



Policy No. 110

Statement on Aversives

Adopted April 27, 1990

The Developmental Disabilities Council supports increasing opportunities for, and protecting the civil rights of, people with developmental disabilities. These rights include the right to live, develop, and fully participate in society; the right to be treated with dignity and respect; the right to live free from mental, physical, or emotional harm; the right to procedural safeguards and informed consent; and the right to be free from discrimination.

The Council supports education and behavior management practices that are positive and appropriate for use in varied, integrated environments and that contributes to the quality of life for people with developmental disabilities.

The Council supports the promotion of positive behavior management techniques and the avoidance of negative behavior management techniques or aversive procedures.

It is the policy of the Developmental Disabilities Council that:

1. Behavior management programs and treatments focus on prevention of maladaptive behaviors, environmental adaptations, and positive reinforcements;
2. Programs are designed and applied in a humane, caring manner with the ultimate goal of growth and development;
3. Staff are given appropriate, ongoing training in state-of-the-art positive programming (including training in how to appropriately handle crisis situations);
4. Successful alternative programs that are appropriate and positive are continually being developed and implemented; and
5. Procedural safeguards include informed consent and review and approval processes that will ensure the use of least restrictive procedures.

The Developmental Disabilities Council advocates for the use of behavior management programs that are:

1. Based upon a thorough analysis of each individual's existing needs, competencies, and characteristics;
2. Based on procedures supported in current clinical/educational research literature;
3. Intended to replace challenging behavior with adaptive and socially productive behavior;
4. Implemented in positive and socially supportive environments;
5. Based on the long-term goals of community integration and independence;
6. Carried out by staff who have been trained and are qualified to effectively apply positive, non-aversive approaches;
7. Monitored continuously and systematically to ensure that the approach is consistent with individual needs and is successful in achieving established goals;
8. The approach is modified in a timely fashion if success is not evident or not occurring at an appropriate rate; and
9. Based on a multi-component, multi-disciplinary approach.

Behavior management programs and procedures should be based on a positive, therapeutic plan. This plan may include the use of mild, non-harmful negatives that we all experience on a regular basis such as frowning, normal verbal reprimands, and nonviolent touching. This plan should not include procedures that are disrespectful, dehumanizing, or involve social humiliation.

We feel that the following aversive behavior management methods should be eliminated as aversive procedures:

- Procedures that inflict pain or harm;
- Procedures that may cause potential or actual side effects such as tissue damage, physical illness, severe physical or emotional stress, or death;
- Procedures that withhold basic human needs;
- Procedures of environmental deprivation or unrestricted incarceration; and
- Procedures of chemical/physical restraint.

The Council recognizes that there are life-threatening emergencies, which require an immediate, effective response. "Life-threatening" means a very severe

threat to the person of disability. Until technology and knowledge are developed to effectively deal with the extremely severe, dangerous behaviors of a few individuals, negative, aversive responses may be necessary to restore safety. Aversives are to be used in emergencies only. What constitutes an emergency and what procedures are acceptable in these situations should be planned in advance in consultation with a treatment team.

They should be part of the individual's personal habilitation plan, spelling out gradations of response that are appropriate to levels of danger. Such procedures are not therapeutic programming and do not take the place of a comprehensive positive behavior management program.

Aversive responses must be applied only as a last recourse and must include the following aspects:

- Procedural safeguards;
- Informed consent of the appropriate person or advocate (a human rights committee if necessary);
- Ongoing notification to the appropriate persons and referenced in the person's individual plan(s) (e.g., Individual Education Plan, Individual Habilitation Plan) with defined objectives and goals;
- Documentation with incidence reports showing a decreasing frequency of undesirable behavior;
- An appropriate corrective plan is in place. This means a distinction is made between emergency short-term procedures and proactive, therapeutic programming that seeks to make long-term behavior changes (the need for using aversives in some situations does not justify the lack of a positive therapeutic program); and
- There is an ongoing effort to find and use effective alternatives.

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