

|  |
| --- |
| Recognising and reducing mechanical restraintPractice guide |
|  |

To receive this publication in an accessible format phone 03 9096 8427, using the National Relay Service 13 36 77 if required, or email the Office of Professional Practice <officeofprofessionalpractice@dhhs.vic.gov.au>.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Department of Health and Human Services, June 2019.

ISBN 978-1-925947-04-5 (pdf/online/MS word)

Available at the [Office of Professional Practice website](https://www.dhhs.vic.gov.au/office-professional-practice)
<https://www.dhhs.vic.gov.au/office-professional-practice>

Contents

[Introduction 1](#_Toc12526620)

[Acknowledgements 1](#_Toc12526621)

[Recognising mechanical restraint 2](#_Toc12526622)

[Definition of mechanical restraint 2](#_Toc12526623)

[Note for services 2](#_Toc12526624)

[Examples of mechanical restraint 2](#_Toc12526625)

[Therapeutic purposes 3](#_Toc12526626)

[Safe transportation 3](#_Toc12526627)

[Frequently asked questions about the definition of mechanical restraint 4](#_Toc12526628)

[Understanding the impact of mechanical restraint use 5](#_Toc12526629)

[Case study 5](#_Toc12526630)

[Responding to mechanical restraint use 6](#_Toc12526631)

[Assessing the person 6](#_Toc12526632)

[Assessing the person’s environment 6](#_Toc12526633)

[Assessing and understanding the behaviour of concern 7](#_Toc12526634)

[Investigating historical and current mechanical restraint use 7](#_Toc12526635)

[Note for respite and community care service arrangements 8](#_Toc12526636)

[Case study 8](#_Toc12526637)

[Monitoring and reducing mechanical restraint 9](#_Toc12526638)

[Complying with the Disability Act 9](#_Toc12526639)

[Information about mechanical restraint 9](#_Toc12526640)

[Collecting data 10](#_Toc12526641)

[Team coordination 10](#_Toc12526642)

[Case study 10](#_Toc12526643)

[Addressing risk for specific groups 11](#_Toc12526644)

[Recommendations for disability services to address at-risk groups 11](#_Toc12526645)

# Introduction

This practice guide provides a framework and evidence-based recommendations for identifying, assessing, planning and implementing mechanical restraint reduction plans. This guide will make reference to positive behaviour support frameworks for reducing behaviours of concern and behaviour support plans as well as previous publications about reducing specific types of mechanical restraint such as the Department of Health and Human Services’ *Reducing the use of restrictive clothing as mechanical restraint practice guide* (2010). Case studies and frequently asked questions are also presented throughout the guide.

This document has been developed following a series of four projects conducted by the Senior Practitioner – Disability about using mechanical restraint within Victorian disability services. The findings of these projects have influenced the recommendations within this practice guide.

The first project looked at people with a disability who were reported to the Restrictive Intervention Data System (RIDS) due to the use of mechanical restraint. The results from this showed that people with certain disabilities are more at risk of being mechanically restrained than others. See [Addressing risk for specific groups](#_Addressing_risk_for) on page 11 for details.

The second project looked at people who had been mechanically restrained for more than two years, taking an in-depth look at the files of these people to see what was known about their health and support needs. Notably, this highlighted that many people who were restrained using mechanical restraint have moderate to severe communication difficulties with high levels of comorbidities and support needs.

The third project assessed a group of people who had multiple complexities and little information about their support needs. The group was provided with comprehensive health assessments, communication, sensory and functional behaviour assessments to highlight interventions to support the individuals and the services to support them to move away from mechanical restraint use. This project also investigated service knowledge about the use of mechanical restraint such as how long it had been used for and where it originated. Services involved in this project received recommendations to move away from using mechanical restraint.

The fourth project supported services to implement the recommendations from the third project. It highlighted the many service/organisational facilitators and barriers to implementing the intervention. During projects three and four, mechanical restraint use was reduced for some participants.

In sum, the four projects suggest it is difficult for services to reduce and eliminate the use of mechanical restraint. A multi-component approach is required to investigate the reasons why mechanical restraint is used and to develop and implement a plan to reduce its use. This approach needs to involve a thorough assessment of the person and their environment, be data-driven and use evidence collected about behaviours and restraint use and have support from all levels of staff within a service, ensuring families and the person are also involved.

## Acknowledgements

The Senior Practitioner – Disability would like to acknowledge and thank the people with a disability, their families and service providers and clinicians who were a part of the Mechanical Restraint Project series 2014–2018, as well as the members of the Mechanical Restraint Reference Group.

# Recognising mechanical restraint

## Definition of mechanical restraint

In Victoria, s. 3 of the *Disability Act 2006* defines mechanical restraint as:

… the use, for the primary purpose of the behavioural control of a person with a disability, of devices to prevent, restrict or subdue a person's movement but does not include the use of devices— (a) for therapeutic purposes; or (b) to enable the safe transportation of the person.[[1]](#footnote-1)

Nationwide, s. 6(c) of the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* defines mechanical restraint as:

… the use of a device to prevent, restrict, or subdue a person’s movement for the primary purpose of influencing a person’s behaviour but does not include the use of devices for therapeutic or non-behavioural purposes.[[2]](#footnote-2)

### Note for services

All equipment and devices used within disability services must be either originally prescribed and/or reassessed by an appropriate professional such as an occupational therapist, physiotherapist or orthopaedic clinician. We know that sometimes people can enter services with equipment or devices for which there is no original assessment or prescription document. Some devices have been made by family members or may have been in use for a long time without considering the changing needs of the person. These devices must be reviewed when the person begins accessing the service and have ongoing regular reviews due to the risk of injury they bring. These devices are considered restrictive and must be reported to the Senior Practitioner until they are assessed and their purpose confirmed as either restrictive or therapeutic by an appropriate professional.

### Examples of mechanical restraint

* Belt/strap: An item of any material used to restrain any part of the body.
* Glove: Any material that is placed on the hand and covers all or part of the hand and/or finger(s).
* Splint: A device that is applied or worn, in original or modified form, to a body joint (usually the elbow) that restricts movement of that joint in any way.
* Helmet: Any type of headwear worn by the person to limit potential physical damage to self.
* Restrictive clothing: An item of clothing that is applied in full or part, in original or modified form, or a specially designed device that is applied to or worn by a person that restricts their movement in any way, including to prevent the person accessing their incontinence/sanitary device or removing their clothing.

## Therapeutic purposes

Therapeutic devices are designed to assist people with everyday activities, improve their functional independence or to help their injuries heal. The definition of mechanical restraint does not include devices that have been prescribed by an appropriate professional after a thorough assessment **and** are used for the specific and approved purposes for which the devices were designed.

Examples of these devices are:

* adaptive devices or mechanical supports used to achieve proper body position, balance or alignment to allow greater freedom of mobility than would be possible without the use of such devices or mechanical supports
* restraints for medical immobilisation (for example, a cast or splint to allow healing).

Before applying devices that are considered therapeutic, services must ensure that an assessment has been undertaken by the appropriate professional such as an occupational therapist, physiotherapist or orthopaedic clinician. Important information to gather from the prescribing clinician about the device includes a detailed plan describing the goals that the assessment that has determined:

* how the device will be used
* how long the device can be applied for and when it must be removed
* what training people need to be able to apply and take off the device safely
* how the device will be reviewed
* how and when the goals will be evaluated.

## Safe transportation

Everyone needs to use a seatbelt, child restraint or booster seat when travelling in a motor vehicle (Road Rule 266).[[3]](#footnote-3) However, Road Rule 267 stipulates:

Some children may be exempt from the child restraint Road Rules. This includes children with a medical condition or physical disability. To qualify for an exemption, certain conditions need to be met such as getting a medical certificate. Even if a child is exempt, they still need to be safe when traveling in a vehicle.[[4]](#footnote-4)

Devices used to allow safe transportation of people with a disability are not considered mechanical restraint. These devices are used to comply with road safety laws when a vehicle is in motion. For example, using a buckle guard on a car seatbelt is not considered mechanical restraint. If additional restraints are used within a vehicle in response to behaviour and not for a medical condition or physical disability (such as a lap belt on a wheelchair for postural support), this is considered mechanical restraint.

Examples of mechanical restraints that may be used in vehicles include:[[5]](#footnote-5)

* H harnesses that comply with AS/NZ 1754:2013 – not recommended due to the risk of misuse, which can result in serious injury (requires careful use and installation)
* special purpose restraints (for example, E-Z-On vest, Hemco harness) – not compliant with Australian Standards and therefore requires prescription and a medical exemption
* a device that limits the movement of a person’s arms, legs or hands.

### Frequently asked questions about the definition of mechanical restraint

1. If a device is prescribed to ‘prevent harm’ or for ‘safety’, is this mechanical restraint?

Yes, if the device is not therapeutic or used to enable movement. A disability service provider would not consider using any restrictive intervention, including mechanical restraint, unless there was a risk of physical harm as required by s. 140(a) of the Disability Act.

The only exemption to this is the use of a seatbelt buckle guard to enable safe transportation.

1. If a parent or a guardian wants a disability service provider to use a device on a person with a disability, is it still mechanical restraint?

Yes. Disability service providers are responsible for all restrictive interventions, including mechanical restraint, and must comply with the requirements of Part 7 of the Disability Act and the NDIS Rules 2018 if they wish to use a restrictive intervention. As stated above, these devices must be reviewed when a person starts using a service.

1. If a person wishes or demands to wear a mechanical restraint device, is this mechanical restraint?

Yes. If staff from a disability support provider apply a device that is not deemed therapeutic or for safe transportation, it is considered mechanical restraint. The Disability Act and the NDIS Rules 2018 do not make a distinction about this. Refer to the [definitions of mechanical restraint](#_Definition_of_mechanical) on page 2.

1. If a person with a disability can remove the device themselves, is the device mechanical restraint?

Yes. If staff from a disability support provider apply a device that is not deemed therapeutic or for safe transportation, it is considered mechanical restraint. If a person can remove a device themselves, staff need to investigate the use and need for the device. It may be that there is an entrenched psychological dependency on the device. The Disability Act and the NDIS Rules 2018 do not make a distinction about mechanical restraint in this way. Refer to the [definitions of mechanical restraint](#_Definition_of_mechanical) on page 2.

# Understanding the impact of mechanical restraint use

Mechanical restraint is commonly used in response to behaviours of concern, primarily behaviours that place a person at a high risk of injuring themselves.[[6]](#footnote-6) We know from the data collected on RIDS that mechanical restraint is being used as a frequent routine and long-term intervention.[[7]](#footnote-7) It is important to highlight the impacts of mechanical restraint use to enhance understanding of the detrimental effects of using mechanical restraint has on a person with a disability and to help reduce or eliminate this type of restrictive practice. Possible impacts of mechanical restraint on people with a disability include:

* risk of suffocation when bed rails and bed poles are in use
* risk of choking on devices
* skin irritation, pressure sores[[8]](#footnote-8)
* muscle atrophy and bone loss from lack of movement and weight-bearing activities[[9]](#footnote-9)
* risk of injury to the person from prolonged use of ill-fitting or incorrectly used devices
* limits on engaging with and participating in activities
* limits on opportunities for skill building
* limits on opportunities for comprehensive assessment[[10]](#footnote-10)
* not addressing the underlying behaviours or personal support needs[[11]](#footnote-11)
* over-reliance on restraint devices resulting in the person asking for restraint or becoming anxious without the restraint.

Mechanical restraint can also restrict a person’s human rights, as laid out by the United Nations *Convention on the Rights of Persons with Disabilities*.[[12]](#footnote-12) This includes the right to freedom of movement and personal mobility (Article 20) as well as freedom of expression (Article 21).

### Case study

Hassan was placed in a one-piece body suit after two occasions where he was observed accessing and smearing the contents of his continence aid. Although there may be risks associated with this type of behaviour, using a body suit restricts Hassan’s freedom of movement and personal mobility. Hassan’s support workers will need to investigate why the behaviour occurred, assess his environment and his person support needs regarding toileting processes.

# Responding to mechanical restraint use

Once it has been determined that a device or piece of equipment is considered mechanical restraint, it is crucial that services complete a holistic assessment of the person and their environment. The recommendations below are based on evidence from our findings from the Mechanical Restraint Project series as well as knowledge from national and international studies on reducing restrictive practices.

This section is presented in dot points to enable services to use it as a checklist when supporting a person who is applied mechanical restraint to ensure a holistic investigation in undertaken.

## Assessing the person

It is crucial to assess a person’s health and wellbeing as well as their skills and abilities; this will help to determine why a person is displaying a behaviour that leads to mechanical restraint use. A person’s behaviour may stem from unmanaged or unidentified pain or discomfort.

Consider the following questions:

* Has a comprehensive health assessment, specifically including the following assessments been completed?
	+ hearing
	+ vision
	+ dental/oral health
	+ review of all medications, and their possible side effects
	+ any underlying causes of pain or discomfort.
* Has the person had a recent communication assessment, including the following investigations?
	+ determining the person’s receptive language skills – the person’s ability to understand other’s messages
	+ determining the person’s expressive language skills and how they communicate for a variety of functions – for example, gaining attention, protesting, commenting, relaying information
	+ identifying how communication partners can best communicate with the person – for example, speech, visual supports, gestures, simple questions
	+ identifying factors that may affect the person’s ability to communicate – for example, environments, time of day, medication, sensory differences
* Has the person had a recent sensory assessment?
* Has the person’s adaptive behaviour skills been assessed?

## Assessing the person’s environment

An assessment of each environment the person occupies that may support or inhibit a person’s ability to function using their skill and abilities is required. This includes assessing the physical surroundings, materials and adaptive equipment available to the person. It also addresses the social and organisational environment, which includes the interactions a person is involved in as well as the skill set and knowledge that staff have about how to best support the person.

Consider the following questions:

* Does the physical environment allow the person to move around freely and gain assistance from others when needed?
* Does the physical environment reflect the person’s likes and sensory preferences?
* Does the physical environment encourage independence and choice in daily activities?
* Are communication partners (staff) aware of and consistently using the most meaningful communication forms? (for example, using simple sentences)
* Does the person have access to adaptive devices, such as modified cutlery, to enable them to engage in activities independently?
* Does the person have access to preferred sensory items that help them to regulate their feelings or assist them to engage in meaningful activities?
* Is the person engaged in activities that they enjoy and choose to do?
* Is the person involved in decision making about their daily routine and the way in which tasks/activities are completed?

## Assessing and understanding the behaviour of concern

A comprehensive investigation of the behaviour of concern is needed. This will inform the positive behaviour support strategies that will form part of the person’s behaviour support plan.

It is important that staff have an understanding about why a behaviour is occurring within an environment. This is commonly termed as the ‘function’ of a behaviour – that is, the reason a person uses a behaviour.

A behavioural assessment is a way of determining a hypothesised function of the behaviour through gathering data via interviews with the person, their staff and significant others. It is important that hypothesised functions are reviewed to ensure strategies are appropriate to the current context of behaviour.

Behaviour assessment may involve the use a range of tools including (not exclusive):

* observation and completion of Antecedent, Behaviour, Consequence (ABC) charts or Setting, Trigger, Action, Response (STAR) charts
* **Motivation Assessment Scale (MAS)**
* **Functional Analysis Screening Tool (FAST)**
* **Functional Assessment Interview (FAI)**
* **reviewing data from incident reports.**

## Investigating historical and current mechanical restraint use

It can be helpful to take a step back and look historically at why mechanical restraint was prescribed in the first place. We know that sometimes mechanical restraint continues to be used due a historical behaviour or incident.

The following questions are designed to facilities investigations into the historical and current use of the mechanical restraint device.

* Who originally prescribed or started using the mechanical restraint device?
* When was it first used?
* When was the behaviour relating to mechanical restraint use last observed?
* What assessments were conducted or what informed its development and use?
* Have there been any recommendations for alternatives to mechanical restraint or to reduce its use?
* What has facilitated or supported reducing the mechanical restraint?
* What have been the barriers to decreasing the use of, or eliminating the need for, mechanical restraint?

### Note for respite and community care service arrangements

We understand that at times it is difficult to have influence over the formal assessments an individual receives; however, when conducting intake for a person entering your service, ask for information about why equipment/devices are used and how to operate/use them correctly. Is it possible to assess the environment and the behaviour of concern displayed while a person is using the service. Investigating the origins of the mechanical restraint is important to ensure practice is consistent and necessary.

### Case study

Kasey wore a mitten-type glove during the day to discourage her continuously sucking on her hands, which was causing damage to the skin. Even with this intervention, however, Kasey still displayed this behaviour by sucking and chewing on the glove. Her doctor suggested that her support team organise a dental examination. It was unknown how long since it had been since she had her last dentist appointment. Following the appointment, the dentist removed 12 of Kasey’s teeth, which would have been causing her pain. Kasey’s hand-to-mouth behaviour reduced after this, and the glove was no longer used. This is an example of how assessing an individual’s health needs has led to a reduction in behaviour and elimination of mechanical restraint.

# Monitoring and reducing mechanical restraint

## Complying with the Disability Act

When using any restrictive practice in a Victorian disability service, there are many Disability Act requirements that services need to comply with to ensure people with a disability’s rights are safeguarded. When using mechanical restraint, disability services are mandated by the Disability Act to develop a behaviour support plan and report monthly to RIDS.

To comply with the Disability Act, services need to ensure the following information is included in a behaviour support plan:

* a description of the behaviour causing physical harm to the person or others, including baseline data about the frequency, duration, severity and outcome of the behaviour of concern
* a statement of how mechanical restraint will be of benefit to the person
* a statement of how the mechanical restraint is the least restrictive option at the time
* a description of what leads to the use of the behaviour of concern and the context in which behaviour is displayed, including triggers and setting events
* a hypothesised function of the behaviour and what the person gets or rejects by displaying this behaviour
* a detailed description of proactive environmental strategies to lessen the need for the behaviour of concern to be implemented consistently by service staff
* replacement behaviour related to function and suited to the person’s skills and abilities
* de-escalation (reactive) strategies that will be used to re-engage, re-direct or calm the person when they start displaying behaviours of concern
* behaviour goals, stating the behaviour change that aims to increase positive behaviour and/or reduce the behaviour of concern, how the goal will be measured and the timeframe within which the goal is to be achieved.

## Information about mechanical restraint

As stated in the first section of this guide, all equipment and devices used within disability services must be prescribed and reviewed by an appropriate health professional.

Services need to have the following information on file and it must be accessible to all staff to ensure consistency in practice:

* a description of the behaviour that the mechanical restraint is being used to prevent or lessen the severity of
* the name, contact details and qualifications of the health professional who prescribed or reassessed the mechanical restraint
* what assessments were completed and their outcomes that led to the decision to prescribe mechanical restraint
* how the device will be applied and under what circumstances (photographs of staff applying the mechanical restraint including the communication strategies to be used can be a useful way to ensure mechanical restraint is applied correctly)
* how long the device can be applied for and when it must be removed
* what training people need to be able to apply and take off the device safely
* how and when the use of the device will be reviewed by the health professional
* how and when the goals will be evaluated.

## Collecting data

Collecting information about mechanical restraint use is vital to understand why it is being used. This information can also inform the review of a behaviour support plan, highlighting useful positive behaviour support strategies.

Consider the following questions:

* What happened and when did the behaviour of concern start?
* Who was around, what was happening within the environment and what were they engaged in?
* What happened before the mechanical restraint was applied? How did the person present?
* Who made the decision to apply mechanical restraint?
* What initiates removing the mechanical restraint?
* What happens after the device is removed?
* What strategies were used before using mechanical restraint? Were they successful?
* How long was the device used for?

## Team coordination

An important factor in successfully reducing and eliminating the use of mechanical restraint is team coordination. The team includes all staff and external members of a person’s support network, including professionals. It is essential that all members of the team, including people in leadership and management roles, know the goals of the behaviour support plan and make sure they have the capacity to act on intervention strategies within the plan to ensure consistency in support.

Consider the following:

* The team should be involved in regular meetings to review the strategies in the plan and to consider feedback on what is being successful and what they may need more support in to achieve the goals of the plan.
* Create a staff culture of reflection – ‘what worked today’, ‘what didn’t’, ‘what do we need to do together’.
* Ensure new team members are supported to enter the service through using shadow shift models, having half shifts where they can be introduced to the person with a disability and where the person with a disability can familiarise themselves with them.

### Case study

James has cerebral palsy, epilepsy and other disabilities. He has self-harmed from the age of two, hitting the left side of his head and face. To stop the self-harm, mechanical restraints, in the form of splints and a helmet, were used. When James began to self-harm using the mechanical restraints, his carers decided to investigate the possible causes of the self-harm. They found he had several underlying medical problems that caused pain and distress, therefore James’s self-harm could be interpreted as cries for help. His carers’ ability to monitor and interpret these cries for help enabled them to support him to have his needs met. This meant they no longer needed to use mechanically restraint.[[13]](#footnote-13)

# Addressing risk for specific groups

From our research, we know there are groups of people who are more at risk of being mechanically restrained in disability services. It is important that disability support services are aware of these and take preventative steps to ensure that mechanical restraint is not used, or if it is in use, that it is reduced.

Groups of people with intellectual disabilities who are at a higher risk of being restricted using mechanical restraints include people with:

* a hearing impairment
* a physical disability
* a speech impairment
* a vision impairment
* autism.

A common thread for people in these groups is that they may not have a formal means of communication.

It has been established that behaviours of concern are often used as the person’s most effective way of communicating. Research has shown that people may display self-injurious behaviour as a form of communication.[[14]](#footnote-14)

This is reflected in other research that shows that some of these groups (people with hearing and vision impairments and people with autism) are more likely to display self-injurious behaviour.

## Recommendations for disability services to address at-risk groups

* Ensure people who may fit into one or more of these groups have a comprehensive communication assessment and that support staff know how to implement interventions.
	+ Determine the person’s receptive language skills – that is, the person’s ability to understand messages.
	+ Determine the person’s expressive language skills and how they communicate for a variety of functions – for example, gaining attention, protesting, commenting, relating information.
	+ Identify how communication partners can best communicate with the person – for example, speech, visual supports, gestures.
	+ Identify factors that may affect the person’s ability to communicate – for example, environments, time of day, medication.
* Ensure regular comprehensive health assessments are completed, including hearing, vision and oral health checks.
1. State Government of Victoria 2006, *Disability Act 2006*, at [Victorian Legislation and Parliamentary Documents website](http://www.legislation.vic.gov.au) <http://www.legislation.vic.gov.au>. [↑](#footnote-ref-1)
2. Australian Government 2018, *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018,* at [Federal Register of Legislation website](https://www.legislation.gov.au/Details/F2018L00632) <https://www.legislation.gov.au/Details/F2018L00632>. [↑](#footnote-ref-2)
3. [*Road Safety Road Rules 2009* (Vic)](http://www8.austlii.edu.au/cgi-bin/viewdoc/au/legis/vic/num_reg/rsrr2009n94o2009289/index.html) <http://www8.austlii.edu.au/cgi-bin/viewdoc/au/legis/vic/num\_reg/rsrr2009n94o2009289/index.html> [↑](#footnote-ref-3)
4. Ibid. [↑](#footnote-ref-4)
5. Department of Health and Human Services 2016, *Transportation of children with disabilities who display behaviours of concern: Clinical reasoning guide for occupational therapists*, Victorian Government, Melbourne. [↑](#footnote-ref-5)
6. McGill P, Murphy G, Kelly-Pike A 2009, ‘Frequency of use and characteristics of people with intellectual disabilities subject to physical interventions’, *Journal of Applied Research in Intellectual Disabilities*, 22(2): 152–158. [↑](#footnote-ref-6)
7. Chan J, Webber L 2013, ‘Key strategies that lead to restraint and seclusion reduction: a four-year study of the use of restrictive interventions in Victoria, Australia’, *Journal of Policy and Practice in Intellectual Disabilities*, 10(2): 110. [↑](#footnote-ref-7)
8. Gastmans C, Milisen K 2006, ‘Use of physical restraint in nursing homes: clinical-ethical considerations’, *Journal of Medical Ethics*, 32: 148–152. [↑](#footnote-ref-8)
9. Ibid. [↑](#footnote-ref-9)
10. Sturmey P 2009, ‘Restraint, seclusion and PRN medication in English services for people with learning disabilities administered by the National Health Service: an analysis of the 2007 National Audit Survey’, *Journal of Applied Research in Intellectual Disabilities*, 22(2): 140–144. [↑](#footnote-ref-10)
11. Ibid. [↑](#footnote-ref-11)
12. UN General Assembly 2007, *Convention on the Rights of Persons with Disabilities*, Adopted by the General Assembly, 24 January 2007 [↑](#footnote-ref-12)
13. Webber L, Major K, Condello C, Hancox K 2017, ‘Providing positive behaviour support to improve a client’s quality of life’, *Learning Disability Practice*, 20(4): 36–41. [↑](#footnote-ref-13)
14. Durand VM 1986, ‘Self-injurious behavior as intentional communication’, *Advances in Learning & Behavioral Disabilities*, 5: 141–155. [↑](#footnote-ref-14)