

IMPLEMENTATION GUIDELINE FOR DISABILITY SUPPORT PROVIDERS



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Artist: Moira Buchholtz, Hanging Rock, Victoria.

‘Be the Key’

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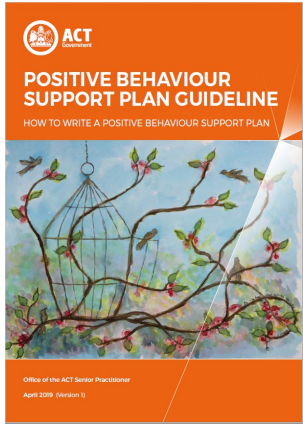
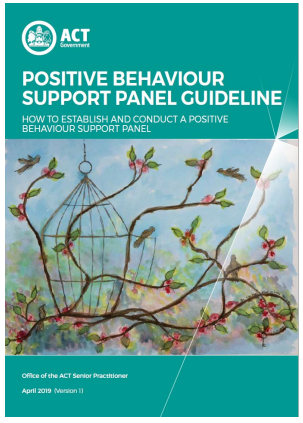
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RELATED SENIOR PRACTITIONER GUIDELINES

	<p>Positive Behaviour Support Plan Guideline</p> <ul style="list-style-type: none">• Detailed information on the development of Positive Behaviour Support Plans• Detailed information on the content of Positive Behaviour Support Plans• Information on monitoring restrictive practice• Detailed information on preparing and submitting a Positive Behaviour Support Plan to a Panel
	<p>Positive Behaviour Support Panel Guideline</p> <ul style="list-style-type: none">• Assessment and approval of Plans by a Positive Behaviour Support Panel• Panel requirements, including composition and registration• Review and registration of Plans by the Senior Practitioner

FOREWORD

The Senior Practitioner in the Australian Capital Territory (ACT) Government has powers and functions provided by the Senior Practitioner Act 2018 (the Act).

The Senior Practitioner helps to guide decisions and provide education to foster positive alternatives to restrictive practices, which preserve a person's rights and freedoms. The Senior Practitioner has independent oversight of the use of restrictive practice in education and care, disability, care and protection of children in out of home care, and any service determined to be covered under the Act.

The Act defines a restrictive practice as a practice that is used to restrict the rights or freedom of movement of a person for the primary purpose of protecting the person or others from harm.¹ The types of regulated restrictive practices are defined in Table 2 on page 10.

The ACT was the first State or Territory in Australia to adopt a legislative charter of human rights in the Human Rights Act 2004 and is now one of three Australian jurisdictions with legislation that imposes binding human rights obligations on public authorities. Any limits on human rights will only be justified where there is a lawful basis for the limitation, and it is the least restrictive way of achieving a legitimate purpose, such as protecting the safety and rights of others.

While the Senior Practitioner Act establishes a legislative scheme for regulating the use of restrictive practices, it coexists with existing obligations or legislative schemes established under other Acts. It is important to consider how other relevant legislation (see Attachment A) may apply in the planning and implementation of behaviour support for the person.

WHO IS THE AUDIENCE FOR THIS GUIDELINE?

Although the Senior Practitioner Act covers three sectors (mentioned above) this guideline is for all persons or entities providing disability services to a person in the ACT.

THE PURPOSE OF THIS GUIDELINE

The Act is the authorising law that allows for the limited use of restrictive practices. The aim of the Act is to reduce and eliminate the use of restrictive practices while keeping people safe and upholding human rights.

¹ Section 7

The Senior Practitioner has issued this Guideline under Section 27 of the Act to help providers and people understand the Act and how it affects them.

Guidelines made under the Act, including this one, are *disallowable instruments*. They have the same legal force as the Act and must be taken into account when making decisions.

This Guideline is based on current research and engagement with a broad range of community sector and government stakeholders. This includes members of the Senior Practitioner Resource Working Group, the Education Working Group, the Senior Practitioner Consumer Reference Group and the Restrictive Practices Oversight Steering Group. The Guideline will underpin future conversations about implementing the Act.

All service providers remain responsible for developing their own policies, procedures and protocols to meet their obligations under the Act. Organisational policies and procedures should reflect the types of services provided, as well as the assessed needs and abilities of the person receiving the service.

The legislative framework aligns with international human rights obligations articulated in the *United Nations Convention on the Rights of the Child (1990)*, the *United Nations Convention on the Rights of Persons with Disabilities (2006)*, and the ACT government commitment to and Australian NDIS providers' obligations under the National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Service Sector.

This guideline complements the National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 and the [Quality and Safeguarding Framework](#) (see Attachment A for more information).

However, it is important to note that the Act protects the rights of all individuals in the above settings, not just those who have a disability. The Senior Practitioner acknowledges the previous effort made within these sectors to safeguard the rights of people who may be subject to restrictive practices.

This Guideline seeks to consolidate this effort with the goal of all providers working collaboratively with all people to maximise the opportunity for positive outcomes and reduce or eliminate the need for use of restrictive practice in support of people with disability.

This Guideline is presented in similar sequencing as the Act but provides the information in an easier to understand format. A glossary of terms used in this Guideline is provided at page 33.

Below is a one-page summary of the overall expectations of providers.

EXPECTATIONS OF PROVIDERS

Providers must recognise, restrictive practices can only be used in very limited circumstances:

- as a last resort, in the least restrictive way to ensure the safety of the person or others; and
- for the shortest period possible in the circumstances.

Providers need to be accountable for restrictive practices within their services and any use of restrictive practices by providers needs to be transparent

Providers cannot use restrictive practices punitively or in response to behaviours that do not cause harm to the person or others;

Providers must regulate the use of restrictive practices and provide services in a way that:

- aims to reduce or eliminate the need for restrictive practice;
- safeguards the person and others from harm;
- is consistent with the person's human rights; and
- uses Positive Behaviour Support planning informed by evidence based best practice

The service must be provided in a way which assumes the person has decision making capacity unless it is established that they do not

- All practical steps must be taken to assist a person to make a decision;
- A provider must not treat someone as being unable to make a decision only because they make an unwise decision

Providers must only use restrictive practices:

- in a way which is consistent with a registered Positive Behaviour Support Plan for the person or
- in an emergency situation that requires an immediate response due to imminent serious harm to the person or others

Providers must implement strategies to produce behavioural change, focussed on skills development and replacement behaviours, and environmental design;

Providers must work closely and collaboratively with the person and their family, their carers, any guardian or advocate for the person and any other relevant person, to develop strategies for the person's care and support;

In developing strategies and interventions to respond to the person's behaviours of concern, providers must seek to:

- reduce or eliminate the need for the use of restrictive practices;
- promote the person's development and physical, mental, social and vocational ability;
- provide opportunities for participation and inclusion in the community and respond to the person's needs and goals.
-

WHO IS A 'PROVIDER' UNDER THE ACT?

While this document has been written for disability service providers, the oversight of the ACT Senior Practitioner extends to providers of:

- **Education:** incorporates the three sectors these being the ACT Education Directorate, Catholic and Independent schools. It also includes education and care providers (i.e., long day care, before and after school care, preschools and family day care)
- **Disability services:** includes both NDIS registered and non-registered providers
- **Care and protection of children:** specifically, any child in out of home care

A Provider is NOT:

- a close family member of the other person; or
- an informal carer for the person; or
- an exempt entity

Table 1 describes provides definitions of the exemptions and further clarity.

TABLE 1: EXCLUSIONS WHO IS NOT A PROVIDER

Close family member:

A person who is:

- the domestic partner of the person; or
- a parent or stepparent of the person; or
- a sibling or stepsibling of the person; or
- a child or stepchild of the person, or another child for whom the person has parental responsibility

Informal carer:

A person who provides personal care, support or assistance to the other person, (Informal support)

An informal carer does NOT provide the care, support or assistance:

- 1) under a contract of service or a contract for the provision of services; or
- 2) while doing voluntary work for a charitable, welfare or community organisation; or
- 3) as part of the requirements of a course of education or training.

Exempt entity:

A person exercising a function under:

- the [Corrections Management Act 2007](#); or
- the [Children and Young People Act 2008](#), chapters 4 to 9 (the criminal matters chapters); or
- the [Mental Health Act 2015](#); or
- the [Mental Health \(Secure Facilities\) Act 2016](#); or
- a police officer acting under lawful authority; or
- a person or other entity prescribed by regulation.

Hospitals are not considered providers under the Act at the time of writing.

Hospitals need to consider the context if a child or person with a disability is transitioning to the community and have clear processes and pathways should a Positive Behaviour Support Plan be required on discharge.

Aged Care is not considered a provider under the Act at the time of writing. However, Aged Care facilities will need to consider their obligations under the NDIS should a resident be an NDIS participant, and the facility uses this funding to implement restrictive practices.

RESTRICTIVE PRACTICES

A restrictive practice is defined as any practice used to restrict the rights or freedom of movement of a person for the primary purpose of protecting the person or others from harm. Restrictive practices can only be used in the following situations:

- in response to a behaviour of concern (situations of serious harm to self or others);
- to avoid imminent serious harm to the person or others;
- as a last resort;
- for the shortest possible time;
- in the least restrictive way;
- in accordance with a registered Positive Behaviour Support Plan; or if there is no such plan;
 - a. in an emergency situation/critical incident requiring an immediate response due to imminent serious harm² to the person or others, or;
 - b. where necessary to prevent serious and imminent injury to any person

RESTRICTIVE PRACTICE DEFINITIONS	
<p>A practice that is used to restrict the rights or freedom of movement of a person for the primary purpose of protecting the person or others from harm, and includes the following:</p> <ul style="list-style-type: none"> • chemical restraint; • environmental restraint; • mechanical restraint; • physical restraint; • seclusion; or • verbal directions, or gestural conduct, of a coercive nature. 	<p>A restrictive practice is NOT</p> <ol style="list-style-type: none"> 1) reasonable action taken to monitor and protect a child from harm, e.g. holding a child’s hand while crossing the road or fencing around a primary school 2) a practice prescribed by regulation not to be a restrictive practice

² The Act defines harm to a person as:

- physical harm to the person; or
- a serious risk of physical harm to the person; or
- damage to property involving a serious risk of physical harm to the person.

Chemical Restraint

The use of medication or a chemical substance for the primary purpose of influencing a person's behaviour or movement.

Chemical restraint is NOT:

- 1) the use of a chemical substance that is prescribed by a medical practitioner or nurse practitioner for the treatment, or to enable the treatment, of a mental or physical illness or condition in a person, and
- 2) used in accordance with the prescription.

Note on Menstrual Suppression:

Menstrual Suppression is the temporary or permanent cessation of menstruation by the use of pharmacologically active substances or surgical intervention. This can include hormonal implants and Intrauterine devices (IUD). Menstrual suppression by medication for the management of behaviours of concern is considered to be a chemical restraint.

<https://www.cddh.monashhealth.org/wp-content/uploads/2016/11/supporting-women-carer.pdf>

<https://www.nps.org.au/australian-prescriber/articles/menstrual-issues-for-women-with-intellectual-disability>

Case Example – Jackie - Chemical restraint

Jackie has autism and at times can hurt herself by hitting herself in the head or banging her head on hard surfaces. She often does this when she is anxious and wants to escape or avoid a situation or activity.

Jackie has been prescribed Risperidone to try and help to reduce or stop this behaviour.

This is chemical restraint.

It is a medication prescribed for the primary purpose in managing Jackie's behaviour.

Jackie will need a Positive Behaviour Support Plan to address the function of her behaviour.

The provider will need to report the use of the Risperidone as a chemical restraint.

Jackie - Medication for treatment of a physical condition

Jackie also has a diagnosis of epilepsy and is prescribed Epilim. *This is not chemical restraint* as it is a medication for a diagnosed physical condition (epilepsy), which the medication (Epilim) is prescribed to treat. Jackie will need an epilepsy management plan and/or a health care plan.

Environmental Restraint

Any action or system that limits a person's ability to freely access the person's surroundings or a particular thing or engage in an activity.

Environmental restraint is NOT:

A safety precaution such as a fence around a primary school playground.

Case Example – Bob – Environmental Restraint

Bob lives in a house with 3 other men. Bob has been known to eat raw foods from the fridge and freezer which has made him sick.

The house staff have locked the fridge so that Bob can't access the food.

The lock on the fridge is an environmental restraint.

Bob will need a Positive Behaviour Support Plan to address the function of his behaviour.

The provider will need to report the locked fridge as an environmental restraint.

Case Example – John – Impact Statement

John lives with Bob and two other men. Bob has been known to eat raw foods from the fridge and freezer, which has made him sick.

The house staff have locked the fridge so that Bob can't access the food.

The lock on the fridge impacts John and the other two men

John and his housemates have a right to access all public areas of their home and to have access to their own food and drinks.

John and the other two men he lives with will need the environmental restraint for Bob acknowledged in an impact statement which is kept with the provider with strategies to help them access the fridge and freezer.

An impact statement is a document created by the provider that acknowledges the impact that the restrictive practice in place for Bob has on John and the others living in the house. It should describe the strategies, including any skill building needed, that John and the others use to lessen the impact that the restriction has on them.

The Senior Practitioner has an example document that staff can use.

Mechanical Restraint

The use of a device to prevent, restrict or subdue the movement of all or part of a person's body.

Mechanical restraint is NOT:

- 1) the use of the device to ensure the person's safety when travelling; or
- 2) the use of a device for therapeutic purposes, for example a postural support harness.

Case Example – Rachel – Mechanical Restraint

Rachel will pull out her incontinence aids and throw them. She will also smear faeces onto walls, furniture and others. Rachel wears a bodysuit under her clothes to prevent her accessing her incontinence aids.

The bodysuit is a mechanical restraint.

It is a device that is used to restrict the access that Rachel has to her own body.

Rachel will need a Positive Behaviour Support Plan to address the function of the behaviour.

The provider will need to report the use of the bodysuit as a mechanical restraint.

Rachel – the use of a device to ensure safe transportation

Rachel likes to move around in the car or bus when it is travelling. She will undo her seat belt and try to get in the front seat.

A buckle guard has been put in place to stop Rachel from undoing her seat belt and moving around in the vehicle.

A buckle guard to ensure that Rachel wears her seat belt in a vehicle is *not a mechanical restraint*. It is Australian law that people wear seat belts in vehicles.

Working out the function of Rachel's behaviour (trying to get in the front seat) and developing strategies to address the behaviour will help reduce the need for the buckle guard and needs to be included in any behaviour support plan that she has. She will not need a plan if the buckle guard is the only device used. The Senior Practitioner can help to clarify specific instances.

Physical Restraint

The use or action of physical force to stop, limit or subdue the movement of a person's body or part of the person's body.

Physical restraint is NOT:

A reflexive action of reasonable physical force and duration intended to guide or direct a person in the interests of the person's safety where there is an imminent risk of harm.

Case Example – Stephen – Physical Restraint

Stephen will use his fists to strike out at others when he wants to be left alone.

Stephen is striking Joe with closed fists to Joe's face and upper body. Calling out to Stephen to stop has not worked and Joe is unable to leave the area. Staff grab and hold Stephen's arms to prevent him from striking Joe while Joe leaves the area.

This is physical restraint.

Staff are using physical force to stop or subdue Stephen from striking Joe.

Stephen will need a Positive Behaviour Support Plan to address the function of the behaviour.

The provider will need to report the holding of Stephen's arms as physical restraint.

Stephen – reflex action

Stephen attempts to step out onto the road without looking. A car is approaching as Stephen moves onto the road. Staff place an arm in front of Stephen to stop his forward movement.

This is not physical restraint. Staff have used a reflex action to stop Stephen's forward movement while the car goes past. Stephen is free to move away in another direction.

Stephen will need careful assessment to make sure that he understands road safety. If he needs assistance in learning road safety, he will need explicit and systematic skill building over time to address these.

Seclusion

The sole confinement of a person, at any time of the day or night, in a room or other space from which free exit is prevented, either implicitly or explicitly, or not facilitated.

Seclusion is NOT:

Social isolation where a child or vulnerable person is in a space away from others. For example a child alone in a room from which they can freely exit.

Case Example – Rebecca – Seclusion

Rebecca has overturned tables and is throwing items at others. She has also picked up a pair of scissors and is threatening to cut others in the room with them.

Staff remove everyone except Rebecca from the room and hold the door shut so that Rebecca can't follow them.

This is seclusion.

Staff are confining Rebecca to an area which she is prevented from exiting. This could be a room, courtyard or any other area on the premises from which Rebecca is prevented from exiting.

Rebecca will need a Positive Behaviour Support Plan to address the function of the behaviour.

The provider will need to report confining Rebecca as seclusion.

Case Example – Anna – Social isolation

Anna can get overwhelmed in situations that are noisy and busy. A planned strategy for Anna is to take a break in a quiet area until she feels she is able to re-join the group and/or situation. Anna had to be taught this strategy and the skills to regulate.

Anna is not prevented from leaving the quiet area and is able to leave the quiet area at any time.

This is not seclusion. This is an example of social isolation that helps Anna to re charge.

Verbal directions, or gestural conduct, of a coercive nature

Restrictive practices of this nature are not acceptable and cannot be included in a plan.

They must, however, be reported.

Verbal Direction or Gestural Conduct of a Coercive Nature is threatening a person to get them to do what you want.

It is also when someone degrades, humiliates or forces a person into a position of powerlessness

Verbal directions or Gestural Conduct of a coercive nature is NOT:

Telling someone what the rules are, or giving a person directions or instructions to help them feel better or calm down, are not Verbal Directions or Gestural Conduct of a Coercive Nature.

Case Example – Jonah – Verbal directions or gestural conduct of a coercive nature

Jonah lives by himself with staff support. He relies on staff support to facilitate visits in the community with his family. Staff say to Jonah that if he doesn't do his chores, he won't be allowed to visit his mum.

This is a coercive practice.

Jonah is being threatened with isolation from his family unless he complies with staff. He is in a position of powerlessness and has received a threat which would result in restricted family and community access unless he complies with the direction to do his chores.

Restrictive practices of this nature are not acceptable and cannot be included in a plan. They must, however, be reported.

The Senior Practitioner needs to be informed of this and this will be dealt with as a complaint.

Case Example – Emma – Directions or instructions

Emma is due to visit her mum at 2pm at a local café. Staff say to Emma that 'first we clean up, then we visit mum'. Staff have developed a good rapport with Emma and understand how best to motivate her and this instruction does not imply that Emma is not visiting her mum.

Staff then provide active support to Emma to help her learn the skills to clean up.

Providing directions or instructions is not coercive. Emma seeing her mum is not dependent on her compliance with staff.

Restrictive practices have the potential to be misused when used:

- as a punishment
- in a non-critical situation (where there is not an imminent risk of serious harm) as a short-term fix rather than as the last resort;
- although the behaviour of concern no longer occurs;
- prior to the use of positive behaviour support strategies; or
- as a permanent 'unquestioned' practice.

When restrictive practices are misused, they could be considered poor quality of care or abuse. In situations where people are concerned about a potential misuse of restrictive practices, they can contact the following:

- The Senior Practitioner
<https://www.communityservices.act.gov.au/quality-complaints-and-regulation/office-of-the-senior-practitioner>
- The Public Advocate
<https://hrc.act.gov.au/public-advocate/> or (02) 6205 2222
- The Disability and Community Services Commissioner
<https://hrc.act.gov.au/disability/> or 02 6205 2222
- The National Disability Insurance Scheme (NDIS)
<https://www.ndis.gov.au/contact/feedback-and-complaints> or 1800 800 110
- In situations where a child is involved you may consider Mandatory Reporting obligations to child protection.
https://www.accesscanberra.act.gov.au/app/answers/detail/a_id/213/~reporting-child-abuse-and-neglect

BEHAVIOURS OF CONCERN AND POSITIVE BEHAVIOUR SUPPORT PLANS

BEHAVIOURS OF CONCERN

Definition

Behaviour of such intensity, frequency or duration that impacts the person's quality of life and/or their or others' physical safety.

Behaviours of concern can be further defined as any behaviour (active or passive) which is a barrier to a person participating in their community that undermines a person's quality of life and poses a risk to the safety of a person and/or others (McVilly 2002). This definition of behaviour of concern has been adopted by the Australasian Society for the Study of Intellectual Disability and the Australian Psychological Society (Budiselik et al. 2011) and remains current at time of writing.

It is extremely rare that the behaviour of any person can be explained by a single reason. A combination of issues may be involved including:

- environmental (physical barriers or influences, systems or practices);
- biological (including health, sensory or physical issues);
- psychological (mental health, trauma, thinking and problem-solving abilities); and
- social issues (complex communication needs, lack of meaningful opportunities, unmet needs).

Most behaviours of concern serve a purpose, or a function, and happen in order to have a need met. The need may be to avoid, or to gain access to something. It is used because the person does not know other ways to get their needs met and/or the behaviour has worked for the person in the past. Sometimes it is because previous attempts to have their needs met have been ignored (McVilly, 2002). In each case, a team approach is most effective in order to collaborate to understand the behaviour and develop a plan.

Providers must develop a clear description of the behaviour of concern that clearly identifies;

- What the behaviour looks like;**
- How often it happens (frequency);**
- How long it normally lasts for (duration); and**
- The impact (intensity).**

Collaboration between 'inter-disciplinary' teams (that may include speech pathologists, occupational therapists, nurses, general practitioners (GPs), mental health services and Board-Certified Behaviour Analysts (BCBA) should

occur with carers and the person themselves (with appropriate support) as equal partners. Plan authors must both consult and build skills with carers and staff. Staff and carers may require both emotional support (through good teamwork, supervision, debriefing and counselling) and technical support (through skills building in care and treatment). The Positive Behaviour Support Plan should reflect this multicomponent, interdisciplinary and multiagency collaboration with the goal being 'one person/one plan'.

POSITIVE BEHAVIOUR SUPPORT

The Act requires providers to implement restrictive practices consistent with a Positive Behaviour Plan. Positive behaviour support is an evidence-based framework aimed towards increasing a person's quality of life and decreasing any behaviours of concern. It is multi-tiered and establishes the social culture and supports which are needed in order to improve outcomes, including safety, for all people.

In order to achieve meaningful outcomes for people, providers should implement:

- practices which rely on evidence for guidance and decision making;
- systems to support the implementation of the evidence based practices, and;
- effective data collection and analysis to monitor the implementation and further guide decision making.

These three aspects are further outlined below:

PRACTICES

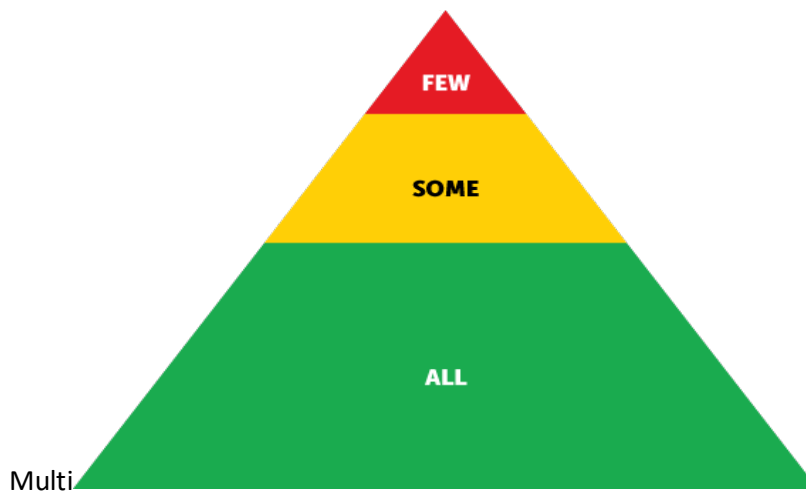
- document a shared vision and approach to supporting people
- establish positively stated organisation wide expectations and define them for each routine or setting
- explicitly teach organisation wide expectations and other key social, emotional and behavioural skills to set all people up for success
- establish strategies to recognise and reward contextually appropriate behaviour including providing specific feedback
- establish response strategies to teach contextually appropriate behaviour and discourage contextually inappropriate behaviour

SYSTEMS

- invest in administrative, professional and organisational systems that facilitate implementation of the multi-tiered approach
- deliver Tier 1, Tier 2 and Tier 3 practices

DATA

- establish and implement processes to collect and analyse data to guide implementation and evaluate outcomes



A Multi-Tiered approach delivers:

ALL: Universal supports (Tier 1) that support universal expectations across the organisation and prompts and reinforces appropriate behaviour. Planning, teaching and reinforcing expectations and values are an example of Tier 1 supports.

SOME: Targeted supports (Tier 2) for those people who require additional teaching and practice opportunities to increase their likelihood of success. This is often delivered within small groups and is intensive active supervision and skill building in a positive and proactive manner.

FEW: Intensive, individualised supports (Tier 3) use formalised assessments such as Functional Behavioural Assessments to match interventions to the behaviours function. Positive Behaviour Support Plans are an example of a Tier 3 support.³

Tier 2 and 3 supports are effective only when tier 1 supports are strong and implemented consistently.

³ OSEP Technical Assistance on Positive Behavioural Interventions and Supports (2019). Positive Behavioural Interventions and Supports (Website). Retrieved from www.pbis.org

POSITIVE BEHAVIOUR SUPPORT PLANS

A Positive Behaviour Support Plan is a plan for a person which describes the proactive (to prevent the likelihood of behaviours of concern happening) and reactive (to respond to warning signs of and actual behaviours of concern) strategies to be used in supporting the person's behaviour, including strategies to:

- meet that person's unmet needs (often a reason for the behaviour of concern);
- address the specific requirements of the environment (or multiple environments) that make it more likely for a person to use behaviours of concern, and a providers' need to use restrictive practices (such as routines and other triggers in the environment);
- build on the person's strengths and increase their life skills, thus improving their quality of life; and
- reduce the intensity, frequency and duration of behaviour that causes harm to the person or others.

Providers should develop clear policies and processes to ensure that:

- Positive Behaviour Support Plans are developed and implemented for people who use behaviours of concern
- All restrictive practices for individuals are clearly identified and contained within Positive Behaviour Support Plans
- Positive Behaviour Support Plans that contain restrictive practices are submitted to a Panel for approval and the Senior Practitioner for registration

[For detail see the Positive Behaviour Support Plan Guideline.]

The plan must also specify the conditions under which restrictive practices (if required) may be used.

It is important to understand a person can engage in behaviours of concern that *do not* result in restrictive practices. Behaviour which impacts on the person's quality of life will benefit from a Positive Behaviour Support Plan, but it does not necessarily need to contain restrictive practices.

Positive behaviour support plans which contain restrictive practices are developed for those behaviours that cause harm to self or harm to others.

NOTE: It is only Positive Behaviour Support Plans that include a restrictive practice(s) that need to be submitted to a Panel for approval and the Senior Practitioner for registration. On registration of a Positive Behaviour Support Plan which relates to a child, a provider must give a copy of the plan to the Public Advocate, who plays an important oversight role in monitoring restrictive practices involving children.

INTERIM POSITIVE BEHAVIOR SUPPORT PLANS

An interim plan is a short (few pages only) protocol for the safe use of restrictive practices on a short-term basis. The focus of an interim positive behaviour support plan is to keep people safe while functional behaviour assessments and the comprehensive behaviour support plan including preventative, functionally equivalent

replacement behaviours, skill building and response strategies can be developed for implementation. An interim behaviour support plan still must adhere to the principles of the least restrictive alternative and practice for that person.

An interim plan which includes the use of restrictive practices must also be submitted to the Panel for approval, and the Senior Practitioner for registration. An interim plan may be registered for a period of up to six months, after which time a comprehensive plan must be submitted. Only in exceptional circumstances will interim plans be extended beyond a six month time frame.

INTERFACE WITH THE NDIS QUALITY & SAFEGUARDS COMMISSION

There are specific protections under the *Senior Practitioner Act 2018* (the Act) and the NDIS Quality and Safeguards Commission (NDIS Commission) for people with disability who receive NDIS registered supports. All providers who have responsibilities under the Act in relation to restrictive practices **and** those providers who are providing a service to an NDIS participant must satisfy the NDIS Commission requirements for Positive Behaviour Support.

Since July 1, 2019, NDIS registered providers in ACT have had to ensure that they meet NDIS Commission requirements for Positive Behaviour Support Plans (PBS Plans). For more information, see

<https://www.ndiscommission.gov.au/providers/behaviour-support>;

If restrictive practices are used across multiple environments, all environments must collaborate and consult so that a plan is developed for the person considering strategies and supports across all environments.

POSITIVE BEHAVIOUR SUPPORT PANELS

This section should be read in conjunction with the Positive Behaviour Support Plan Panel Guideline which describes the role and responsibilities of a Panel, as well as considerations for providers who submit plans for approval to a Panel.

The Act requires a service provider to prepare a Positive Behaviour Support Plan for a person and give the plan to a PBS Panel for approval. The primary function of a PBS Panel is to assess whether:

- the Positive Behaviour Support Plan is consistent with the Positive Behaviour Support Plan Guideline issued under Section 12; and
- any restrictive practice included in the plan is necessary to prevent harm to the person or others and is the least restrictive approach reasonably available.

Written reasons outlining the Panel's decision to approve or not approve a Positive Behaviour Support Plan will be given to the provider.

Once approved the Positive Behaviour Support Plan must be submitted **by the provider**, (or with agreement, by the Panel), to the Senior Practitioner for registration.

Where restrictive practices are used by a regulated service provider, a PBS Panel's role is not to approve the restrictive practice as such, rather the panel approves a Positive Behaviour Support Plan which demonstrates the measures by which all restrictive practice will be reduced and eliminated.

The use of any restrictive practice within an approved plan is only authorised once registration has been confirmed by the Senior Practitioner. It is important to note only Positive Behaviour Support Plans that include a restrictive practice need to be approved by a PBS Panel and registered by the Senior Practitioner.

A person may apply to the Senior Practitioner for registration of a Positive Behaviour Support Panel. The application must be in writing and include:

- the name and business address of the applicant; and
- the particulars of each member of the proposed panel, including the member's name, contact details, experience and qualifications; and any other matter prescribed by regulation.

The Senior Practitioner may, in writing, require the applicant to provide additional information to make an informed decision on the application. If the applicant does not comply with the requirement within 28 days after the day the request is made, the Senior Practitioner may refuse to consider the application further and the application will lapse.

On application, the Senior Practitioner must either register the panel or refuse to register the panel.

All Panels must be registered with the Senior Practitioner and the Senior Practitioner must keep a register of the PBS panels.

The register must include the following details for each panel:

- the name of the person who applied for registration of the panel;
- the nominated contact person for the panel, including their contact details;
- the particulars of each member of the panel;
- the date the panel was registered.

APPROACH TO REGULATION

The Senior Practitioner works in collaboration across the whole of ACT government and the Canberra community to create significant systemic cultural change. The Senior Practitioner will drive change through wide ranging discussions about restrictive practices across the jurisdiction.

Cultural change will be achieved through creating a common language to dispel myths and preconceptions and develop a shared understanding of restrictive practices; openly discussing restrictive practices; understanding restrictive practices can be minimised or eliminated using evidence-based, least restrictive approaches; and reducing and eliminating restrictive practices is the responsibility of everyone. Driving this discussion to change cultures, attitudes and practices across the ACT will be through the implementation of the Positive Behaviour Support (PBS) approach across sectors and providers to whom this Act applies.

The Senior Practitioner has an essential role to support this whole of government and community approach to reduce and eliminate the use of restrictive practices through actions to:

PROMOTE UNDERSTANDING OF THE ACT:

- foster the reduction and elimination of the use of restrictive practices by providers to the greatest extent possible;
- oversee the use of restrictive practices in accordance with this Act;
- develop guidelines and standards on the use of restrictive practices; and
- undertake any other function as directed, in writing, by the Director-General, Community Services Directorate (CSD), or any other function given to the Senior Practitioner under the Act or another territory law.

Providers should take steps to:

- ❑ **Review policies, practices and procedures within their service settings to identify compatibility with the Positive Behaviour Support Framework**
- ❑ **Set clear goals for implementing change to work towards achieving consistency with the Positive Behaviour Support Framework**
- ❑ **Understand what restrictive practices are and identify where they occur within their service settings**
- ❑ **Actively work towards reducing and eliminating restrictive practices where they occur**

BE PROTECTIVE/ DIRECTIVE:

- ensure, to the greatest extent possible, that the rights of people who may be subject to restrictive practices are protected; and
- ensure providers comply with any applicable guidelines and standards on the use of restrictive practices.

BE EDUCATIVE:

- disseminate information, provide education, and give advice about restrictive practices and the rights of people who may be subject to them;
- provide advice to people who may be subject to restrictive practices;
- give directions to providers about the use of restrictive practices under Positive Behaviour Support Plans;
- develop links and access to professionals, professional bodies and academic institutions promoting knowledge and training in restrictive practices; and
- carry out research into the reduction, elimination and use of restrictive practices and provide information on best practice options to providers.

REGULATION :

The Act requires the Senior Practitioner to regulate the use of restrictive practices by providers. This includes the approval and registration of panel chairs and panellists, registration of Positive Behaviour Support plans, monitoring providers compliance with the approved Positive Behaviour Support Plans, monitoring compliance with reporting requirements outlined in the *Senior Practitioner Act 2018*.

The Office of Senior Practitioner uses a risk -based framework of regulation. Risk based regulation practice is defined as Hutter (2015, cited in Freiberg 2017) as being a commitment to a philosophy of risk management as the framework for governance. Risks are identified and assessed, ranked and inspection and enforcement undertaken based on the established risks to the cohort of people or products serviced (in the SP context, vulnerable children and adults subject to restrictive practices). It is a systemic approach which takes a wholistic view of regulation and risk management and conceptualises risks as being interrelated and having potential consequences for broader social and political environments.

In regulating the use of Restrictive Practices, the Senior Practitioner will apply the following principles of regulations to providers:

- proportionate – enforcement powers will only be used when necessary and in a way that is appropriate to the level of risk;
- accountable – able to justify assessments and be subject to scrutiny;

- consistent- regulation and monitoring will be consistent regardless of the area in which the provider operates;
- transparent- clear and open communication with providers and persons subject to restrictive practices about regulatory decisions and enforcement;
- flexible- regulation will avoid unnecessary rules about how providers comply with the purposes of the Act.
- targeted- regulatory functions will be focused on the reduction and elimination of restrictive practices and the use of restrictive practices only in accordance with the Act. The purpose of regulation and enforcement is to improve the safety and well being of vulnerable people.

ENFORCEMENT

Under the Act, the Senior Practitioner has a range of enforcement powers for use if there is a reasonable belief that a provider is not complying with the Act.

These include:

- Issuing a direction;
- Cancellation of plan registration;
- Referral for criminal prosecution for use of restrictive practices not in accordance with the Act or failing to comply with a direction under the Act.

A separate guideline will be issued by the Senior Practitioner in relation to how the Act will be enforced, including the offences and penalties under Part 8 of the Act that may apply.

An Offences and Penalties Fact Sheet is also available on the Senior Practitioner webpage, at https://www.communityservices.act.gov.au/_data/assets/pdf_file/0018/1556001/Part-8-Penalties-and-Offences-under-the-Act-Fact-Sheet.pdf.

INFORMATION SHARING

The Senior Practitioner can share protected information with a range of agencies. Protected information means information about a person that is given to, or obtained by, the Senior Practitioner or any other person who does so as being under this Act.

The Senior Practitioner may give protected information to any of the following if satisfied on reasonable grounds that the information is necessary for the exercise of the Senior Practitioner's or entity's functions:

- the Director-General responsible for the [Education Act 2004](#);
- the Director-General responsible for the [Education and Care Services National Law \(ACT\)](#);
- the Director-General responsible for the [Health Act 1993](#);
- the Director-General responsible for the [Children and Young People Act 2008](#), other than chapter 20 of that Act;

- the Chief Executive Officer of the ACT Teacher Quality Institute;
- the Commissioner for Fair Trading;
- a member of the Human Rights Commission;
- an Official Visitor;
- the Ombudsman;
- an entity the Senior Practitioner has referred a complaint to under section 31
- the NDIS Quality and Safeguards Commission
- the Chief Police Officer if the Senior Practitioner is satisfied on reasonable grounds that the information is necessary for an investigation into the commission of an offence against a territory law;
- any other entity prescribed by regulation.

This facilitates cooperation and referral between the Senior Practitioner and other oversight agencies and investigative entities by authorising the sharing of necessary information necessary to appropriately accept, respond or deal with a matter.

NOTIFICATION AND REVIEW OF DECISIONS

Certain decisions that the Senior Practitioner makes under legislation may be subject to review.

A reviewable decision made by the Senior Practitioner as specified in the Act is to:

- register Positive Behaviour Support Plan
- refuse to register Positive Behaviour Support Plan;
- refuse to register Positive Behaviour Support Panel ;
- give direction or
- cancel registration of Positive Behaviour Support Plan.

The following people may apply to the ACT Civil and Administrative Tribunal (see [ACT Civil and Administrative Tribunal Act 2008](#), s 67A) requesting a review of the relevant reviewable decision listed above:

- person the subject of a Positive Behaviour Support plan;
- applicant for registration of a plan;
- applicant for registration of a panel;
- a provider given a direction;
- provider responsible for a cancelled plan
- any other person whose interests are affected by the decision.

If a reviewable decision is made, a reviewable decision notice must be provided to the people mentioned above.

For example: See PBS Panel Guideline in Appendix C for a sample letters sent to people who are the subject of the PBS plan. ADD HYPERLINK

OTHER INFORMATION IN SP ACT

- To ensure that the powers and functions of the Senior Practitioner remain transparent, an annual report will be prepared and provided to the Director-General, Community Services Directorate who will then include this report in the Director-General's annual report.
- The Senior Practitioner or any other person exercising a function under this Act is not civilly liable for anything done or omitted to be done honestly and without recklessness under this Act as long as:
 - (a) in the exercise of a function under this Act; or
 - (b) in the reasonable belief that the act or omission was in the exercise of a function under this Act.

Any civil liability that would attach to an official, attach instead to the Territory.

- Civil or criminal liability for others is not incurred only because of any of the following done honestly and without recklessness:
 - (a) the making of a complaint under this Act;
 - (b) the making of a statement, or the giving of a document or information, as required or permitted under a territory law, to the Senior Practitioner.
- The Executive has the power to make regulations under the Act.

Regulations are intended to provide for more detailed rules and operation of an Act where necessary.

The existence of a regulation making power does not oblige the Executive to make regulations. Any regulations made must be consistent with any provisions of the Act.

- The Minister is to arrange for the review of the operation of the Act as soon as practicable after the end of its fifth year of operation.

This review will include any statutory instruments made or in force under the Act, including a regulation.

As this Act establishes the role of Senior Practitioner and an oversight and support mechanism to reduce the use of restrictive practices in the ACT, it is important that the legislation empowering the Senior Practitioner is reviewed to ensure the Government's purpose, scope and objectives of the role are met.

There is currently no provision in the Act for further reviews.

ATTACHMENT A: GLOSSARY

Term/Abbreviation	EXPLANATION/ DEFINITION
ACT Civil and Administrative Tribunal (ACAT)	ACAT handles matters such as guardianship, financial management and enduring powers of attorney, mental health treatment and care.
Behaviours of Concern	Behaviour of such intensity, frequency or duration that impacts the person's quality of life and/or their or others' physical safety. Restrictive practices can be used only in response to a behaviour of concern.
Complaint	An expression of dissatisfaction made to the Senior Practitioner about a provider in regard to a positive behaviour support plan that permits the use of a restrictive practice, including its development or implementation, or the use of a restrictive practice by a provider.
Duty of care	Refers to a legal duty to take reasonable care not to cause harm to another person that could be reasonably foreseen.
Functional Behavioural Assessment (or FBA)	The process for determining and understanding the function or purpose behind a person's behaviour and involves the collection of data (such as observations and information from those who know the person well) to develop an understanding of the circumstances that trigger and maintain the behaviour of concern.
Exempt entities	Exempt entities are those persons or entities to which the Act does not apply such as: close family members, informal carers, members of the police, people working under the Corrections Management Act, or Mental Health Act. For example, this Act does not apply to jails, hospitals or nursing homes.
Harm	<p>Harm to a person means</p> <ul style="list-style-type: none"> • physical harm to a person; or • a serious risk of physical harm to a person; or • damage to property involving a serious risk of physical harm to a person.
Guardian	A public or private Guardian is appointed by ACAT to make a range of personal and health decisions for a person who is found to have impaired decision-making capacity
Least restrictive alternative	A practice that is not more restrictive or intrusive than necessary to prevent the person from inflicting harm on themselves or others; and is applied no longer than necessary to prevent harm or danger.

Term/Abbreviation	EXPLANATION/ DEFINITION
NDIS	National Disability Insurance Scheme
NDIS Quality and Safeguarding Framework	Is a national regulatory framework which aims to provide a nationally consistent approach to help empower and support NDIS participants to exercise choice and control, while ensuring appropriate safeguards are in place, and establishes expectations for providers and their staff to deliver high quality supports. Came into effect in the ACT on 1 July 2019. Available on the Department of Social Services website , at https://www.dss.gov.au/disability-and-carers/programs-services/for-people-with-disability/ndis-quality-and-safeguarding-framework . See also National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 at https://www.legislation.gov.au/Details/F2018L00632
Positive Behaviour Support (or PBS)	An evidence-based approach, which aims to: increase the person’s quality of life; and decrease the person’s behaviours of concern.
Positive Behaviour Support Panels (or PBS Panels)	Positive Behaviour Support panels assess, review, amend and approve Positive Behaviour Support Plans that meet the PBS panel guidelines, under the oversight of an Independent Chair.
Positive Behaviour Support Plan (or PBS Plan)	Positive Behaviour Support Plan (PBS Plan) describes the strategies to be used in supporting the person’s behaviour, including strategies to build on the person’s strengths and increase their life skills; and reduce the intensity, frequency and duration of the behaviour of concern.
PRN	Stands for <i>pro re nata</i> , a Latin term meaning “as required/needed”. PRN is used generally in the administration of medication, but also includes any emergency restraint.
Provider	A provider under this Act means a person or other entity who provides any of the following services to another person: (a) education; (b) education and care (c) disability; (d) care and protection of children; (e) an area prescribed by regulation.

Term/Abbreviation	EXPLANATION/ DEFINITION
Restrictive practice	<p>Defined under the <i>Senior Practitioner Act 2018</i> as a practice that is used to restrict the rights or freedom of movement of a person for the primary purpose of protecting the person or others from harm.</p> <p>The intent of the legislation is to ensure that restrictive practices are only used:</p> <ul style="list-style-type: none"> • in response to a behaviour of concern; • as a last resort; • for the shortest possible time; • in the least restrictive way; • to avoid imminent risk of serious harm to the person or others; • in accordance with a registered Positive Behaviour Support Plan, or; • in an emergency situation/critical incident requiring an immediate response due to an imminent risk of serious harm to the person or others.
Person	The person who is receiving the service who may be subject to a restrictive practice. Maybe an adult, young person or child.

ATTACHMENT B: GUIDELINES FOR PROVIDERS ABOUT POSITIVE BEHAVIOUR SUPPORT PLANS (PBS PLANS)

TABLE 3: GUIDELINES FOR PBS PLANS THAT INCLUDE RESTRICTIVE PRACTICES	
This table should be read in conjunction with the <i>Positive Behaviour Support Plan Guideline</i> .	
Who?	Guidelines
1) Developing the plan	
Provider (including individual and team)	<p>A provider must:</p> <ul style="list-style-type: none"> engage as appropriate with the person, their family, carers, any guardian or advocate for the person and any other relevant person; and use the assistance of a person with professional expertise or appropriate experience in relation to Positive Behaviour Support.
2) Writing the plan	
Provider (including individual and team)	<p>A Positive Behaviour Support Plan must identify and document:</p> <p>1) a description of the behaviour of the person that is causing harm to the person or others, including:</p> <ul style="list-style-type: none"> the intensity, frequency and duration of the behaviour; and the consequences or outcomes of the behaviour; and the early warning signs and triggers for the behaviour, if known. <p>2) the positive strategies that must be attempted before using a restrictive practice</p> <p>3) for each restrictive practice proposed to be used:</p> <ul style="list-style-type: none"> the circumstances in which the restrictive practice is to be used; and the procedure for using the restrictive practice, including observations and monitoring that must happen while the restrictive practice is being used; and any other measure that must happen while the restrictive practice is being used that is necessary to ensure the person's proper care and treatment and that the person is safeguarded from abuse, neglect and exploitation; and the intervals at which use of the restrictive practice must be reviewed by the provider.
3) Preparing the plan for the panel	
Provider	<p>A provider must apply to the panel for approval of a plan that includes one or more restrictive practices.</p> <p>The application must be in writing and include:</p> <ul style="list-style-type: none"> the name and business address of the provider; and a copy of the plan including restrictive practice protocols; and supporting documentation such as reports from therapists, doctors or psychologists.

4) Panel approval of the plan

Panel	<p>A panel must assess the plan and decide whether to approve the plan. The panel may approve the plan only if satisfied:</p> <ul style="list-style-type: none">• the plan is consistent with these guidelines; and• any restrictive practice included in the plan is necessary to prevent harm to the person or others and is the least restrictive approach reasonably available. <p>The panel must give written reasons for its decision to the provider.</p>
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5) Registration of the plan

Provider, or with agreement the Panel	<p>Following the panel's approval of the plan, it will be forwarded (with the provider's permission) to the Senior Practitioner for registration. On application, the Senior Practitioner must either:</p> <ul style="list-style-type: none">• register the Positive Behaviour Support Plan; or• refuse to register the plan. <p>The Senior Practitioner may register the plan only if satisfied:</p> <ul style="list-style-type: none">• the plan is consistent with the guidelines; and• any restrictive practice included in the plan is necessary to prevent harm to the person or others and is the least restrictive approach reasonably available. <p>If the person is a recipient of the NDIS, the plan will also be forwarded to the NDIS Quality and Safeguarding Commission for registration and be given a registration number.</p>
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6) Sharing the plan

The provider	<p>On registration of a Positive Behaviour Support Plan, the provider must give a copy of the approved plan to:</p> <ul style="list-style-type: none">• the person who is the subject of the plan; and• if the person has a guardian, the person's guardian; and• if the person is a child, each person with parental responsibility for the child; and the Public Advocate.
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7) Review and amendment of plans

The provider
(including
individual and
team)

The provider must keep the plan under review and take steps to have it amended whenever necessary to reflect a change in circumstances such as if a plan includes a restrictive practice and it becomes no longer necessary to use the restrictive practice.

The provider must review the plan at any time on written request of the person who is the subject of the plan.

If the person has difficulty putting the request in writing, the provider must give the person reasonable assistance to do so.

8) Expiry of plans

The provider
(including
individual and
team)

A registered Positive Behaviour Support Plan expires 12 months after the day the plan is registered and been through a panel. In certain cases, the Senior Practitioner may choose to register for a specified period of time, which may be less than 12 months. The provider must then review the plan, and if there is still a need for the restrictive practice, reapply to the panel (step 1).

9) Maintaining a register of plans

Senior
Practitioner

The Senior Practitioner must keep a register of positive behaviour support plans that include restrictive practices. The register must include the following details for each plan:

- the name of the provider that applied for registration of the plan;
- particulars of the panel that approved the plan;
- particulars of the plan;
- the date the plan was registered;
- the date the plan expires; and
- anything else prescribed by regulation.

The register may:

- include any other information the Senior Practitioner considers relevant; and
- be kept in any form, including electronically, that the Senior Practitioner decides.

The Senior Practitioner may:

- correct a mistake, error or omission in the register; and
- change a detail included in the register to keep the register up to-date.

10) Provider to monitor and record use of restrictive practices

The provider

The provider must—

- monitor and make a record of any use of restrictive practices under the plan; and
- report to the Senior Practitioner about the use of restrictive practices in accordance with these guidelines

Use of restrictive practice other than under a registered Positive Behaviour Support Plan

If a provider uses a restrictive practice outside a plan, the provider must:

- report the use of the restrictive practice to the Senior Practitioner. This may be termed an emergency restrictive practice.
- The report must be made within five days of the restrictive practice being used.
- Reports should be made through the Restrictive Interventions Data System,(RIDS) available on the Senior Practitioner's webpage.

Providers can use the reporting Guidelines available on the Senior Practitioner's webpage, at

<https://www.communityservices.act.gov.au/quality-complaints-and-regulation/office-of-the-senior-practitioner>

ATTACHMENT C: OTHER RELEVANT LEGISLATION

- *Human Rights Act 2004 (ACT)*

The *Human Rights Act 2004* can be interpreted through the application of the Universal Declaration of Human Rights and United Nations Convention on the Rights of Persons with Disabilities (CRPD), with particular reference to the following articles of the CRPD:

Article 4 1(b)

To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities.

Article 4 1(c)

To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programs.

Article 4 1(d)

To refrain from engaging in any act that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention.

Article 4 1(e)

To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organisation or private enterprise.

Article 14

Liberty and Security of the person.

Article 15

Freedom from torture or cruel, inhuman and degrading treatment or punishment.

- International Covenant on Civil and Political Rights
- International Covenant on Economic, Social and Cultural Rights
- United Nations Convention on the Rights of the Child 1990
- *Discrimination Act 1991 (ACT)*
- *Disability Discrimination Act 1992 (Cth)*
- *Disability Services Act 1991 (ACT)*
- *Children and Community Services Act 2004*

- *Children and Young People Act 2008*
- National Standards for Disability Services (2013)
- National Framework for Reducing and Eliminating the use of Restrictive Practices in the Disability Services Sector (2014)
- *NDIS (Restrictive Practices and Behaviour Support) Rules 2018*
- *Workplace Health and Safety Act 2011 (ACT)*

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