Office of the Senior Practitioner

Practice Guide

Reducing the use of restrictive clothing as mechanical restraint

May 2010

Supporting people to achieve dignity without restraints
Introduction

The Disability Act 2006 defines mechanical restraint as ‘the use, for the primary purpose of 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; (b) to enable the safe transportation of the person’ (section 3). Restrictive clothing is one example of mechanical restraint.

This Practice Guide provides evidence-based suggestions for assessing behaviours associated with using restrictive clothing. It recommends positive behaviour support strategies to address why the behaviour is occurring and suggests a number of interventions that can be attempted in order to reduce – and ultimately cease – the use of restrictive clothing. The Disability Act 2006 requires that disability service providers, such as residential, respite or day services, identify when restrictive practices are used (such as the use of restrictive clothing as mechanical restraint), develop a behaviour support plan and report the use of the restrictive intervention to the Senior Practitioner through the Restrictive Intervention Data System (RIDS).

For the purposes of this Practice Guide, restrictive clothing refers to any item of clothing that is applied in full or part, in original or modified form; or specially designed device that is applied to or worn by a person that restricts their movement in any way for the purpose of controlling behaviour.

Some people with a disability display behaviours that pose difficulties for parents, carers and staff to manage, such as: taking clothes off in inappropriate places; smearing faeces; masturbation or touching genitals at inappropriate times; and tampering with their incontinence or sanitary aid. Some of these behaviours can pose a risk to the person with a disability themselves or to others, and sometimes parents, carers and staff may try to stop the behaviour by using some form of clothing that impedes the person from performing the behaviour. Clothing identified as restrictive may include:

- bodysuits
- overalls
- bike shorts, lycra garments, leotards, swimming garments
- pants and tops or underwear and singlets sewn together
- wetsuits
- jumpsuits
- specially designed ‘dementia suits’.

Methods of making clothing restrictive to a person with a disability include: reversing garments so that openings are on the back; placing arms or legs out of sleeves or pant legs but under the garment; and deliberately using fasteners that cannot be opened by the person.

An example of when a carer might use restrictive clothing is with a young man who removes his clothing while in public. Because this is embarrassing and limits the opportunity for him to go into the community, his disability support workers might place him in overalls that are under his everyday clothing so that he is unable to unfasten the buckles and he cannot take his clothes off. Another example is a young child who places her hands inside her nappy and smears faeces on the walls and her clothing. To stop this behaviour, the child’s parents place her in a ‘bodysuit’ fashioned by sewing tracksuit pants and a top together, therefore preventing her from placing her hands in the nappy.

These two examples demonstrate that, while these clothing items may work in stopping the behaviour, they do not address why the behaviour is occurring and how the person may learn over time to change the behaviour. In these cases, the altered clothing items are ‘band-aid’ solutions that do not promote long-term change in the behaviour itself (without positive behaviour support) and the altered clothing more often than not will be used indefinitely.

These behaviours are often difficult for families, carers and staff to manage, and, as such, they need support to understand why the behaviours occur and understand what alternatives might be used.
Underlying principles

Three studies have demonstrated that behavioural interventions are more likely to be effective if they are based on a functional behaviour assessment (FBA) than if they are not.\textsuperscript{1,2,3} FBA is a process that identifies the purpose of a person’s behaviour of concern, develops and implements a plan to change the behaviour using positive interventions and teaches the person with a disability new ways of obtaining what they want. FBA is especially recommended in people with toileting and clothing-related behaviours of concern.\textsuperscript{4,13,21,26,23,12} (Please refer to the Office of the Senior Practitioner publication \textit{Positive solutions in practice: The value of a good assessment} for further information regarding FBA.) available online at www.dhs.vic.gov.au/ds/osp

Applying restrictive clothing when there is no immediate context to a displayed behaviour is of no value to a person with a disability. For example, leaving a restraint on 24 hours a day whether or not the behaviour is displayed can lead to impairment in psychological and social development and negative physical impact.\textsuperscript{5} Restrictive clothing has also been found to reduce the positive behaviours of people with disabilities (such as involvement in work, play and social interaction) and reduce the positive behaviours of staff (through positive attention and reinforcement) towards the person. Increases in stereotyped movements have also been found to increase when restrictive clothing is worn.

A thorough assessment of the need for the restrictive clothing should be undertaken by an experienced clinician and the use of any restraint must be in the context of a broader and comprehensive behaviour support program.\textsuperscript{6}

For example, involving an occupational therapist or a physiotherapist is good practice. These professionals can provide written advice regarding the use of any restrictive clothing and this advice should include:

- what exactly the restrictive clothing is
- why it is being used
- the circumstances in which it is applied
- how long it is applied for and periods of time when the restrictive clothing can be removed
- what adverse effects to look for and what to do if they are observed
- when the use of the restrictive clothing is to be reviewed.

This information should be sought and kept in the person’s file regardless of whether the restrictive clothing is used as a restrictive intervention or for therapeutic purposes (such as treating an identified health or medical condition).

Some of the most common reasons modified clothing is used for people with a disability are discussed below.

\begin{thebibliography}{9}
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Removing clothing is highly conspicuous and of great concern to parents and carers.\(^7\) Identifying why it occurs is a critical step in identifying the best way to intervene; however, it must be remembered that it may not be completely eliminated but can be significantly reduced.\(^4\) Forcing the person to engage in an activity they dislike in response to taking off their clothing and using “time-out” (placing the person in a room alone) have been found to be generally unsuccessful in managing clothing removal.\(^8\) Jumpsuits (and similar one-piece garments) have also been tried but not worked.\(^9\)

When considering why clothing removal may be occurring, it is easy to assume that issues such as different activities, times of the day, individual carers or staff may be factors; however, this may not necessarily be the case.\(^4\) When investigating why it may be occurring, it is important that the frequency of clothing removal and the events immediately preceding it are recorded so that this information can be used for FBA. Studies have shown that clothing removal may occur for a number of reasons, for example, poor social awareness, hot weather,\(^10\) preference for certain clothes,\(^4\) adverse effects of medication (which may cause physical illness such as diarrhoea and the need to remove clothing frequently to toilet)\(^11\) and perhaps sensory abnormalities associated with clothing in contact with the skin (tactile sensitivity).\(^11,12\)

When functional behavioural assessment is conducted, decreases in disrobing have been observed when the person is engaged in work\(^13\) and other daily activities,\(^4\) and when provided with scheduled times to change clothing.\(^4\)

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Smearing faeces is considered perhaps one of the most difficult behaviours because of the health concerns associated with body waste and hygiene. It is these reasons that the interventions used in response to faecal smearing are often inappropriately based on punishment. Perhaps it’s also because this behaviour is so undesirable that there is limited evidence for behavioural intervention for faecal smearing.

Learning how to use the toilet is the first step towards reducing smearing behaviour. It is therefore vital that people with disabilities are provided with opportunities to learn how to toilet, either independently or with prompting or assistance in order for behavioural intervention to be successful.

Some of the reasons why smearing may occur includes sensory stimulation and escaping from a disliked situation, or the behaviour may be a form of non-verbal aggression. As an example, failing to assist a young woman with a severe intellectual disability when she woke in the morning resulted in smearing. Waking her immediately before her usual waking time to assist her to toilet stopped the smearing behaviour. In another case, the times of the day for showering and allowing playing while showering for a young boy with a profound disability was altered to successfully reduce smearing.

Gastrointestinal infection is often associated with rectal digging and faecal smearing in people with disabilities, which suggests that a medical review be conducted for anyone who demonstrates this behaviour. A number of authors have also indicated that faecal smearing in people with intellectual disability may be a result of possible physical or sexual abuse and, as such, suggests that the onset of this behaviour is a factor to be considered in some individuals.

A screening process to determine why faecal smearing may be occurring is offered below.

- Identify if a physical condition could be producing irritation in the anal area. If this is true, the person may be touching their anus and therefore inadvertently getting faeces on their hands.
- Does this behaviour tend to occur when activities and play materials are unavailable? If yes, the faecal smearing may be because the person has nothing to do.
- Does the behaviour occur in situations that are known to be disliked by the person? When the behaviour occurs, is the person taken from one place to another in order to be cleaned? If yes, faecal smearing may occur in order for the person to be removed from a situation or environment they dislike, or is stopped from participating in an activity they dislike, which makes the smearing likely to occur again to achieve the same outcome.
- Does the person receive little attention for appropriate behaviour? Does the person present themselves to staff or parents after they have smeared faeces? Does the person

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attempt to shower or bath themselves at times other than standard washing times? If yes, the behaviour may occur because the person likes the attention they receive from being cleaned and this causes the smearing to reoccur.

Sexual behaviour

Restrictive clothing is sometimes used because a person with a disability touches their genitals or masturbates in inappropriate environments. In these cases, intervening in this behaviour is viewed as more straightforward. It is important to note that masturbation is a normal expression of sexual development. Hence, in order to address inappropriate masturbation, it is essential to accept and promote appropriate masturbation.22 Every person has the right to access their own bodies and the use of restrictive clothing significantly limits this right without addressing the underlying cause of why the behaviour is inappropriate. Inappropriate sexual behaviour in people with intellectual disability has also been suggested as a possible result of physical and sexual abuse20,23 and any onset of this behaviour should prompt consideration of this factor.


Tampering with sanitary aids

Menstrual-related behaviours, such as getting blood on the hands\(^{24}\) and smearing\(^{25}\) are reported behavioural difficulties for some women with a disability. Difficulties with comprehension, hygiene management and the physical burden of care required may cause parents, carers or staff to seek advice. Teaching menstrual management skills can be approached proactively, and women with a range of support needs can be assisted to develop independence in menstrual management skills\(^{24}\). Managing menstrual blood by carers is no different to managing urine or faeces\(^{25}\). The principles of behavioural assessment and intervention for menstrual blood smearing are the same for faecal smearing in conjunction with individual education for the woman.

The Centre for Developmental Disability Health Victoria (CDDHV) has produced two resources for menstrual management, one for General Practitioners and one for staff, carers and women with disabilities. These resources are available on the CDDHV website at www.cddh.monash.org.

Incontinence and tampering with incontinence aids

While many people with disabilities experience bowel and/or bladder incontinence, intellectual disability should never in itself be regarded as the cause of incontinence\(^{26}\). Behavioural approaches offer an effective way to intervene, particularly in regards to faecal problems where the effectiveness of behaviour interventions is 70 per cent or better\(^{26}\). People with severe levels of intellectual disability can benefit from behavioural approaches to bowel-related behaviours of concern\(^{26}\). These approaches focus on the behaviours of inappropriate toileting as opposed to the underlying reasons for incontinence. Despite this, many people with disabilities are placed in restrictive clothing for either part of the day or for 24 hours a day because they remove or interfere with their incontinence pad. The aim, therefore, should be to improve the toileting skills of the person so that restrictive clothing is not necessary in order to maintain an incontinence device.

People with a disability might display a number of different bowel-related behaviours of concern, including:\(^{27}\)

- encopresis: repeated bowel movements in inappropriate places (such as on clothing or the floor) in a child at least four years of age

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soiling: a small leakage of faeces resulting in stained underwear
• constipation: infrequent bowel movements that result in encopresis and/or soiling.

Incontinence is unlikely to improve by itself beyond late childhood or adolescence. Many children with developmental disabilities require training to acquire toileting skills and, without effective intervention, problems can persist into adulthood. Children under the age of 12 years respond to toileting interventions faster than adults with a similar disability and this supports the focus of intervention early in life. Nappies and pads, although convenient for parents, carers and staff, may slow a person’s progress in developing continence skills. Wet nappies or pads often provide an incorrect rationale for their own continued use (the fact that they are wet erroneously indicates the need for their use).

While behavioural intervention has been proven to be effective, there are reported difficulties with some people with disabilities with toileting in some settings and not others, such as home

and not at respite. Changes in the person’s daily routines and with the design or layout of bathrooms themselves, as well as difficulties with transitions between tasks or activities, are related to toileting problems in people with autism. Even if these problems don’t exist, behavioural intervention for incontinence-related behaviours requires substantial commitment from staff, parents and carers as well as professional support and supervision.

Level of IQ (a measurement of intelligence), male gender and being non-verbal are associated with toileting problems. Constipation is associated with not being able to walk independently, cerebral palsy, anticonvulsant and proton-pump-inhibiting medication and food refusal. People with autism, many of whom have intellectual disability, can have toileting problems regardless of their cognitive ability and, compared with the general population, their acquisition of bowel control can be more problematic than bladder control.

Suggested behavioural methods for toilet training

Additional information and advice on improving toileting skills for children can be obtained from child health services and from the Better Health Channel at www.betterhealth.vic.gov.au.

Moving from nappy/pad to toilet
Some people with disabilities show a problem recognising when to urinate or pass a bowel motion in the toilet or potty because they have learnt to pass urine or faeces only when they wear a nappy or pad. Changing this behaviour consists of identifying what assists the person to urinate or defecate and using this to help pass urine or faeces in a toilet or potty. For example, wearing a nappy while seated on the toilet and gradually withdrawing it over time (such as keeping the nappy or pad on the lap but not covering the genitals or anus) is a successful method reported frequently in the research; some cases are reported to take many months to achieve the desired outcome.

Prompted and scheduled toileting
Using a schedule for going to the toilet has been used successfully for some people with disabilities and scheduling toileting towards the end of the day increases the likelihood of a full bladder and therefore urination in the toilet. There is no evidence to support the choice of either prompted versus self-initiated toileting, or for after-meal prompts versus prompts at other times; however, it is recommended that the person be sat on the toilet or potty for no more than 10 minutes at a time.

Bed wetting has been identified more correctly as ‘early morning wetting’ in some cases where people with disabilities are dry all night and empty their bladders into the nappy or pad when they wake in the morning.

Toilet priming
Another method is toilet priming, which involves previewing the person’s toileting for them in a non-threatening and exploratory manner. For example, a toilet training video was shown consistently three times a day to a child with autism as part of his toileting program, which allowed him to become accustomed to the task of toileting before engaging in the toileting program. Other options include social stories of using the toilet; this involves a story being written and presented in a visual format that shows the person with a disability using the toilet in the desired way.

Other more sophisticated methods of toilet training for people with disabilities (including alarm systems built into the clothing) are complex, expensive and have limited evidence for their use. Behavioural approaches involving aversive techniques have not shown improvements. Strategies that involve punishment are not lawful in Victoria. One study found opposite effects from punishing soiling while another found that a child withheld opening.

References
42 Charter of Human Rights and Responsibilities Act 2006, s. 10(b).
their bowels when punishment was used.\textsuperscript{44} Many medical interventions, such as stool softeners and laxatives, have been found to be generally ineffective,\textsuperscript{27} while the response-restriction method\textsuperscript{45} (forcing a person to stand in front of the toilet, sit on the toilet or urinate or defecate in the toilet) is an aversive practice. The often cited method of ‘rapid toilet training’ by Azrin and Foxx\textsuperscript{46} contains a number of aversive techniques and relies heavily on punishment. Aversive practices must be avoided.

Before any toileting program can be implemented, it is necessary to assess if the person has the physical skills that will enable them to sit on the toilet or potty, that they have the bladder capacity to hold urine and that they can respond to a verbal or visual command or prompt to go to the toilet.\textsuperscript{33} It is also important that adaptive behaviour has been assessed.\textsuperscript{21} Adaptive behaviour is the ability of the person with a disability to manage the everyday demands of society. This can be formally assessed by an appropriately qualified clinician. Free access to drinks and the toilet itself throughout the day is also necessary to promote bowel and bladder function and opportunities for independent toileting.\textsuperscript{33}

Prior to implementing any behaviour intervention, a baseline recording of usual bowel and/or bladder function is required. For as many days as possible, record the exact times when the person emptied their bowel or bladder (by removing the nappy or pad because many products have excellent absorbency and therefore do not ‘feel’ wet) and visually inspecting. Refer to the example chart below for a recording method.\textsuperscript{37}

When considering implementing a toileting program:\textsuperscript{39}

- Choose a convenient time to start the assessment and intervention.
- Provide a toy or activity during timed toileting to encourage remaining seated.
- Change clothing, nappy or pad with minimal fuss.
- Praise successful urination or defecation
- Make sure you are consistent and plan for extra time to transfer the skill in other settings.

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Pants: W = wet; D = damp; P = poo
Toilet: U = wee; B = poo


Clothing for people with disabilities has been found to influence impressions of intelligence. People with disabilities are often evaluated negatively and any other factor that can further influence this opinion should be minimised. Conversely, clothing can have rehabilitation potential through building life skills and improving self-esteem. How you are presented, with the embedded meanings so implied can be a source of ease and calm – or the reverse. As such, clothing can be used to disempower people if used as a restraint. To support the dignity of people with a disability, it is essential that the person exercises choice of appropriate and non-disability-identifying clothing.

As restrictive clothing is a form of modified clothing, it is essential that we understand how the restrictive clothing itself may be contributing to behaviours of concern. Research has identified a number of problems with clothing for people with disabilities including poor freedom of movement, poor comfort and irritating features. There is no research guiding the use of modified clothing for people with intellectual disability or autism spectrum disorder; however, there is information available concerning people with physical disabilities, the principles of which can be appropriately applied.

Anecdotally, the use of lycra products as restrictive clothing is common; however, lycra is reported to be difficult to put on and is uncomfortable. Increased bowel and bladder problems, both incontinence/constipation and reduced independent toileting, have been identified as complications associated with wearing lycra clothing. There are also reported cases of irritated skin conditions and friction sores and aggression as the garment is applied. Another common clothing fastener used is Velcro; however, Velcro can hurt the skin. Parents of seven out of twelve children in one study reported that their children disliked lycra clothing while seven out of eight in another study also disliked wearing them. Importantly, circulation difficulties, such as blue fingers and excessive warmth leading to dehydration, have also been reported. These examples are important reminders that while lycra garments are readily available, they can pose a number of risks, many of which can be health-related, but they can also potentially contribute to behaviours of concern themselves.

Using restrictive clothing can also increase the physical workload and strain of parents, carers and staff who have to apply the clothing. People with disabilities may have existing limitations in motor abilities and stamina and therefore restrictive clothing may:

- not account for the individual preferences and abilities of the person
- promote excessive heating or cooling
- interfere with sensory abilities

• increase hazards and adverse consequences of accidental or adverse actions (such as falling down or turning over in bed)
• increase fatigue
• limit the ability to reach and manipulate objects.

An easy way to reduce restrictive clothing already in use is to slowly increase the time that the restrictive clothing is left open, undone or unfastened. One study reports that a jumpsuit was unfastened for 10 minutes each hour and this period of time was increased over time until it was removed completely. This was a component of a more comprehensive behavioural intervention involving toilet training.

Summary

Behavioural interventions for behaviours of concern leading to the use of restrictive clothing are effective if they are evidence-based, use FBA and include teaching and skill development for the person with a disability that is tailored to their individual needs. It is important to acknowledge that long-term behaviour change requires commitment and consistency from families and disability service providers. Basic interventions, such as toilet training, provides an opportunity for behaviour support that will have a positive impact on reducing the use of restrictive clothing.

For any behavioural intervention to be successful, toileting skills are a necessary ability for the person with a disability. It is therefore important that interventions commence as early as possible in life, as would be expected for a person without a disability. There are many methods of toilet training for people with disabilities; however, considering toilet training as ‘too hard’ commits the person with a disability to a life with restrictive clothing, which may actually be contributing to the behaviour of concern itself.

Any person with a disability who engages in behaviours of concern resulting in the use of restrictive clothing should be reviewed using the following guidelines.

1. Does the person with a disability have an effective means of communication? Can they understand what is said to them (receptive communication skills) and express themselves in a way that others can understand (expressive communication skills)?

2. Stressors: has the person experienced any changes, disruptions or losses in their life or potential traumatic experiences recently? Seemingly small stressors for us may be significant for someone with a disability and should not be overlooked.

3. Physical health: Could the person be unwell? How does the person communicate feeling unwell? How do you know if the person is unwell? If you have any concerns about the health of a person with a disability then they should be reviewed by a medical practitioner.
4. Adverse effects of medication: Many people with disabilities are prescribed medication whether as chemical restraint or therapeutic purposes and these medications can have adverse effects. Do you know what the side effects of the medication prescribed for a person with a disability are and how to look for them? What do you do if you see them? The Office of the Senior Practitioner recommends that any person prescribed psychotropic (psychiatric) medication as chemical restraint or for therapeutic purposes is reviewed at least annually by a medical specialist, for example, a psychiatrist, neurologist or paediatrician.

5. Baseline data about the behaviour of concern should be collected using the ABC (Antecedent-Behaviour-Consequence) or STAR (Setting-Trigger-Action-Response) method so that an FBA can be conducted.

6. A behaviour support plan must be devised if the person is subject to a restrictive intervention as required by the Disability Act. Further information about behaviour support plans is available on the Office of the Senior Practitioner website.

In summary, the use of such restrictive interventions, including restrictive clothing, is ineffective because they:

- only have a short-term impact (there is no change in long-term behaviour)
- don’t teach adaptive skills (the person does not learn to use other skills to obtain what they want through demonstrating the behaviour of concern)
- restrict human rights and dignity
- may result in staff or others getting hurt (the restrictive clothing may be difficult to apply and/or the person with a disability may not want to wear it and may become physically agitated)
- don’t address why the behaviour is occurring
- have inherent risks for people wearing them.

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