Saint John of God Community Services Limited
Policy on Behaviours that Challenge

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1. Policy Statement

Saint John of God Community Services Limited is committed to providing support to individuals with intellectual disability and behaviours that challenge through the Multi-Element Behaviour Support Model. It is committed to respond to behaviours that challenge using non-aversive and non-restrictive strategies.

2. Purpose

The purpose of this policy is to ensure a collaborative and consistent approach in supporting individuals with behaviours that challenge within Saint John of God Community Services Limited.

It seeks to ensure a proper balance between an individual's needs and the needs of others responsible for supporting them.

3. Scope

This policy is for all staff working in services for children and adults with intellectual disabilities in Saint John of God Community Services Limited.

4. Legislation/other related policies:

These policy statements and the subsequent procedures and practices outlined in this document are informed by:

4.1 Quality Measures. CQL 2005;

4.2 Health Information and Quality Authority *National Quality Standards: Residential Services for People with Disabilities* (2009);

4.3 Data Protection Act 1999;

4.4 Linking Service and Safety: Strategy for Managing Work Related Aggression and Violence within the Irish Health Service 2009;

4.5 Policy & Procedures for Managing Allegations of Abuse, Adult Mental Health Services, Saint John of God Hospital Limited, Saint John of God community Services Limited 2010;

4.6 Policy & Procedures for Managing Allegations of Abuse, Child & Adolescent Mental Health Services, Saint John of God Hospital Limited, Saint John of God community Services Limited 2010;

4.7 Policy & Procedures for Managing Allegations of Abuse, Intellectual Disability Services, Saint John of God community Services Limited 2010;

4.8 Policy & Procedures for Managing Allegations of Abuse, Child & Adolescent Mental Health Services, Saint John of God Hospital Limited, Saint John of God Community Services Limited 2010;

4.9 Policy & Procedures for Managing Allegations of Abuse, Elderly Services, Saint John of God Health Services Limited;

4.10 Policy & Procedures for Managing Allegations of Abuse Against Staff, Saint John of God Hospital Limited, Saint John of God Community Services Limited, Saint John of God Health Services Limited 2010;

4.11 Risk Management Policy 2007;

4.12 Complaints Policy 2008: St John of God *Hospitaller* Services;

4.13 The Universal Declaration Human Rights (1948);

4.14 Values in Practice, Saint John of God Community Services 2009.

5. Definitions

Aversive Practices: These refer to practices which the person does not like and may be considered as punishing. These practices may or may not be rights restrictive practices. For example, a trip to the cinema may be aversive to someone who does not like the dark but not to someone who wants to see the movie. What is considered aversive is very much based on the individual likes and dislikes of the individual person.

Behaviour Management: This refers to a set of techniques that are used to manage behaviours that challenge. These techniques are usually based on the topography of the behaviour i.e. what the behaviour looks like or the physical manifestation of the behaviour. These techniques are generally speaking not functionally based. For example, if a person runs out the front door onto the road, the front door may be locked, this is a behaviour management technique.

Behaviours that Challenge: 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 behaviour which is likely to seriously limit use of, or result in the person being denied access to ordinary community facilities. (Emerson 1998)

Behaviour Support Services: This includes a range and variety of supports that the person may be receiving for behaviours that challenge, including MEBS, and any planned restrictive interventions.

Clinical Supervision in MEBS: A person with post-graduate training and experience in Multi-Element Behaviour Support who can provide support and technical assistance to another staff person who is completing a comprehensive behaviour assessment, developing a MEBS plan and implementing and monitoring the plan on a quarterly basis.

Clinical Support: A professionally qualified person with post-graduate training and experience in MEBS and is employed as a Behaviour Specialist, CNS in Behaviour, Psychologist or Psychiatrist.

Consent: see Informed Consent.

Due process: A process that protects a person's rights as identified in the UDHR, specifically in the area of informed consent and decision making.

Emergency Restrictive Reactive Strategy: A restrictive reactive strategy that is used in an emergency, focusing on the topography of the behaviour. For example, holding the person by the arms when they

suddenly bolt out on to the road; locking a door to prevent the person from accessing dangerous equipment in a kitchen.

Functionally Based Reactive Strategies: These are strategies which are based on a comprehensive behaviour assessment and address the function of the behaviour. Functionally based means responding to the function.

Human Rights: Human Rights are a valid universal claim which applies to all people by virtue of being human. There are 30 Rights in the Universal Declaration of Human Rights (UDHR) and each one is called an article. In the Convention on the Rights of Persons with Disabilities there are 50 articles. These articles expand on the 30 articles of the Universal Declaration of Human Rights. (Rights are civil, political, economic social and cultural and are listed in other documents like Irish constitution etc.)

Human Rights Based Approach: The Human Rights Based Approach (HRBA) is a process that occurs within a framework of five guiding principles. These principles aim to ensure that human rights enshrined in the UDHR are enjoyed by all. The five guiding principles of a HRBA are; expressed linking to rights; accountability; empowerment; participation and non-discrimination.

Incident forms: These are formal forms that are required to record data on behavioural incidents.

Independent advocate: A person who is independent of the service and can assist the person in making a decision or resolving an issue.

Informed Consent: The person gives permission based on information presented in an understandable manner, the person understands all the options available to them and the decision is made voluntarily. The person is able to communicate their decision based on the information they have received in a format that can be understood. Informed consent is specific to the decision on hand and is time limited. Where the person is unable (deemed to not have capacity to consent) a suitable qualified person/ appointed guardian can provide informed consent on behalf of the person.(refer to policy Rights Protection and Promotion in Values in Practice 2009)

Multi-element Behaviour Support (MEBS): This is the approach used by St John of God Community Services/Callan Institute to manage behaviours that challenge within this organisation. It involves a comprehensive behaviour assessment, a Multi-Element Behaviour Support plan with both proactive and reactive strategies. These strategies are non-aversive and non restrictive. The MEBS process also incorporates an evaluation process. The MEBS model of service delivery is explicitly linked to a Human Rights Based Approach. It has four parts.

1. Informed Consent and a Comprehensive Behaviour Assessment which comprises of a background assessment and a functional assessment.

2. A Multi-Element Behaviour Support Plan, with Proactive and Reactive Strategies.

3. A review of the supports required to implement the MEBS plan.

4. Implementation and Monitoring for effectiveness across a range of outcomes.

Non-restrictive: A strategy which does not restrict the rights of a person.

Non-aversive: A strategy that the person likes, which also supports the person to exercise their rights

Periodic Service Review (PSR): An individual PSR is a quality assurance tool used to monitor and score the implementation of each intervention in the individuals Multi-Element Behaviour Support plan.

Planned Restrictive Reactive Strategy: A restrictive reactive strategy that has been authorised or prescribed by a suitably qualified professional, has informed consent and is part of an individual's restrictive reactive plan. This plan is subject to regular review and a strategy must be in place to reinstate the restricted rights in a timely manner.

Rights Based Interventions: Interventions that focus on honouring a person's rights and enabling the person to exercise their rights as identified in the UDHR and other rights related documentation.

Social Validity: Is the intervention acceptable to all stakeholders, and is the desired outcome of the intervention important for all stakeholders.

Restrictive Reactive Strategies: These are strategies that restrict a person's rights as interpreted through the Universal Declaration of Human Rights, for example, physical restraint, mechanical restraint, psychopharmacological restraint, seclusion, punishment, etc..

6. Roles and Responsibilities

6.1 All staff members are responsible to ensure that individuals consent to Multi-Element Behaviour support by:

6.1.1. Providing information on Multi-Element Behaviour Support.

6.1.2. Ensuring the individual's consent before making a referral for MEBS.

6.1.3. Assisting an individual to make a referral for MEBS through the local services referral system.

6.2 All staff members have a responsibility for implementing Multi-Element Behaviour Support by:

6.2.1. Assisting with the comprehensive behaviour assessment and the development of a Multi-Element Behaviour Support plan and to identify any further supports required. If further supports are required these should be requested from the appropriate line manager in order to facilitate the implementation and maintenance of interventions as designed.

6.2.2. Implementing the Multi-Element Behaviour Support Plan (to include, environmental accommodations, skills teaching, direct interventions and reactive strategies) by following the written protocols on a daily basis.

6.2.3. Scoring the Periodic Service Review (PSR) on a regular agreed basis, but no less than once a month.

6.2.4. Recording data related to the Multi-Element Behaviour Support Plan on a daily basis.

6.2.5. Summarising behavioural data and PSR score on a graph at regular agreed intervals, but no less than once a month.

6.2.6. Checking that each intervention is consented to by the individual and the individual is satisfied and comfortable in receiving such interventions.

6.2.7. Checking that the team are comfortable and able to implement the interventions in all environments, including community based environments.

6.2.8. Changing interventions, based on assessment, as needed.

6.2.9. Checking that each intervention is non-aversive and non-restrictive. If an intervention is identified as aversive or restrictive, the guidelines outlined in Human Rights Promotion and Protection and the relevant restrictive strategy polices should be followed.

6.10. Ensuring that there is clinical supervision and support available to the team and the individual on the design, implementation and review of MEBS.

6.11. Ensuring that all staff working with an individual receiving MEBS have an outline of the MEBS plan and are introduced to the key interventions.

6.12. Ensuring correct records and files are maintained on MEBS for each individual, to include, consent, assessment, MEBS plan, Quarterly report, Graphs, Incident Forms, Complaints, Resource Requests, and Rights Restrictions for behavioural purposes.

6.3 All staff members have responsibility to review the Multi-Element Behaviour Support Plan by:

6.3.1 Reviewing the MEBS plan with each individual formally on a quarterly basis, by completing a Quarterly Report with an up-to-date graph and a scored PSR.

6.3.2 Ensuring that they have clinical supervision and input on each MEBS plan that they put in place. This supervision should occur on an ongoing basis, at a minimum quarterly, or more frequently if required.

6.3.3 Ensuring a review of each individual's MEBS (plan occurs every 3 months).

6.3.4 Supporting an individual to make a complaint on any aspect of MEBS, if required.

6.3.5 Reviewing any rights restrictive procedures for behavioural purposes that the individual may be experiencing by following the procedure for reviewing Rights Restrictions in the local service.

6.3.6 Advocating for additional resources, with evidence to support the request.

6.3.7 Supporting each individual to access an independent advocate should they require one and to ensure the individual has time and privacy with the independent advocate.

6.3.8 Ensuring that people responsible for the daily implementation of the MEBS plan meet at regular agreed intervals, no less than once a month to review an individual's MEBS plan.

6.3.9 Meeting as a team after a serious incident and/or the use of an emergency restrictive reactive strategy to review the incident, provide support to the team, review the MEBS plan, and amend any interventions in line with data analysis and notify relevant authorities as appropriate in accordance with HIQA standards.

6.3.10 Providing support to a colleague should they require it. This can be done informally, by facilitating a break or formally through, supervision, and accessing the Employee Assistant Programme.

6.4 The Line Manager:

6.4.2 Ensures that access and support is provided to any individual who is involved in or witnessed a behavioural incident of a serious nature. This can be done informally, by facilitating a break and talking with the individual or formally, in counselling or therapy for an individual should they require or request this.

6.4.3 Ensures that staff members, with the appropriate training, experience and clinical supervision are expected and supported to conduct additional Comprehensive Behaviour Assessments and develop Multi-Element Behaviour Support Plans, as identified by the waiting list for MEBS in the service and in consultation with the Positive Behaviour Support Committee.

6.4.4 Identifies training needs in their area, which is then recorded in the local Human Resource Department.

6.4.5 Support staff members in defining behaviours that challenge and in recording data on the frequency, episodic severity, response to the behaviour and the outcome of such responses.

6.5 The Director of Service:

6.5.1 Establishes a Behaviour Support Committee.

6.5.1.1. Appoints the Chairperson of the Positive Behaviour Support Committee. It is recommended that the chairperson has successfully completed the longitudinal training course in Multi-Element Behaviour Support and it is

recommended that they maintain an active case load in Multi-Element Behaviour Support.

6.5.1.2 Appoints the membership of the Positive Behaviour Support Committee and ensures:

6.5.1.3 Membership is multi-disciplinary /or representative of the local service, in character.(where possible the disciplines overseeing/authorising or prescribing the interventions used in the service are present).

6.5.1.4 A majority (more than half) of members have successfully completed the longitudinal training course in Multi-Element Behaviour Support.

6.5.1.5 It is mandatory, where physical management techniques are used in the service, that at least one member of the committee is a certified instructor in the approved crisis management physical intervention training programme used in the local service.

6.5.1.6 All members of the committee have completed a 1-day training course on Multi-Element Behaviour Support.

6.5.1.7 Monitors the work of the committee by monitoring Basic Assurances on Positive Services and Supports.

6.5.2 Organisational Supports:

6.5.2.1 Ensures that all staff members are familiar with this policy.

6.5.2.2 Ensures that staff members have access to information, literature, training, materials, resources and supervision required to implement this policy.

6.5.2.3 Ensures that supervisors and managers attend education and training events and are competent in implementing this policy document.

6.5.2.4 Aims to collaborate with families through the provision of information, education, advice and support in MEBS for their family members receiving support from Saint John of God Community Services Limited.

6.5.2.5 Ensures that a Rights Review Committee is available to each service to review any rights issues as they might relate to behaviours that challenge on behalf of individuals with intellectual disability (supported by the Provincial Human Rights Committee).

6.5.2.6 Ensures that a Complaints Procedure is in place.

6.5.2.7 Ensures that an independent advocate is available to individuals, should they require it.

6.5.2.8 Ensures legal representation is available to any individual, should they require it.

6.6 The Positive Behaviour Support Committee (PBSC):

6.6.1 Oversees and supports the full implementation and compliance of this policy document in Saint John of God Community Services Limited.

Administration:

6.6.1.1 Promotes and implements Saint John of God Community Services Policy and Guidelines as outlined in this document in line with local needs.

6.6.1.2 Develops and submits relevant reports against a 1-3 year strategic implementation plan (based on this policy), on a quarterly basis to the Director of the Service.

Implementation:

6.6.1.3 Advises and supports front line managers and staff regarding the effective application of these guidelines;

6.5.1.4 Advises on a staff-training plan to support persons with behaviours that challenge and liaise in this regard with Human Resource Department.

6.6.1.5 Ensures the design, implementation and maintenance of Multi-Element Behaviour Support plans have the required clinical support and supervision.

6.6.1.6 Audits data on behaviours that challenge, waiting lists for MEBS, numbers of people in receipt of MEBS and those for whom restrictive reactive strategies are in place. The PBSC will then provide trend analysis on the data collated in the service on behaviours that challenge;

6.6.1.7 Supports staff implement and monitor existing MEBS plans by enabling the provision of a forum for a quarterly review of the MEBS plan. This forum should be facilitated by a qualified professional in MEBS for example, a psychologist, behaviour specialist, clinical nurse specialist in behaviour. The data collected by this forum is then summarised and presented back to PBSC.

6.6.1.8 Supports staff to conduct additional comprehensive behaviour assessments with the support of a mentor (someone trained in MEBS) and clinical input from a qualified professional.

6.6.1.9 Enables discussion and review on the policy implementation with focus groups, to include individuals with intellectual disability, family members and staff.

6.6.1.10 Works collaboratively with Saint John of God Community Services Human Rights Committee, the Local Rights Review Committees and the local quality steering committees by providing data on Restrictive Reactive Strategies.

6.6.1.11 Regularly reviews and agrees a list of all non-aversive and non-restrictive interventions that can be used and a list of all aversive and restrictive interventions that cannot be used.

7. Procedure

7.1 Training and Education

Training courses should be provided by individuals with experience and post-graduate education in Multi-Element Behaviour Support**.**

7.1.1 Staff members are trained to recognise if a difficult behaviour may require additional support and intervention and how to record that behaviour.

7.1.2 **Mandatory training:** The following training is mandatory for all staff working with individuals with intellectual disability and behaviours that challenge:

7.1.2.1 One-day introductory course to Multi-Element Behaviour Support.

7.1.2.2 Physical management techniques, NVCI or other recognised and approved crisis management training, including up-date trainings.

7.1.2.3 'Implementing and Monitoring a Multi-Element Behaviour Support Plan' (9 hour course).

7.1.3. **Desirable Training:** The following training is desirable:

7.1.3.1 Supervisor trained in implementing and monitoring Behaviour Support Services (3 hour);

7.1.3.2 Longitudinal Training Course in Multi-Element Behaviour support (9-month); priority given to staff providing support to individuals requiring MEBS.

7.1.3.3 To participate in ongoing professional development through the attendance and presentations at workshops, conferences and fora on Multi-Element Behaviour Support or related areas.

7.1.3.4 The following training courses are optional and provided as required: Skills teaching; LAMH/PECS Augmentative and Alternative Communication Systems; Assisted Technology; Sensory Integration; Medical Issues; Medication and side effects; Mental Illness and Behaviours that Challenge;

7.1.3.5 Training in any authorised physical management courses is given by accredited instructors in accordance with criteria established by the HSE and our services.

7.1.3.6 Instructors in any physical management courses have successfully completed the Longitudinal Training Course in Multi-Element Behaviour Support with Callan Institute;

7.1.3.7 Training in MEBS is provided to family members, as required.

7.2 Application of the MEBS Model in Practice

7.2.1 The Multi-Element Behaviour Support model occurs in the context of a person-centred plan.

7.2.2 Consent is sought for all interventions and supports and each individual is supported to be actively involved in all decisions related to their MEBS, where appropriate.

7.2.3 Staff members, through skills teaching support each individual to learn new skills. Learning new skills builds capacity and enables an individual to participate and be empowered to make decisions in their own life.

7.2.4 Multi-Element Behaviour Support is provided by a skilled facilitator or practitioner (a person who has successfully completed a Longitudinal Training Course in MEBS) with appropriate supervision and input provided by an assigned clinician.

7.2.5 Each service has access to clinical input in MEBS from an appropriately qualified professional, such as a behaviour specialist, CNS in behaviour, Psychologist, Psychiatrist, with experience in MEBS.

7.2.6 Multi-Element Behaviour Support is based on a comprehensive behaviour assessment and a Multi-Element Behaviour Support Plan. This plan has proactive and reactive strategies which are mainly functionally based.

7.2.7 Multi-Element Behaviour Support is always non-aversive and non-restrictive.

7.2.8 Reactive Strategies which are non-aversive, non-restrictive and respond to the function of the behaviour are used, in order to reduce the episodic severity of the incident of behaviour (see Appendix 3 for further information on MEBS Reactive Strategies).

7.2.9 Multi-Element Behaviour Support, once selected as a support is required to be implemented, monitored and reviewed on a daily, weekly and monthly basis for efficacy and outcomes.

7.2.10 In supporting individuals with behaviours that challenge it is expected that staff will respond in a positive, respectful and professional manner and:

- Seek and make appropriate use of information, advice and training.
- Ensure that each individual is free from abuse, neglect or intimidation and that each individual is treated with respect, privacy and dignity in a safe and enabling environment.
- To report any incidents of abuse, neglect or poor practice in line with the Procedures for the Investigation and Management of Alleged Incidents of Non-Accidental Injury and Abuse, Hospitaller Order of St John of God , 1999/1995 (NAI),
- To identify risk and safety procedures in accordance with the Risk Management Policy 2007.

7.2.11 If an emergency restrictive reactive strategy is used on more than one occasion a case review is required. An incident report is completed. The person is advised of his/her right to seek advice, including advice from a legal representative and the incident is notified to the appropriate supervisor. If there are more than 3 incidents requiring an emergency restrictive reactive strategy within a 6 month period a full MEBS plan is required. (See Appendix 4 for further information on Restrictive Reactive Strategies eligible for use within Saint John of God Community Services Limited and Prohibited Restrictive and Aversive Strategies).

7.2.12 All emergency restrictive reactive strategies will be notified to Social Services Inspectorate, within 3 working days. This will occur when this service is established as outlined by HIQA. (HIQA 2009).

(See Appendix 2 for further information on indicators for the Multi-Element Behaviour Support Model and Appendix 3 for further information on MEBS Reactive Strategies).

Bibliography

Dench, C. (2005) A model for training staff in Positive Behaviour Support. Learning Disability Review, Tizard, University of Kent, 10(2) 24-30.

Doody, C. (2009) Multi-Element Behaviour Support (MEBS) as a Model for the Delivery of a Human Rights Based Approach (HRBA) for Working With people with Intellectual Disability and Behaviours that Challenge. British Journal of Learning Disability 37, 293-299. Blackwell Publishing Ltd.

Gearty, C. (2005) 'Can Human Rights Survive?' Cambridge University Press.

Health Information and Quality Authority *National Quality Standards: Residential Services for People with Disabilities* (2009)

La Vigna, G. (2009). Nonlinear Applied Behaviour Analysis: Implications for Supporting People with Challenging Behaviour. International Conference Brisbane, Australia.

La Vigna, G., Willis, T., Koegel, R. (2005) Episodic Severity: An Overlooked Dependent Variable in the Application of Behaviour Analysis to Challenging Behaviour. Journal of Positive Behaviour Interventions, Vol. 7, No. 1, 47-54.

La Vigna, G. & Donnellan, A (1986); Alternatives to Punishment. Irvington Publishers, New York,.

LaVigna, G. & Willis, T. (2002) Counter-intuitive strategies for crisis management within a non-aversive framework. In *Ethical Approaches To Physical Interventions Responding To Challenging Behaviour In People With Intellectual Disabilities* (ed.D. Allen). BILD publications.

La Vigna G.& Willis Thomas J. (1996) A model of Non-Aversive Behavioural Support. Positive Practices: 1: 9-16.

La Vigna GW, Willis TA (1996a) Behavioural Assessment: An overview.. Positive Practices: 1: 9-16.

LaVigna, G. & Willis, T. (1994) The Periodic Service Review. Paul H. Brookes.

La Vigna, G & Willis Thomas J;(1989) Role of Positive Programming in Behavioural Treatment in *The Treatment of Severe Behaviour Disorders*. ed. Ennio Cipani. Monographs of the American Association on Mental Retardation, 12.

Law Reform Commission (2005) *Consultation Paper on Vulnerable Adults and the Law: Capacity*. Dublin: The Law Reform Commission

Linking Service and Safety: Strategy for Managing Work Related Aggression and Violence within the Irish Health Service, HSE 2008

Managing Aggression and Violence; HSE 2007.

O'Brien, J., Lovett, H., (1992) Finding a Way Toward Everyday Lives. The Contribution of Person Centred Planning. Harrisburg. Pennsylvania. Pennsylvania Office of Mental Retardation.

Psychological Interventions for Severely Challenging Behaviours shown by People with Learning Disabilities. Clinical practice Guidelines. The British Psychological Society. August 2004.

Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists; Challenging behaviour: A Unified Approach: Clinical and service guidelines for supporting people with learning disabilities who are at risk of receiving abusive or restrictive practices. : March 2007.

United Nations 1948 Universal Declaration of Human Rights

United Nations (2006): *Convention on the Rights of Persons with Disabilities*

Willis, T., LaVigna, G. (2004) Emergency Management and Reactive Strategies within a Nonaversive Framework. Institute of Applied Behaviour Analysis.

Appendix 1
Sample list of interventions that make up a reactive strategy in a MEBS plan

The following reactive strategies can be used when responding to behaviours that challenge within a MEBS model; These interventions are non-aversive and non-restrictive.

1. Strategic Capitulation: If you know what the person wants and what would calm the person down then provide it immediately (providing access to the reinforcer known to be maintaining the behaviour early on in behavioural escalation)

2. Redirection or diversion to a preferred activity/object.

3. Active listening (an empathetic response involving identification of the communicative intent of behaviour, verbal feedback allowing the person to further discuss any issues. Eg stimulus naming (identifying and naming the trigger, e.g. 'I can see you're tired'), positive framing and affirmation/confirmation of the person**)**

4. Facilitative Strategy (prompts to use coping skills, relaxation skills, communication skills, move to calm place) [NB. NOT forced to]

5. Stimulus change (introduction of a completely different trigger, e.g. person, place, object, activity, humour)

6. Diversion to compelling activity (diversion to an activity that the user is typically compelled to do or wants to do)

7. Proxemics (i.e. awareness/modification of personal space intrusions)

8. A change in non-verbal, body language, tone of voice, personal style, and verbal behaviour protocol, in response to early indicators of behaviour escalation.

9. Ignore (respond to person as if the behaviour has not occurred. Note: This is not extinction and should not be included if the behaviour functions in order to elicit attention). May ignore the physical (topographical) behaviour not the function of the behaviour

10. Remove un-necessary demands or requests.

11. Self-protective, for example, blocking a strike.

12. Inter-positioning: placing an object between the physical act of aggression, for example a table, a cushion, and another person.

13. Use of Physical Prompts or Positive Touch:

At times it may be necessary to use a gentle touch on the arms, hands, shoulders or upper body (back) of an individual. This touch is used to calm an individual, to get an individual's attention and is always done gently and if at any time the individual's behaviour escalates as a result of this touch, it should be discontinued immediately.

The use of physical prompts or positive touch is used with the following guidelines:

a. The person gives permission to be touched on the arm, hand shoulder or upper body (back). The individual shows no resistance and no pressure is used.

b. The touch is used to calm the person down and to address the function of the behaviours that challenge.

c. The touch is used to enable access to a 'right', so serves the purpose of honouring a right, be it accessibility, participation for example.

d. If touch is used to assist a person who is resisting this may be a form of physical restraint and as such requires authorisation by an appropriate professional and written consent from the individual or their advocate. This intervention must be consistent with the policy guidelines on physical restraint.

Each of these strategies can be used as a reactive strategy to any behaviour that challenges. They are non-restrictive, and for most people are non-aversive. Should any of these strategies escalate behaviour that challenges, this would mean they are aversive for the person and should be discontinued immediately.

For these strategies to be most effective they should be used as the result of a comprehensive behaviour assessment and as part of a Multi-Element Behaviour Support Plan. If these are used on an ongoing basis a comprehensive behaviour assessment and a Multi-Element Behaviour Support plan is required. Reactive Strategies within the MEBS model can be functionally based and non-functionally based, but are always, non-restrictive and non-aversive. Functionally Based means that the reactive strategy is based on the function of the behaviour, so if an individual hits another individual and the function is 'to leave the room' then the reactive strategy is to support the person to leave the room. Non-functionally based, this can be when an individual hits another individual to 'leave the room', and the individual is affirmed and the message is acknowledged by saying 'I know you want to leave the room, however, (redirection is used, a non functionally based intervention, while the staff member waits for a colleague to return) can you help me with this first until 'staff member' comes back and I can leave the room with you'.

Appendix 2

Multi-Element Behavioural Support: The MEBS Model is based on evidence that behaviours change for the better when people are supported to live in a manner that better suits their own individual needs.

Indicators:

1. Each Individual (with behaviours that challenge)* has a Multi-Element Behaviour Support Plan.

2. Each Individual* has person-centred planning, through the Personal Outcomes Measures.

3. Each Individual* participates in all aspects of their Multi-Element Behaviour Support plan, which includes, informed consent, the assessment process, the design of the Multi-Element Behaviour Support plan, the implementation and monitoring of this plan. The individual should also be offered the opportunity to participate in any meeting that is required to review and discuss their Behaviour Support Services.

4. Each Individual's* Multi-Element Behaviour Support plan is implemented on a weekly basis as evidenced by on going evaluation using the Periodic Service Review.

5. Each Individual's* Multi-Element Behaviour Support plan is reviewed, formally, on a quarterly basis as evidenced by a quarterly report.

6. Each Individual* has information available in an accessible format, about all the Behaviour Support Services relevant to their individual needs that are used in St John of God Community Services, for example, Multi-Element Behaviour Support, physical restraint, mechanical restraint, seclusion and pharmacological restraint.

7. Each Individual* is informed that restrictive reactive strategies for behaviours that challenge may be used in an emergency or as a planned strategy to protect or keep an individual(s) safe. These restrictive reactive strategies are governed by strict conditions outlined in the respective policies

8. Each Individual* is supported to complain about any aspect of their Behaviour Support Services, if required.

9. Each Individual* has additional resources requested on their behalf, with evidence to support the request.

10. Each Individual* can withdraw their consent to any aspect of Behaviour Services at any time.

11. All interventions are socially valid and consented to by the individual.

12. Where any individual's rights are restricted for behavioural reasons it is noted and there is a plan in place to reinstate those rights in a specified time frame in accordance with our services human rights guidelines.

13. Each person involved in providing support to an individual with behaviours that challenge attends the appropriate training in Multi-Element Behaviour Support (MEBS).

14. Each staff member involved in providing support to an individual with behaviours that challenge is trained in emergency management strategies such as Non-Violent Crisis Intervention (NVCI) or other approved models.

15. Each Individual* including the people that support them/live with them, are supported to have a private space to talk about and reflect on a behavioural incident that they may have been involved in and/or witnesses. This can be in a formal way, through accessing psycho-therapeutic services or an informal way by talking /meeting with a staff member.

16. Each Individual* and the people who live and work with them have a safe environment and are free from any type of abuse, intimidation, threat or assault.

Appendix 3
MEBS Reactive Strategies

Reactive strategies in a Multi-Element Behaviour Support Plan must always reflect:

1. The use of non-aversive, non-restrictive strategies to respond to behaviours that challenge.

2. The reduction of the episodic severity of each incident of behaviour that challenges by responding t the function of the behaviour.

3. Functionally based and non-functionally based strategies that are always non-restrictive and non-aversive.

4. Their use in the context of a functionally equivalent skill.

5. On occasion an intervention which is considered non-aversive and non-restrictive may escalate a behaviour. If this it occurs, the intervention should be discontinued immediately.

6. Strategic Capitulation: This intervention forms the basis of a MEBS reactive strategy and it identifies that 'if you know what the individual wants and what would calm the individual down then provide immediately' (providing access to the reinforcer known to be maintaining the behaviour early on in behavioural escalation can reduce the episodic severity of the incident).

7. In the absence of a MEBS plan it is ethical and consistent within a Human Rights Based Approach to respond functionally and use non-aversive approaches to de-escalate the behaviour that challenges

(Please see Appendix 1 for a sample list of interventions that make up a reactive strategy in a MEBS plan.)

Appendix 4

1. Restrictive Reactive Strategies eligible for use within Saint John of God Community Services

There may be occasions when restrictive interventions may be deemed necessary and are then authorised in accordance with the following policies to manage behaviours that challenge:

1.1 Physical and Mechanical Restraint
1.2 Seclusion
1.3 The use of Medication for behavioural purposes
1.4

The key principle underlying the use of authorised restrictive reactive interventions is that they shall only be used as a last resort. In line with best practice, the least restrictive strategy should always be used to manage behaviour.

The health, safety, welfare and rights of individuals (service-users and staff) should always be considered paramount and the use of restrictive reactive strategies should only be used if an individual poses a significant threat of serious harm to self or others and there is evidence that all other means of managing the behaviour have been considered and deemed ineffective.

2. Prohibited Restrictive and Aversive Strategies

The following strategies are only permitted with the appropriate authority in certain limited and strictly monitored cases as treatment strategies (teaching strategies) in Saint John of God Community Services Limited:

1. Any type of punishment strategies:

- Positive punishment: application of an intervention the person finds unpleasant;
- Negative punishment: something the person finds rewarding is taken away;

Should any of these interventions be necessary for safety reasons, the intervention requires authorisation. This authorisation requires:

1.1 Evidence to support the intervention;

1.2 A risk assessment

1.3 Informed consent

1.4 Formal notification to the Human Rights Committee as a Human Right may be restricted as a result of the intervention.

1.5 If rights are restricted by any intervention(s), a plan will need to be developed to reinstate the restricted right within a given timeframe.

Appendix 5

Sample Addendum to Policies 8a, 8b, 8c

(Name of service) subscribes to the St John of God Community Services Policy on the Management of Behaviour that Challenges but adds the following statement that will apply to …… Service

(Name of Service) prohibits the use of Seclusion (the placing or leaving of a person in any place alone, at any time, with the exit locked or barred in such a way as to prevent the person leaving) and prone restraint (holding a person in a face down position).

If your service does not intend to activate the use of this policy the relevant pages should be removed & the addendum at Appendix 5 (page 22) inserted and disseminated accordingly.

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Revision Number	Second Version	Document Approved by	Board of SJOGCS
Approval Date	October 2009	Responsibility for implementation	Directors of Services All employees Saint John of God Community Services Limited (Intellectual disability services only) Positive Behaviour Support Committees
Revision Date:	October 2011	Responsibility for evaluation and audit	Positive Behaviour Support Committees
		Number of Pages:	52 inc appendices

1. Policy Statement

Saint John of God Community Services Limited is committed to the provision of Multi-Element Behaviour Support for individuals with intellectual disability and behaviours that challenge. It is committed to respond to behaviours that challenge using non-aversive and non-restrictive strategies. It is the policy of Saint John of God Community Services Limited to use Physical Restraint or Mechanical Restraint for behavioural purposes as an intervention of last resort.

In line with best practice, the least restrictive strategy should always be used to manage behaviour. The health, safety, welfare and rights of individuals (service-users and staff) should always be considered paramount. The use of restraint should only be used if an individual poses a significant threat of serious harm to self or others and there is evidence that all other means of managing the behaviour have been considered and deemed ineffective.

1.1. Physical or Mechanical Restraints are not used

There are certain circumstances in which Physical or Mechanical Restraint for behavioural purposes are never used:

1.1.1 To demonstrate authority, enforce compliance, inflict pain, harm, to punish or discipline an individual;

1.1.2 Solely to ameliorate operational difficulties or to maintain a smooth running programme, including where there are staff shortages;

1.1.3 With an individual with a known psycho-social/medical condition, in which restraint would be contraindicated;

1.1.4 Where the functional assessment of the behaviour indicates that restraint would be contraindicated;

1.1.5 Where the risk of harm from the restraint becomes greater than the risk posed by the acute episode of physical aggression;

1.1.6 In the case of a physical restraint, where it involves the individual in the 'prone', face down position. This should be avoided. In extreme circumstances it may be conducted within the local guidelines of the accredited crisis management system;

1.1.7 With people who are tactile defensive;

1.1.8 Where it is deemed unsafe to do so.

2. Purpose

The purpose of this policy is to ensure a collaborative and consistent approach in supporting individuals with behaviours that challenge within Saint John of God Community Services Limited. In particular, it aims to provide guidance to all staff members who may require to support an individual using restrictive practices.

It seeks to ensure a proper balance between an individual's needs and the needs of others responsible for supporting them.

3. Scope

This policy is for all staff working in services for children and adults with intellectual disabilities in Saint John of God Community Services Limited.

4. Legislation and other related policies

These policy statements and the subsequent procedures and practices outlined in this document are informed by:

4.1 Quality Measures. CQL 2005;

4.2 Health Information and Quality Authority *National Quality Standards: Residential Services for People with Disabilities* (2009);

4.3 Data Protection Act 1999;

4.4 Linking Service and Safety: Strategy for Managing Work Related Aggression and Violence within the Irish Health Service 2009;;

4.5 Procedures for the Investigation and Management of Alleged Incidents of Non-Accidental Injury and Abuse, Hospitaller Order of St John of God , 1999/1995 (NAI);

4.6 Risk Management Policy 2007;

4.7 Complaints Policy 2008: St John of God *Hospitaller* Services;

4.8 The Universal Declaration Human Rights (1948);

4.9 Values in Practice, John of God *Hospitaller* Services 2009.

5. Definitions

5.1 Physical Restraint

Physical restraint is the use of physical intervention (by one or more persons) for the purpose of preventing the free movement of a individual's body.

5.2 Emergency use of Physical Restraint

Emergency use of Physical Restraint is the use of physical restraint which has not been approved in advance and is not part of the agreed individual restrictive reactive plan. A response is not considered to be an emergency if it is required to be used on more than 3 times in a six month period [American Association on Mental Retardation].

5.3 **Mechanical Restraint**

Mechanical restraint is the use of devices or garments for the purpose of preventing or limiting the free movement of an individual's body. Devices used should in general be devices manufactured for such purposes and approved by the relevant personnel. Any means of mechanical restraint used in an emergency situation must not compromise the safety of the individual being restrained.

5.4 Postural Support Appliance/Equipment as a means of mechanical restraint

Any postural support appliance/equipment that is not being used for the purposes for which it was supplied or manufactured and which is used to manage behaviour comes within the remit of this Policy. There must be evidence that the use of such equipment for this purpose has been subject to due consideration and its use outlined. The circumstances where it can be used for this purpose must be delineated in the service-user's restrictive reactive strategy*.

5.5 Emergency Use of Mechanical Restraint

Emergency use of mechanical restraint is the use of mechanical restraint which has not been approved in advance and is not part of the agreed individual restrictive reactive plan. A response is not considered to be an emergency if it is required to be used on more than 3 times in a six month period [American Association on Mental Retardation].

5.5 Multi-Disciplinary Team (MDT)

For the purpose of prescribing physical or mechanical restraint for behavioural purposes the MDT must include the discipline of Psychiatry/ Psychology.

To classify Postural Support appliances/equipment as 'mechanical restraint' is inaccurate as it suggests that this is the primary purpose of this equipment. In this context Postural Support equipment does not come within the scope of this policy. Such appliances/equipment can only be referred to as 'Mechanical Restraint', if used for a purpose other than that for which they were supplied or manufactured. Guidelines outlining best practice in terms of supply, use and maintenance of postural supports, including equipment donated to the Services, should be available locally as a means of minimising

6. Roles and Responsibilities

6.1 **All staff ensure:**

6.1.1 That appropriate documentation is maintained in accordance with procedure (see section 7).

6.1.2 The restrictive reactive strategy is carried out as authorised.

6.1.3 Their certification in the use of physical interventions is current if they are required to participate in an authorised restraint.

6.1.4 That they communicate effectively with families/other staff members and individuals as set out in the procedure.

6.2 **Multi-Disciplinary Team or Clinical personnel ensure:**

6.2.1 Appropriate clinical personnel together with the team directly responsible for the care of the individual authorise the restraint in writing.

6.2.2 There is evidence that the consent process has been adhered to.

6.2.3 That no single opinion or report alone influences decision on authorisation of the restraint.

6.2.4 That local processes include a documented record of the full team's views which is brought to the attention of the prescribing members of the MDT.

6.2.5 Authorisation is documented in the individual's agreed Restrictive Reactive strategy. This authorisation shall remain in force for a maximum of three months and must be renewed thereafter.

6.2.6 The strategy details the restriction to be implemented, the circumstances, the duration and any specific precautions.

6.2.7 Authorisation of the restraint is only agreed where a current physical/medical report or functional assessment does not contraindicate use of the restraint. The MDT determines if a medical report is required.

6.2.8 Authorised restraints must be reviewed on a 3-monthly basis or within 72 hours in the case of an emergency restraint.

6.2.9 The restraint employed is proportionate to the risk posed and in accordance with the individual's agreed restrictive reactive plan and risk assessment findings.

6.2.10 The strategy includes a description of the circumstances under which restraint may be applied, and a description of the restraint authorised. This authorisation must also detail the means by which the individual will be monitored during the episode.

6.2.11 That any device used for mechanical restraint is regularly checked to ensure it is intact, clean and is safe for the individual for whom it is intended.

6.2.12 The decision to initiate the use of physical restraint is taken in accordance with the agreed restrictive reactive plan by the designated staff member on duty. One staff

member must be identified as the designated staff member, taking responsibility for implementation of the restraint.

6.2.13 A referral is made to the Rights Review Committee outlining the process undertaken in regard to the authorisation of the restraint.

6.3 **Positive Behaviour Support Committee ensures** that all restrictive practices are appropriately authorised and reviewed with a plan in place to remove or reduce the restriction in accordance with agreed timelines.

6.4 **Rights Review Committee ensures** due process has been followed in imposing a rights restriction on an individual.

7. Procedure

7.1 Use of Physical Restraint or Mechanical Restraint

7.1.1 Restraint must only be used when an individual poses a significant threat of harm to self or others and it is considered the safest intervention at that time. Where the use of restraint is foreseeable a risk assessment must be undertaken. The potential hazards associated with each physical intervention must be identified and the level of risk associated with each intervention determined for the specific service-user on which it is being applied. This must be documented.

7.1.2 All alternative interventions to manage the individual's unsafe behaviour must have been considered and the process recorded in the relevant documentation.

7.1.3 Except in the case of extreme emergency the use of restraint should be discussed with the individual and their family and/or their advocate as part of the development of their individual plan, and recorded. There is evidence that the consent process has been adhered to.

7.1.4 In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the individual's record.

7.1.5 The duration of the period of restraint must be the minimum necessary to protect the individual being restrained, or others, from immediate and serious harm, in accordance with the individual's agreed restrictive reactive strategy.

7.1.6 Special consideration should be given when restraining individuals who are known by the staff involved in applying the restraint, to have experienced physical or sexual abuse.

7.1.7 The individual must be monitored as per their individual restrictive reactive plan throughout the use of restraint to ensure his or her safety, dignity, health and wellbeing.

7.1.8 The relevant documentation/protocols, as appropriate to the use of restraint are completed.

7.1.9 Where a restraint is being used to manage behaviour consideration must be given to the possibility of the individual becoming restraint dependent. Attention should be given to minimising its use to ensure the individual does not become restraint dependent.

7.2 The Implementation of physical restraint involving physically holding or moving an individual who is resisting

7.2.1 The use of physical restraint may only be initiated by the designated staff member, who takes the lead throughout the procedure.

7.2.2 Only staff members who are certified in approved accredited crisis management systems may conduct physical restraint.

7.2.3 The individual should be informed of the reasons for and likely duration of physical restraint, unless the provision of such information might be prejudicial to the individual's mental health, well-being or emotional condition, as outlined in the individual's agreed Restrictive Reactive Plan. In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the individual's record.

7.2.4 The individual must be continuously monitored throughout the use of restraint by the designated staff member, to ensure his/her dignity, safety, health and wellbeing.

7.2.5 Following each episode of physical restraint the team is allocated time for analysis of the incident. This analysis/review must include an appraisal of the effectiveness of the protective/preventative measures employed to manage the risks associated with the restraint.

7.3 Recording

7.3.1 The use of restraint is recorded in accordance with the individual's restrictive reactive plan or individualised restraint protocol.

7.3.2 **Physical Restraint:** Each episode of physical restraint should be clearly documented. This record should include, but is not limited to the following:

- The reasons for its use;
- Date and duration of its use;
- Alternatives which were implemented and unsuccessful and the reasons why or considered and deemed ineffective and the reasons why;

- If the behaviour resulting in physical restraint was the same behaviour as that addressed in the Multi-element Behaviour Support Plan;

- Members of the team involved directly in management of the physical restraint episode;

- A record is made at 15 minute intervals of the individual's level of distress, their physical status, mental status and presenting behaviour. The record is signed by two staff members including the designated staff member.

7.3.3 Communication with an individual's next of kin or advocate in relation to the use of physical restraint is dictated by the individual's agreed restrictive reactive strategy.

7.3.4 A contemporaneous account of the use of physical restraint must be placed in the individual's record on each occasion, to include a description of the type of physical restraint used, the reasons for its use and the duration of its usage.

7.3.5 **Mechanical Restraint:** Where any mechanical restraint is implemented, a record of its usage must be made at least every 15 minutes for the initial 48 hours. This record should detail the individual's level of distress, their physical status, mental status and presenting behaviour during the preceding 15 minute period.

7.3.6 If the mechanical restraint is continued beyond 48 hours the frequency of recording may be reduced and will be dictated by the individual's needs and responses.

7.3.7 The frequency of observation may be decreased in accordance with the individual's response, needs and clinical assessment as recorded in the individual's restrictive reactive plan.

7.4 Reviewing the Use of Physical Restraint or Mechanical Restraint

7.4.1 The use of approved mechanical restraint should be reviewed by the MDT involved in the care and treatment of the individual within a week or earlier if any concerns arise. Thereafter review should occur at least every 3 months or earlier if required. Where this review does not occur within this timeframe, the reasons must be documented in the individual's record.

7.4.2 The review considers all the evidence for continuing or discontinuing the restraint and other important factors, including the reasons why interventions were deemed unsuccessful or ineffective. The review should also consider plans to reduce or eliminate the use of the mechanical restraint for the individual. The outcome of this review and a plan for future review should be recorded in the individual's record.

7.4.3 The individual should be involved in the review process unless they do not have the capacity to do so (at this time), or their involvement is prejudicial to their mental health, well-being or emotional condition. In such cases a family

member/parent/advocate acting on behalf of the individual should be involved in the review process.

7.4.4 If the individual or their advocate objects to application of the restraint, the plan is reviewed in light of this objection by the MDT/Rights Review Committee. Following this review, if it is determined that the plan is in the best interests of the individual, it is only introduced if a neutral and appropriately qualified second opinion supports this view.

7.4.5 Where the individual or their advocate objects to the restrictive procedure they are advised of the role of the Rights Review Committee and that they can seek legal representation as per HIQA Standards, 2009.

7.5 Emergency Use of Restraint

7.5.1 In the event of an emergency situation arising staff should take all reasonable and proportionate steps to maintain the safety of the individual and those in the environment.

7.5.2 Assistance is summoned as soon as practicably possible.

7.5.3 Appropriate and proportionate crisis management strategies are implemented.

7.5.4 In an emergency situation where the use of restraint has not been previously authorised, and where an individual poses a risk of significant harm to self or others and all alternative interventions to manage the individual's unsafe behaviour have been given due consideration and deemed ineffective/unsafe, restraint may be initiated by designated staff/team leader Each service must have guidelines as to the competencies required by such staff and must have a nominated person with these competencies rostered at all times**.**

7.5.5 The emergency use of restraint should be reviewed by the MDT involved in the care and treatment of the individual within 72 hours of the episode. Where this review does not occur within this timeframe, the reasons must be documented in the individual's record.

7.5.6 In the case of use of emergency restraint being used more than 3 times in a six month period (see 7.4). This review should lead to a planned restrictive reactive strategy and a full multi-element behaviour support plan put in place.

Bibliography

Department of Health (2002), *Guide for Restrictive Physical Interventions. How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder*. London.

Department of Health and Children (2006), *A Vision for Change, Report of the Expert Group on Mental Health Policy,* Dublin, Stationery Office.

Gournay, K et al (2003), *The Recognition, Prevention And Therapeutic Management Of Violence In Mental Health Care. A Consultation Document*.

Government of Ireland (2001) *Mental Health Act* Dublin, Stationery Office

Health Information and Quality Authority (HIQA), 2009, National Quality Standards for Residential Services for People with Disabilities

Irish Nurses Organisation (2003), *Guidelines on the use of Restraint in the Care of the Older Person.*

McKenna, K. (2004), *Study of Work-Related Violence*. North Eastern Health Board Committee on Workplace Violence.

Mental Health Commission (2006) Approved Centres Regulations

Mental Health Commission *(2006)* Code of Practice on the Use of Physical Restraint in Approved Centres

Mental Health Commission *Reference Guide Mental Health Act 2001 Part One – Adults*

N.I.C.E 2005, *Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments*

NAMHI, Policy Research Institute 2003, *Seclusion and Restraint, Task Force Report.* (USA)

National Institute for Mental Health in England, NIMHE (2004), *Mental Health Policy Implementation Guide*. London. NHS

Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) Principle 11).

Saint John of God Community Services Limited
Policy on the Use of Medication for Behavioural Purposes

If your service does not intend to activate the use of this policy the relevant pages should be removed & the addendum at Appendix 5 (page 22) inserted and disseminated accordingly.

Document Reference Number:	SJOGCS 08b	Document drafted by	Behaviours that Challenge Policy Group
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		Number of Pages:	52 inc appendices

1. Policy Statement

Saint John of God Community Services Limited is committed to the provision of Multi-Element Behaviour Support for individuals with intellectual disability and behaviours that challenge. It is committed to respond to behaviours that challenge using non-aversive and non-restrictive strategies.

It is the policy of Saint John of God Community Services Limited that Psychotropic Medication for Behavioural Purposes shall only be used in combination with other non-pharmacological interventions. In line with best practice, the lowest effective dose of medication should always be used to manage behaviour. The health, safety, welfare and rights of individuals (service-users and staff) should always be considered paramount and medication should only be used to control behaviour if the behaviour is due to a diagnosed underlying psychiatric condition that responds to medication or in a narrow group of situations (see below) where behavioural interventions alone have not been effective.

Research shows that people with intellectual disability are more likely to be prescribed Psychotropic Medication than those without such a disability and that such comparative overuse is difficult to justify (King, B., 2007). Research has also shown that people with intellectual disability are more vulnerable to the side-effects of such medication and that such medication is of questionable use in treating behaviours that challenge in the absence of mental illness (Baumeister et al, 1998). Thus Psychotropic Medication should only be prescribed for people with intellectual disabilities in certain situations.

2. Purpose

The purpose of this policy is to ensure that Psychotropic Medication is only prescribed for people with intellectual disabilities after a full psychiatric assessment and with a targeted mental illness as the rationale for prescribing it.

Exceptions to this include:

2.1 The use of anxiolytic/sedative medication where an active Multi-element Behaviour Support Plan is in place and where it is necessary to reduce anxiety with medication in order for the person to benefit from the plan;

2.2 The extraordinary use of anxiolytic/sedative medication to facilitate an individual availing of an opportunity that anxiety would prevent them from availing of (e.g. hospital visit);

2.3 In the case of a person without mental illness who manifests regular behaviours that challenge of an aggressive nature and the medication has been demonstrated to reduce the frequency and/or intensity of the behaviour;

and

2.4 in the case of a person who displays intermittent serious behaviours that challenge where the use of P.R.N. Psychotropic Medication has been shown to help in the safe management of such behaviours that challenge;

2.2), 2.3) and 2.4) should be considered as forms of restraint.

3. Scope of Policy

This policy is for all staff working in services for children and adults with intellectual disabilities in Saint John of God Community Services Limited.

4. Legislation and other related policies

These policy statements and the subsequent procedures and practices outlined in this document are informed by:

4.1 Quality Measures. CQL 2005;

4.2 Health Information and Quality Authority *National Quality Standards: Residential Services for People with Disabilities* (2009);

4.3 Data Protection Act 1999;

4.4 Linking Service and Safety: Strategy for Managing Work Related Aggression and Violence within the Irish Health Service 2009;

4.5 Procedures for the Investigation and Management of Alleged Incidents of Non-Accidental Injury and Abuse, Hospitaller Order of St John of God , 1999/1995 (NAI);

4.6 Risk Management Policy 2007;

4.7 Complaints Policy 2008: St John of God *Hospitaller* Services;

4.8 The Universal Declaration Human Rights (1948);

4.9 Values in Practice, John of God *Hospitaller* Services 2009;

4.10 Irish Medicines Board (Miscellaneous Provision) Act 2006 (No. 3 of 2006) (Section 10 (ii);

4.11 Irish Medicines Board (Miscellaneous Provisions) Act 2006 (Commencement) Order 2007;

4.12 Medicinal Products (Prescription and Control of Supply) (Amendment) Regulations 2007, Statutory Instrument No 201 of 2007;

4.13 Misuse of Drugs (Amendment) Regulations 2007, Statutory Instrument No. 200 of 2007;

4.14 Nurses Rules (An Bord Altranais 2007);

4.15 To give effect to nurse prescribing for the Drugs Payment Scheme (DPS) the following was signed into law on 25th February, 2009 Irish Medicines Board (Miscellaneous Provisions) Act 2006 (Commencement) Order Statutory Instrument No 67 of 2009.

5. Definitions

5.1 Psychotropic Medication

Psychotropic Medication is any medication capable of affecting the mind, emotions, and behaviour.

5.2 Psychotropic Medication for Behavioural Purposes

This is the use of Psychotropic Medication for the purpose of curtailing the behaviour of an individual. Medication used for this purpose can either be prescribed for regular use or for use in certain specific circumstances (PRN use) or prescribed in an unexpected emergency where the staff involved believes its use is the only way to alleviate a dangerous situation. Medication treatments for medical or psychiatric conditions which underlie the disturbance are not included.

5.3 Anxiolitic Medication/Sedative

Medications that are sedative are those medications having a soothing, calming, or tranquilizing effect and can be classified as minor or major tranquilizers. Minor tranquillizers, also called anxiolytic medications, are medications, such as diazepam or lorazepam, that in approved doses are usually mildly sedative and are used for relief of anxiety or to promote sleep. Their effect depends on the dose in which they are given as all minor tranquillizers in sufficient doses will cause sleep. Major tranquillizers are those medications designed to treat major psychiatric illnesses such as schizophrenia and the agitation that accompanies them. Major tranquilisers are also used to decrease activity, diminish irritability, and reduce excitement in aggressive people in to decrease risk. This group of medications includes drugs such as Chlorpromazine and Olanzapine. Minor and major tranquillisers are used in the management of challenging behaviour both in cases where it is secondary to mental illness and when no mental illness can be diagnosed.

5.4 Multi-Disciplinary Team (MDT)

For the purpose of prescribing Psychotropic Medication for behaviours that challenge the MDT must include the discipline of Psychiatry.

5.5 P.R.N. Medication

P.R.N. / :(Abbreviation meaning "when necessary", from the Latin "pro re nata", for an occasion that has arisen, as circumstances require, as needed). This abbreviation is used in prescriptions and/or medication cardex when the medication is used only in certain circumstances particular to the patient in question. For the purposes of this document the circumstances are in response to behaviours that challenge and/or circumstances that are known to precipitate such behaviours where medication has been shown to be effective.

5.6 Emergency use of Psychotropic Medication as Restraint

The use of Psychotropic medication as restraint prescribed on a once-off basis in an emergency situation that has not been anticipated by a restrictive reactive strategy or medication prescription on a once off basis.

6. Roles and Responsibilities

6.1 All staff ensure:

6.1.1 That appropriate documentation is maintained in accordance with procedure (see section 7).

6.1.2 The prescribed medication is administered as authorised.

6.1.3 That they communicate effectively with families/other staff members and individuals as set out in the procedure.

6.2 Multi-Disciplinary Team or Clinical personnel ensure prescribed medications are reviewed in the context of a multi-element behavioural support plan

6.3 The Rights Review Committee ensures that due process has been followed in imposing a rights restriction on an individual.

7. Procedure

7.1 Use of Psychotropic Medication for Behavioural Purposes

7.1.1 **Psychotropic Medication** for behavioural purposes must only be used when an individual poses a significant threat of harm to self or others and assessment has shown that no other intervention alone is helpful.

7.1.2 **Psychotropic Medication** for behavioural purposes should only be used after completion of a psychiatric and behavioural assessment to exclude treatable causes of behaviours that challenge such as mental illness.

7.1.3 **Psychotropic Medication** for behavioural purposes should only be prescribed by a Psychiatrist. In emergencies another medical practitioner may be more readily available to prescribe but the situation should be reviewed by a Psychiatrist before any long term prescription is initiated. The prescription must specify the medication to be used, the circumstances of its use, the dosage, frequency and period covered by the prescription.

7.1.4 Any person prescribed **Psychotropic Medication** for behavioural purposes must have a Multi-element Behavioural Support Plan and a Restrictive Reactive Strategy stating the reason for prescription of the **Psychotropic Medication** for behavioural purposes and guidance as to its use.

7.1.5 The individual and their family and/or their advocate should be informed and involved, where appropriate (with individual consent) for the use of Psychotropic Medication for behavioural purposes and the associated treatment plan, including the reasons for it, potential side effects and signs of success. Where the individual lacks capacity to consent, the individual's family member, as appropriate, should be involved in decisions regarding its use.

7.1.6 In the event that this communication does not occur, a record explaining why it has not occurred must be entered in the individual's record.

7.1.7 There is written evidence that the consent process has been adhered to.

7.1.8 The dosage, frequency and duration of prescription for Psychotropic Medication for behavioural purposes must be the minimum necessary to protect the individual and/or others from harm in accordance with the individual's agreed Restrictive Reactive strategy.

7.1.9 The use of Psychotropic Medication for behavioural purposes should be approved by the Multi-Disciplinary Team (MDT) together with the team directly responsible for the care of the individual.

7.1.10 In all MDT deliberations on the use of Psychotropic Medication for behavioural purposes, processes (to include documentary evidence) must be in place to ensure that no single opinion or report alone influences the decision on the prescription.

7.1.11 Local processes must be in place to ensure that a documented record of the full team's views are brought to the attention of the prescribing medical practitioner.

7.1.12 Approval must only be provided where a current physical/medical report or functional assessment does not contraindicate the use of Psychotropic Medication for behavioural purposes.

7.1.13 A referral is made to the Rights Review Committee outlining the process undertaken in regard to authorisation of the use of Psychotropic Medication **(including P.R.N.)** for behavioural purposes.

7.2 Reviewing the Use of Psychotropic Medication for Behavioural Purposes

7.2.1 Frequent medical monitoring of the dosage and assessment of its continuing need should be carried out as long as the medication is prescribed.

7.2.2 The prescription must be reviewed by a Psychiatrist in consultation with the appropriate staff at least every three months and this review must monitor effectiveness and occurrences of side effects and must include an examination of the individual for any negative consequences of the medication used. This review must be recorded in the individual's clinical notes.

7.2.3 Both the above reviews must consider any episode requiring use of Psychotropic Medication for behavioural purposes having regard to the individual's care and personal plan, the trend in relation to how often Psychotropic Medication for behavioural purposes has been dispensed and other influencing factors. The findings of the review should include an assessment of the effectiveness of the Psychotropic Medication for behavioural purposes and the reasons why Psychotropic Medication for behavioural purposes should or should not be continued and describe plans to decrease/cease its use for the individual. The findings of this review should be recorded in the individual's record.

7.2.4 The individual should be involved in the review unless they do not have the capacity to do so, or their involvement might be prejudicial to their mental health, well-being or emotional condition. In which case a family member/parent/other carer/advocate acting on behalf of the individual should be involved in the review process.

7.2.5 If the individual or their advocate objects to Psychotropic Medication for behavioural purposes, the plan is reviewed in light of this objection by the MDT/Rights Review Committee. Following this review, if it is determined that the plan is in the best interests of the individual, it is only introduced if a neutral and appropriately qualified second opinion supports this view (i.e. external Psychiatrist). Where the individual or their advocate objects to the restrictive procedure they are also advised of the role of the Rights Review Committee and that they can seek legal representation as per HIQA Standards, 2009.

7.3 The use of P.R.N. Psychotropic Medication for Behavioural Purposes

7.3.1 The decision to use P.R.N. Psychotropic Medication for behavioural purposes is taken in accordance with the agreed individual Restrictive Reactive Plan and supervised by the Psychiatrist.

7.3.2 The prescription must be reviewed by a Psychiatrist at least every three months and this review must monitor effectiveness and occurrences of side effects and must include an examination of the individual for any negative consequences of the medication used.

7.3.3 Where Psychotropic Medication for behavioural purposes is being given as P.R.N. and being used daily, or more often, the person should be reviewed by a Psychiatrist and consideration given to the prescription of regular medication rather than emergency/PRN Psychotropic Medication.

7.3.4 P.R.N. Psychotropic Medication for behavioural purposes should only be given if it is written up on the appropriate form (usually known as a drug cardex) and signed by a Psychiatrist or a medical practitioner on the direction of a Psychiatrist.

7.3.5 Each time P.R.N. Psychotropic Medication is used for behavioural purposes it should be clearly documented and a copy placed in the individual's record. This documentation should include, but is not limited to the following:

- Medication and dosage;
- The reasons for its use;
- Date and time of its use;
- Alternatives which were implemented and unsuccessful or considered and deemed ineffective;
- If the behaviour resulting in the prescription of Psychotropic Medication is the same behaviour as that addressed in the Multi-element Behaviour Support Plan;
- The individual's level of distress, their physical status, mental status and presenting behaviour is recorded at the time of dispensing the PR.N. Psychotropic Medication and at 15 minute intervals for at least an hour afterwards. It may not be possible to safely ascertain the person's physical status if they are agitated and if so this fact should be recorded and the appropriate physical examination (e.g. blood pressure & pulse monitoring) should be done as soon as it is safe to do so.

7.3.6 The use of P.R.N. Psychotropic Medication for behavioural purposes is reported in accordance with local policy.

7.3.7 Communication with an individual's next of kin or advocate in relation to the use of P.R.N. Psychotropic Medication for behavioural purposes is dictated by the individual's agreed restrictive reactive strategy.

7.4 Emergency use of Psychotropic Medication for Behavioural Purposes

7.4.1 In an emergency situation where the use of Psychotropic Medication for behavioural purposes has not been previously authorised, and where a individual poses a risk of significant harm to self or others and all alternative interventions to manage the individual's unsafe behaviour have been given due consideration and deemed ineffective/unsafe Psychotropic Medication may be given in an emergency by a designated staff/team leader on the direction of the Psychiatrist on call. The medication can be prescribed by phone but each service must have in place criteria for the acceptance of a phoned prescription. It is preferable that some form of written prescription be available to staff but this is not always possible (An Bord Altranais, 2007).

7.4.2 The use of Psychotropic Medication for behavioural purposes in an emergency should be reviewed by the MDT involved in the care and treatment of the individual a soon as practicable after the event.

7.4.3 If the emergency use of Psychotropic Medication for behavioural purposes is required more than three times in a seven-day period a planned response is required. This should include a full functional assessment, initiation of a MEBS plan and a full review by a Psychiatrist.

7.5 Medication for Restraint should not be used:

7.5.1 Where it is contraindicated by the individual's medical condition in accordance with the individual's risk assessment;

7.5.2 Where the possible benefits of the medication are outweighed by the risk of side effects;

7.5.3 To demonstrate authority, enforce compliance, inflict pain, harm, to punish or discipline an individual;

7.5.4 Where it is deemed unsafe to do so;

7.5.5 Where the functional assessment of the behaviour indicates that this intervention would be contraindicated;

7.5.6 Medication for restraint should not be used to ameliorate operational difficulties or to maintain a smooth running programme. For example, medication for restraint should not be used as a response to staff shortages.

Bibliography

An Bord Altranais (2007) Guidance to Nurses and Midwives on Medication Management Item 4.7.1.

Psychopharmacology in Intellectual Disabilities (2007) King, B. pps 310 - 329 in Psychiatric and Behavioural Disorders in Intellectual and Developmental Disabilities, Bouras N. and Holt G. (Eds.) Cambridge University.

Saint John of God Community Services Limited
Policy on the Use of Seclusion for Behavioural Purposes

If your service does not intend to activate the use of this policy the relevant pages should be removed & the addendum at Appendix 5 (page 22) inserted and disseminated accordingly.

Document Reference Number:	SJOGCS 08a	Document drafted by	Behaviours that Challenge Policy Group
Revision Number	Second Version	Document Approved by	Board of SJOGCS
Approval Date	October 2009	Responsibility for implementation	Directors of Services All employees Saint John of God Community Services Limited (Intellectual disability services only) Positive Behaviour Support Committees
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		Number of Pages:	52 inc appendices

1. Policy Statement

Saint John of God Community Services is committed to the provision of Multi-Element Behaviour Support for individuals with intellectual disability and behaviours that challenge. It is committed to respond to behaviours that challenge using non-aversive and non-restrictive strategies.

2. Purpose

The purpose of seclusion is that it shall only be used as a last resort. In line with best practice, the least restrictive strategy should always be used to manage behaviour. The health, safety, welfare and rights of individuals (service-users and staff) should always be considered paramount. Seclusion should only be used if a person poses an immediate threat of serious harm to self or others and there is evidence that all other means of managing the behaviour have been considered and deemed ineffective.

3. Scope of Policy

This policy is for all staff working in services for children and adults with intellectual disabilities in Saint John of God Community Services Limited.

4. Legislation/Other related policies

These policy statements and the subsequent procedures and practices outlined in this document are informed by:

4.1 Quality Measures. CQL 2005;

4.2 Health Information and Quality Authority *National Quality Standards: Residential Services for People with Disabilities* (2009);

4.3 Data Protection Act 1999;

4.4 Linking Service and Safety: Strategy for Managing Work Related Aggression and Violence within the Irish Health Service 2009;

4.5 Procedures for the Investigation and Management of Alleged Incidents of Non-Accidental Injury and Abuse, Hospitaller Order of St John of God , 1999/1995 (NAI);

4.6 Risk Management Policy 2007;

4.7 Complaints Policy 2008: St John of God *Hospitaller* Services;

4.8 The Universal Declaration Human Rights (1948);

4.9 Values in Practice, John of God *Hospitaller* Services 2009.

5. Definitions

5.1 Seclusion

Seclusion is the placing or leaving of a person in any room where the person's egress is prevented, or the person believes it to be so.

5.2 Emergency use of seclusion

Emergency use of seclusion is the use of seclusion which has not been approved in advance and is not part of the agreed individual Restrictive Reactive Pan. A response is not considered to be an emergency if it is required to be used on more than 3 times in a six month period [American Association on Mental Retardation].

5.3 Direct observation

Direct observation is the observation of the individual by a staff member is within sight and sound of the person. The observation of an individual by CCTV does not constitute "direct observation".

5.4 Indirect observation

Indirect observation is the observation of the individual which may include the use of CCTV.

5.5 Best Interest

Due regard shall be given to respect the right of the person to dignity, bodily integrity, privacy, autonomy and health and safety.

5.6 Acute physical aggression

Acute physical aggression is behaviour likely to result in physical injury to the individual, other individuals [service-users and staff] who are at imminent risk of physical harm.

5.7 Multi-Disciplinary Team

For the purpose of prescribing Seclusion for behaviours that challenge the MDT must include the discipline of Psychiatry.

5.8 Rights Review Committee

The purpose of the Rights Review Committee is to consider if due process has been followed in imposing a rights restriction on an individual.

6. Roles and Responsibilities

6.1 All staff ensure:

6.1.1 That appropriate documentation is maintained in accordance with procedure (see section 7).

6.1.2 That they communicate effectively with families/other staff members and individuals as set out in the procedure.

6.2 The Positive Behaviour Support Committee ensures that all restrictive practices are appropriately authorised and reviewed with a plan in place to remove or reduce the restriction in accordance with agreed timelines.

6.3 The Rights Review Committee ensures that due process has been followed in imposing a rights restriction on an individual.

7. Procedure

7.1 Use of seclusion

7.1.1 Seclusion must only be used when an individual poses a significant threat of harm to self or others and it is considered the safest intervention at that time. Its use must be in proportion to the risk posed. All alternative interventions to manage the individual's unsafe behaviour must be recorded the process recorded in the relevant documentation.

7.1.2 The use of seclusion must be approved by the MDT.

7.1.3 This approval must only be agreed where a current physical/medical report or functional assessment does not contraindicate the use of seclusion.

7.1.4 In all MDT deliberations on the use of restraint for behavioural purposes, processes (to include documentary evidence) must be in place to ensure that no single opinion or report alone influences decision on authorisation of the restraint.

7.1.5 Local processes must be in place to ensure that a documented record of the full team's views are brought to the attention of the prescribing medical practitioner.

7.1.6 The decision to initiate the use of seclusion is taken in accordance with the agreed individual restrictive reactive plan by the designated staff member on duty.

7.1.7 Except in extreme emergency the use of seclusion should be discussed with the person and their family and/or their advocate as part of the development of their individual plan, and recorded. There is evidence that the consent process has been adhered to.

7.1.8 In the event that this communication does not occur, a record explaining why it has not occurred must be entered into the individual's record.

7.1.9 Where seclusion is planned a risk assessment of the environment is carried out to ensure that the facility is appropriate for seclusion prior to its use as a seclusion facility.

7.1.10 The seclusion area is checked prior to and following its use to ensure that it is in tact.

7.1.11 The maximum duration of seclusion is 15 minutes. If an extension of this time is required, a formal review is undertaken by the senior team on duty.

7.1.12 The duration of an episode of seclusion must be the shortest possible in accordance with policy and the agreed individual restrictive reactive plan.

7.1.13 One staff member must be identified as the staff member taking responsibility for the implementation of the intervention.

7.2 Reporting and recording of the use of Seclusion

7.2.1 The use of seclusion is reported in accordance with the individual's restrictive, reactive plan. This record should include, but is not limited to the following:

7.2.1.1 The reasons for its use;

7.2.1.2 Date and duration of its use;

7.2.1.3 Alternatives which were implemented and unsuccessful or considered and ruled out;

7.2.1.4 If the behaviour resulting in seclusion was the same behaviour as that addressed in the Multi-element Behaviour Support Plan;

7.2.1.5 Members of the team involved directly in management of the seclusion episode;

7.2.1.6 A written record of observation of the individual in seclusion must be made at least every 15 minutes (in emergency situations every 5 minutes) in a specific Seclusion document. The individual's level of distress, physical status, mental status and presenting behaviour during the preceding 15 minute period must be recorded and signed.

7.2.2 Where the transfer of an individual into the seclusion facilities involves the use of physical restraint techniques, staff must adhere to Saint John of God Community Services policy on the use of physical restraint.

7.2.3 A referral is made to the Rights Review Committee outlining the process undertaken in regard to the authorisation of the restraint.

7.3 Procedure for the monitoring of an individual during seclusion

7.3.1 The individual should be observed at all times during the use of seclusion.

7.3.2 If facilities for indirect observation (CCTV) are available, these can be used. However, in such circumstances direct observation is undertaken by a second staff member every 15 minutes. A record is maintained every 15 minutes.

7.3.3 Communication with the individual whilst in seclusion is dictated by the individual plan.

7.4 Ending Seclusion

7.4.1 Seclusion must be immediately terminated if a significant risk to the person is identified and its management dictates that the person needs to leave the room.

7.4.2 Seclusion must be discontinued at the earliest possible time. Discontinuation of seclusion means that the person physically leaves the room in which they were secluded.

7.4.3 When the individual's unsafe behaviour has abated, termination of seclusion must be considered.

7.4.4 When a person exits the seclusion area this is considered the end of the seclusion period.

7.4.5 The decision to discontinue seclusion will be informed by the predefined criteria as identified in the individual's written Restrictive Reactive strategy.

7.4.6 The reason for discontinuing seclusion must be recorded.

7.4.7 When seclusion is discontinued, any concerns regarding the individual's well-being are addressed. The individual is observed for a defined period in accordance with his/her agreed plan. This is recorded and signed.

7.4.8 Re-establishing relationships: The opportunity to discuss and/or reassure the individual is taken as soon as is practicable unless to do so would be prejudicial to the service-user's mental health, wellbeing or emotional condition. In the event that this communication does not occur, the reason for this must be documented in individual's record.

7.5 Reviewing the use of seclusion

7.5.1 The use of seclusion should be reviewed by the MDT involved in the care and treatment of the individual a soon as practicable after the event.

7.5.2 The review considers each episode having regard to the individual's care and personal plan, the trend in relation to how often and for how long and where seclusion has been initiated and other influencing factors. The findings of the review should include

the reasons why seclusion should or should not be continued and describe plans to decrease/cease seclusion for the individual. The findings of this review should be recorded in the individual's record.

7.5.3 The individual should be involved in the review unless they do not have the capacity (at this time), their involvement might be prejudicial to their mental health, well-being or emotional condition. In which case a family member/parent/advocate acting on behalf of the individual should be involved in the review process.

7.5.4 If the individual or their advocate objects to seclusion, the plan is reviewed in light of this objection by the MDT/Rights Review Committee. Following this review, if it is determined that the plan is in the best interests of the individual, it is only introduced if a neutral and appropriately qualified second opinion supports this view. Where the individual or their advocate objects to the restrictive procedure they are also advised of the role of the Rights Review Committee and that they can seek legal representation as per HIQA Standards, 2009.

7.6 Emergency Seclusion

Where possible, two staff agrees that seclusion is necessary, having considered and deemed ineffective all other means of managing the behaviour.

7.6.1 In an emergency situation where the use of seclusion has not been previously authorised, and where a individual poses a risk of significant harm to self or others and all alternative interventions to manage the individual's unsafe behaviour have been given due consideration and deemed ineffective/unsafe. Seclusion may be initiated by designated staff/team leader. Each service must have guidelines as to the competencies required by such staff and must have a nominated person with these competencies rostered at all times.

7.6.2 In the event of an emergency seclusion taking place, the senior person on call is contacted immediately. If there is a medical concern during or at the end of seclusion the G.P. is contacted. A review of the seclusion episode is conducted within 72 hours by the team with responsibility for the welfare of the individual, or earlier as required. In reviewing the use of seclusion, the environment is also reviewed.

7.6.3 In an emergency seclusion a written record is kept every 5 minutes.

7.6.4 In an emergency situation the environmental risks are immediately identified and managed.

7.6.5 The duration of an episode of seclusion must be the shortest possible in accordance with policy.

7.6.6 The maximum duration of seclusion is 15 minutes. If an extension of this time is required, a formal review is undertaken by the senior team on duty.

7.6.7 The use of emergency seclusion must only be agreed where a current physical/medical report or functional assessment does not contraindicate its use.

7.6.8 One staff member must be identified as the designated staff member taking responsibility for the implementation of the intervention.

7.6.9 All episodes of emergency seclusion should be clearly documented. This record should include, but is not limited to the following:

7.6.9.1 The reasons for its use;

7.6.9.10 Date and duration of its use;

7.6.9.11 Alternatives which were implemented and unsuccessful or considered and deemed ineffective;

7.6.9.12 If the behaviour resulting in seclusion was the same behaviour as that addressed in the Multi-element Behaviour Support Plan;

7.6.9.13 Members of the team involved directly in management of the seclusion episode.

7.6.9.14 A written record of observation of the individual in seclusion must be made at least every 5 minutes. The individual's level of distress, mental status and presenting behaviour during the preceding 15 minute period must be recorded and signed.

7.6.10 Where the transfer of an individual into the seclusion facilities involves the use of physical restraint techniques, staff must adhere to Saint John of God Community Services Limited policy on the use of physical restraint.

7.6.11 In the case of seclusion being used in an emergency situation, the use of seclusion should be discussed with the person and family/relevant advocate/s after the event. The individual plan should be discussed and agreed with the relevant parties and recorded.

7.6.12 In the case of use of emergency seclusion being used more than 3 times in a six month period (see 3.2) this review should lead to a planned restrictive reactive strategy and a full multi-element behaviour support plan is put in place.

7.7 Seclusion is never used

There are certain circumstances in which seclusion is never used:

7.7.1 To demonstrate authority, enforce compliance, inflict pain, harm, to punish or discipline an individual;

7.7.2 Solely to ameliorate operational difficulties or to maintain a smooth running programme, including where there are staff shortages, for example, seclusion being used during staff breaks, dinnertime or at night;

7.7.3 With an individual with a known psycho-social/medical condition, in which close confinement would be contraindicated;

7.7.4 Where the functional assessment of the behaviour indicates that this intervention would be contraindicated;

7.7.5 Where the risk of harm from the seclusion becomes greater than the risk posed by the acute episode of physical aggression;

7.7.6 Where it is deemed unsafe to do so.

7.8 The planned use of seclusion ensures that:

7.8.1 Its use is governed by organisational policy;

7.8.2 There is immediate and serious risk to the safety of individuals or staff and there is evidence that all other means of eliminating the risk have been considered and deemed ineffective;

7.8.3 It is subject to multidisciplinary approval and review;

7.8.4 The consent of the individual/advocate is obtained;

7.8.5 A comprehensive risk assessment has been conducted;

7.8.6 An agreed individual Multi-element Behaviour Support Plan is in place;

7.8.7 A written restrictive reactive plan that outlines least to most restrictive strategies is in place;

7.8.8 The development of a functional assessment is prioritised in the absence of a Multi-Element Behaviour Support Plan;

7.8.9 The individual plan has been subject to review by the Rights Review Committee;

7.8.10 There is a safe, suitable environment for seclusion;

7.8.11 There is evidence that the consent process has been adhered to.

Bibliography

Department of Health and Children (2006), Vision for Change. Report of the Expert Group on Mental Health Policy, *Dublin: Government Publications Office.*

Government of Ireland *Mental Health Act* (2001) Dublin: Government Publications Office

Health Information and Quality Authority (2009) *National Quality Standards: Residential Services for People with Disabilities*

HSE (2008) Linking Service and Safety, *Together Creating Safer Places of Services*

McKenna, K. (2004), *Study of Work-Related Violence*. North Eastern Health Board Committee on Workplace Violence

Mental Health Act 2001 (Approved Centres) Regulations 2006

Mental Health Commission (2006) *Draft Code of Practice: Guidance for Persons working in Mental Health Services with people with Intellectual Disabilities*

Mental Health Commission (2008) *Rules Governing the use of Seclusion and Mechanical means of Bodily Restraint*

Mental Health Commission *Reference Guide Mental Health Act 2001 Part One – Adults*

N.I.C.E 2005, *Violence: The short-term management of disturbed/violent behaviour in in-individual psychiatric settings and emergency departments.*

NAMHI, Policy Research Institute 2003, *Seclusion and Restraint Task Force Report* (USA)

National Institute for Mental Health in England, NIMHE 2004, Mental Health Policy Implementation Guide *London: NHS*

Principles for the Protection of Persons with Mental Illness & the Improvement of Mental Health Care (1991) Principle 11

The British Psychological Society (2001) *Learning disabilities: Definitions and contents*

Victoria Law Reform Commission 2003, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care,* Australia:
Victoria Government Printer

Washington State Department of Social and Health Services (2003), *Physical Intervention Techniques,* The Division of Developmental Disabilities.