant to people with a disability
• identifies best evidence on trauma care as the adopted organisational approach
• identifies the signs that may indicate trauma
• identifies an approach to accomplishing and evaluating a 'safe' organisation
• establishes a trauma assessment process that is compliant
• ties trauma care into BSPs, individualised planning, dignity of risk and a personalised human rights resource package where necessary.</td>
<td rowspan="5">Train staff.
Make sure the APO is fully trained and follows the policy.</td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Commission the working group to consider these areas and create or adapt your policy.
Place a timescale on this work and identify the best people to be involved.</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Move to pit stop 6.</td>
<td></td>
</tr>
</table>

Action for the board: Adopt the principles of trauma-informed care.

Actions for the CEO/management: Make addressing trauma and preventing trauma a priority. Have experts available to assess trauma and to address trauma. Build positive relationships with clients that prevent re-traumatisation.

Pit stop 6: The importance of human rights

Why are human rights important?

- Autonomy, self-determination and choice are the foremost principles of the CRPD
- Public authorities (government or organisations that do the work of government) are subject to the Victorian Charter of Human Rights and Responsibilities and to the United Nations Convention on the Rights of Persons with a Disability (CRPD).
- People with disabilities deserve a FAIR GO like everyone else in Australia.
- Behaviours of concern may be caused by infringements to a person's human rights. They
- may also be caused when those rights are not fulfilled in ordinary everyday practice:

Behaviours of concern can result from a human rights infringement		Fulfilled lives are likely to arise from a human rights-based approach to service delivery

Your organisation will therefore need to address human rights in a number of ways.

You will need to:

1. Assess your organisation's human rights **compliance** – a self-audit guide and resource are available[8] and should be studied by your organisation's working group (a human rights service model)
2. Develop a practical means of **assessing** each paerson, situations and your organisation using a human rights framework so that everyday practice can be built upon a common, rehearsed and internalised approach by staff (assess causes of BOC – see below)
3. Develop methods of **personalising** human rights. These can be designed for use in the individualised planning process – individual planning focus (preventing behaviours of concern – see below).

[8] See French P 2012, *Implementing the Convention on the Rights of Persons with Disabilities: self audit guide*, OSP, Melbourne; Office of the Senior Practitioner and French P 2012, *Implementing the Convention on the Rights of Persons with Disabilities: a resource for service providers*, OSP, Melbourne.

Pit stop 7: Assessing human rights: people, situations and organisations

Your working group may use measures already in place in your organisation to assess human rights or it may develop its own methods. For example, to assess your organisation you might use the *Dignity in care checklist*[9] (see Appendix 4 of the roadmap) or the PANEL (participation, accountability, non-discrimination, empowerment and linkage to human rights principles) approach adopted by the Victorian Equal Opportunity and Human Rights Commission.[10] You may need to adapt your policies and practices to be human rights compliant.

Assessing your organisation is important. But it is also important to assess situations and indeed individuals to ensure that human rights define all your organisation's work and that each individual's rights are fulfilled in each circumstance and situation.

The *principles* of human rights might be understood using the I RAN FREE mnemonic:

I	Individual autonomy including the freedom to make one's own choices and respect for inherent dignity
R	Respect for difference … human diversity and humanity
A	Accessibility
N	Non-discrimination
F	Full and effective participation and inclusion in society
R	Recognise and respect for evolving capacities
E	Equality of opportunity
E	Equality between men and women

A tool is provided in Appendix 4 and sets out these principles on a wheel. The second part of the tool is the Human Rights Wheel, which includes the articles from the CRPD.

1. Place the CRPD principles on top of the Human Rights Wheel (the rectangular box is a cut-out).
2. Identify a person in your organisation who demonstrates behaviours of concern.
3. Question which articles on the Human Rights Wheel apply to the person or situation.
4. Which of the I RAN FREE principles apply most to the limitation on human rights or infringements on the person's rights that you have identified?
5. Commit the assessment to paper and seek to meaningfully adopt a strategy that makes a difference.

Human rights are central to achieving dignity without restraint. It is vital that the working group acts to make sure the organisation acts based on human rights at every level of operation. Figure 5 will help your working

[9] Social Care Institute for Excellence (SCIE) 2008, *Practice guide 9: Dignity in care*, SCIE, London.

[10] VEOHRC 2008, *From principles to practice: implementing the human rights based approach in community organisations*, VEOHRC, Melbourne.

group to develop a human rights-based organisational approach for your organisation.

Figure 5: Developing a human rights-based organisational approach

<table>
<tr><td>Is your organisation human rights compliant?</td><td>No</td><td>The working group checks compliance and adapts policies.</td><td></td><td></td></tr>
<tr><td>Yes</td><td>No</td><td></td><td></td><td rowspan="5">Train staff.

Inform and involve clients, family carers and advocacy organisations.</td></tr>
<tr><td>Is your organisation able to assess if it is a human rights-based organisation?</td><td></td><td>The working group adopts a human rights-based assessment of the organisation.</td><td></td></tr>
<tr><td>Yes</td><td>No</td><td></td><td></td></tr>
<tr><td>Can your organisation assess the human rights of an individual or a situation?</td><td></td><td>The working group adopts a human rights-based assessment of individuals and/or situations.</td><td></td></tr>
<tr><td>Yes</td><td></td><td></td><td></td><td rowspan="2"></td></tr>
<tr><td>Move to pit stop 8.</td><td></td><td></td><td></td></tr>
</table>

Actions for the board: Is your organisation a human rights-based organisation? Is human rights stated in the organisation's mission and aims? Are your policies human rights compliant? Do you measure your organisation's success against human rights outcome measures?

Actions for the CEO/management: Is there a human rights leader, champion or a human rights ambassador role? Do staff understand their role in fulfilling the human rights of clients? Have your human-rights assessments in place for the organisation and for service delivery? Can you measure human rights change in your organisation?

Look at the case studies in Appendix 3 once again. From the information provided consider the human rights issues in the lives of James, Jenny and Maurice. What are the important principles and the important human rights articles? What can your organisation do to address these issues?
Pit stop 8 may help you to deepen your human rights approach for each person using your service.

Pit stop 8: Deepening human rights for the individual

Planning for individuals: a resource kit and implementation guide for service providers[11] sets out methods through which to explore goals, needs and aspirations. Goal setting will be considered in a moment. It is extremely important for human rights to be individualised, which involves a number of approaches that may be linked to the person-centred planning process:

Principle 1: *Over time reclaim and use positive identities* (see Chapter 5 of the roadmap).

- Files and documents about a person should be positive and not deficit-focused.
- Files should not damage reputations.
- A new person reading the file should know the positive things upon which to work and the things that are likely to create problems. The source of problems should be seen in the factors that produce problems and not in the person themselves.
- Damaged reputations need to be repaired. Interests, relationships (past and present), skills, their unique story, strengths and preferences should feature strongly as the (recorded) basis for any engagement with the person and designing a service based on their choices.
- The personalised human rights resource is central to accomplishing these outcomes (see below).

Principle 2: *'Choice' and self-determination are key to fulfilling human rights and are the starting point for personalised planning arrangements* (see Chapter 3 of the roadmap).

Maximise communication with the person so they can express a choice and identify what supports are required to make choices (such as: supported decision making, planning and accessing resources; and support to pursue and accomplish the choice).

Know the person well enough to know their preferences (past and present) even if they cannot express them to you directly.

Know how to facilitate the person in their: *everyday choices* (What drink? Which shop?); lifestyle choice and routines (for example, their decorations, their style of clothes and their waking routine); and pervasive choices (for example, work, education, family and intimate relationships).

Planning must originate or start with a person's hopes, dreams, wishes and aspirations.

Principle 3: *Movement towards personal goals is essential* (see Chapter 6 of the roadmap).

Too many individualised plans fail and too little is often done to address these breakdowns in action. People's behaviour often reflects a frustration or protest to 'lives without a purpose', without change and without hope.

- Achieving personal goals should be a mission of all agencies that provide services and supports for people with a disability.
- Interdisciplinary assessment should identify how developmental needs move the person to their chosen goals.
- A program focused on skills that the person needs to master, tailored to the person's skills and maximising competence, relationships and autonomy should be written with clear review points and funding committed.
- Review and monitoring should lead to adjustments of the pace and type of approach to ensure the person achieves their goals.

Principle 4: *Involve, consult and empower* (see Chapter 7 of the roadmap).

Generally services that are built together are jointly owned and this reduces complaints. It opens the way for a dialogue between the person, their allies and the service. Such involvement produces checks and balances on the power of any party, it makes the service more visible and accountable, it has the potential to make sure

[11] See Department of Human Services 2007, *Planning for individuals: a resource kit and implementation guide for service providers*, State Government of Victoria, Melbourne, viewed,

<http://www.dhs.vic.gov.au/__data/assets/pdf_file/0006/601098/dsapp_planningpolicy_implementationguide_20071128.pdf>.

people are working in collaboration to a single goal, it distributes responsibility and ties people into wider networks and, where there are issues, it gives the person an independent voice through advocacy.

Principle 5: *Design a personalised human rights resource for each person* (see Chapter 5 and Appendix 5b of the roadmap).

Each person who uses your service should have a personalised rights resource. Any interaction with the person should comply

with these personalised rights. This means staff need to know the person well enough to ensure they act so as not to breach these rights. Among other things the resource might contain:

- non-negotiables (those things the person will not do without or which the person refuses to accept), goals, interests, personal strengths, hopes, dreams and aspirations
- everyday, lifestyle and pervasive choices (see Principle 2 above)
- a person‘s friends and those the person avoids
- rituals and routines (see Appendix 5b of the roadmap for a more detailed list).

Figure 6 may help your working group to deepen individualised human rights for each person for whom you provide a service.[12]

Figure 6: Deepening individualised human rights

Does the person have a positive identity?	**No**	The working group should review how case files are kept, examine the past and build a positive strengths-based identity for each person.		
Yes				
Does your organisation have a model of choice making linked to individualised plans?	**No**	The working group should consider how to systematically assess and address a person’s communication needs, and consider how to operationalise and monitor choice making.		Training for staff and participation of clients, family carers and advocates in an agreed governance structure that accomplishes a culture of personalisation of human rights, accomplishing individual goals.
Yes				
Does your organisation have a way to make sure a person is moving towards their chosen goals?	**No**	The working group should consider how to achieve ‘goal mastery’ (see footnote).		
Yes				
Does your organisation have a policy on participation and involvement?	**No**	The working group should address the participation of clients, family and advocates in policy, decision making, and		

[12] The term ‘goal mastery’ has been used in a generic sense. Goal mastery involves the organisation setting goals that move a person towards their goals and aspirations. Each timed goal has a budget attached to it and a date for review. If the target is not met the team meets to adapt the target or the outcome, but always to move the person towards their goals with appropriate resources attached. The mission and governance arrangements of the organisation should reflect this approach.

		individual and behaviour support planning.		
Yes				
Has your organisation developed personalised human rights resources?	**No**	The working group should develop, pilot and refine personalised human rights resources for each client.		
Move to pit stop 9.				

Actions for the board: Is your organisation a leader in providing quality personalised services to its clients? What measures of success link your mission and aims to your personalisation and human rights agenda? Are your governance structures participative?

Actions for the CEO/management: Have your policies and practices been designed to achieve a reduction in restraint and an increase in personalised human rights planning? How are you making sure people are moving towards clear and stated goals based upon their own choices? How are you ensuring services fulfil human rights and are quality-producing?

Pit stop 9: New ways to manage risk

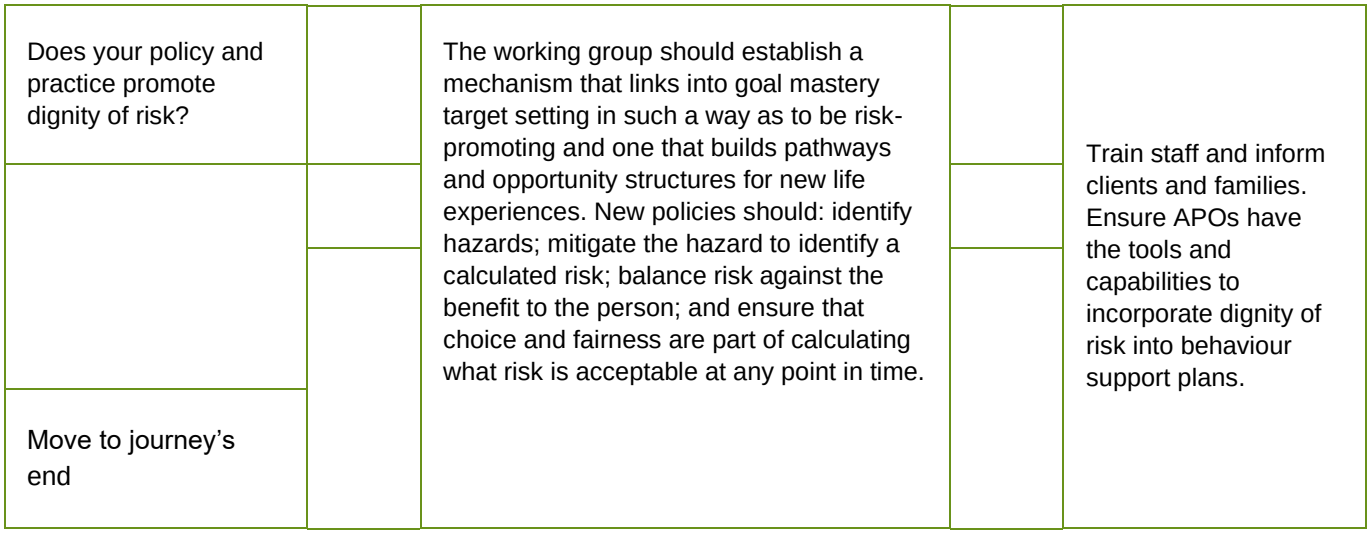
Look at the case study of James (Appendix 3). James's wish to wander is clear and intractable. Yet to simply let James wander would be risky. Because of this some movement to accomplishing personal goals and choices may be produce risks.

However 'dignity of risk' is essential (see Chapter 6 of the roadmap). People cannot grow without taking risks and cannot become resilient. Not taking risks leads to loss of hope, to learned helplessness and lassitude. There are several things that can be done to address the issue of risk.

- Recognise that there is a clear difference between risk and hazard. A risk involves a calculation of how to reduce or mitigate the chances of a hazard becoming real.
- When risk is calculated it must be balanced against the benefit to the person. Risk is not a one-sided equation.

Balancing risk and benefit requires consideration of whether the person has chosen to take a risk and whether the decision is fair (whether you would apply the same rules to others as you would to this person) as well as the tangible benefits that might accrue.

Figure 7: Navigating dignity of risk



Action for the board: A 'no risk' policy will damage the outcomes to people who use your services. An assumption of risk on the grounds of disability is labelling. Your organisation needs to identify itself as one that stretches clients and supports them to take risks to achieve their aims.

Actions for the CEO/management: Closely oversee situations in which plans incorporate calculated risk; develop a policy and practice approach promoting dignity of risk; train and support staff regarding achieving client growth through risk taking.

Journey's end: organisational structure

This resource has focused on the ways in which to build a quality human rights-based service and, in doing so, setting the context within which preventing restrictive practices can take place. The central assumption is that better lives produce fewer behaviours that can be construed as concerning. Evidence shows that this approach can be very successful over time.[13]

However, change does not come easily, and it is essential to be patient but, more importantly, to have an organisational framework that supports staff at difficult times and one that encourages best practice (see Chapter 8 of the roadmap). The working group will contribute significantly to this by working through this document and by seeking to put in place and embed the recommendations being made.

Appendix 5 provides just one organisational structure regarding behaviours of concern in which the focus of this document takes places in the boxes to the left of the diagram.

Staff will need close mentoring, expert advice and someone to whom they can turn to discuss their struggles regarding behaviours of concern and concerning behaviours. It is also recommended that there is a trained person on duty able to provide advice at all times where there are situations that are stressful for staff and in which the prospect of using the restrictive intervention as part of a BSP is likely.

There may be cases in which, despite best efforts, restrictive practices continue to be used. There should be some mechanism for considering and dealing with such cases that draws on the commonwealth of expertise within your organisation. In Appendix 5 this is shown as a human rights committee. You might choose to operationalise this in another way.

The culture you are looking to accomplish in your organisation is one that: is based on positive support, positive behaviour support, human rights and dignity of risk; is founded on each person's choices and life goals; involves people and family carers; and builds on the person's strengths. It will be an organisation in which people feel they have a meaningful engagement and a real say, one in which people feel safer and one that is efficient and productive, and one that has a mission, policies and practices that are designed to accomplish a quality life for clients without the use of restraints.

[13] National Association of State Mental Health Program Directors (NASMHPD) 2001, *Reducing the use of seclusion and restraint – Part II: Findings, principles and recommendations for special needs populations*, viewed, <www.nasmhpd.org/seclusion_restraint_2htm>.

Appendix 1: Leadership – an example

A worker in a CSO, Kerry, was recently nominated for an award in recognition of the excellence in practice leadership that she demonstrates and that is recognised and valued by colleagues.

Kerry's strengths are her ability to contribute to the service system to achieve outcomes for people with a disability. In undertaking this Kerry uses her ability to bring people together, identify issues and solutions and be actively involved in these solutions. In recent months Kerry has successfully (while supporting and mentoring a case manager) coordinated a very disparate service system around a particularly complex client. The resultant cohesive solution-based care team have all worked together to achieve positive outcomes. In undertaking this task Kerry has maintained the client's needs as the constant reference point.

Kerry is a respected member of the disability service system across the region and is regularly called on for advice and guidance on complex client situations. She analyses issues from different perspectives, makes sound assessments from the information available and proposes workable solutions.

Kerry is a positive professional and uses every opportunity to ensure the best outcome is being achieved for the person with a disability. She achieves this through sound communication and listening skills while keeping the person at the centre of all decisions.

Kerry is solution-focused and participates in the journey to achieve resolution. Kerry is always ready to take whatever steps are required to protect a person within the system even if at times that may put her in difficult situations with other programs. Kerry is known to bring in an advocate when she has thought the person with a disability is not being represented appropriately or their rights may be being breached.

Questions:

What are the features of Kerry's leadership?

Does Kerry pay a cost for her leadership?

What is the key outcome that Kerry is working for?

What would be helpful to support leaders like Kerry in your organisation?

Appendix 2: Positive behaviour support – a case study

Alex is 21 years of age and lives within supported accommodation. During the past 12 months Alex has experienced a number of positive changes in his life that have significantly affected who he is today including: being surrounded with staff he can trust and who he considers to be honest; being given control over his life and his decisions; being allowed to make mistakes rather than staff sheltering him from experiences or punishing him for 'wrongdoing'; being provided strategies to cope with anxiety provoking situations; and being given control over his money from his paid employment.

Background

Alex has been diagnosed with autism and associated anxiety disorder. He has had previous involvement with area mental health following threats and attempts of self-harm. During the first half of 2011, Alex was working at a nursery every Monday, which he was 'sort of enjoying' but 'didn't like what the staff at work were saying'. Alex reported that during this period he felt very angry and confused, often manifesting as 'violence towards the support staff and his family members', and characterised by punching windows and breaking them, as well as threatening physical assault towards staff. In addition to risk-taking behaviour such as train surfing and throwing himself in front of traffic (some of which resulted in police intervention), Alex further reported that he was mixing alcoholic drinks to get drunk. He notes that this was difficult for his housemates as they 'were tired of it'. Alex was subject to physical restraint numerous times as a means of keeping himself and others safe.

Current situation

Alex now presents as a very different person than that of 12 months ago. He reports feeling 'quite good' and has achieved a number of his goals including:

- working in landscaping Monday–Thursday 9–3 pm and Saturdays 9–12 pm, to which he travels independently
- flying to Fiji in May with his family for a wedding and going camping with a mate for two nights without staff support
- riding his bike from Black Rock to Melbourne then catching the train home
- attending the gym
- no longer drinking to get drunk and no longer mixing his alcoholic drinks
- recognising when something is making him feel anxious and regulating his feelings
- speaking to his mother on a regular basis and calling her every Wednesday to find out if he is visiting the family home the following weekend (this has assisted Alex to manage the anxiety he feels around uncertainty)
- developing positive relationships with his neighbours, including engaging them in conversations
- reducing his medication.

Alex acknowledges that he still gets anxious; however, this does not occur as often as it has in the past because he feels he has more control over what happens in his life. Alex is no longer managing his anxiety through violence, instead he uses learned techniques such as taking a few deep breaths, going for a bike ride or taking the dog for a walk if he is visiting his mother. During the past 12 months Alex has not been physically restrained and has had significant reductions in his medication (Seroquel) from 500 mg per day to 250 mg per day.

What was it about this case study that made a difference to Alex?

A significant amount of time and energy will have been committed by the specialist services, by the staff and APO, and then by staff coordinating their services to implement a behaviour support plan.

What are the things that have made Alex's life experience better for him?

What resources would have been required?

What processes would need to be implemented?

What is the investment made by the organisation?

What are the things that could have been done to prevent this expenditure?

What are the things that could have prevented Alex from becoming aggressive in the first place?

Why are Alex's needs not addressed as a matter of course? Why does change need to take place after things have become a crisis?

Appendix 3: Case studies

Walk a mile in James's shoes

James, a young man on the autistic spectrum who uses few words, has absconded too many times to count. He goes for long walks, some of which can last many hours. Over the years his absconding has led to tighter and tighter restrictions. Doors have been locked, windows have been reinforced (additional cost) and most recently James has been placed in more secure accommodation (cost of accommodation and higher staff ratio) with three other young men who can be aggressive. The surroundings are spartan, with furniture and windows screwed down (additional cost) and few things available to occupy the residents. While staffing levels are higher (additional cost) James has become very agitated in his present environment, especially when secluded to his room when he shows even more aggression. James has had several specialist assessments (additional cost) and a behaviour support plan for several years (additional cost).

James's parents have convinced staff to see his behaviour as 'accessing the community independently' and not as 'absconding'. A multidisciplinary meeting puts things in place to help James learn about road safety; a member of the team agrees to introduce James to the safer cycle paths; safe routes to regular haunts are designed and introduced to James; over time and after much negotiation James is introduced to a transport company where he acts as the driver's mate for which he is paid a nominal amount at this stage and he gets to see different places more often.

What are the causes of James's behaviours of concern?

Is trauma likely to be a cause of James's behaviour? What other causes can you see?

Apply a human rights assessment to James's situation using the tools in Appendix 4. What would you now change?

How would you make James safe while providing a dignity of risk?

How might a personalised human rights resource help James?

Walk a mile in Jenny's shoes

Jenny is a gentle and quiet lady in her late 50s. She likes nothing more than musicals, dancing and having lovely pictures on the walls of her room. She likes her day service but is scared at home especially when people come into her room. Some residents have even walked into the shower while she is using it. When I met Jenny she cried and it was one of the most moving experiences of my life. She said nobody listened to her when she complained and told me she had missed out in life, and she desperately wanted to move to a new home.

Jenny is not easily seen and seldom if ever heard. Yet Jenny's seeming acquiescence should be seen as a behaviour of concern. Jenny has been broken by a system that does not respond to her wishes and needs. Her response to being ignored has been to withdraw into her shell and show signs of depression.

Are Jenny's behaviours a problem in any way?

What is the first thing you might put into Jenny's individualised plan as her primary wish?

What are the key human rights issues in Jenny's life?

How might you support Jenny to have a better quality of life?

Have you got other clients who may not show behaviours of concern but whose behaviour is concerning? Apply the learning from this resource. Has it helped?

Walk a mile in Maurice's shoes

Maurice, 56, spent many years in a large institution. He now lives in a home in the community with five other people. Maurice has a close relationship with one support worker in his home and is generally well behaved. However, he is destructive in his day centre and particularly dislikes some male members of staff and some male clients. He lashes out at some men and has a bad reputation for his behaviour. He has been on a BSP for several years and has had a plan designed by the BSS team.

It will take a lot of exploration to find out why this is a problem and if this is the reason for his behaviour and whether the setting or the people are his central.

Maurice is known as 'potentially troublesome'.

How would you produce a more positive identity for Maurice?

What work is required for Maurice in relation to trauma?

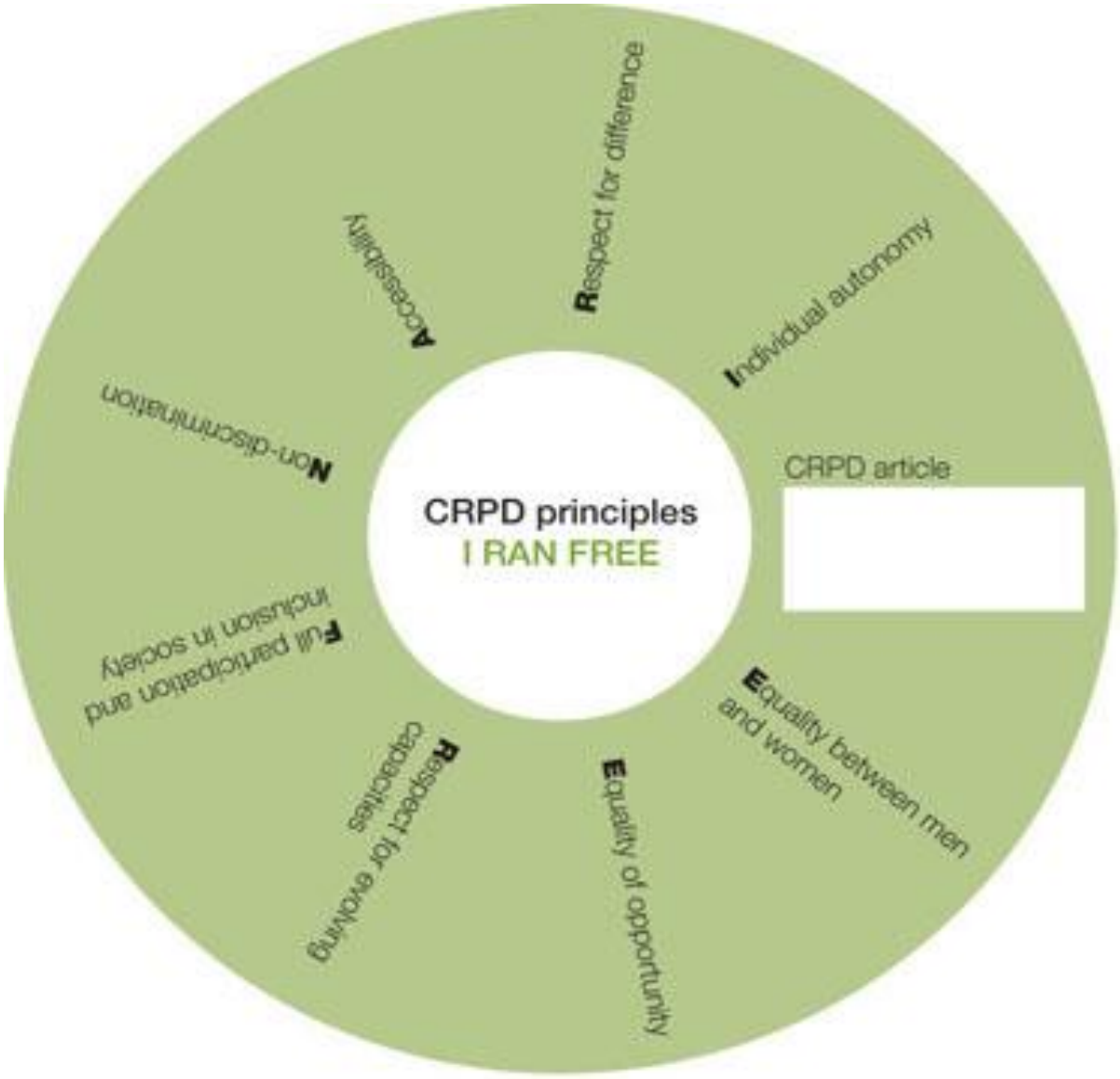
How can you reassure Maurice about male members of staff?

What are the human rights issues in Maurice's life?

How might you build more positive outcomes for Maurice? Do you know his hopes, dreams and aspirations?

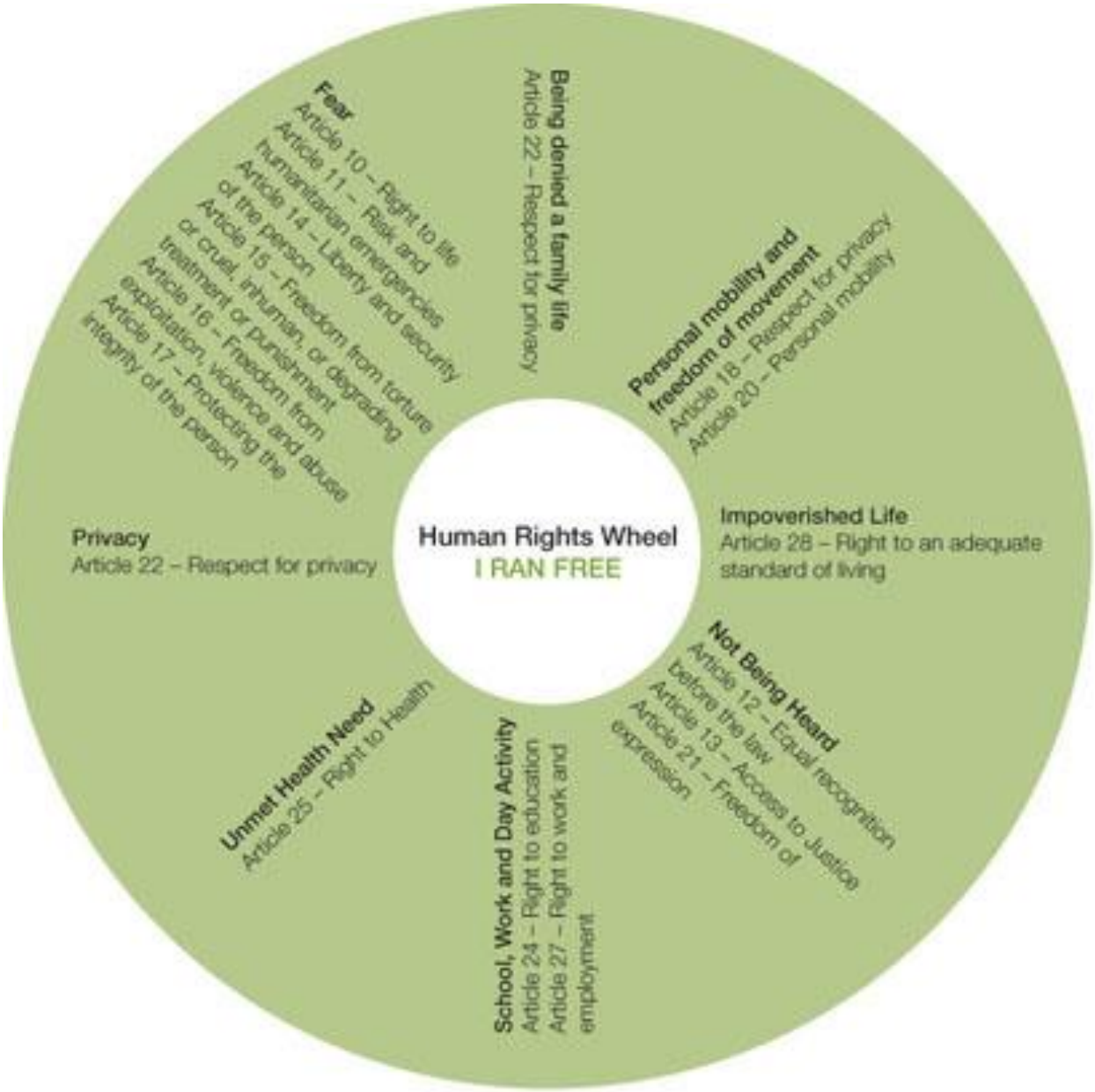
Work through your own clients using the recommendations in this resource. How long does it take to do this work? How can staff be supported to do this work systematically? How can you measure the changes and benefits over time? Has this resource helped? If not continue to build upon what is here, drawing on your own experience.

Appendix 4: Human Rights Assessment Tool – the Principles Tool [14]



[14] Ramcharan P 2012, *Roadmap for reducing restrictive practices in Victoria: Achieving dignity without restraint*, Office of the Senior Practitioner, Melbourne.

Appendix 4: Human Rights Assessment Tool – the Human Rights Articles Tool[14]



Appendix 5: One proposed organisational structure to support the reduction of restrictive practices

	Service management support	**24-hour advice/support intervention**			**Senior Practitioner**
Prior to (next) behaviour of concern	Situation where there is a threat of a behaviour of concern	Behaviour of concern causing danger to self and others, leading to restraint or seclusion	After an event in which a restraint or seclusion has been used	APO assessment for BSP	Human rights committee
Human rights Preventive model	**Preventive model**	**Minimise harm model**	**Care and comfort model**	**Collaborative model**	**Human rights committee**

* Personalised human rights resource and assessment of autonomy * Fulfil chosen life aims in individualised plan * Dignity of risk relating to life aims * Dialogue with support network and allies * Human Rights Wheel * Reclaimed and positive identity in case file * Celebrate the person * Circle, advocate guardian have open scrutiny * Dignity in care checklist	Staff: * De-escalation reflecting personal preferences * Remove cues * Persuade person to leave the area Staff–client: * Soles of our feet * Stress thermometer * Grounding techniques Staff–person–circle: * Dialogue * All preventive measures taken? * Exception or referred for BSP? * Checklist of things to say after a person becomes angry	* Have a planned response * Be safe and make the person safe * Employ planned replacement behaviours * Support cathartic release * Actions that support trust to be maintained	* Checklist of things to say after using any restrictive practice * Make people safe after the event * Reassure rather than reprimand * Do not use blame/shame or keep the upper hand	* Checklist of issues to be addressed with wider circle of support * Consider whether the preventive model has been used, the prevention of harm model and the care and comfort model * Establishing failures of the organisation or service * Establish causation of behaviour and refer for other assessments (App 1a) where necessary * Functional behavioural assessment on what is left after the above * Assessment of any proposed restrictive practice as a risk in itself	* Authorises a restrictive practice as part of a BSP * Presents alternatives to APO in individual cases * Advises managers of services about issues they are experiencing * Manages staff complaints about restrictive practices * Has a second-stage complaint function in relation to human rights infringements on clients