Evidence Matters: Organisational approaches to reducing restrictive practices

*Prepared for the NDIS Quality and Safeguards Commission*

Authored by:

Emeritus Professor Leanne Dowse

**Suggested Citation:**

Dowse, L (2022). *Evidence Matters:* *Organisational approaches to reducing restrictive practices.* NDIS Quality and Safeguards Commission.

© NDIS Quality and Safeguards Commission

The material in this document, with the exception of logos, trademarks, third party materials and other content as specified is licensed under Creative Commons CC-BY-NC-ND licence, version 4.0 International.

You may share, copy and redistribute the document in any format.

You must acknowledge the NDIS Quality and Safeguards Commission as the owner of all intellectual property rights in the reproduced material by using ‘©NDIS Quality and Safeguards Commission’ and you must not use the material for commercial purposes.

If you remix, transform or build upon the material contained in this document, you must not distribute the modified material. The NDIS Quality and Safeguards Commission expects that you will only use the information in this document to benefit people with disability.

Information provided in publications and resources of the NDIS Commission are considered to be accurate and current at the time of publication. These resources and publications are made available on the understanding that the NDIS Commission is not providing professional advice.

Before relying on any of the material provided by the NDIS Commission, users should carefully evaluate its accuracy, currency, completeness and relevance for their purposes and should obtain appropriate professional advice, as these materials and resources are not intended to replace the need for professional or expert advice.

**Acknowledgements:**

The NDIS Commission would like to acknowledge the contribution made to this Evidence Matters Summary by The Disability Trust.

Contents

[Evidence Matters: Organisational approaches to reducing restrictive practices 1](#_Toc135829109)

[Background 4](#_Toc135829110)

[Purpose of the guide 5](#_Toc135829111)

[Scope of this guide 5](#_Toc135829112)

[Organisational commitment to least restrictive alternatives 6](#_Toc135829113)

[Address known contextual and environmental risk factors for restrictive practice 8](#_Toc135829114)

[Behaviour as communication 11](#_Toc135829115)

[Clarity around which is and what is not a restrictive practice 14](#_Toc135829116)

[Organisational culture and processes embed scrutiny and reflective practice 19](#_Toc135829117)

[Organisational approach to quality management of behaviour support plans 21](#_Toc135829118)

[Congruence between and across support plans 23](#_Toc135829119)

[Whole of house plan congruence 26](#_Toc135829120)

[Role clarity, responsibility and accountability 28](#_Toc135829121)

[Meaningful data collection and evaluation to inform decisions and actions 30](#_Toc135829122)

[Wrap around support for staff via training, supervision, coaching and mentoring 35](#_Toc135829123)

[Concluding remarks 38](#_Toc135829124)

[References 39](#_Toc135829125)

[Additional resources 41](#_Toc135829126)

# Background

The NDIS Quality and Safeguards Commission (NDIS Commission) was established to develop a nationally consistent approach to quality and safeguarding for people with disability receiving supports and services under the National Disability Insurance Scheme (NDIS). In fulfilling this role, the NDIS Commission is committed to promoting, protecting and ensuring the full and equal enjoyment of all human rights and fundamental freedoms by people with disability and promoting respect for their inherent dignity (United Nations, 2006).

This resource was developed in line with the Commission’s behaviour support function as set out in section 181H of the [NDIS Act 2013](https://www.legislation.gov.au/Details/C2020C00392), that states the Commissioner’s behaviour support function is to provide leadership in relation to behaviour support, and in the reduction and elimination of the use of restrictive practices, by NDIS providers, including by:

* developing policy and guidance materials in relation to behaviour supports and the reduction and elimination of the use of restrictive practices; and
* providing education, training and advice on the use of behaviour supports and the reduction and elimination of the use of restrictive practices”.

The use of regulated restrictive practices by registered NDIS providers is subject to conditions outlined in the [National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018](https://www.legislation.gov.au/Details/F2020C01087). Further information about the use of regulated restrictive practices can be found here: [Regulated Restrictive Practices Guide](https://www.ndiscommission.gov.au/document/2386)*.*

This Evidence Matters summary acknowledges that organisations have a significant role to play in safeguarding those they support whilst actively promoting their development and upholding their legal and human rights.

The Evidence Matters summary draws on the experience of The Disability Trust, a provider delivering services to participants in supported independent living and with community participation supports in New South Wales. A whole of organisation approach was used to implement least restrictive alternatives in these settings. The Disability Trust applied this approach specifically to the transition of residents from Large Residential Centres (LRC) into community homes.

Organisational oversight, policy and programming have been recognised in Australia (Australian Government, 2014; Office of the Senior Practitioner, 2012) and internationally (LeBel et. al., 2014; Paley-Wakefield, 2013; NASMHPD, 2008) as important elements in the strategic approach to the reduction and elimination of restrictive practices. Core strategies targeting leadership (Huckshorn 2004), effective use of data, workforce development (Skills for Care & Skills for Health, 2014) and the use of tools and debriefing strategies alongside involvement of service users (Advonet & Change, 2020) have been shown to help achieve this (Deveau & Leitch, 2020; Huckshorn, LeBel & Jacobs, 2014). The role of Boards and governance mechanisms are also an emerging consideration in an organisational approach to governing for safeguarding and least restrictive outcomes (Hough, 2022).

Educational resources such as this are an important part of building capacity in the sector to improve the capability of organisations to act beyond individual solutions and to acknowledge the importance of organisational leadership and proactive policy and practices in taking steps towards to reducing and eliminating restrictive practices.

# Purpose of the guide

The purpose of this guide is to:

* Promote the rights and inherent dignity of people with disability
* Highlight the role that organisational governance, policy and practice oversight can play in reducing and eliminating the use of restrictive practices
* Assist in identifying issues, actions and potential challenges that may be encountered in implementing organisational approaches to the reduction of restrictive practices
* Exemplify, via the use of practice examples, the impact of organisational approaches to the use of restrictive practices with people with disability in order to work towards the reduction and elimination of these practices
* Provide practice advice consistent with a positive behaviour support framework and contemporary evidence-informed practice
* Address questions asked by NDIS provider organisations in relation to broader strategic and practical steps organisations can take to reduce and eliminate the use of restrictive practices in their services.

# Scope of this guide

The content of this guide is derived from a case study of The Disability Trust centring on the development and implementation of the organisation’s approach to the prevention, avoidance and elimination of restrictive practices as well as current research evidence in the field. It sets out ten key issues identified, actions taken to address that issue and the challenges encountered in these efforts. Examples are included to ground the issues in practice.

This guide was developed for registered NDIS provider organisations, in particular, personnel with a managerial or leadership or practice quality role, and for members of organisational governance bodies. It may also be of interest to NDIS behaviour support practitioners supporting NDIS participants, participants, their families, and others supporting people with disability.

This guide applies to organisations who provide services to people with disability who are participants of the NDIS.

# Organisational commitment to least restrictive alternatives

A key foundational stance for an organisation at the management level and expressed in organisational values is the commitment to human rights and specifically that participants are subject to the least restrictive alternatives in all support practice. This explicit commitment at a leadership level serves to shape the culture of the organisation, informs its operations and creates clear expectations regarding the behaviour of all staff. Leaders play an important role in facilitating processes, structures and resources for supporting change (Williams and Grossett, 2011).

## Actions to consider

* Embed the voices of people with a disability in decisions relating to organisational commitment to the delivery of services that include restrictive practices. This includes processes, policies and procedures relating to restrictive practices.
* Develop, implement and report against an organisation-wide plan to reduce or eliminate restrictive practices.
* Prioritise skills and supports for a preventative approach.
* Commit time and resources to develop a specific focus on prevention of restrictive practices.
* Vertically integrate quality expectations across all layers of the organisation from disability support workers, team leaders, operations managers, practice leaders and senior leadership via clear policies and processes.
* Regularly review changes to legislation and policy at national and state/territory levels and ensure organisational policies and training packages are updated accordingly.
* Encourage a culture of questioning and advice seeking via staff coaching and mentoring.
* Make reduction of restrictive practices a focus in organisational governance including for example, time devoted in Board meetings to discussing quality and safeguarding, recruiting Board members with specific expertise in restrictive practices and providing training to Board members about least restrictive alternatives and restrictive practice reduction.

## Potential challenges

* Teams need to understand that the ‘least restrictive’ option may still be a restrictive practice.
* Staffing teams need a commitment to a framework for principles of inclusion and quality of service provision, to ensure values and behaviours required are clear.
* The regulatory context for the approval, monitoring and reporting of restrictive practices can present a significant burden on administration and practice oversight for organisations.

## Examples

| Supporting attendance and advocacy at restrictive planning panelsJennifer has recently moved in to a new home she shares with two other people. Jennifer receives support with communication and has limited road safety skills; she is always supported in some way (paid staff or family/ friends) in the community. One morning, staff arrive and noticed her leaving the property. Jennifer appeared distressed and it took some time to support her to come home. Later that week, a similar incident occurred with Jennifer wandering from the house and seeming lost. An interim BSP was developed with the restrictive practice of locking the door, whilst an assessment was completed to explore what was happening and minimise the risk from Jennifer leaving the property. Jennifer and her parents were provided with the details of the incidents, the follow up measures enacted, and provided information on restrictive practices (via some easy read resources). They all attended the restrictive practices panel to discuss the introduction of the practice (locking the door), the process for implementation and the fade out plan were discussed.Jennifer and her parents were engaged with the service provider and behaviour support practitioner whilst a functional behaviour assessment was completed. During this time medical practitioners were also engaged to review from this perspective. Data was collected and skill development strategies introduced to familiarise Jennifer with her new environment. She was supported to go for a walk each morning in her local neighbourhood. Jennifer and her parents were keen to engage in the fade out strategy to remove the locked door from her plan with the reduction of the risk. Their engagement in the process assisted driving the organisational focus to remove restrictive practices when they were no longer appropriate. |
| --- |

| Restrictive practices training: mandatoryHaving frontline line teams and leaders who understand practice issues, implications, terminology, compliance requirements and strategies around restrictive practices and concepts such as least restrictive, fading reduction and elimination is a critical component of organisations ‘getting it right’. During on-boarding, all staff at The Disability Trust are required to complete “Recognising and Responding to Restrictive Practices” training to help them understand how to identify a practice that might be restrictive and to understand how to respond to and report that practice. Training also includes overview of the role of the Quality and Safeguards Commission, identifying prohibited practices and provides links between positive behaviour support, communication, behaviours of concern and restrictive practices. |
| --- |

# Address known contextual and environmental risk factors for restrictive practice

Contextual and environmental and factors may dictate the need for restrictive practices beyond the actual support needs of the individual. This may be more likely to occur in contexts where resources are constrained and where risk management may become the key driving factor in organisational decision making. For example, restrictive practices may relate to the built environment, resident compatibility, ignoring a person's wants and needs and staffing considerations including ratios, skills and shortages.

Vigilance is required to recognise when such factors arise, to identify their impact and to act to avoid or undo them.

## Actions to consider

* Ensure the person is involved in decision making about the services they access including where they live, who they live with, and where they work.
* In the development of new properties, building design should avoid construction that limits access to kitchens or other household indoor and outdoor spaces and avoids the automatic installation of locks on all doors.
* Before agreeing to any aspect of building design or construction, seek alternatives to environmental restrictions via behaviour support strategies or require verified evidence that restrictive environmental measures are required under an approved Restrictive Practice.
* Post-construction, take the time to independently verify that environmental constraints have not been installed.
* In already constructed premises be prepared to ‘examine what is possible’ and aim for the progressive removal of unnecessary environmental restrictions.
* Resist pressure to fill vacancies in favour of thorough compatibility matching, even in circumstances of placement shortages.
* Engage people who are recipients of the service (i.e. other residents/service users) in a meaningful way in the process of vacancy management.
* Ensure that specialist individualised clinical intervention (via Positive Behaviour Support) is aligned with organisation-wide capacity to promote the general principles of good support practice so that individualised intervention works in concert with a systems approach.

## Potential challenges

* Sometimes environmental restrictions that are required to keep one person safe will impact on others in a shared environment. Organisations must work with individuals to minimise impact restrictions.
* Changing the approach in disability service provision from ‘the way things have always been done’ can prevent or avoid restrictive practices and requires vigilance and investment by leadership to identify embedded risks for restrictive practice.
* Change in culture and practice takes time and may not be immediate but rather a long-term commitment to organisational values.
* Balancing funding to support someone with a restrictive practice and to implement positive programming requires collaboration in planning with support coordinators, behaviour support practitioners and family members to ensure sufficient funding to support good participant outcomes.

## Examples

Determining what constitutes an environmental restraint should be an integral aspect of premises design and construction. This involves considering the definition of environmental restraint outlined in the [*NDIS (Restrictive Practices and Behaviour Support) Rules 2018*](https://www.legislation.gov.au/Details/F2020C01087)and further explained in the [*Regulated Restrictive Practices Guide*](https://www.ndiscommission.gov.au/document/2386). Organisations will need to consider each specific context in which building design and construction proposes an environmental restraint and verify whether or not this is actually required.

The following example highlights that there may be a lag between current understandings of the nature of environmental restraint and traditional approaches to design and construction of specialist disability accommodation.

| Verify all aspects of constructionOn a first inspection of a new house under construction, the design specification meant that the kitchen had been blocked off; there was a servery window and locked doors. The organisational representative inquired as to whether there were any restrictive practices associated with any of the residents who would be moving in. The construction authority replied that there was a generally accepted approach to design of properties where “these people don’t have access to the kitchen”.The organisational representative took steps to verify that there were no restrictive practices associated with the incoming residents. The organisation delayed taking the house for four months to ensure that the design issues were addressed because “If we had allowed that we would never have been able to undo it.”Ensuring that the supports funded for a participant accurately reflect the individual’s support needs in context is central to avoiding the potential for restrictive practices. |
| --- |

| Organisations supporting service users to engage in recruiting staffMatching staff to the right people and services can reduce behaviours of concern and the need for restrictive practices. During recruitment, service users and their advocates are engaged in the interview process, to ensure this perspective is included in the hiring of staff. This process also assists in transitioning and training new staff in services as relationships may be established early and the choice and control of the people being supported is at the forefront. |
| --- |

| Vacancy matchingAlbert and Amanda were looking for a person to share their house, as they had a spare room. Their key workers helped put together a one-page profile about themselves to share with prospective housemates, by way of introduction and initial assessment of matching needs. A manager assisted in reviewing prospective profiles of people who may be compatible and supported Albert and Amanda in discussion with potential suitable applicants. They both thought Bob might be a good fit as he was the same age and liked going to the movies too. Bob came to visit the house and met Albert and Amanda. Amanda has particular dietary needs (requiring mealtime support to manage choking risk), which meant there were some environmental restrictions in place to support her safely. On inspection of the house and further discussion about this, Bob said that these restrictions were difficult for him to live with. It was decided that the matching would place unneeded restrictions on Bob, and that another place may be a better match. Bob decided to look elsewhere for a place to live. Not rushing decisions about filling vacancies in services, collaborating with the people and actively supporting them to have a voice and choice around their services assists in the minimising of restrictions on others. |
| --- |

#

# Behaviour as communication

Understanding what a behaviour may be communicating is key to supporting people who may display behaviours of concern. This will mean understanding that some behaviours of concern are about communicating something and not simply a ‘person being difficult’ or a ‘risk that needs to be managed’. This perspective changes our response from ‘they are displaying challenging behaviour’ to asking ‘what are they telling us?’ The most important thing staff can do in their support practice is to listen to people and respond to what they are saying, and recognising that for many people, their views may not be expressed in words.

## Actions to consider

* Embed training in recognising and responding to Restrictive Practices and Principles of Positive Behaviour Support in organisational training requirements (for example the Zero Tolerance resources).
* People who require communication support have access to services to assist in assessing and guiding communication strategies.
* Ensure that staff (via training, coaching and mentoring) are attuned to the nuances of expression/communication of the people they work with in order to pick up on small behavioural changes that can provide clear indicators of changes for that person. .
* Check medical issues as a priority: sometimes unrecognised medical issues can impact on behaviours of concern (for example: dental - a toothache may present as food refusal, self-injury etc.)
* Promote in all staff a strong working knowledge of person-centred services so that they are better able to know and understand the person they support. This familiarity allows staff to recognise nuanced changes in a person’s behaviour and understand these changes as communication. This prompts them to look at what is going on for the person.
* Provide direct care staff with guidelines for best practice in note taking and documentation to ensure clear and objective descriptions of behaviour are recorded.

## Potential challenges

* Service staff may miss the point when people are trying to communicate their preferences and view a behaviour of concern as unrelated to what the person is trying to communicate (i.e. a complaint or a dislike)
* Staff who are not trained to understand all behaviour as communication may misinterpret a person’s behaviour, and not understand the underlying message.

## Examples

Taking a person-centred approach to each person in a service involves understanding that all ‘behaviour’ serves an important function and is a form of communication. Alongside this, is the importance of recognising that a person’s behaviour will be influenced by many factors including any chronic or acute physical conditions such as high temperature, epilepsy, pain or the influence of drugs or alcohol. It is also important to understand a person’s behaviour may be influenced by their environment and the behaviour of others (Skills for Care & Skills for Health, 2014). The following examples highlight the simple but powerful impact of staff being alert to and mindful of the nuances of a person’s communication and taking pre-emptive and proactive steps to check health and wellbeing at the first signs of a potential issue and to consider all potential functions of a behaviour.

| Check medical first – Communicating painJordan is 19, lives with his family and engages in NDIS funded group activities during the day. Jordan communicates non-verbally; his support team work on being attuned to his behaviour as his means of communicating his needs. In the past six months Jordan's self-injurious behaviour has increased. He will often bang his head and hit his arm on walls/furniture near him, sometimes up to six times a day. As a response, his doctor has prescribed medication classified as a chemical restraint, to assist in reducing the behaviours of concern. In consultation with Jordan and his family, key support staff from his programs, medical professionals, behaviour support practitioner and speech pathologist, it was hypothesised that Jordan may be experiencing increased pain due to his physical disability. Work with medical professionals commenced to establish a pain management plan with Jordan and to cease the use of the chemical restraint as the function of the behaviour was identified and managed. |
| --- |

| Check medical first – Communicating painJordan is 19, lives with his family and engages in NDIS funded group activities during the day. Jordan communicates non-verbally; his support team work on being attuned to his behaviour as his means of communicating his needs. In the past six months Jordan's self-injurious behaviour has increased. He will often bang his head and hit his arm on walls/furniture near him, sometimes up to six times a day. As a response, his doctor has prescribed medication classified as a chemical restraint, to assist in reducing the behaviours of concern. In consultation with Jordan and his family, key support staff from his programs, medical professionals, behaviour support practitioner and speech pathologist, it was hypothesised that Jordan may be experiencing increased pain due to his physical disability. Work with medical professionals commenced to establish a pain management plan with Jordan and to cease the use of the chemical restraint as the function of the behaviour was identified and managed. |
| --- |

| Avoidance of environmental restraintAhmed is 27and lives in a SIL property with 3 others. He is a non-verbal communicator. Over a period of 3 months, there are increasing reports from his staff that they feel unsafe when they arrive at Ahmed’s house due to him running out of the front door and approaching them quickly with his hands raised. Staff report that they have been backing away and telling Ahmed to be calm and respect their space, but he is acting in a threating way, and they feel unsafe. There have been suggestions that the front door to the property is locked when staff arrive so that staff can safely move from their vehicle into the house and greet Ahmed in a controlled environment. The team leader contacts Ahmed’s behaviour support practitioner and family to discuss the current concerns of the staff. Ahmed’s support team meet and the behaviour support practitioner attends the house to do some observations. Based on current and historical knowledge from all contributors, it is hypothesised that rather than being aggressive Ahmed is excited to see the staff arriving to shift; he was saying “I am really happy and excited to see you”. Staff worked with Ahmed to develop their own personal greeting such as high fives and fist bumps and they used language that expressed that they were also happy to see Ahmed and to spend some time with him. Ahmed continues to excitedly run out to greet staff, who are now able to match his energy and communicate with him, and the locked door was avoided. |
| --- |

#

# Clarity around which is and what is not a restrictive practice

Restrictive practices can emerge as a result of the complex interaction of factors. Internal and external stakeholders may rely on different working definitions to assess whether a support constitutes a restrictive practice and in some instances a support can be incorrectly attributed as restrictive. This commonly occurs around the prescription of psychotropic medications but also applies to other forms of restrictive practice. The NDIS Commission definition of a restrictive practice as outlined an earlier section of this guide and available in the [*NDIS (Restrictive Practices and Behaviour Support) Rules 2018*](https://www.legislation.gov.au/Details/F2020C01087)and further explained in the [*Regulated Restrictive Practices Guide*](https://www.ndiscommission.gov.au/document/2386) should form the foundation for all decision making and organisational staff including disability support workers, team leaders and senior management should be able to understand and identify in practice what is and is not a restrictive practice.

## Actions to consider

* Consistently utilise the NDIS Commission definitions of Behaviours of Concern and of restrictive practice.
* Cultivate organisational expertise in determining the nature of a support practice as restrictive or not, potentially through a designated practice leader or other quality oversight personnel.
* Improve skills and capability in team leaders and disability support workers to question the nature of restrictive practices.
* Create and follow a decision-making pathway to determine whether a practice meets the criteria for a restrictive practice.
* Utilise documentation for all instances of medication (including date of diagnosis and nature of mental health condition) and retain as a record to show the decision-making process and/or which can be provided as evidence for decision-making for external practitioners and for organisational leadership.
* It is good practice to include the use of a psychotropic medications within the RP framework where we do not have clarity of purpose. Whilst this might be viewed as being ‘unnecessarily’ included in a PBSP, it helps to provide oversight and safeguarding for the person.
* Educate staff around practices that may be restrictive in nature but are not reportable to the NDIS Commission-(safe transportation, PRN prior to medical). Ensure that oversight of these practices remains even if they are not reportable to NDIS Commission.
* Implement organisational procedures to capture and examine all instances where a new medication is prescribed for a person.

## Potential Challenges

* Lack of shared definitions of restrictive practices means that an organisation must be constantly vigilant and scrutinise all existing, new and proposed support practices.
* Medication may be prescribed by a medical practitioner for a verified mental health condition. In instances where a prescription does not directly address behaviour but rather is considered treatment for a diagnosed mental health condition there may be confusion as to whether the medication constitutes a restrictive practice and it may be unnecessarily included in a behaviour support plan as a restrictive practice.
* Conversely psychotropic medications may be prescribed in the absence of a diagnosed mental health condition. In some instances, clinicians may assume that because the medication has been prescribed by a medical practitioner its’ use does not constitute a restrictive practice. In others, the medication may be included as an authorised restrictive practice which could be avoided with the development of an evidence-based approach across communication, sensory or other support plans.
* Organisations spend significant staff time and resources in multiple liaison, administration and education processes clarifying with medical practitioners, NDIS behaviour support practitioners and regulatory authorities the nature of a practice as restrictive or not according to accepted definitions and policy requirements.
* Some practices have different reporting requirements, or their restrictive nature may be assessed differently according to the context of use, for example, child safety strategies for young children versus adolescents, some mechanical restraints for safe transportation and PRN medication prior to medical appointments.

## Examples

There is recognition that psychotropic medicines may be overprescribed and overused with people with disability. However, there is little evidence that psychotropic medicines are effective for managing behaviours of concern and instead can contribute to risks of harm and affect the wellbeing and quality of life of people with disability (Aged Care Quality and Safety Commission, NDIS Commission & and the Australian Commission on Safety and Quality in Health Care, 2022). Using psychotropic medicines, such as antipsychotics and benzodiazepines, to calm, soothe, sedate or influence or control the behaviour of people who exhibit behaviours of concern is a restrictive practice and is subject to regulatory oversight. The NDIS Commission provides [*Guidance for Implementing Providers for the Reporting of Restrictive Practices*](https://www.ndiscommission.gov.au/sites/default/files/2022-02/portal-user-guide-implementing-providers-v30-april-2021.pdf)*.*

The following examplespresent different scenarios from practice which highlight some of the complex issues that can apply to the potential misuse of, proper use of and attribution of the use of psychotropic medications as a restrictive practice.

| Prescription of psychotropic medication due to environmental factorsAt the beginning of COVID lockdowns Anthony, who had previously been quite settled in his residence and had been accessing the community, became very unsettled. A team leader took Anthony to the doctor, indicating that he was experiencing anxiety. The doctor prescribed a psychotropic medication which Anthony’s behaviour support practitioner appraised as not being a restrictive practice ‘because it was prescribed by a doctor’. The organisation assessed this as an unauthorised restrictive practice and sought advice from a specialist intellectual disability clinical team who, on assessment, found no sign of a mental health condition, but rather suggested a thorough assessment of Anthony’s physical health and environmental conditions. The organisation, after this structured investigation, sought special approval for Anthony to re-engage with the community and he soon returned to his pre-lockdown disposition. A clear understanding emerged that in the absence of a mental health diagnosis the prescription of a psychotropic medication to address the environmental impact of lockdown was not appropriate and a restrictive practice was avoided. |
| --- |

| Medication for mental health symptomatology attributed to ‘behaviour’Daniel has schizophrenia and is prescribed psychotropic medication to counter associated symptomatology including ‘withdrawal’ and ‘retreating’. A behaviour support practitioner, in preparing a support plan opted to include this mental health symptom as attributable to Daniel’s ‘behaviour’ rather than his condition as diagnosed by an experienced medical practitioner. As a result, a restrictive practice around the use of this medication was included in Daniel’s behaviour support plan. The organisation, after being alerted to the presence of this restrictive practice, undertook to work through a process of clarification with the behaviour support provider, the NDIS Commission and Anthony’s medical practitioner which took many months to resolve. The restrictive practice attribution for the prescribed mental health medication was subsequently removed.Often, if there is ambiguous diagnostic information, medication prescription can fall under the restrictive practice framework for oversight, until a firm diagnosis is established. In the context of oversight and surveillance of restrictive practices, this can be seen as a positive safeguard for people who are subject to potential prescription of psychotropic medication and polypharmacy practices. |
| --- |

Similar to the use of psychotropic medications, there can be grey areas for providers and practitioners in the use of other forms of support which may require consideration of the sometimes unclear boundaries between a support and a restrictive practice. This involves considering the definition of a restrictive practice outlined in the [*NDIS (Restrictive Practices and Behaviour Support) Rules 2018*](https://www.legislation.gov.au/Details/F2020C01087)and further explained in the [*Regulated Restrictive Practices Guide*](https://www.ndiscommission.gov.au/document/2386). Organisations will need to consider each specific context in which a support may be a potential restraint and verify whether or not this is the case.

| Support or restraint?Rebecca has limited verbal communication and experiences periodic episodes of excessive hand scratching which may be due to eczema or anxiety. Rebecca and her team have decided to use a pair of soft cotton gloves to assist her to avoid exacerbating the condition when it arises. Rebecca voluntarily retrieves the gloves from her room and puts them on when the condition appears. Given that the use of the gloves is Rebecca’s own independent choice and that their use would be a choice all people in the same situation would consider to assist with avoiding scratching until the condition subsides, Rebecca’s voluntary use of the gloves was not deemed as a restrictive practice. |
| --- |

The following two examples explore how the same practice can have different outcomes for restrictive practice status. It is important that practitioners and service providers have a developed understanding of Restrictive Practices and the applications.

| Monitoring – safety or restriction?Penelope loves stationary and will always try and procure pens and notebooks when she can. During the day she is supported by staff who can assist in reminding her where her stationary is and that her housemates also have their belongings. Overnight staff are sleeping, and Penelope would access her housemates’ bedrooms and take their pens to add to her collection. A motion sensor is placed in the hall overnight to alert staff that someone may be awake and needing support. Staff will assist Penelope in what she needs and remind her she has her pens in her room. Instances of pens going missing from housemates’ rooms has decreased, and quality of relationships increased. This monitoring device would be considered a restrictive practice as in place as a strategy for a behaviour of concern – and more importantly, a less restrictive option than locks.  |
| --- |

A further differentiation in attributing restrictive practice status concerns child safety and injury prevention (child proofing) measures. These strategies are considered age appropriate, in line with community standards and use irrespective of whether a child has a disability and/or a behaviour of concern.

| Child proofing – safety or restriction?Aisha is 5 year old and attends vacation care in the school holidays. She is a highly energetic and curious girl who loves to explore her environment, climb and play. The site of vacation care has fences that restrict children’s access to certain areas and a key locked gate to prevent exit from the site and into the street. The fences and locked gate are not considered to be restrictive practices. They are strategies that are commonly used in children’s service settings that help to create safe play spaces and to minimise risk of harm to children. The provider would need to monitor and re-assess the use of these strategies as Aisha moves through her stages of development into her teenage years, as child proofing strategies must be age appropriate. If the same strategies were in place when Aisha is 15, they may be considered a restrictive practice. |
| --- |

#

# Organisational culture and processes embed scrutiny and reflective practice

The nature of support practice when working with people with varying needs can result in the use of restrictive practices, often without staff realising. This is often driven by the key concern for safety of people and conflicting priorities and restrictive measures may become ‘just how we do business to keep everyone safe’, sometimes under the guise of duty of care.

To counter this, organisations may prioritise oversight of practice quality, a culture of peer review and reflective practice and feedback to address the risk of inadvertent use of restrictive practices.

## Actions to consider

* The organisation has processes that ensure the person/key supports are included in all decisions about their support such as appointments, medication etc.
* The person is supported to know and engage in both feedback and complaints processes.
* Implement clear organisational procedures to capture and examine all instances where a new medication is prescribed for a person.
* Embed processes where managers review and discuss practices collaboratively with teams e.g. checking if any doors are locked, any restrictions in place, considering minimal impact on the privacy and dignity of the people living at the residence. A checklist of practices that are regularly reviewed at team meetings or supervisions that prompts reflection, discussion and practice change is recommended.
* Organisational culture to embed scrutiny can include training, commitment to learning, regular review of practice and supports (including review of restrictive practices), team discussions and collaboration across services delivery, management and clinical supports.
* Create an expectation that all staff (including leaders) are engaged in a meaningful way with the services they are overseeing. This may include visits to service delivery locations, engaging in feedback processes with service users and their families, and attendance at team meetings.
* Staff have clear work roles and expectations that are achievable in their shift in order to balance conflicting priorities such as engagement in activities with a person versus household duties.
* Embed peer review, supervision, coaching and mentoring, in all organisational leadership roles.

## Potential Challenges

* Enabling person-centred risk assessments and balancing dignity of risk and duty of care is a challenge for service providers.
* Where there are multiple internal and external providers involved in a person’s support, everything must work together to ensure support is coordinated for a good outcome but conversely lack of coordination can result in things going wrong without vigilance, scrutiny and oversight from all providers involved. Often there is strength in a person receiving supports from multiple providers, however the challenge to coordinate and collaborate is often present. Clear leadership and good communication are essential. It should also be noted that this leadership may come from any avenue and not necessarily only the accommodation provider.

## Example

| The right culture, the right leadership, the right languageA new staff member in a service raised concerns with their team leader about the alleged use of unauthorised restrictive practices for several participants. The team leader supported the worker to complete detailed incident reports and completed reports of alleged use of unauthorised restrictive practices to the NDIS Quality and Safeguards Commission. The organisation undertook an investigation into the allegations, with human resources personnel and the manager conducting interviews with staff and participants. The investigation indicated that there were unauthorised restrictive practices being used and some of those practices were abusive and/or neglectful. There were quick adjustments made to the staffing team and face to face on-the-ground supports provided to help the team understand how to assess a practice as restrictive and to clarify the difference between a regulated restrictive practice and a prohibited practice. Leaders engaged with the team and facilitated opportunities to reflect on their practices and consider the impact of their actions and strategies on the people who access the services. The team completed a refresher training in recognising and responding to restrictive practices. The team soon reported that when positive behaviour support and person-centred practices were used, and least restrictive options were considered, behaviours of concern reduced and there was no further use of URP’s. |
| --- |

The above example highlights that while individual staff members may hold or act on beliefs about the people they support, these may not always be in line with organisational values and culture which premise communication and collaborative problem solving in order to avoid or reduce restrictive practices. Processes of scrutiny and oversight embedded in organisational practice leadership play a crucial role in identifying where such instances may arise. Responses which include clear articulation of organisational culture, oversight by organisational leadership, the use reflective practice and a shared approach can mean avoiding or preventing unwarranted restrictive practices.

# Organisational approach to quality management of behaviour support plans

Organisations recognise that good quality behaviour support plans play a crucial role in preventing, avoiding and fading the use of restrictive practices. Experience suggests assessment of plan quality is best achieved through a partnership that recognises the person at the centre of the plan, in collaboration with the experience of staff on the ground and the expertise of good practitioners. There are often many people involved in the development of a behaviour support plan and therefore it is important there is a cohesive organisational approach to the contribution, review and implementation of a behaviour support plan. To achieve a quality plan, this must be a collaboration with agreed principles of least restrictive alternative.

## Actions to consider

* Implementing providers are expected to use their knowledge of the person, the services, and quality indicators for behaviour support.
* Encourage and equip staff through the training, coaching and mentoring.
* Implementing providers take steps to work with the behaviour support practitioner to review the plan to include more appropriate strategies, particularly those that work to avoid a restrictive practice.
* Work through a partnership model with practitioners and providers.
* Provide clear guidance regarding when and how to escalate issues outside of these partnerships with practitioners and providers in order to problem solve, to for example, the support coordinator, the NDIS Commission or an independent advocate.
* Encourage staff to understand that ‘the person is the expert in their own life’ and the staff are ‘working with and walking alongside them’.
* Staff are aware and have training on the current restrictive practices authorised for the people they are supporting, including fade out and skill development strategies.

## Potential challenges

* Staff may lack confidence and need support to discuss elements and contribute their knowledge and expertise throughout the process.
* Individual participants choose their own behaviour support practitioners, and so in some contexts the service may be required to work with many different behaviour support practitioners.
* Requesting that behaviour support practitioners review plans based on the organisation’s assessment of appropriateness and quality can be a time consuming and challenging process which may include providing feedback on clinical appropriateness and quality or to the behaviour support practitioner’s senior organisational management or supervising clinician.
* Stakeholders may find the technical nature of plans difficult to understand. Plans can be lengthy documents and contain jargon or acronyms. This can impact on how the plan is understood and implemented.
* Plan quality and effective implementation can vary depending on a number of factors; for example: the experience of the behaviour support practitioner, the availability of accurate and thorough data, the funding available for the behaviour support service, and available funding for implementation of the plan and recommended strategies.

## Example

Collaboration between clinicians and staff has a crucial impact on the extent to which organisations are able to reduce restrictive practices. When working in true partnership and collaboration, the strategies should be least restrictive, used as a last resort and reviewed for effectiveness, with consistent implementation.

An organisation’s job is supporting the person to live a good life their home and in their community. This idea of partnership is that the give and take is reciprocal, with the best outcome for the participant at the centre of all effort. Ultimately this is an issue of capacity building in the sector and enhancing the skill level of staff so that they are not just doing the restrictive practice, which is often the easiest thing to do.

| An approach to quality review of behaviour support plansWhen a behaviour support practitioner finalises a positive behaviour support plan, the provider has a formal and documented process of reviewing the plan and accepting it into the organisation. When the manager receives the plan, they ensure that it is distributed to key people and contributors for review of the strategies contained in it, including the ecological, capacity building, reactive and restrictive strategies. Staff are encouraged to consider the practices in the plan in the context of their service setting to be sure that they understand the strategies and they are doable, reflective of current practice and easy to understand.The manager convenes a meeting with the key staff and the behaviour support practitioner to discuss the plan prior to accepting it. As a team, they review the plan and answer the following questions:* Does this plan meet the needs of the client?
* Does it meet the needs of the organisation (including RP legislation/policy requirements)?
* Do we have the resources to implement the plan with integrity (i.e., is it fit for purpose) and if not do we have a plan to be able to meet the needs (i.e., funding for training etc)
* Does plan meet the NDIS Quality and Safeguards Commission requirements?
 |
| --- |

# Congruence between and across support plans

## Individual plan congruence

Support plans for any one individual, including behaviour support plans, communication plans, healthcare plans, sensory plans, mealtime management plans and lifestyle plansare generally developed by several different personnel. This combination of plans may be developed by individual clinicians and this can result in support practices being prescribed under one plan not aligning with or being in direct opposition to the approach suggested in another. There is strength in a person’s support needs being reviewed from a number of different perspectives and areas of expertise, however this can also come with the challenge of plan congruence.

 There is a need for coordination of plans as they share the same context and purpose - the support of the individual person. The role of the organisation then is to assess all of the disparate plans that a person may have and align these with the choice and control approach in which individual preferences are respected.

### Actions to consider

* Ensure that each plan (e.g. lifestyle, healthcare, behaviour support and mealtime management plans) that is required to support a person is written with the person and key people involved (advocates and decision makers), with clear information about the evidence for and approach to implementing each support.
* Require all staff in a support team to read and understand all support plans. This may include providing paid work time without the responsibilities of direct care support to read plans and asks questions. Regular team meetings are critical to sharing information amongst the team and collaborating with clinicians and others.
* Utilise coaching and mentoring with all staff to ensure they are able to recognise inconsistencies in support practice, raise them within the team, and have them addressed. Regular practice supervision sessions are a good mechanism for this.
* Ensure clear responsibility and a documented process for assessing the congruence of all plans for each person to ensure that there is a consistent approach across all plans.
* Assess the impact of changes made to any one plan on support approaches in others.

## Potential Challenges

* Lack of a supported decision-making framework and meaningful engagement with the person may result in the person and their advocates not being in a central role when designing supports. The risk of this is the varying roles in the system (i.e. planners, services, therapists) having a more focused view on their needs, rather than the holistic view of the person in the context of their environment.
* Good clinicians take an integrated approach to working with other disciplines in the service context. In some instances, there may be a focused or narrow view of the person which takes a less global view of communication, health and well-being. This may need to be addressed through collaboration and partnership so that all supports align with the organisation’s whole of environment approach to support and prevention of restrictive practice.
* There can be challenges in getting funding for a whole of environment/whole of house basis.

## Examples

People with disability have the right to safe and quality supports and services as set out in [*The NDIS Code of Conduct: Guidance for NDIS Providers*.](https://www.ndiscommission.gov.au/sites/default/files/2022-02/code-conduct-providers-june-2021.pdf) A person-centred approach will mean that supports are tailored to each person in their unique context. The following examples demonstrate that, for people who have multiple support needs, person-centeredness requires careful organisational attention to the ways that the various aspects and practices of support must be are harmonised in context and that staff are clear about agreed supports to ensure consistency and efficacy and an understanding of why or why not a support may be designated as a restrictive practice.

| Using a helmetJason has been diagnosed with epilepsy and was prescribed the use of a helmet by his medical specialist. Jason’s behaviour support practitioner incorporated this requirement to wear a helmet into his behaviour support plan as a restrictive practice. In assessing the appropriateness of this inclusion, the organisation assessed that this should be removed from Jason’s behaviour support plan on the grounds that the helmet had been prescribed on the basis of a medical condition and should be appropriately monitored as part of an epilepsy management plan and not be considered a restrictive practice.  |
| --- |

| Aligning support needsSamantha lives in supported accommodation. In her unit she has her own kitchenette where staff assist her in preparing her meals. Samantha has had an incident of near choking and engaged with a speech pathologist who reviewed her mealtime management plan. This plan recommended a consistency change to soft foods only and that she needs to be always supervised. This was a big change for Samantha as she enjoyed the independence of her kitchenette and also loved crunchy crackers for afternoon tea.It was immediately obvious that these restrictions were increasing Samantha’s distress and behaviours of concern. She was attempting to leave the property unsupported to access food, or accessing her neighbours/peers’ units which was causing distress and friction in the relationships. The service contacted the behaviour support practitioner and speech pathologist, to develop a plan with Samantha and her father who is her key support with decision making. The speech pathologist was keen to explore options that reduced the risk of Samantha eating certain foods whilst also factoring in the impact this had on her and the risks heightened in other areas. Together with Samantha there was a decision that she would have access to a range of foods that are lower risk to eat unaccompanied in her unit, and she would be able to eat the foods she likes with supervision at mealtimes. This compromise in aligning support needs has meant no restrictive practices have had to be introduced for Samantha. |
| --- |

#

# Whole of house plan congruence

In the SIL context there may be a number of individuals who have plans which include behaviour support strategies and/or restrictive practices. These plans are often developed by different clinical practitioners who are tasked with developing supports which pertain specifically to one individual. Behaviour support practitioners must also list in their plans the impact of any restrictions on the other people that may be impacted by them and specify how this is minimised. However, it would not be appropriate to be reviewing other's personal information. Support strategies or restrictive practices stipulated in one individual’s plan may directly impact on other members of a household and may result in undocumented environmental restrictions for a whole household. This highlights the critical role of the organisation to firstly know and understand an individual’s support needs, to assist the clinicians to understand the cross impacts of any recommendations and facilitate the ways the recommendations can intertwine to ensure all individuals have their support needs addressed.

## Actions to consider

* Prioritise practice leadership as a crucial enabler for quality management. Experienced practice leaders can work with team leaders and others in a SIL context to review all behaviour support strategies and restrictive practices to assess congruence across the whole of house context, identify conflicting issues or strategies and creatively problem solve them.
* Ensure that the coordination of supports in the service context is managed and overseen by experienced staff. This type of coordination should be recognised as being a different responsibility to those of an NDIS support coordinator at the system level.
* Exercise persistence when an issue of whole of house incongruence arises. The organisation ensures, via its team leaders and practice leaders, that it works productively and collaboratively with clinicians, families, support coordinators and others to advocate for a solution that is equitable and respectful of the human rights of all residents.
* Invest in training team leaders to recognise what is and is not a restrictive practice.
* Clarify the team leader role to work with disability support workers to look at their practice and notice higher level dynamics, and issues around their response and support and work through team meetings to improve practice.

## Potential Challenges

* It can be difficult to get a ‘whole of environment’ perspective about how to work with individuals in a SIL context as a group.
* Staff in SIL may tend to concentrate on how to implement an individual’s program and are not tasked with or do not necessarily think through how one person’s funded support strategies or restrictive practice may impact other people.
* Responsibility to manage the impact of multiple behaviour support strategies or restrictive practices for multiple residents which are prescribed and monitored on an individual basis is borne by the organisation. The coordination of supports in the service context must be recognised as a key part of this role.
* Services are expected to provide evidence for planning meetings regarding the person’s support needs in the context of their service settings. Service providers often hold significant information about the support needs of the person so ensuring these are well communicated and meet the needs of funding body can add a layer of administration. This ensures that support needs are met and lessen the likelihood of restrictive practices being utilised in place of their required supports.
* There may be a mismatch between the extent or nature of strategies set out in a behaviour support plan and the funding available in that person’s plan to enable an organisation to comprehensively implement those strategies. In this event, the organisation is faced with a challenge in balancing risks and rights.
* Leadership roles are crucial to ensure quality standards in support practice. However, there is an increasing challenge in maintaining their focus on quality and not simply compliance.

## Example

[*The NDIS Code of Conduct Guidance for Workers*](https://www.ndiscommission.gov.au/sites/default/files/2022-02/code-conduct-workers-march-2021-11.pdf)requires that staff take steps to raise and act on concerns about matters that may impact the quality and safety of supports and services provided to people with disability. The importance of practice leadership to achieving this within an organisation is highlighted in the following example in which support practice for one resident inadvertently negatively impacts on others in a shared SIL context. Addressing the whole of house context is an important function for practice leaders to support staff who may not have the skills, experience or confidence to challenge strategies, and so to identify, understand or address restrictive practices.

| Reducing impact on othersJames stays at short term accommodation one weekend a month with some other people he goes to school with. James may often try and leave the house to seek the playground across the busy highway (even at night). There are times when the door is locked to ensure James is safe and supported at the house. The other people who James shares his stay with have less risk in the community and can therefore leave at different times. To minimise the restriction for James on others, they are provided a key to access the locked door independently. |
| --- |

#

# Role clarity, responsibility and accountability

Reducing, fading and avoiding restrictive practices requires organisations to have clarity about their expected roles and responsibilities in relation to behaviour support and be prepared to work collaboratively with clinicians and others.

While the NDIS has requirements for behaviour support practitioners in relation to the content of behaviour support plans (see for eg. [*NDIS Behaviour Support Plan – Comprehensive*](https://www.ndiscommission.gov.au/providers/understanding-behaviour-support-and-restrictive-practices-providers/submitting-behaviour#paragraph-id-2754)*)*, the role of organisations in implementing behaviour support is less clear. When an organisation accepts a behaviour support plan containing a restrictive practice the organisation bears the risks and responsibilities for the implementation of that restrictive practice, positive support and fading strategies contained in the plan.

## Actions to consider

* The organisation meaningfully engages the person, their advocates, and/or decisions makers in the development, review, authorisation and fade out of restrictive practices. Supporting key people to be involved in these processes can drive efforts to reduce restrictive practices to be centred around the person. This can include participation in authorisation panels, plan development and training sessions.
* Provide clear delegations for staff for involvement in plan development and review, implementation, feedback and restrictive practice authorisation processes.
* Ensure staff present at any clinical assessments for behaviour support are those who know the person best and can positively contribute to the development of the plan.
* Require that staff providing information for this process speak respectfully about the person and contribute documented facts and evidence about the person and the service context.
* Ensure that when a behaviour support plan is delivered, staff review the plan to ensure that they are satisfied that the information they have given on behalf of the person in the assessment process is accurately and properly reflected.
* Clarify that staff are aware that accepting a behaviour support plan on behalf of the person and the organisation means that the organisation is accountable for its implementation.
* Coach and mentor staff in assessing whether the strategies outlined in the plan itself are implementable in context.
* Ensure that there is a formal and documented process for accepting behaviour support plans into the organisation with clear delegations for responsibility.
* Ensure that training modules include information about roles and responsibility of staff at all levels.
* Ensure staff involved in the acceptance of behaviour support plans and restrictive practice panel processes are familiar with the relevant definitions, rules and requirements.

## Potential challenges

* Staff may have the perception that the clinician is the ‘expert’ and so attention to building capacity and confidence in staff is needed to create a culture in which it is ok to ask questions, which encourages collaboration at all levels.
* Organisational structures and resourcing differ, which may mean that the opportunity for dedicated roles can vary. People might be responsible for numerous roles, for example, a team leader may also be the practice lead for restrictive practice. This may result in competing priorities and conflicting approaches to manage the same issue

## Example

Organisational staff play a key role in operationalising a restrictive practice and in the process verify whether it is appropriate, proportional and a last resort.

| Plan to panel: process and rolesA provider identifies that there were significant gaps in processes associated with positive behaviour support practice, implementation and review and authorisation and reporting of regulated restrictive practices. After consultation with operational, clinical and quality/compliance teams, a ‘plan to panel’ workflow is developed to provide a clear and documented allocation of roles and responsibility from behaviour support practitioner plan completion though to the restrictive practice authorisation panel. During restrictive practice authorisation panels, the convenors lead robust conversation around the fading strategies contained in the plan. After the panel/authorisation process, operational teams are supported by leaders and clinicians to continue to explore safe opportunities to implement fading strategies and look for less restrictive options. The provider encourages support workers, family members and advocates to be involved in every step of the process and to collaborate, contribute or lead positive change for people. |
| --- |

#

# Meaningful data collection and evaluation to inform decisions and actions

In order to prevent and eliminate the use of restrictive practices organisations can proactively use their data collection systems to monitor, identify and respond to emerging issues. Achieving this requires clear expectations as to who is responsible for monitoring data entries and a detailed approach to the evaluation of data is used to inform the design of an action plan to respond to issues that may arise. This approach ensures that all decisions related to support practice are evidence-based and that action plans are transparent and are monitored and evaluated for their effectiveness for the person and their support team to prevent or avoid a restrictive practice.

## Actions to consider

* Data collected may not be the same for everyone and so organisations should be conscious to avoid a ‘cookie cutter approach’. Working with the person and identifying their needs will assist in guiding meaningful data collection. Sharing collected data with the person and their key supports can enable collaborative and meaningful decision making.
* Set the expectation that data is not just collected about challenges or incidents, but also to measure skill development, capacity building, strengths and successes. Building a culture that emphasises the positive outcomes from data collection can be powerful in gaining meaningful participation from staff.
* Sharing the reasons why data is being collected, and the results, can assist in contextualising the process for staff to increase engagement in data collection. Exploring time limited methods, a variety of modalities (checklists, observations, notes) can assist with ‘data fatigue’ and provide richness in information.
* Build data collection methods that can be shared with ease with other key people in the person’s life, such as therapists, doctors etc. Platforms that easily enable collaboration ensure there are not multiple people collecting data about similar things.
* Take a proactive whole-of-environment approach to using data to capture issues in the person’s environment that might be impacting them. This means a ‘focus on the bigger picture’ of incidents and issues rather than looking in isolation and problem solving one issue.
* Ensure training and coaching for disability support workers explicitly addressees how to provide meaningful entries in routinely collected data**.**
* Regularly review routinely collected data entries to ensure the nature and quality of data is appropriate for case monitoring and review. This is best done by team leaders or senior staff.
* Set an expectation that team leaders and operations managers monitor routinely collected data for the purpose of recognising and identifying factors that potentially signal emerging issues in a support context.
* Require all staff to proactively enter issues that appear to be escalating into the organisation’s incident reporting system.
* Use coaching and mentoring of team leaders so they understand that incident reports are a positive tool which can provide valuable insights rather than an administrative activity that has to be achieved on shift.
* Maintain active oversight of the organisation’s incident reporting system by senior staff and require that an incident report triggers a review of routinely collected data or recognition that ‘there may be a problem going on’.
* Establish clear lines of escalation to senior staff when an incident or a pattern of incidents is recorded in the organisation’s incident reporting system for an individual or for a household.
* Respond to the escalation of an issue by implementing a careful holistic ‘practice review’ or ‘case review’.
* Effectively establish a practice/case review by allocating roles to designated staff members, with clarity in particular about who is responsible for collecting relevant data and to whom that data should be provided for analysis or evaluation. This may be a senior staff member or a team leader who is being coached and mentored to be able to undertake the process.
* Develop a *Practice/Case Review Guide* which sets out in detail an approach to assist staff to drill into all of the different types of things that could be impacting in the day to day and so develop an understanding of what is happening for the person.
* Be explicit about the skills a staff member needs to be able to complete a practice/case review, including for example, data collection and analytical skills.
* Take a ‘trial and error’ approach to investigation, analysis and evaluation of data in a practice/case review. This emphasises not to presume, but rather “test what you think the data is telling you”.

## Potential challenges

* Routine day to day data collection in disability support settings may be seen as primarily a procedural or administrative task and so the quality of information and its useability for improving practice may be impacted.
* Incident reporting in a disability support setting is often seen as a negative outcome and staff can become acutely focused on problem solving each individual incident to the exclusion of examining the whole context of what may be going on for the person.

## Examples

The capture and use of data is a universally accepted principle underpinning organisational approaches restrictive practices (Huckshorn et al 2014; Australian Psychological Society 2011; Vollmer et al, 2011) and is recognised as a crucial element in the national framework for reducing and eliminating restrictive practices (Australian Government 2014).

The ways that staff record day to day observations about the people they support can provide an organisation with valuable insight into how person-centred practice is enacted in a person’s environment and support context. Staff notes can demonstrate the ways that a proactive ‘communication first’ approach is operationalised for each person. The following example demonstrates how regular review of the nature and quality of staff practices in documenting behaviour and communication can provide pointers to beliefs or approaches to communication and behaviour support which may need to be addressed in order to ensure a reflective, positive and solution-focused approach.

| Reflective practice in staff documentation Senior staff, together with team leaders and operations managers regularly review entries into the client information record to assess disability support worker capability in taking a proactive ‘communication first’ approach to their support practice. Entries which centre on behaviour only such as “Tom’s behaviour was unsettled today”, “Sarah was heightened when she got off the bus today”, “Harry refused to eat his evening meal” or “I told Fiona…” raise a flag and should prompt team leaders to take up issues of ‘communication first’ in supervision, coaching and mentoring with their staff. The objective of this is to have staff reflect on their own thinking about and response to the people they support and shift the way they record their observations from simply reporting what the person does or does not do to a more engaged, nuanced and reflective practice that seeks to understand what the person is communicating or in fact complaining about what the staff member may or may not be doing. Example entries that capture this approach will be things like “I misunderstood what Tom was saying when he was upset and when I tried something different it worked” or “Sarah makes a loud high-pitched noise when she is happy and the same when she is not happy – so we have to try a few different things with her to be able to establish what she is communicating about”. |
| --- |

Both the presence and absence of issues in data collection can provide meaningful information.

| Take action based on meaningful data Staff providing support to residents are expected to collect day to day data on a range of factors relevant to each person. However this data collection is not simply an end in itself but rather should provide meaningful observations which must be regularly reviewed to monitor the quality of supports and potentially emerging issues. For example, individual’s bowels movements may be logged in routine data collection, however if a person hasn’t used their bowels for three days it takes someone to look at the data and understand that there is a problem and something has to be done. “If nothing is done then in this case you are collecting evidence that you did nothing”. This highlights the importance of collecting data that is meaningful and demonstrates the necessity for clear lines of responsibilities in terms of who is tasked with evaluating it and what actions will be taken with what is found out. |
| --- |

| Data enables reduction Nathan engages in self injurious behaviour, biting his hand when he is distressed. To help protect his skin integrity, a hand split was introduced for him to wear (mechanical restraint). The implementing provider collected specific data, which when analysed indicated this behaviour was only occurring during periods of transition to and from home. A reduction in the restraint was then phased in, only putting on the splint during these times. This was coupled with the implementation of other strategies to minimise distress during these times and build on Nathan’s skills. Data collection continues with the aim that the restrictive practice will be faded further as other strategies reduce the impact of this behaviour of concern. |
| --- |

When multiple sources of data are examined, often no one issue may account for a person’s distress, but rather multiple relatively minor things contribute to a broader pattern. The following example shows that by examining the whole context and problem solving through trial and error the resolution may require a number of relatively small changes to multiple things.

| Understanding the pattern of thingsEllie has a long history of large residential care and limited community engagement. In her early days in her new home Ellie was quite animated and it was clear from multiple incident reports that she was not comfortable with how things were being done and that some staff were being injured as a result. Senior staff and Ellie’s home team leader undertook a comprehensive practice/case review process.The investigation initially looked at who worked with Ellie and the number of people around when incidents occurred. Evidence showed that two particular staff members had a higher number of incidents than the others. One hypothesis was that this could be because they weren’t working well with her. However, after observation of these workers it was clear that in fact they were reporting more because they were directly working as her support person. Ellie’s plans were then checked for congruence, revealing that there were conflicting strategies in Ellie’s behaviour support and her communication plans, so that staff were inconsistently responding to her when she became distressed. The team leader talked to staff about communication and understanding what her communication was conveying and provided clarity as to the approach to supporting Ellie when she was distressed to ensure there was consistency. In examining the staff notes it was immediately clear that there was a staff issue with one of Ellie’s favourite tasks in the home – to change the garbage bin bags. In understanding why “I told Ellie” appeared 35 time in staff notes, questioning revealed that staff were unhappy when Ellie put the wrong colour bag in the garbage bin because they were expected to observe the instructions for colour coded garbage bags for recycling. Senior staff attended a staff meeting and pointed out that the priority is to recognise that Ellie has done something which she thinks is important and contributing and the colour of the garbage bag is much less important. One further issue involved Ellie tipping out meals prepared by staff and pouring herself drinks and tipping those out. The team leader looked at the drinks issue and found that Ellie liked milk but that she would want to drink all the milk. A review was made of Ellie’s medication to establish whether any were known to cause thirst and so might account for Ellie wanting to get drinks all the time. It was found that three of the medications cause dry mouth, so a referral was made back to the doctor to investigate alternatives with fewer side effects. Staff also bought Ellie her own fancy little milk container and filled that up with milk. Ellie then knew that was hers and she was able to judge how and when she had that milk throughout the day. Ellie would also get anxious when other people went into her room. To address this staff felt justified in locking Ellie’s room (a potential restrictive practice). On an unannounced visit to the home senior staff noted the locked door and asked “how does Ellie unlock her room when she wants to?” Staff indicated that Ellie had to ask staff for the key because it was kept in the office. This was judged to be problematic and a potential restrictive practice, because Ellie shouldn’t have to ask for the key to have access to her room. Staff found a solution where the key now hangs on a hook on Ellie’s door and she knows she can access it when she wants to. Ellie is now much more settled in her home and incidents of distress are very rare. |
| --- |

# Wrap around support for staff via training, supervision, coaching and mentoring

Organisational capacity for the avoidance, prevention and reduction of restrictive practices lies with the staff. Wrapping the right supports around each staff member according to their role is an important focus to ensure constant capability building for quality practice. This will entail an explicit program of practice leadership, which involves for example, one-to-one and group observation, supervision, coaching and mentoring for skill building. The overall objective of this approach is to assess whether staff have the skills and knowledge they need, build capacity in all staff for reflective practice and to use coaching and mentoring to bring all those things together in quality support practice.

## Actions to consider

* Ensure person-centred practices are embedded across all organisational operations and processes.
* Develop an organisational *Practice Quality Framework* which articulates how the organisation actions its planning, implementation and evaluation of initiatives to ensure quality support practice.
* Utilise a structured training, assessment and monitoring framework for all new staff mapped to the [*NDIS Workforce Capabilities Framework*](https://workforcecapability.ndiscommission.gov.au/) and to an organisational Practice Quality Framework.
* Include a focus at initial intake and training for new staff which takes employees to values and how the behaviour of the values is critically important to quality practice including ideas of respect, equality, and human rights.
* Take every opportunity in all staff development and training activities to do reflective practice.
* Embed in staff training a focus on quality rather than simply compliance to ensure that the organisation’s people are consistently ‘lifting their performance’.
* Enact a model of monthly supervision (one-to-one support conversations) meetings for all staff and on the job coaching and mentoring in all levels of the organisation. Experienced senior staff (eg. operations managers) have this role with team leaders and team leaders have this role with disability support workers.
* Highlight applied learning (Plans to Practice/Practice to Plans) where team leaders work in a coaching relationship with disability support workers to ensure that they understand people’s plans and that this understanding is reflected in their practice.
* Ensure engagement with PBSP implementation training to enable teams to understand environmental, capacity building and fading strategies contained in the current plan.
* Develop tools, mechanisms and processes to guide and coach team leaders and managers in putting in to practice their roles in observing, coaching and mentoring rather than to simply monitor compliance. These may include for eg. *Practice* *Observation Framework*; *How to Run an Effective Team Meeting*; *Buddy Shift Tool*.

## Potential challenges

* Budgets for training are tight and organisations may struggle to prioritise training beyond those which are mandatory.

## Examples

Organisational staff, particularly front-line support staff and their immediate supervisors, are the key resource in which service providers can invest to ensure organisational values of least restrictive environments permeate all support practice. Equipping staff with the right skills, supervision and resources creates an expectation and an environment that provides the optimal conditions for the prevention and reduction of the use of restrictive practices with the people they support.

| Supported problem solvingCapacity building team leaders is a key priority for ensuring organisational adherences to the principles of least restrictive alternative. Senior staff conduct monthly in-service training which aims to equip team leaders with knowledge around important or emerging issues in practice, many of those directly or indirectly related to the avoidance of restrictive practices. Topics include for example: Complaints, Risk Management and Action Planning, Congruency, and Effective Engagement with Clinical Supports. One further capacity building approach is to encourage team leaders to bring issues they may be experiencing with a disability support worker to their regular meetings with senior staff. Together they work through the issue including considering: • How many times it has this happened? • What type of training does this suggest is needed?• What would need to be part of an action plan as to how to tackle it?• What kind of data would need to be collected to know when the issue has resolved? Senior staff work directly with team leaders to ensure that they are confident in using the organisation’s coaching and mentoring resources and tools effectively and consistently to address issues and improve practice within their own teams. |
| --- |

| Finding the right people to be team leaders Team leaders are the key frontline organisational position to maintain close oversight of the avoidance and prevention of restrictive practice. Identifying and recruiting the right people for team leadership requires organisational managers to target experienced people, recognise and understand their skill sets and work out a structure/process where that can be tapped to develop the right skills. This process requires a flexible and intuitive approach. Team leaders are often drawn from the ranks of good disability support workers, but it cannot be assumed that any one person will have the kinds of practice leadership skills that are required to understand, address and manage restrictive practice issues. People may have good aptitude, but someone who has high competence in one-to-one client support practice will not necessarily have the skills or understanding needed to be a team leader. A trial-and-error approach can be best when exploring the potential of disability support workers to become team leaders. This process entails assessing people’s aptitude for agile problem solving and being prepared to put them back down if they cannot learn or demonstrate aptitude for what a team leader has to do. The expertise that various educational pathways can bring is one, but not the only, aspect that is valued in this process. Other necessary attributes including critical thinking and the capacity to utilise insights gleaned from those with training and experience in various aspects of clinical practice. The key attributes are found in people who understand how to observe, coach and mentor others to improve their practice. Values-base recruitment should be used when recruiting team leaders which includes:• Understanding human rights as the foundation – “if they don’t have that after working in the sector it’s hard to teach or develop”• The ability to articulate how quality support relates to human rights • A foundational appreciation of behaviour as communication• An ethical commitment to restrictive practice is a last resort |
| --- |

Team leaders are expected to be able to demonstrate that they have thought critically about human rights and what they look like in practice, to the able to identify the behaviours associated with the organisation’s stated values and how values are put into action in the support relationship. This knowledge will equip them well for the coaching and mentoring role they are expected to fulfil.

# Concluding remarks

This good resource provides pointers for organisations to assess their readiness and capability as a starting point. They demonstrate how organisations can make changes to their governance, policy, processes and practices which can explicitly address the reduction and elimination of restrictive practices for the NDIS participants they support. These approaches can increase both the quality and safety of services provided under the NDIS.

For NDIS participants, these steps can lead to greater realisation of their human rights and improvements in their quality of life by reducing the use of restrictive practices, listening to their voices, developing strategies to better meet their needs and implementing a plan of action to bring about long lasting and positive change.

# References

Advonet and Change. (2020). *Lived experience of restraint, seclusion and segregation: Stories and recommendations for safer care*. Retrieved from <https://www.cqc.org.uk/sites/default/files/20201021_rssreview_livedex.pdf>

Aged Care Quality and Safety Commission, NDIS Commission & and the Australian Commission on Safety and Quality in Health Care (2022) *Joint Statement on the Inappropriate Use of Psychotropic Medicines to Manage the Behaviours of People with Disability and Older People.* Retrieved from https://www.ndiscommission.gov.au/sites/default/files/2022-07/joint-statement-inappropriate-use-psychotropics-medicines.pdf

Australian Government. (2013). *National Disability Insurance Scheme Act 2013*. Retrieved from https://www.legislation.gov.au/Details/C2020C00378

Australian Government. (2014). *National framework for reducing and eliminating the use of restrictive practices in the disability service sector.* Retrieved from https://www.dss.gov.au/sites/default/files/documents/04\_2014/national\_fraemwork\_restricitive\_practices\_0.pdf

Australian Government. (2018a). *National Disability Insurance Scheme (Code of Conduct) Rules 2018.* Retrieved from https://www.legislation.gov.au/Details/F2018L00629

Australian Government. (2018e). *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018.* Retrieved from https://www.legislation.gov.au/Details/F2018L00632

Australian Psychological Society. (2011). *Evidence-based guidelines to reduce the need for restrictive practices in the disability sector*. Retrieved from <https://www.psychology.org.au/getmedia/c986ad95-d312-4b2c-89da-3157b215f118/Restrictive-Practices-Guidelines-for-Psychologists.pdf>

Deveau, R. & Leitch, S. (2020) Implementation of policy regarding restrictive practices in England. *Tizard Learning Disability Review*, *25*(1) pp. 1-8. <https://doi.org/10.1108/TLDR-05-2018-0016>

Hough, A. (2022) Governing for quality and safeguarding: what might disability service provider boards learn from others? *Research and Practice in Intellectual and Developmental Disabilities.* <https://doi.org/10.1080/23297018.2022.2109193>

Huckshorn, K . A. (2004). Reducing seclusion restraint in mental health use settings: core strategies for prevention. *J Psychosoc Nurs Ment Health Serv 42*(9). pp:22-33. doi: 10.3928/02793695-20040901-05.

Huckshorn, K. A., LeBel, J., & Jacobs, H. E. (2014). An organizational approach to reducing and preventing restraint and seclusion use with people with acquired brain injury. *Neurorehabilitation*, *34*(4) pp:671-680.

LeBel, J. L., Duxbury, J., Putkonen, A., Sprague, T., Rae, C. & Sharpe, J. (2014). Multinational Experiences in Reducing and Preventing the Use of Restraint and Seclusion. *Journal of Psychosocial Nursing and Mental Health Services, 52* (11). pp. 22-29.

National Association of State Mental Health Program Directors (NASMHPD). (2008). Six Core Strategies for Reducing *Seclusion and Restraint Use©.* NASMHPD Publications. Retrieved from <https://www.nasmhpd.org/content/six-core-strategies-reduce-seclusion-and-restraint-use>

Office of the Senior Practitioner. (2012). Roadmap resource for achieving dignity without restraint. Victorian Office of the Senior Practitioner. Retrieved from <https://providers.dffh.vic.gov.au/sites/default/files/2017-08/Roadmap-resource-for-achieving-dignity-without-restraint.doc>

Paley-Wakefield .S. (2013). *Framework for reducing restrictive practices*. Kidderminster. U.K. British Institute of Learning Disabilities.

Skills for Care & Skills for Health. (2014). *A positive and proactive workforce: A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health.* Retrieved from <https://www.skillsforcare.org.uk/resources/documents/Developing-your-workforce/Care-topics/Behaviours-which-challenge/A-positive-and-proactive-workforce.pdf>

United Nations (2006). [United Nations Convention on the Rights of Persons with Disability](https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html).

Vollmer, T. R., Hagopian, L. P., Bailey, J. S., Dorsey, M. F., Hanley, G. P., Lennox, D., Riordan, M. M. & Spreat, S. (2011). The association for behavior analysis international position statement on restraint and seclusion. *Behav Anal*. *34*(1). pp.103-10.

Williams, D.E., & Grossett, D.L. (2011). Reduction of restraint of people with intellectual disabilities: An organizational behavior management (OBM) approach. *Research in Developmental Disabilities, 32*, 2336–2339

# Additional resources

**Centre for Perfect Care (UK) HOPE(S) Model**

The HOPE (S) Model is a human rights based approach to working with people with disability in complex settings developed from research and clinical practice to reduce restrictive practices.

<https://www.centreforperfectcare.com/documents/what-is-hope-s/>

**Skills for Care & Skills for Health (UK)**

The resource *A positive and proactive workforce* is a guide to workforce development for employers seeking to minimise the use of restrictive practices in social care and health

<https://www.skillsforcare.org.uk/resources/documents/Developing-your-workforce/Care-topics/Behaviours-which-challenge/A-positive-and-proactive-workforce.pdf>

**The Restraint Reduction Network (RRN)**

The RRN is a UK based independent network which brings together professional bodies, government departments, people with lived experience, practitioners and academics focused on sharing learning and developing quality standards and practical tools that support restrictive practice reduction. <https://restraintreductionnetwork.org/>

* [Post-Incident Debriefing and Support Toolkit](https://restraintreductionnetwork.org/uncategorized/rrn-launches-post-incident-debriefing-and-support-toolkit/)
* [Post-incident Debriefing Guidance For health care staff working with autistic people and/or people with a learning disability.](https://restraintreductionnetwork.org/wp-content/uploads/2022/06/Post-Incident-Debriefing-Guidance-for-staff-working-with-autistic-people-or-people-with-learning-disabilities.pdf)
* [Ethical training standards to protect human rights and minimise restrictive practices](https://restraintreductionnetwork.org/wp-content/uploads/2021/08/RRN_standards_phase_8_accessible.pdf)

**Zero Tolerance**

Zero Tolerance is an initiative led by National Disability Services in partnership with the disability sector. It assists disability service providers to understand, implement and improve practices which safeguard the rights of people they support.

<https://www.nds.org.au/resources/all-resources/zero-tolerance>