



**NDIS Quality
and Safeguards
Commission**

Regulated Restrictive Practices Guide

Chemical restraint
Environmental restraint
Mechanical restraint
Physical restraint
Seclusion

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Introduction

Background

The NDIS Quality and Safeguards Commission (NDIS Commission) is a Commonwealth agency established to protect and prevent people with disability from experiencing harm arising from poor quality or unsafe supports or services under the National Disability Insurance Scheme (NDIS). This includes monitoring the use of regulated restrictive practices and promoting their reduction and elimination.

Purpose of this guide

The purpose of this guide is to:

- a) promote the rights and inherent dignity of people with disability;
- b) assist in identifying each regulated restrictive practice;
- c) provide practice advice consistent with a positive behaviour support framework, contemporary evidence informed practice, intended to reduce and eliminate the use of restrictive practices; and
- d) assist registered NDIS providers and NDIS behaviour support practitioners to meet their obligations under the [National Disability Insurance Scheme Act 2013 \(NDIS Act 2013\)](#) and relevant Rules.

Scope of the guide

This guide was developed for registered NDIS providers and NDIS behaviour support practitioners supporting NDIS participants, but it may also be of interest to anyone who supports a person with disability. The guide supports a contemporary positive behaviour support framework.

This guide explains what a restrictive practice is, and sets out information on the five types of regulated restrictive practices, being:

- chemical restraint
- environmental restraint
- mechanical restraint
- physical restraint
- seclusion.

Legislative context

This guide furthers some of the NDIS Quality and Safeguards Commissioner's specific behaviour support function as set out in [section 181H of the NDIS Act 2013](#), relevantly:

- "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:
- (b) developing policy and guidance materials in relation to behaviour supports and the reduction and elimination of the use of restrictive practices;
 - (c) providing education, training and advice on the use of behaviour supports and the reduction and elimination of the use of restrictive practices;

- (e) undertaking and publishing research to inform the development and evaluation of the use of behaviour supports and to develop strategies to encourage the reduction and elimination of restrictive practices by NDIS providers.”

The NDIS Act 2013 gives effect to Australia’s obligations under the [Convention of the Right of People with Disabilities](#) (CRPD). The CRPD is the first binding international human rights treaty to recognise the rights of all people with disability. Australia signed the CRPD in 2008. 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.

Restrictive practices – General information

What is a restrictive practice?

Section 9 of the [NDIS Act 2013](#) defines a restrictive practice as ‘any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability’. Under the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*, there are five restrictive practices that are subject to regulation and oversight by the NDIS Commission. These are chemical restraint, mechanical restraint, physical restraint, environmental restraint and seclusion.

The use of restrictive practices for people with disability can present serious human rights breaches. The decision to use a restrictive practice needs careful clinical and ethical consideration, taking into account a person’s human rights and the right to self-determination. Restrictive practices should be used within a positive behaviour support framework that includes proactive, person-centred and evidence-informed interventions. There are some circumstances when restrictive practices are necessary as a last resort to protect a person with disability and or others from harm.

The NDIS Commission’s role is to provide registered NDIS providers and NDIS behaviour support practitioners with clear guidance to ensure appropriate safeguards are in place with the aim of reducing and eliminating the use of regulated restrictive practices where possible. Under the NDIS Act 2013, if an NDIS provider, or a person employed or otherwise engaged by an NDIS provider, is found to have contravened the NDIS Act 2013 or Rules, the NDIS Quality and Safeguards Commissioner may undertake compliance and enforcement action, in a risk responsive and proportionate manner, applying the strongest actions to the most serious breaches. Non-compliance may be handled using a range of tools that are outlined in the [Compliance and Enforcement NDIS Quality and Safeguards Commission Policy](#).

When can a restrictive practice be used?

The following legislative instruments outline the conditions under which regulated restrictive practices can be used:

- [National Disability Insurance Scheme \(Restrictive Practices and Behaviour Support\) Rules 2018](#)
- [National Disability Insurance Scheme \(Provider Registration and Practice Standards\) Rules 2018](#)
- [National Disability Insurance Scheme \(Incident Management and Reportable Incidents\) Rules 2018](#).

Some of these conditions include that the use of a regulated restrictive practice must:

- a) be clearly identified in the behaviour support plan
- b) if the State or Territory in which the regulated restrictive practice is to be used has an authorisation process (however described) in relation to that practice, be authorised in accordance with that process
- c) be used only as a last resort in response to risk of harm to the person with disability or others, and after the provider has explored and applied evidence-based, person-centred and proactive strategies
- d) be the least restrictive response possible in the circumstances to ensure the safety of the person or others
- e) reduce the risk of harm to the person with disability or others
- f) be in proportion to the potential negative consequence or risk of harm
- g) be used for the shortest possible time to ensure the safety of the person with disability or others.

Key points and general considerations about restrictive practices

The information below includes sourced legislative requirements including the conditions of registration with the NDIS Commission:

- **Reporting obligations and authorisation:** Registered NDIS providers and NDIS behaviour support practitioners need to be aware of their reporting obligations to the NDIS Commission. They also need to follow State and Territory authorisation, consent and reporting requirements consistent with relevant legislation, policy and/or procedures.
 - **Least restrictive:** A restrictive practice must be the least restrictive response possible in the circumstances to ensure the safety of the person or others.
 - **Shortest time and last resort:** A restrictive practice must be used for the shortest possible time and only as a last resort after exploring and applying evidence-based, person-centred and proactive strategies.
 - **A functional behaviour assessment:** This is a key component in the development of a comprehensive behaviour support plan. A functional behaviour assessment is a requirement under section 20(5) of the NDIS (Restrictive Practice and Behaviour Support) Rules 2018.
 - **Behaviour support plan:** The use of a restrictive practice must be detailed in a behaviour support plan and only used within a framework of positive behaviour support. An example of information that should be considered in detailing a restrictive practice in a plan can be found in [Appendix A: Restrictive Practice Protocol](#).
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- **Report use:** NDIS providers implementing regulated restrictive practices need to keep records on their use of restrictive practices and report use to the NDIS Commission (NDIS (Restrictive Practices and Behaviour Support) Rule 2018 under sections 14 and 15).
 - **Reduction and elimination:** From the outset, consideration should be given on how to gradually reduce (and eliminate over time) the use of the restrictive practice. Strategies for this should be included in the comprehensive behaviour support plan and informed by a functional behaviour assessment.
 - **Supports should be trauma informed.** This involves recognising the high prevalence of traumatic experiences in people with disability, understanding and responding to trauma as

well as ensuring that any restrictive practice does not result in re-traumatisation to the person.

- **Communicate appropriately with the person:** It is a requirement under section 20(4) of the NDIS (Restrictive Practice and Behaviour Support) Rules 2018 that the intention to use a regulated restrictive practices is communicated to the person with disability and their family in an accessible format. Consider obtaining a current communication assessment by a speech pathologist to identify how communication partners can best communicate with the person, for example, the use of speech, visual supports, gestures, simple questions.
- **Collaboration between NDIS behaviour support practitioners and implementing providers:** It is important that the NDIS behaviour support practitioner and the registered NDIS provider implementing the behaviour support plan work with the person with disability, and with one another, to develop and understand the behaviour support strategies for the person with disability.
- **Collaborate with health and allied health professionals:** A medical practitioner should exclude any medical or physical conditions for the onset of the behaviour. A collaborative approach with different professions including health, occupational therapist, speech pathology, and physiotherapist can help to assess the person's context, systems and environment in which the restrictive practice will be used.
- **Consider the individual:** Culture, religion, beliefs, sexual expression, linguistic circumstances, the gender of the person, and their family should be taken into account. This reflects good practice and is consistent with the NDIS Act 2013, the NDIS Practice Standards and Quality Indicators, and the values and principles outlined in the Positive Behaviour Support Capability Framework.
- **Physical and psychological risk assessment:** A risk assessment should be conducted taking into account any physical health problems (e.g. musculoskeletal risks), psychological risks (such as a history of abuse and trauma), risk of injury, or health concerns. This should occur before a regulated restrictive practice is considered. Error! Bookmark not defined.
- **Staff training:** Staff need to be appropriately trained in how and when they can use the regulated restrictive practice safely and in the behaviour support plan.
- **Regular reviews:** The use of the regulated restrictive practice needs to be regularly monitored and reviewed.
- **Get advice if unsure:** If you are unsure whether the practice is a restrictive practice, seek advice from a clinical supervisor or from the NDIS Commission.

Possible impacts of using restrictive practices on people with disability

- Restrictive practices do not address the underlying factors that cause the behaviour of concern (LeBel, Nunno, Mohr, & O'Halloran, 2012). For example, people with disability who have limited communication skills and/ or emotional regulation skills may self-harm in response to underlying factors such as confusion, anxiety, trauma, sensory impairments, or an underlying illness or pain (Emerson et al., 2014).
- Controlling one behaviour using a restrictive practice can lead to other behaviours of concern (Deshais, Fisher, Hausman, & Kahng, 2015).

- A restrictive practice may be triggering to a person with a history of trauma and abuse.
- A restrictive practice can cause trauma and psychological distress (LeBel et al., 2012).
- The use of a restrictive practice may result in a loss of dignity for the person with disability.
- A restrictive practice can limit personal freedom and the person's ability to engage in activities of daily life (Deshais et al., 2015).
- They can reduce meaningful interactions with carers and support staff.
- Long-term use of restrictive practices may lead to an over-reliance, which could result in the person seeking restraint or becoming anxious without the restraint (Department of Health and Human Services, 2019).

Culturally sensitive practice

All people, including people with disability have the right to enjoy and benefit from their own culture, practise their own religion and use their own language. Supports and services provided to people under the NDIS should be family-centred and culturally inclusive. They should take into account the culture, religion, beliefs, linguistic circumstances and the gender of the person, and their family. This reflects good practice and is consistent with the NDIS Act 2013, the NDIS Code of Conduct, the NDIS (Provider Registration and Practice Standards) Rules 2018 and the values and principles outlined in the Positive Behaviour Support Capability Framework. Data indicates that as of 31 March 2020, 6.2% of all NDIS participants identified as Aboriginal or Torres Strait Islander and 9.1% as culturally and linguistically diverse (COAG Disability Reform Council Quarterly Report, 2020).

In providing culturally inclusive, safe and responsive services, NDIS providers should take steps to develop their cultural awareness and limit cultural bias. This includes developing an understanding of the role and importance of culture, religion and beliefs in the life of the person and their family. Beyond this, culturally sensitive practice in behaviour support involves being aware of the potential impact of restrictive practices on people and communities who may have additional vulnerabilities. For example, Aboriginal and Torres Strait Islander peoples, migrants and refugees from war-torn or conflict zones, asylum seekers, people who have been involved with child protection or the criminal justice system, lesbian, gay, bi-sexual, transgender and intersex people, and women with disability are all more likely to have experienced trauma (Jackson & Waters, 2015). As such the use of restrictive practices risks being re-traumatising for these individuals and may amplify fear and mistrust of services.

Reducing and eliminating restrictive practices

Consistent with a positive behaviour support framework and the NDIS Act 2013, regulated restrictive practices should only be used as a last resort in response to risk of harm. Also, they should only be used for the shortest time possible. This highlights the need for clear plans to reduce and eliminate the use of regulated restrictive practices over time, replacing them with proactive and less restrictive alternatives based on an understanding of the person's needs and the function of the behaviour.

Australia is committed to the reduction and elimination of restrictive practices. The *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* identified the following six core strategies for reducing and eliminating restrictive practices:

1. Person-centred focus

2. Leadership towards organisational change
3. Use of data to inform practice
4. Workforce development
5. Use of restraint and seclusion reduction tools (including evidence-based assessment, prevention approaches, emergency management plans, environmental changes and meaningful activities integrated into the individual's support plan)
6. Debriefing and practice review.

The primary goal of behaviour support is to improve quality of life; with the reduction of behaviours of concern being the secondary goal. Reducing and eliminating restrictive practices upholds the rights of people with disability, and is a critical part of promoting quality of life.

Chemical restraint

What is chemical restraint?

Section 6(b) of the [NDIS \(Restrictive Practices and Behaviour Support\) Rules 2018](#) defines chemical restraint as:

‘the use of medication or chemical substance for the primary purpose of influencing a person’s behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition’.

Research has shown that people with intellectual disability or cognitive impairments have been prescribed high rates of medication to address behaviours of concern (Bowring, Totsika, Hastings, Toogood, & McMahon, 2017; Saloviita, Pirttimaa, & Kontu, 2016; Scheirs, Blok, Tolhoek, Aouat, & Glimmerveen, 2012; Webber, McVilly, & Chan, 2011). There is some evidence supporting medications such as ariprazole and risperidone to reduce behaviours of concern in the short term (Ching & Pringsheim ; Jesner, 2007). However, overall, research including rigorous randomised control studies in children and adults with disability have found that the evidence regarding the effectiveness of medication to address behaviours of concern, such as aggression or agitation is limited and insufficient (Sokolowski, 2011; Tsiouris, 2010; Tyrer et al., 2009; Tyrer et al., 2008.)

When medications are prescribed for people with disability, the prescribing medical practitioner is the clinical decision-maker who determines the purpose of medication. The NDIS Commission does not regulate medical practitioners. However, where medication has been prescribed to influence a person’s behaviour, the NDIS Commission seeks to ensure that registered NDIS providers have appropriate positive behaviour support strategies in place, that together with pharmacological interventions may assist the medical practitioner to review whether the medication can be reduced or eliminated. Knowing when medication is a chemical restraint and considering the potential impact to the person is necessary to protecting the dignity and human rights of people with disability, and reducing and eliminating its use.

Examples of chemical restraint

- Bill has an intellectual disability. When Bill gets upset, he hits others and himself. Bill’s GP prescribed a small dose of quetiapine PRN (as needed basis) to help reduce the behaviour of hitting. This is a chemical restraint.
- Christian has a diagnosis of Autism Spectrum Disorder. Christian bangs his head on the wall. His psychiatrist prescribed a low dose of benzodiazepine daily to help reduce head banging. The primary purpose of the medication is to influence the behaviour of head banging. This is a chemical restraint.
- Loa is a 6-year-old with a diagnosis of a developmental delay. Loa sometimes bites and scratches herself. Loa’s paediatrician prescribed Olanzapine on a PRN (as needed basis). This is only given under clearly specified circumstances. The primary purpose of the medication is to influence the behaviour of biting and scratching. This is a chemical restraint.
- Pamela is a 58 year old with a diagnosis of dementia and a moderate intellectual disability. Pamela recently transitioned to an NDIS group home. Pamela was experiencing distress and was constantly trying to leave the group home. Pamela’s GP prescribed a small dose of

risperidone to keep her calm. Her distress was not linked to her diagnosis of Dementia. This is a chemical restraint.

- Diazepam prescribed to reduce agitation is for the primary purpose of influencing behaviour.
- Sodium valproate prescribed to reduce self-harm behaviour is for the primary purpose of influencing the person's behaviour. This is a chemical restraint. (Department of Communities and Justice, NSW, 2019).

A case study example of chemical restraint can be found in [Appendix B](#) and an example chemical restraint protocol can be found in [Appendix C](#).

Examples that are not chemical restraint

- Ahmed has a diagnosis of schizophrenia. This is monitored by his GP and regularly reviewed by his long-standing psychiatrist. Ahmed was prescribed risperidone for the treatment of his diagnosis of schizophrenia. Risperidone has been prescribed to treat a diagnosed mental disorder.
- Diazepam prescribed and used as muscle relaxant after seizure activity is for the primary purpose of treating a physical condition.
- Sodium valproate prescribed to treat or minimise seizure activity is for the primary purpose of treating a physical condition or physical illness (Department of Communities and Justice, NSW, 2019).

Other considerations regarding chemical restraint

Pre-medical appointment medication

Medication prescribed by a medical practitioner for anxiety or agitation to support a person with disability to attend a medical appointment does not require reporting to the NDIS Commission. For example, a person who is given a small dose of diazepam before attending a dental appointment. The purpose of these medications is to 'enable treatment of, a diagnosed mental ill health, a physical illness or a physical condition'. This is not a chemical restraint.

Medication for menstrual suppression

The use of medication for menstrual suppression due to behaviours of concern for example, distress and hygiene (e.g. smearing) is a chemical restraint under the NDIS (Restrictive Practices and Behaviour Support) Rules 2018. The use of medication for menstrual management is not considered chemical restraint when:

- 1) it is prescribed for the treatment of a diagnosed medical condition (e.g., endometriosis); or
- 2) the person with disability has requested and consented to this treatment.

It is important that women with disability are provided with information in a meaningful way to support their decision-making about their reproductive and sexual health. Informed consent needs to be documented and the person must also understand that they can withdraw consent at any time.

Menstrual suppression should only be considered when other options have failed or if there are significant gynaecological or other medical reasons. Alternative strategies should be trialled to solve issues such as fear of blood, smearing, hygiene problems and/or pain and distress.

With appropriate education, most women with disability can learn to manage their own menstruation independently or with support. Ideally, this education should be proactive and begin at an early age before the onset of menstruation (Tracy, Burbidge, Butler, & Donley, 2010). Any form of menstrual suppression (including surgical suppression) has medical, legal, ethical, and social implications (Quint & O'Brien, 2016).

There are many resources available to assist in this area including:

- [Supporting Women Guidelines](#)
- [Supporting decision making in reproductive and sexual health for people with disability](#)

Anti-libidinal medication used to influence behaviour

Anti-libidinal medications reduce sexual arousal. When prescribed for people with disability to address problematic sexual behaviours, this is a chemical restraint. Anti-libidinal medication should only be considered for a small population of people who engage in sexual offending behaviour where other interventions alone have not worked, and where there is a high risk of further offending by the person (Thomas & Daffern, 2014).

A person's risk of sexual offending behaviour should be determined by thorough assessments conducted by trained practitioners, using current evidence-based risk assessment tools, self-reports and a functional behaviour assessment. Anti-libidinal medications must not be used in males under the age of 18 years, or in other instances where bone and testicular development is not yet complete (Thomas & Daffern, 2014).

Anti-libidinal medication should not be used on its own to manage problematic sexual behaviour. Instead, it should be one part of treatment in addition to behaviour support strategies and psychological therapy. Due to the complex nature of these behaviours, a collaborative approach is needed to provide the best support and to work towards less restrictive practices. Anti-libidinal medications have significant physical side effects and require ongoing close medical monitoring and regular review (Thomas & Daffern, 2014).

Possible impacts of using chemical restraint on people with disability

- Research has shown that there is an over-reliance for the use of medication to address behaviours of concern in people with disability. Medication may be sought as the first step in addressing behaviours of concern. Over time, medication can become the only intervention used to address the behaviours of concern. With a reliance on medication, the underlying causes of the behaviour tend to be missed including serious mental health conditions that can manifest as behaviours of concern (Bowring et al., 2017).
- Medication does not address any environmental and social factors that may contribute to, or exacerbate a person's behaviour of concern. It can also mask underlying health conditions that can manifest itself in a behaviour of concern.
- There is potential for long-term negative side effects (Deutsch & Burket, 2020).
- Polypharmacy and/or high doses of psychotropic medication increases risk for drug interactions and can lead to sedation, confusion, constipation, falls, weight gain, metabolic side effects, respiratory suppression, toxicity, and ultimately tardive dyskinesia (motor difficulties, tremors, and restless legs) (Deutsch & Burket, 2020).

- Other side effect include the risk of dysphagia that may result in aspiration pneumonia and choking (Flanagan & Ronaldson, 2016).
- People with disability are often unable to identify or communicate the side effects they are experiencing.
- Using medication for long-term treatment may introduce new issues such as tolerance, dependence and addiction.

Also refer to '[Possible impacts of using restrictive practices on people with disability](#)'

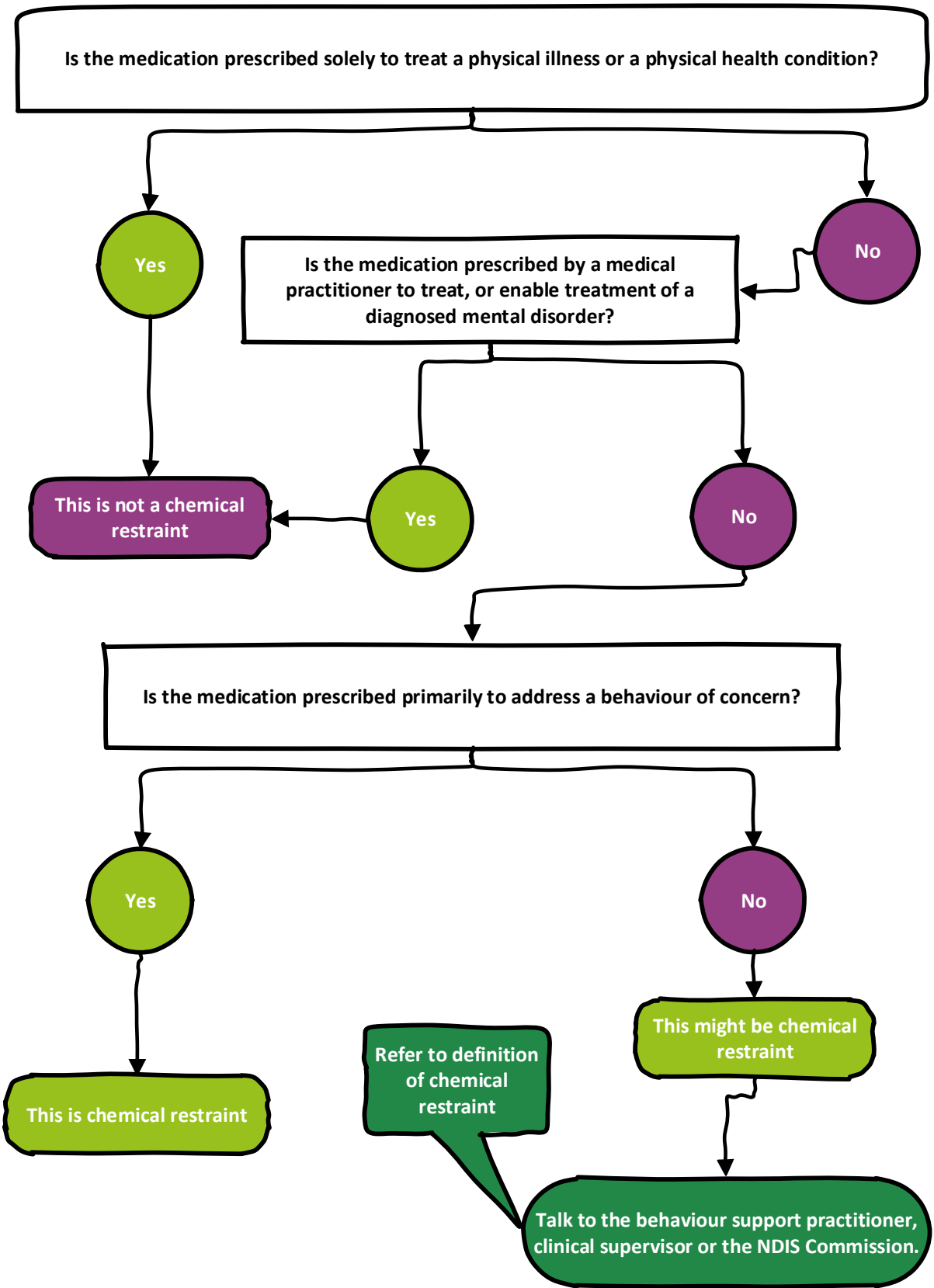
Important considerations when using chemical restraint

- Collaboration between the prescribing practitioner, the NDIS behaviour support practitioner and the registered NDIS provider implementing chemical restraint is crucial to the person's care and to reducing and eliminating chemical restraint.
- If a registered NDIS provider or NDIS behaviour support practitioner is unclear about the purpose of a participant's medication, they should seek clarification directly from the prescriber by asking questions around why the medication has been prescribed, and when and how the medication should be administered to ensure the safety and best outcomes for the person.
- A functional behaviour assessment can also help to inform decision-making on the purpose of medication.
- Carefully monitor for potential side effects. It is important that registered NDIS providers avoid misinterpreting side effects as behaviours of concern.
- Medication should only be used in combination with psychological or other interventions (including positive behaviour support) (National Institute for Health Care Excellence, 2015).
- National Institute for Health Care Excellence (NICE, 2019) guidelines recommend the following for the use of antipsychotic medication used for a behaviour of concern:
 - consider this medication for managing behaviour in people with disability only when other interventions have not been helpful and when the risk to the person or others is very severe.
 - only offer in combination with psychological or other interventions to help manage behaviours of concern.
 - review the effectiveness of antipsychotic medication after 3–4 weeks.
 - stop use if there is no sign of improvement after 6 weeks, reassess the behaviour of concern and consider further psychological or environmental strategies
- For effective medication reviews, it is important that registered NDIS providers monitor and collect meaningful data that can be shared with the prescribing medical practitioner. The behaviour support practitioner can guide understanding on how to capture meaningful data.
- Misdiagnosis is possible, especially for people who have limited communication skills; therefore, if a registered NDIS provider feels the person they support should have a second opinion, get one.

Also refer to '[Key points and general considerations about regulated restrictive practices](#)'.

Chemical restraint decision tree

This tool aims to support decision-making and provide guidance on whether a practice could be a form of chemical restraint.



Environmental restraint

What is environmental restraint?

Section 6(e) of the [NDIS \(Restrictive Practices and Behaviour Support\) Rules 2018](#) defines environmental restraint as follows:

“environmental restraint, which restricts a person’s free access to all parts of their environment, including items or activities”.

It includes practices that are beyond ordinary community standards for the purposes of addressing a behaviour of concern that can cause harm to persons with disability and/or others. An example of ordinary community practice includes locking the front door at night for safety (the person is still able to leave their home if they choose to).

Environmental restraint can be difficult to identify, as this category of restriction is broad and vast. Knowing when a practice is an environmental restraint and considering the potential impact to the person is necessary to protecting the dignity and human rights of people with disability, and reducing and eliminating its use.

Examples of environmental restraints

- Locking a door, cupboard or fridge to prevent a person’s access. For example, ‘Mark is known to run out of the house and onto the road. The front and back door are locked to prevent Mark from running onto the road and oncoming traffic’.
- Preventing or placing restrictions on a person engaging in an activity such as cooking, or watching TV.
- Preventing access to a person’s possessions such as their mobile phone, iPad or cigarettes.
- Preventing access to a certain area in their environment, such as the backyard or kitchen.
- Restrictive access to the community, for example ‘Amy is able to go out independently, however, due to engaging in self-harm behaviour, Amy is only allowed to access the community with staff supervision’.
- Restrictive access to hazardous items, sharps and chemicals (for example toiletries, cutlery, and other sharps to reduce the risk of self-harm behaviours).

A case study example of environmental restraint can be found in [Appendix D](#) and an example environmental restraint protocol can be found in [Appendix E](#).

What is not environmental restraint?

Locked medication

Under the [National Disability Insurance Scheme \(Provider Registration and Practice Standards\) Rules 2018](#) (NDIS Practice Standards), registered NDIS providers responsible for administering medication to participants, are obligated to administer, store and monitor the effects of the participant’s medication and work to prevent errors and incidents.

The [National Disability Insurance Scheme \(Quality Indicators\) Guidelines 2018](#) (NDIS Quality Indicators) provide that “All medications are stored safely and securely, can be easily identified and differentiated, and are only accessed by appropriately trained workers.”

In line with the NDIS Practice Standards and the NDIS Quality Indicators, registered NDIS providers that are responsible for administering medication to participants are not required to report the locking of medication to the NDIS Commission.

Administering medication needs to be person-centred to maximise choice and control for people with disability. Where appropriate, opportunity to build capacity to safely store and self-manage some or all of their medications should be encouraged.

Impact of environmental restraint on other people with disability

Environmental restraint practices can have an impact on others who share the same facilities or residence, affecting their rights and freedom. For example, in a group home, a locked door can limit the rights and freedoms of other people who live there. Therefore when implementing restrictive practices it is important to take a broad look at any communal 'ripple effects' on the human rights of others sharing a service or residence. It is also important that registered NDIS providers take steps to reduce the impact of a restrictive practice on other people who access the same service.

For example, 'Emily is an NDIS participant who receives supports at the same location as another NDIS participant, Lucas. Emily and Lucas both share the kitchen, and like to eat lunch together. Lucas is able to use knives safely and enjoys preparing his own food.

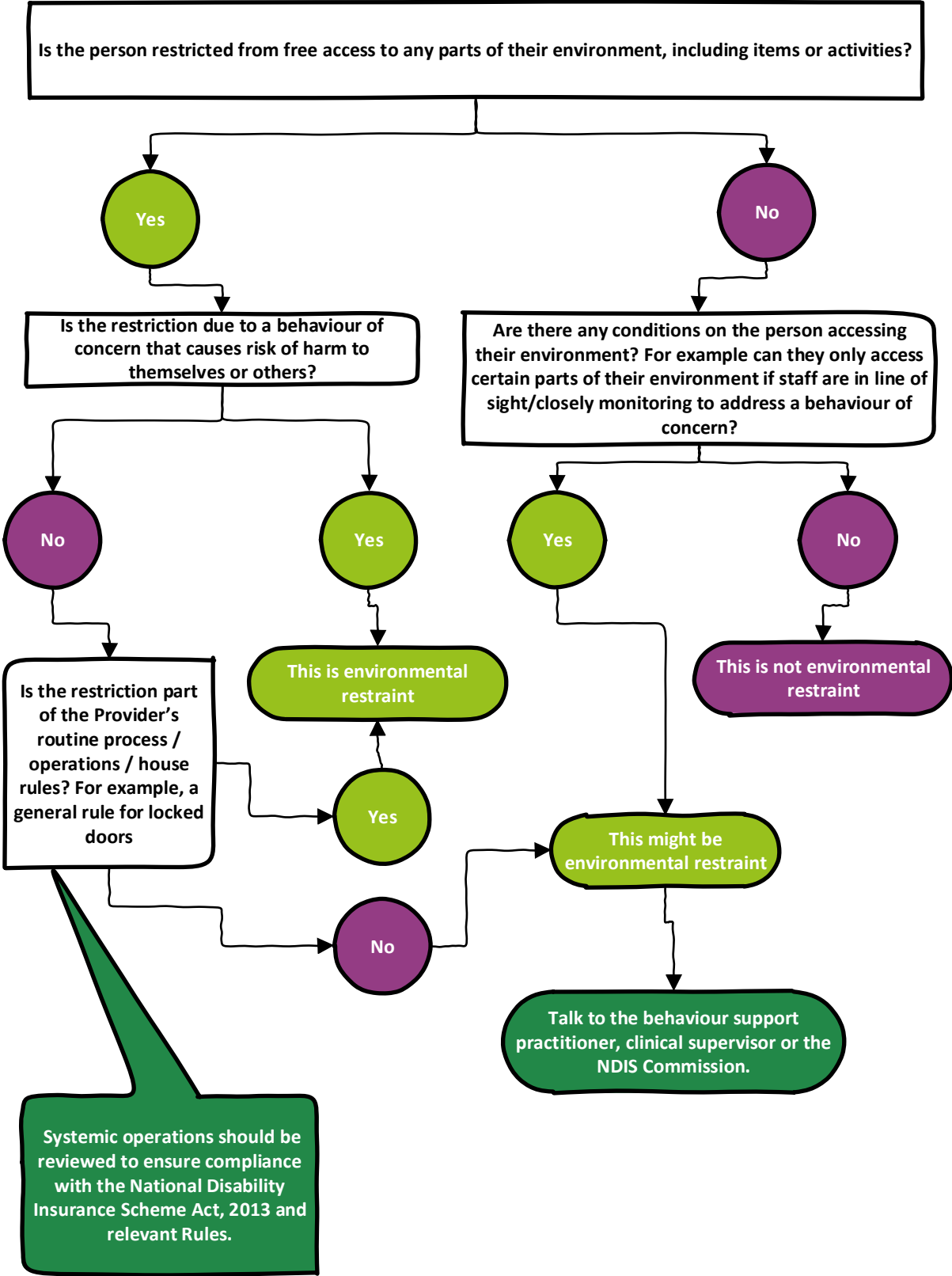
Emily has a restrictive practice in place for locked cutlery. The kitchen drawers are locked and Emily is unable to access cutlery without staff supervision. NDIS staff have given Lucas his own key to the kitchen drawers to access the cutlery, including knives. Staff have explained to Lucas the importance of locking the cutlery away after use.'

By giving Lucas a key, NDIS staff have reduced the impact of the locked drawers to his rights and freedom. It is good practice for registered NDIS providers to develop a one-page protocol that outlines how the impacts of restrictive practices will be addressed to uphold the rights of other persons' with disability.

Also refer to '[Possible impacts of using restrictive practices on people with disability](#)' and '[Key points and general considerations about regulated restrictive practices](#)'.

Environmental restraint decision tree

This decision tool aims to support decision-making and provide guidance on whether a practice could be a form of environmental restraint.



Mechanical restraint

Section 6(c) of the [NDIS \(Restrictive Practices and Behaviour Support\) Rules 2018](#) defines mechanical restraint as:

“the use of a device to prevent, restrict, or subdue a person’s movement for the primary purpose of influencing a person’s behaviour but does not include the use of devices for therapeutic or non-behavioural purpose”.

Mechanical restraint is sometimes used to address behaviours of concern, for example, it is sometimes used to prevent injury from self-harm behaviours for people with disability (Webber et al., 2019). Knowing when a practice is a mechanical restraint and considering the potential impact to the person is necessary to protecting the dignity and human rights of people with disability and reducing and eliminating its use.

Examples of mechanical restraint

- Splints, gloves or a helmet to prevent a person from self-harming (e.g. head butting, pulling out their hair, hand biting, skin picking).
- Restrictive clothing, for example to prevent a person from smearing or accessing a part of their body (e.g. bodysuit, overalls, onesies). For example, ‘Paul is known to try and pull out his Peg tube (feeding tube). Paul wears a onesie, this is to stop Paul from accessing his Peg tube’.
- The use of straps to restrain any part of the body to stop a behaviour of concern.

A case study example of mechanical restraint can be found in [Appendix F](#) and an example mechanical restraint protocol can be found in [Appendix G](#).

What does ‘therapeutic or non-behavioural purpose’ mean?

Devices for therapeutic or non-behavioural purposes are not mechanical restraints. These are defined as devices that assist a person with everyday functional activities or help their injuries heal (Department of Health and Human Services, 2019).

Examples of therapeutic or non-behavioural purpose (not mechanical restraint).

- Adaptive devices or mechanical supports used to achieve proper body position, balance or alignment to allow greater freedom of mobility than would be possible without the use of such devices or mechanical supports i.e. a harness for postural support.
- Splints used on a person’s arm to assist with independent eating.
- The use of a cast to heal a broken arm or leg.
- The use of a wheelchair for a person who cannot walk long distances.

Only an appropriately qualified health professional (such as a registered medical practitioner, occupational therapist, physiotherapist, speech pathologist, dentist, podiatrist, assistive technology technician, exercise physiologist or orthotist) can prescribe therapeutic devices. Therapeutic devices should be thoroughly assessed and only used for the specific and approved purposes for which they were designed (Department of Health and Human Services, 2019). When a device is modified it may no longer meet the Therapeutic Goods Administration’s Standards and could present a risk to the safety of the person with disability.

A device can be used as a mechanical restraint or used for therapeutic /non-behavioural purposes in different situations. What distinguishes a device from being a mechanical restraint or therapeutic/non behavioural depends on why it is being used.

For example, a harness:

- when used to respond to a person engaging in a behaviour of concern during transportation, is a mechanical restraint.
- when used in a wheelchair for postural support as prescribed by an occupational therapist to help a person with functional activities, is not a mechanical restraint.

The use of splints, when:

- placed on a person's arms to prevent them from scratching their head is a mechanical restraint.
- used on a person's arm to facilitate independent eating is not a mechanical restraint.

Who is most at risk of mechanical restraint?

Some people with disability are at a higher risk of being mechanically restrained than others, and these include the following characteristics:

- People who engage in self-harm behaviours (Webber et al., 2017; Deshais et al, 2015).
- Children (Webber et al., 2017; McGill, Murphy & Kelly-Pike 2009).
- People with a physical disability. This may be associated with medical conditions such as cerebral palsy where the person is experiencing undiagnosed chronic pain leading to behaviours of concern such as self-harm (Webber et al., 2017; McMorris, et al, 2015).
- People with Autism Spectrum Disorder (McGill et al., 2009).
- People with communication difficulties (Webber et al., 2017; Merineau-Cote & Morin, 2013; Emerson, 2002).
- People with sleeping problems, bowel and abdominal problems (Poppes, Putten, Post, & Vlaskamp, 2016).
- People with sensory impairment including visual and hearing impairment (Webber et al., 2019).

It should be noted that people with hearing impairments are nearly eight times more likely to be mechanically restrained than those who are not (Webber et al., 2017). Hearing and vision impairments may affect a person's ability to communicate, and express their needs. This can lead to misunderstandings and behaviours of concern (Webber et al., 2017).

Possible impacts of using mechanical restraint on people with disability

- Having a mechanical restraint device in place while conducting a functional behaviour assessment makes the function of the behaviour difficult to identify as the mechanical restraint can stop the behaviour of concern from physically occurring (Sturmey, 2009).
- Risk of triggering the re-emergence of distress for a person with a history of trauma and abuse.
- Physical injury, including muscular atrophy, bone loss, shortening of tendons, and arrested motor development can occur due to long-term lack of weight bearing activities and movement (White, 2019; Gastmans & Milisen, 2006).
- Risk of injury to the person from prolonged use of the device, not fitting well or incorrectly used (Department of Health and Human Services, 2019).
- Skin irritation and pressure sores of tendons, and arrested motor development (Department of Health and Human Services, 2019).
- Risk of suffocation when bed rails/ bed poles are used (Department of Health and Human Services, 2019).
- Risk of choking on devices (Department of Health and Human Services, 2019).
- Can limit a person's ability to communicate effectively, especially when the person uses non-verbal means to communicate, such as pointing to a communication device, or predominately uses their body language to communicate (White, 2019).
- Can limit a person's freedom and their ability to engage in activities of daily life, skill building, leisure, and reduce the amount of interaction with carers (Best Practice Guidelines for Occupational Therapists, 2010).

Also refer to ['Possible impacts of using restrictive practices on people with disability'](#) and ['Key points and general considerations about regulated restrictive practices'](#).

When does mechanical restraint become abuse?

Certain types of devices are associated with increased risk of harm and infringements on a person's human rights. Mechanical restraints that cause harm to a person with disability can constitute abuse and can be unlawful.

The following devices may constitute abuse:

- Hand cuffs in any form.
- Devices that restrain a person's legs/ feet from moving.
- Ropes used to tie hands or other body parts.

Any mechanical restraint that is intended to cause hurt or harm to a person with disability is considered abuse.

The use of mechanical restraints which are abusive must be ceased and reported to the NDIS Commission within 24 hours.

Mechanical restraint decision tree

This decision tool aims to support decision-making and provide guidance on whether a practice could be mechanical restraint.



Physical restraint

What is physical restraint?

Section 6(d) of the [NDIS \(Restrictive Practices and Behaviour Support\) Rules 2018](#) defines physical restraint as:

“the use or action of physical force to prevent, restrict or subdue movement of a person’s body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person”.

Physical restraint should only be used for serious behaviours of concern to prevent significant harm to the person or others when other strategies have not worked. Physical restraint is sometimes used in response to behaviours of concern such as significant self-harm, aggression, and other behaviours that pose a high risk of harm to the person or others (Singh, Lancioni, Karazsia, Myers, Winton, Latham, 2015). Identifying when a practice is a physical restraint and considering the potential impact to the person is necessary to protecting the dignity and human rights of people with disability and reducing and eliminating its use.

Examples of physical restraint

- Holding a person’s hand down to prevent them from hitting themselves.
- Holding down any part of the body to address a behaviour of concern. For example, ‘Staff hold down Yogesh’s arm when he goes to the doctor for a blood test as Yogesh is scared of needles and tries to move his arm away’.
- Taking the person’s hand and pulling them in a direction they do not want to go.

A case study example of physical restraint can be found in [Appendix H](#) and an example physical restraint protocol can be found in [Appendix I](#).

Examples that are not physical restraint

Reasonable safety measures and practices used to assist a person with daily living and therapeutic activities where the person is unable to perform a task alone and safely are not physical restraints, for example:

- physically assisting a person to dress, shave or brush their teeth.
- helping a person to learn a new skill, such as physically guiding their hand to use a knife when preparing food.
- physically guiding a person in a swimming pool if they are not able to swim independently.
- using hand over hand modelling to support a person to complete a task, such as dressing or eating.
- physically supporting a person with their physiotherapy program.
- physically guiding a person away from a busy road or an unsafe situation, such as moving their hand away from a hot plate.

Note: The level of physical force used can also make a practice a physical restraint. For example, a person can be led into the bathroom for a shower (physical assistance). But, if force is applied to lead them into the shower, this would be considered physical restraint. Physical assistance should not be coercive (Department of Health and Human Services, September, 2011).

Prohibited forms of physical restraint

The following forms of physical restraint are prohibited practices in relation to all NDIS participants as they are associated with high risk of injury and death:

- prone restraint (subduing a person by forcing them into a face-down position).
- supine restraint (subduing a person by forcing them into a face-up position).
- pin downs (subduing a person by holding down their limbs or any part of the body, such as their arms or legs).
- basket holds (subduing a person by wrapping your arm/s around their upper and or lower body).
- takedown techniques (subduing a person by forcing them to free-fall to the floor or by forcing them to fall to the floor with support).
- any physical restraint that has the purpose or effect of restraining or inhibiting a person's respiratory or digestive functioning.
- any physical restraint that pushes a person's head forward onto their chest.
- any physical restraint that compels a person's compliance by inflicting pain, hyperextending joints, or applying pressure to the chest or joints (Department of Health and Human Services, 2011).

Who is most at risk of physical restraint?

Some people with disability are at a higher risk of being physically restrained than others, and these include the following characteristics:

- lower adaptive functioning, particularly social functioning (people who engage in less social interactions, and or are socially isolated (Scheirs et al.,2012; Fitton & Jones,2020).
- more severe intellectual disability (Webber et al., 2011).
- severe aggressive behaviour (Mérineau-Côté & Morin,2013).
- speech impairment, and people who communicate using signs. This may influence other's ability to interpret the person's communications (Webber et al., 2011).
- multiple behaviours of concern (Matson & Boisjoli, 2009).
- living in a hospital (long stay admissions) (Matson & Boisjoli, 2009).
- living in situations where there are higher ratios of senior staff and higher cost of residential services. This may be indicative of people with more behaviours of concern living in more restrictive environments (Emerson et al., 2000).

Possible impacts of using physical restraint on people with disability

- There is a high risk of injury and or death, such as the risk of soft tissue injury, and positional asphyxiation (deprived of oxygen). (Hughes & Lane, 2016; Williams, 2009).
- Can be easily misapplied resulting in injury or death (Hughes, et al., 2016).
- Risk of injury to the person implementing physical restraint (Hughes et al., 2016).

- Older people who are physical restrained are at greater risk of injury due to associated conditions such as, pressure sores, osteoporosis, epilepsy and cardiac problems. (Ridley & Jones, 2012; Tang, Chow & Koh, 2012).
- Can negatively affect the relationship between the person who is physically restrained and the person applying physical restraint, thereby impacting the therapeutic relationship. (Hughes et al., 2016).
- Can be a triggering experience for a person with a history of trauma and abuse.
- People with disability can associate physical restraint with negative feelings such as sadness, powerless, or dehumanisation. They can also see it as punishment and can experience emotional distress (Heyvaert, Saenen, Maes, 2015; Strout, 2010).
- Physical restraint can put someone at risk of developing additional behaviours of concern, including agitation, and aggression (Luiselli, Trembl, Kane, & Young, 2004).

Also refer to [‘Possible impacts of using restrictive practices on people with disability’](#)

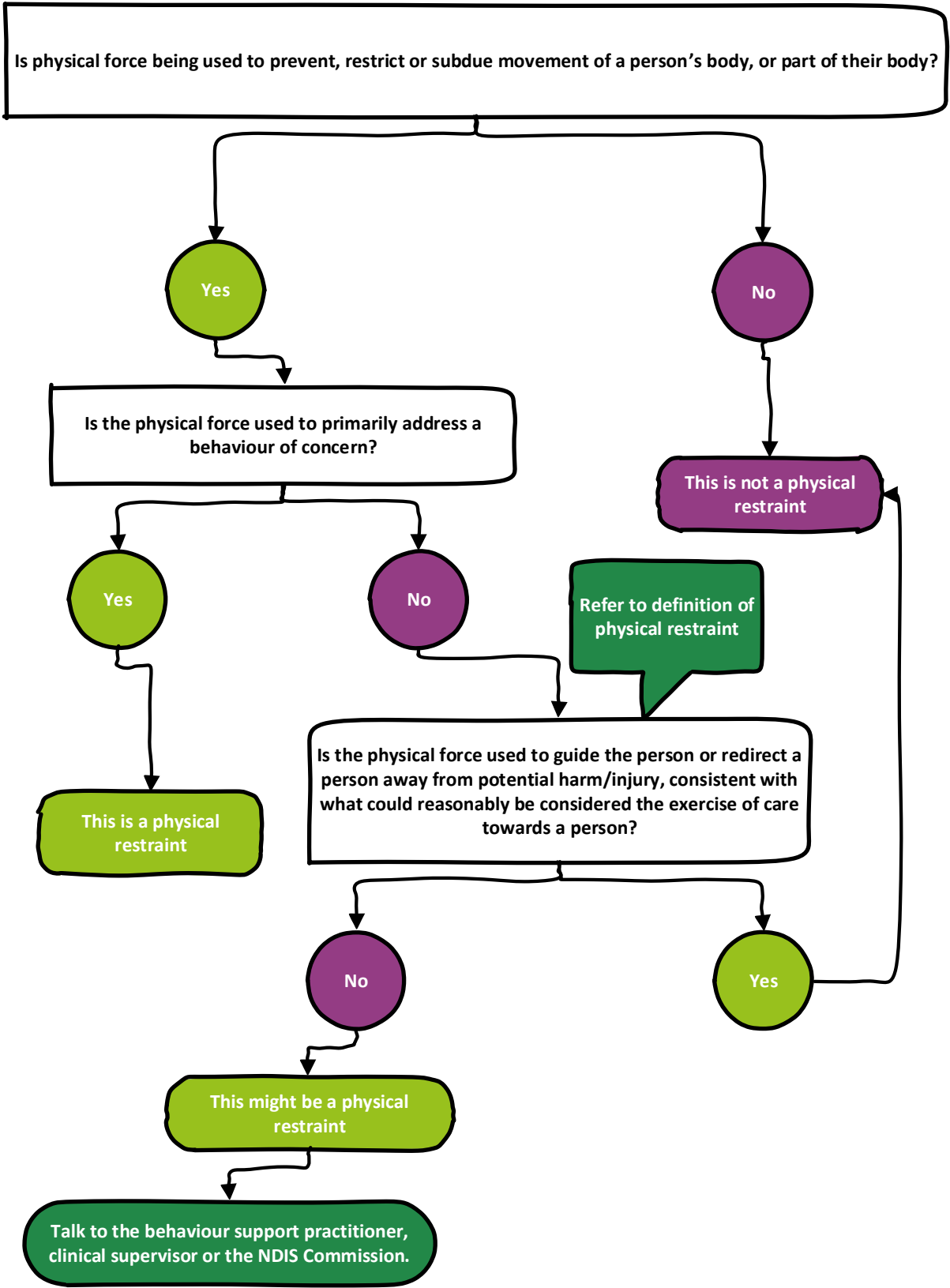
Important considerations when using physical restraint

- Physical restraint should only be used as a last resort. The risk of using physical restraint as a practice should outweigh the possible negative effects on the person and the risk involved if the restrictive practice was not used (acknowledging physical restraint can result in physical injury and even death).
- The person must be treated with dignity and respect at all times.
- Support staff using physical restraint must be appropriately trained on how to safely implement physical restraint, and under what conditions it can be used. Error! Bookmark not defined. Alternative strategies may be necessary in circumstances where support staff are not able to use physical restraint safely.
- Cultural, spiritual, and gender issues during the duration of physical restraint should be considered (McKenna, Furness, & Maguire, 2014).
- It is critical to be aware of health conditions and specific risk factors that put a person at more risk if they are being physically restrained. For example:
 - general physical health,
 - issues that may affect the heart,
 - the weight of the person,
 - medications (for example, medication such as chlorpromazine and carbamazepine, which may affect particular heart function),
 - specific diagnoses such as Down Syndrome and Turner Syndrome (who may have cervical spine instability or abnormality). People with Down Syndrome often have unstable neck joints – known as atlantoaxial instability; Rett syndrome are prone to scoliosis; or a person with cerebral palsy may have impaired respiratory function),
 - neurological or psychological factors (Department of Health and Human Services, 2019).

- Staff should monitor the person carefully during the period of restraint and a physical health review should occur after the use of physical restraint. Monitoring includes observing the person's breathing, complexion (paleness/yellow skin), blue colouration of the hands, feet, lips or other parts of the body (indicates reduced oxygen circulation in the blood) and any signs of distress, psychological impact or pain (Department of Health and Human Services, September,2019).
- Physical restraint should be immediately stopped when the person no longer presents harm to themselves and/or others. Clear directions should be in place to ensure that the physical restraint stops immediately when the serious risk of harm to the person or to others is no longer present (Department of Health and Human Services, September,2019).
- Also refer to ['Key points and general considerations about regulated restrictive practices'](#).

Physical restraint decision tree

This decision tool aims to support decision-making and provide guidance on whether a practice could be a form of physical restraint.



Seclusion

What is seclusion?

Section 6(a) of the [NDIS \(Restrictive Practices and Behaviour Support\) Rules 2018](#) defines seclusion as the:

“sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted”.

Seclusion should only be used as a last resort for serious behaviours of concern to prevent significant harm to the person or others when other strategies have not worked. Seclusion is prohibited in some States and Territories in Australia for people under the age of 18 years.

Knowing when a practice is seclusion and considering the potential impact to the person is necessary to protecting the dignity and human rights of people with disability and reducing and eliminating its use. The key defining feature of seclusion is that the freedom of movement of the person is restricted because they cannot voluntarily exit, or *believe* that they cannot voluntarily exit, a physical space.

Examples of seclusion

- Time out alone in a room or area where the person is unable to leave. For example, ‘When Mary engages in behaviours that can harm others, the room or area she is in is evacuated and Mary is left alone and is unable to leave’.
- A person alone in a room or a physical space with a barrier (including half doors) where they cannot leave.
- A person sent to their room to calm down and told they cannot come out until they have calmed down. This is seclusion if the person *believes* they cannot leave the room until they are calm.
- Staff and other residents retreating to an office/ secure room/ backyard while the person is restricted to the remainder of the house and is unable to leave, or *believes* they are unable to leave.

A case study example of seclusion can be found in [Appendix J](#) and an example seclusion protocol can be found in [Appendix K](#).

Examples that are not seclusion

- A person going to their room or bathroom and locking the door by choice for privacy while they are free to leave at any time.
- A person being alone in their home and choosing to lock the doors while being able to open them voluntarily when they want to leave at any time.

Who is most at risk of seclusion?

Some people with disability are at a higher risk of seclusion than others, and these include the following characteristics:

- Those with lower adaptive functioning (specifically with regard to social interaction) (Scheirs, et al., (2012).
- People with a diagnosis of Autism Spectrum Disorder (Webber, Richardson & Lambrick , 2014).
- People who engage in behaviours that are a risk of harm to others (McGill et al., 2009; Office of the Public Advocate, 2012).
- People engaging in aggressive and destructive behaviours (McGill et al., 2009).
- People under the age of 18 years (Webber et al., 2014).

Possible impact of seclusion on people with disability

- Preventable injury or death (The Australian Psychological Society, 2011).
- Psychological trauma (The Australian Psychological Society, 2011).
- Feelings of sadness, being powerless, undervalued, humiliation, unsafe, punished and emotional distress (Melbourne Social Equity Institute, 2014).
- Feelings of abandonment and rejection due to having limited or no contact with staff. (Melbourne Social Equity Institute, 2014).
- Can be triggering for a person who has experienced abandonment as a child, or trauma.
- Negatively affect the relationship between the person with disability and the person who implements the seclusion (Melbourne Social Equity Institute, 2014).
- Difficulty supervising the person, and adequately supporting them.

Also refer to [‘Possible impacts of using restrictive practices on people with disability’](#).

Important considerations when using seclusion

- It is critical to be aware of health conditions that may put the person at risk if they are being secluded. For example, a heart condition, effect of medications, choking risk.
- Seclusion should only occur within an environment that is safe and non-threatening to the person with disability, while maintaining the dignity and respect of the person (McKenna et al, 2014).
- The physical environment used for seclusion should be assessed in advance for safety risks. If necessary, the physical environment should be modified to prevent risk of injury (McKenna et al., 2014).
- Consideration should be given to the physical environment of the seclusion area and any items that can be offered to ensure the person has appropriate sensory input, subject to a risk assessment (McKenna et al., 2014).
- The person being secluded should be told of the plan to seclude them and the reasons for this in a way they can understand.
- Support should be offered to help the person de-escalate whilst in seclusion, if safe to do so. For example verbally offering calming suggestions.
- A person in seclusion should be observed frequently to ensure the safety and wellbeing of the person for the whole duration of seclusion (McKenna et al., 2014).

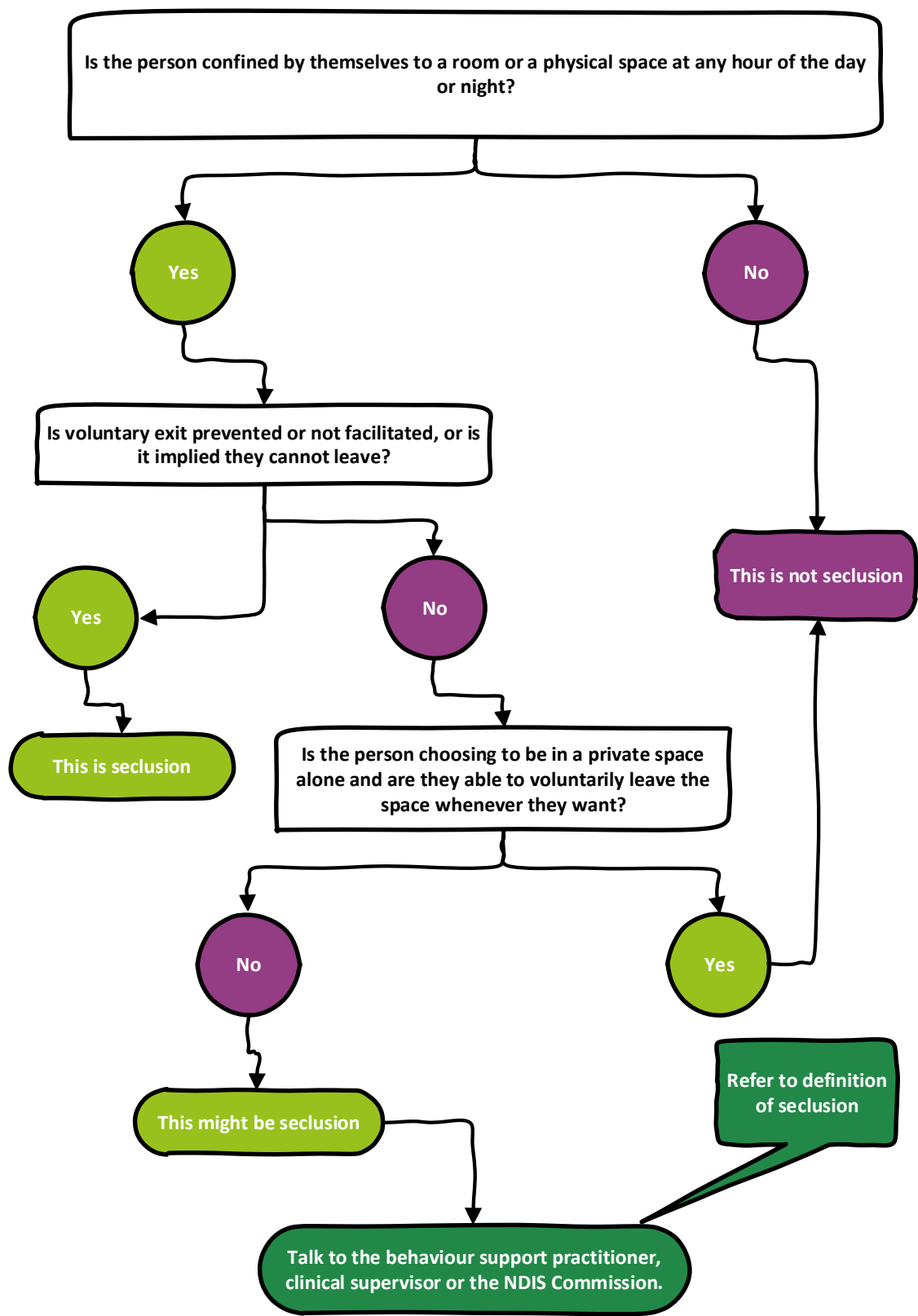
- An observation schedule should be set out over short intervals (for example, observe every 3 minutes). Intervals between visual observations may need to be more frequent depending on individual circumstances. Support staff should be vigilant for verbal and behavioural cues. Verbal and behavioural cues should include any deterioration of condition, risk assessment, and an assessment of the need for continuing seclusion. These should be documented and reviewed frequently (Hyde, Fulbrook, Fenton, & Kilshaw, 2009).
- The duration of the seclusion should be the shortest time possible, as soon as the immediate risk of harm subsides.
- Support staff should help promote feelings of safety and non-judgemental support before, during and after seclusion and support a return to normal patterns of activity after seclusion.
- If seclusion is used in combination with another restrictive practice (such as physical restraint), then the strategies should adhere to the guidelines in each relevant section of this guide. The impact of using multiple restrictive practices or in combination needs to be the least restrictive option and proportionate to the risk of harm.

For an illustrative case example of seclusion, please refer to [Appendix J](#) and [Appendix K](#) to see an example of a seclusion protocol

Also refer to '[Key points and general considerations about regulated restrictive practices](#)'

Seclusion decision tree

This decision tool aims to support decision-making and provide guidance on whether a practice constitutes seclusion.



Further information or support

Contact the NDIS Quality and Safeguards Commission

Website: www.ndiscommission.gov.au/providers/behaviour-support

Phone: 1800 035 544 (Mon-Fri)

Email: BehaviourSupport@ndiscommission.gov.au

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Appendix A: Restrictive practice protocol – Detailing the restrictive practice in the behaviour support plan

This resource helps guide NDIS behaviour support practitioners in developing a behaviour support plan with a regulated restrictive practice.

All regulated restrictive practices must be thoroughly detailed in the behaviour support plan in accordance with Part 3 of the NDIS (Restrictive Practice and Behaviour Support) Rules 2018.

A restrictive practice protocol is a good way to detail regulated restrictive practices in the behaviour support plan. It helps guide registered NDIS providers on how to use the regulated restrictive practice consistently and safely.

The following headings and points are helpful to consider in detailing a regulated restrictive practice in a behaviour support plan.

- **Description of the restrictive practice:** What is it?
- **Rationale:** Why is it being used? Explain why positive strategies alone were not effective. For example, what strategies were tried before the restrictive practice was considered?
- **Frequency?** PRN (on an 'as needed' basis) or routine (i.e. at a set time in the day)
- **Procedure:** Include detailed instructions of how, where, when the restrictive practice will be used, and for how long.
- **Reviews:** How will the use of the restrictive practice be monitored, and how often will it be reviewed?
- **Data recording and monitoring:** How will incidents be recorded and reviewed? How will you monitor the effectiveness of the positive behaviour support strategies in reducing the restrictive practice? How will you monitor side effects of the restrictive practice?
- **The plan to reduce and eliminate the restrictive practice:** What strategies are in place to reduce the restrictive practice? Details can be included in the protocol or other sections of the behaviour support plan (i.e. under preventative or skill building strategies that target the function of the behaviour). How will you measure the fade out of a restrictive practice?
- **Training:** How will training occur? For example, a 'train the trainer' approach might be used, staff may be trained at the registered NDIS provider's team meeting, or a video training resource is developed.

Appendix B: Chemical restraint case study

The following is a case example of chemical restraint. The case example is intended to be illustrative only.

Behaviour of concern

Sue is a 38-year-old female with a moderate intellectual disability. Sue enjoys playing board games, baking and having a cup of tea. From the age of 31, Sue has received support from a registered NDIS provider and has also been living in an NDIS Specialist Disability Accommodation (SDA) home. As Sue's mum got older, she was unable to continue caring for Sue in the family home. Sue has a long history of self-harm behaviour that started when she was 13, including; slapping her face, scratching and cutting her skin on her arms. Some severe incidents required treatment in the hospital.

Restrictive practice

For the past 6 months, Sue's psychiatrist has put her on a trial of Seroquel, primarily to address self-harm behaviours. This is administered as PRN (as needed basis). Medication for the primary purpose of influencing a behaviour of concern is a chemical restraint.

Psychiatric review

During a psychiatric review meeting, Sue's psychiatrist reviewed the use of Seroquel and recommended a medication reduction plan that involved slowly lowering the dosage over time. Sue's psychiatrist did not think that the trial of Seroquel was effective in reducing the self-harm. This decision was based on ongoing reviews with Sue, insight from Sue's mum, a copy of the functional behaviour assessment report and data reports brought in by her NDIS provider. Over the past 6 months, Sue was engaging in self-harm two to three times a week. There was no evidence of decrease in incidents and severity. Previous months and historical functional behaviour assessments showed similar trends.

Sue was involved in all the decision making regarding her medication and agreed to the medication reduction plan that was provided by her psychiatrist with guidelines. This was also explained to Sue using an Easy Read document. Sue was closely monitored for any side effects with regular reviews by her psychiatrist and GP, and close monitoring by her NDIS provider.

Functional behaviour assessment

The functional behaviour assessment was informed by previous psychiatric assessments, an adaptive assessment, ABC charts, natural observations, meetings with Sue, and functional behaviour interviews with Sue's mum and NDIS support staff.

It indicated that one reason (function) for the self-harm was to regulate her emotions (to calm and soothe negative feelings). Some of Sue's triggers included not knowing what will happen next in her day and loud voices.

Comprehensive behaviour support plan review

Sue's NDIS behaviour support practitioner updated Sue's comprehensive behaviour support plan. While the strategies were still relevant and addressed the function, Sue was able to identify additional ways she wanted to be supported. Sue's own personal goals, values and preferences in

how she wanted to be supported with her medication reduction plan were also included in her behaviour support plan. The restrictive practice protocol detailing the use of the chemical restraint was also reviewed (**for an example protocol of chemical restraint, see [Appendix C](#)**).

Some of the strategies aimed to increase Sue's quality of life and help support the medication reduction plan and reduce the incidents of chemical restraint focused on:

- Creating safety, stability and consistency in Sue's environment, for example, developing a predictable routine, consistent care, unconditional positive regard, acceptance and non-judgment support.
- Communication strategies based on the speech pathologist's recommendations
- Functional equivalent alternatives. For example, engaging in deep breathing exercises with the support of staff in fun and creative ways (e.g. smelling flowers); and mindfulness activities with staff, including colouring in, going for a walks, and paying attention to the trees.
- Problem solving and emotional regulation skill building.
- Having a quiet space in her home with sensory and relaxation items.
- Distraction strategies, such as listening to music, or watching a funny movie. As an addition to the behaviour support plan, Sue asked that staff spend an hour a day with her in a one-to-one activity, such as playing cards or a board game, baking or having a cup of tea.
- A collaborative relationship was formed with Sue at the centre of care, with Sue's psychiatrist, G.P, mum, and NDIS support staff. Sue was regularly engaged in discussions on what aspects of support strategies she considered important.
- Sue's psychiatrist provided education on possible side effects to Sue and her NDIS support staff. NDIS support staff closely monitored Sue and had regular discussions with her about any side effects she may be experiencing.

Outcomes

After 12 months, Sue was no longer taking Seroquel for her self-harm behaviours. Sue was also engaging in more community activities. While Sue still engaged in self-harm, her support staff observed a decline, which was consistent with data reports. Giving Sue more ownership and self-determination in the plan to reduce her medication helped lead to sustainable changes. Staff were also more confident in supporting Sue and responding to incidents of self-harm. The use of chemical restraint was removed from Sue's behaviour support plan.

Key points

- People with disability should play an active role (to the best of their ability) in decisions about medication, particularly for the purposes of chemical restraint. Medication information should always be explained in a way they can understand, including side effects.
- Medication for chemical restraint should be regularly reviewed by the prescribing practitioner and should always be used in combination with therapeutic/positive behaviour support strategies informed by a behaviour functional assessment. Discussions on medication efficacy, and side effects should be part of the review.
- Collaboration with the prescribing medical practitioner, with the person with disability at the center, and a team approach is essential in working towards a reduction and elimination of chemical restraint.

Appendix C: Chemical restraint protocol example

This resource is to help guide behaviour support practitioners detail the use of a restrictive practice in a behaviour support plan. Also see [Appendix A](#).

PRN MEDICATION PROTOCOL	
Client Information	
Name: Sue xx DOB: xx xx xxxx	
Medication	
Medication Name: Seroquel Prescribing doctor: Dr Smith (Psychiatrist)	
Frequency	
PRN (As needed)	
Purpose of medication	
Calm/ relaxation	
Indicators for administration	
<p>Less restrictive interventions to attempt <u>before</u> administering PRN:</p> <ol style="list-style-type: none">1. Attempt to identify potential triggers and remove if possible.2. Attempt to problem solve reasons why Sue may be feeling distressed. Look for environmental and physical factors (Refer to the response section of this behaviour support plan on de-escalation strategies).	<p>Behaviours present for the administration of PRN:</p> <p>Seroquel has been prescribed to address self-harm behaviour, including:</p> <ul style="list-style-type: none">• Expressing thoughts of self-harm and Sue is unable to be redirected.• Observed scratching her skin and Sue is unable to be redirected.• Attempting to cut her skin on her arms or other parts of her body. <p>If any of the above are observed and Sue is unable to be redirected using the de-escalation strategies in this behaviour support plan, Sue may need to be administered PRN. Follow the procedure instructions.</p>
Procedure	
<ol style="list-style-type: none">1. The primary way for ensuring the ongoing safety of Sue and others is by following the positive strategies listed in the behaviour support plan.2. Staff are to follow this protocol with the safe medication administration policy in place.3. Staff are to refer to medication chart and current prescribing practitioner instructions /form for information on dosage per administration, route, maximum dosage in 24 hours, side effects and administration instructions.4. Check the medication chart. If the medication has not been administered in 24 hours or if enough time has passed since it was last administered as per the prescribing practitioner instructions, ask Sue if she would like some medication to help her to relax.5. If Sue agrees, administer medication according to the medication form/ prescribing practitioner instructions. Do <u>not</u> force Sue to take the medication.6. Observe and ensure medication has been taken.7. Monitor for side effects. Sue is to be monitored closely while being administered the medication and afterwards for any side effects. Document any side effects in the chemical restraint monitoring log.8. Report any side effects to Sue’s G.P and or psychiatrist.	

PRN MEDICATION PROTOCOL	
9. Document in medication chart the time medication was given and dosage. 10. Staff are to double-check the medication chart and make sure all documentation is accurate.	
Data recording	
<ul style="list-style-type: none">• Document the incident of chemical restraint, and document appropriate information in an ABC chart.• Document any frustration shown by Sue or other issues in relation to the use of chemical restraint and any physical or psychological side effects (in the chemical restraint log).• With Sue’s consent, share the above with her NDIS behaviour support practitioner, and her psychiatrist to assist in the behaviour support plan review and the medication reduction plan.• Complete reporting requirements for the use of chemical restraint to the NDIS Commission.	
Reviews	
<ul style="list-style-type: none">• Sue to have monthly general health check-ups with her G.P, Dr Jones.• Sue is to have six-week reviews with psychiatrist, Dr Smith.	
PRN Protocol Reviewed by:	Date:
The reduction and elimination of chemical restraint (fade out plan)	
<ul style="list-style-type: none">• The plan to reduce and eliminate the use of chemical restraint is based on the outcomes of other less restrictive options and positive strategies in Sue’s behaviour support that can support the medication reduction plan.• The reduction and elimination of chemical restraint will be measured over time recording the total number of times (frequency) chemical restraint is used each month. This will be reported to Sue’s Psychiatrist and GP for review.	
Training	
Training will occur regularly during team meetings where this protocol will also be reviewed.	

Appendix D: Environmental restraint case study

The following is a case example of environmental restraint. The case example is intended to be illustrative only.

Background and behaviours of concern

Daku is a 14 year-old male who has been diagnosed with an acquired brain injury. Daku enjoys being outdoors and going to cafes. Daku lives with his parents and attends a special needs school. Daku has recently started receiving in home support from a registered NDIS provider 5 days a week. Daku frequently attempts to wander away from his home and is at risk of running onto the road and harming himself. Daku requires support in the community due to his limited road and navigation skills. He also has a fascination with shiny objects, particularly knives. In the past, this has resulted in several incidents where Daku accidentally cut himself after waving and running around with a knife.

Restrictive practice

To prevent Daku from running onto the road and harming himself, his parents began locking the front door. Daku's parents also lock away the knives in the kitchen and provide access only under supervision. NDIS support staff also follow the same procedure in Daku's family home. Locking the front door to prevent Daku from wandering and restricting access to sharps are regulated restrictive practices that fall under environmental restraint. Daku's NDIS behaviour support practitioner developed an interim behaviour support plan that contains an environmental restraint protocol for locked doors and locked knives (**for an example protocol of environmental restraint, see [Appendix E](#)**)

Functional behaviour assessment

After developing the interim plan, Daku's behaviour support practitioner completed a functional behaviour assessment, in consultation with Daku, his family, staff, and a speech pathologist. While locking the front door was a strategy intended to keep Daku safe, Daku began to engage in new behaviours of concern, including hitting and kicking his parents and NDIS staff when he wanted to go outside. Data collection and a thorough functional behavioural assessment showed that the reason (function) for the behaviour (attempting to leave) was mainly due to feeling unstimulated and having limited choice and control in his day.

Daku enjoyed going to the shops and cafes, however, he needed support to navigate and access the community safely. When he felt his parents or staff were unable to support him, he would attempt to leave on his own. Daku has difficulties with attention, memory, impulsivity, and limited problem solving and communication skills. Daku's fascination with shiny objects particularly knives was pleasurable to him and gave him comfort, however, he was at risk of accidentally hurting himself or others when handling knives. These behaviours were not observed at school as his school had a front locked gate, and knives were not accessible.

Comprehensive behaviour support plan

Daku's NDIS behaviour support practitioner developed a comprehensive behaviour support plan in consultation with Daku, his family, NDIS staff, and a speech pathologist. This was informed by the functional behaviour assessment. Communication strategies and tools were developed to support

Daku to communicate his needs, including visual supports. Person centred strategies were developed to address the reason for the behaviour (the function).

Some of the strategies in the behaviour support plan to help improve Daku's quality of life, and reduce, and eliminate the use of environmental restraint focused on:

- Adding meaningful activities to Daku's week consistent with his goal to go out, and supporting him to find meaningful activities to do at home with his family, NDIS staff and on his own (to meet with his stimulation and engagement levels).
- Developing a daily visual routine board with the speech pathologist to assist Daku understand his daily routine.
- Supporting Daku to be part of planning his routine board for the next day each night and giving him options to make changes to his activities during the day if he wished to.
- Providing immediate praise to Daku for asking to go out by pointing to his routine board instead of attempting to wander.
- Modelling safe road practices every time either his parents or NDIS staff support Daku in the community. Due to Daku's acquired brain injury, repetition is important to his learning of road skills.
- Introducing new items that are shiny and silver that were safe to use.
- Building Daku's emotional regulation skills.
- Building Daku's skills in how to safely use knives.

Daku's parents and NDIS staff used the above strategies and other strategies in his behaviour support plan consistently and some strategies were shared with Daku's school.

Outcome

These evidence based positive strategies helped to improve Daku's quality of life and increased both the quality and safety of services provided under the NDIS. Over a period of 8 months, Daku's attempts to wander gradually reduced. He learned how to use his routine board and was able to express times he wanted to go out instead of attempting to wander. Together, Daku's parents and his NDIS support staff were eventually able to fade out the restrictive practice of locking the front door by using the positive strategies in his behaviour support plan consistently. Daku learnt that support was available to him when he wanted to go out. The protocol for knives remained longer, however, strategies were implemented to continue to attempt to fade it out. Daku required lots of repetition for learning due to his acquired brain injury.

Key point

- While regulated restrictive practices may sometimes be necessary to keep a person with disability safe, they can also lead to escalations in other behaviours of concern.
- Strategies need to be designed to promote consistent implementation across all support systems to produce effective outcomes.

Appendix E: Environmental restraint protocol example

This resource is to help guide behaviour support practitioners detail the use of a restrictive practice in a behaviour support plan. Also see [Appendix A](#).

Rationale

Daku has a fascination with shiny objects, particularly knives and has a history of accidentally cutting himself by running with and waving a knife around. Unsupervised and free access to knives poses a significant risk to Daku and others. Less restrictive strategies are being trialled, however, Daku requires more time to learn the alternative skills to support the fade out of this restrictive practice.

Frequency of use: Routine, daily.

Procedure

1. The primary way for ensuring the ongoing safety of Daku and others is by following the positive strategies listed in the behaviour support plan.
2. Daku is to be supervised when he has access to knives. Daku's family and his NDIS support staff must be vigilant during this time.
3. All knives are kept in the kitchen in a locked drawer when not in use.
4. Daku can have access to a knife during meal times if required.
5. Daku is provided with the knife he wants under supervision and for appropriate use.
6. Praise Daku for using the knife safely during and after use.
7. After use, wash the knife immediately and pack it away into the kitchen drawer.
8. Complete a knife count to ensure all knives have been returned to the drawer and lock the drawer.

If Daku attempts to run with or begin to wave the knife he has access to during meal time:

1. Remind Daku that he can get hurt and gently ask him to stop running and/or put the knife down.
2. Offer alternative safe shiny objects to use.
3. Praise Daku if he puts the knife down.
4. If Daku does not put the knife down attempt to redirect him to his meal or another activity until he puts the knife down.
5. Offer first aid as appropriate and if needed.

Data Collection

- Document the use of environmental restraint, and document appropriate information in an ABC chart.
- Document any frustration shown by Daku or other issues in relation to the use of environmental restraint and any physical or psychological side effects (in the environmental restraint log).
- With Daku's consent, share the above documentation with his NDIS behaviour support practitioner to assist in the behaviour support plan review.

- Complete reporting requirements for the use of environmental restraint to the NDIS Commission.

The reduction and elimination of environmental restraint (fade out plan)

The plan to reduce and eliminate the use of environmental restraint is based on the outcomes of other less restrictive options and skill-building strategies as highlighted in Daku's behaviour support plan. This includes educating Daku about how to safely use knives during mealtime under close supervision through repetition.

Training

All staff including new staff need to be appropriately trained in Daku's behaviour support plan including the environmental restraint protocol. Training will occur in team meetings where this protocol will also be reviewed.

Appendix F: Mechanical restraint case study

The following is a case example of mechanical restraint. The case example is intended to be illustrative only.

Background and Behaviour

Samira is an 8-year-old female with a moderate intellectual disability and sensory processing disorder. Samira can find things in her environment (e.g. lights, noise, and crowds) distressing. Samira receives support from a registered NDIS provider who provides after school care. Samira's parents, school, and NDIS staff at after school care recently observed Samira engaging in a new behaviour of concern; banging her head on walls and other hard surfaces. Medical conditions for the behaviour were ruled out by a thorough medical and dental review.

Restrictive practice

An initial trial of positive strategies did not stop the head banging. This included providing reassurance and positive interactions, staff/adult sitting beside her, reducing environmental noise, and attempting to engage Samira in one-to-one activities that she enjoys. Samira's family bought a helmet to prevent Samira from injuring her head. Samira takes the helmet with her to school, and to after school care. Her parents have asked NDIS staff and her teachers to use the helmet when they see Samira start to bang her head. The helmet is used to address a behaviour of concern. This is a regulated restrictive practice that falls under mechanical restraint.

Interim behaviour support plan

Samira's NDIS behaviour support practitioner developed an interim behaviour support plan, which included the restrictive practice for the use of a helmet with a detailed protocol for its use (**for an example protocol of a mechanical restraint, see [Appendix G](#)**). The behaviour support practitioner recommended that an occupational therapist assess and recommend the right type of helmet. Staff at after school care, Samira's school, and Samira's family were trained in the interim behaviour support plan. The helmet protocol was explained to Samira using visual support.

Functional behaviour assessment

A functional behaviour assessment based on data collection, clinical observations, functional behaviour interviews, and motivational assessment scale indicated that the head banging was linked to changes in Samira's environment. Her parents recently had a baby, and this was Samira's first sibling. New people were also attending her after school care. Data collection showed that Samira mostly banged her head at home when there was a change to her routine, and at after school care, when she was sitting close to unfamiliar people. Samira was not observed to bang her head at after school care when she was next to people she knew. It was hypothesised that unfamiliar new people and changes at home were causing Samira distress. Head banging was a way for Samira to communicate her distress and regulate her emotions.

Comprehensive behaviour support plan

An occupational therapist conducted an assessment and recommended activities to help reduce Samira's levels of distress, such as going for a walk when her environment gets too noisy or overwhelming, and avoiding sensory overload. The occupational therapist also recommended an appropriate helmet with instructions for safe use.

A speech pathologist worked with Samira and the NDIS behaviour support practitioner to develop an Augmentative and Alternative Communication (AAC) system to help Samira communicate her feelings. This included teaching Samira to use a hand sign to let her parents, NDIS staff, and teachers know when she was feeling upset.

After working with Samira, her family and support team, the NDIS behaviour support practitioner developed a comprehensive behaviour support plan, integrating strategies developed by the speech pathologist and the occupational therapist.

Samira's family, teachers and staff were all trained in the behaviour support plan. It was important that everyone supporting Samira understood the underlying reason Samira was banging her head (function) and how to support her.

Some of the other strategies in the behaviour support plan to help improve Samira's quality of life, reduce, and eliminate the use of mechanical restraint focused on:

- Giving Samira more space from others when she needed it.
- Preparing Samira when someone new was attending after school care, including new staff and any changes to her routine by using visual supports.
- Supporting and praising Samira when she used her hand sign and responding immediately to her when she used it (positive reinforcement).

Outcomes

Over time, Samira learnt how to tell her family, teachers and NDIS staff when she was feeling distressed and she developed more appropriate coping strategies and skills. The head banging reduced and was eventually no longer observed. The use of the helmet was slowly faded out.

Key points

- Working collaboratively with the person, their family and support team across all settings of a person's life is important to developing a person-centred behaviour support plan.
- No single profession holds all the expertise. Often, a key role of a behaviour support practitioner is to integrate knowledge and assessments from different disciplines and bring together approaches in a positive behaviour support plan.

Appendix G: Mechanical restraint protocol example

This resource is to help guide behaviour support practitioners detail the use of a restrictive practice in a behaviour support plan. Also see [Appendix A](#).

Rationale

Samira repeatedly bangs her head on walls and hard surfaces. A helmet is used to protect Samira from sustaining injuries to her head. In some circumstances, positive strategies alone are not always effective in addressing this behaviour safely.

Mechanical device: The helmet as recommended by the occupational therapist. No other helmet should be used.

Frequency of use

PRN (as needed). Only to be used as a last resort.

Procedure

- The primary way for ensuring the ongoing safety of Samira and others is by following the positive strategies listed in the behaviour support plan.
- Identify potential triggers and remove if possible.
- Attempt to problem solve reasons Samira may be feeling distressed. Look for environmental and physical factors, and offer reassurance. Has there been a change in her environment?
- Attempt to redirect Samira to an activity she enjoys (**follow the de-escalation strategies in this behaviour support plan**).
- The decision to use mechanical restraint needs to be based on a risk assessment and characterised by respect and empathic decision-making.
- If Samira cannot be redirected and continues to bang her head, mechanical restraint may need to be used, if so follow the below instructions:
 - Inform Samira that you will be placing the helmet on her head by showing Samira the helmet and saying “Samira putting helmet on”.
 - Attempt to put the helmet on her head if it is safe to do so (securing the clip under her chin; ensure this is not too tight).
 - If Samira does not stop head banging, continue attempts to redirect her and problem solve what might be causing her distress, provide verbal and visual support.
 - Take off the helmet immediately when Samira has returned to a calm state and not engaging in head banging. This generally should not be more than 20 minutes.
 - Monitor Samira when the helmet is on and after for any health concerns, seek immediate medical treatment if there is a concern.

Indicators that Samira is calm are:

- She is not banging her head repeatedly.
- Happily engaged in an activity of her choice or happily resting.

Taking off the helmet:

- Tell Samira, “Samira taking off helmet now”.
- Gently and slowly move beside Samira and unclip the chin clip, being careful not to pinch her skin.
- Offer Samira an activity of her preference.

Data Collection

- Staff to complete incident reports about Samira’s behaviours of concern and the use of the restrictive practice, ensuring meaningful data is captured on the potential triggers, behaviour and consequences of the behaviour.
- Staff to record the frequency of use and duration each week using the mechanical restraint monitoring log.
- Staff to record any physical health conditions, frustration or distress shown by Samira in relation to the use of this practice.
- With Samira’s consent, share the above documentation with her NDIS behaviour support practitioner to assist in the behaviour support plan review.
- Complete reporting requirements for the use of mechanical restraint to the NDIS Commission.

The reduction and elimination of the mechanical restraint (fade out plan)

- The plan to reduce and eliminate the use of mechanical restraint is based on the outcomes of other less restrictive options and positive strategies as highlighted in Samira’s behaviour support plan. This includes consistently using the augmentative and alternative communication system (ACC) developed by the speech pathologist and teaching Samira to use her hand sign.
- The aim is to reduce the amount of time and incidents Samira has the helmet on. This will be measured over time recording the average and comparing this to previous months to see if there is a decline.
 - The total number of times (frequency) mechanical restraint is used.
 - The duration (minutes) of each incident of mechanical restraint (to the nearest minute).
 - The total minutes of mechanical restraint each month are to be divided by the frequency (incidents) for that month to calculate the average duration per mechanical restraint incident.

Training

- The behaviour support practitioner will provide staff training to the family, teachers and NDIS staff in the behaviour support plan and positive behaviour support.
- The occupational therapist will provide training to Samira’s family, teachers and NDIS staff on how to help address distress and how to safely use the helmet using video training.

Appendix H: Physical restraint case study

The following is a case example of physical restraint. It is intended to be illustrative only.

Background and Behaviour

Sandeep is a 25-year-old male with a diagnosis of psychosocial disability and Autism Spectrum Disorder. He enjoys watching television, going for walks, listening to music and drawing. Sandeep has a long history of aggressive behaviours including; hitting, grabbing, and kicking others. These incidents have caused significant injury to others, sometimes requiring hospitalisation. Sandeep's family were unable to continue caring for him in his family home due to his complex needs. Sandeep has experienced several placement breakdowns. For the past 5 years, Sandeep has been living in a hospital psychiatric unit. Staff at the hospital report that the aggressive behaviour can be unpredictable and difficult to manage. As a last resort, when Sandeep's behaviours of concern place him or others at risk, hospital support staff would use physical restraint. Sandeep recently transitioned to a specialist disability accommodation setting, supported by an NDIS registered provider. This transition happened gradually over six months.

Interim behaviour support

Sandeep's NDIS behaviour support practitioner developed an interim behaviour support plan in collaboration with Sandeep, his family, hospital staff, and his NDIS provider. Due to the risk of the behaviour and his transition to community living, the use of physical restraint needed to be faded out gradually. It was included in the interim behaviour support plan as a last resort. The behaviour support practitioner trained all staff in the interim behaviour support plan. Staff received training in the use of specific response strategies in how to avoid, release or move away when Sandeep's behaviours of concern presented a significant risk of harm. Staff also received training in physical restraint techniques as a last resort. A certified instructor who had completed an accredited program and maintained current certification and skills, taught these techniques.

Functional behaviour assessment

Sandeep's NDIS behaviour support practitioner completed a functional behaviour assessment informed by interviews with Sandeep, his family, psychiatrist, and several assessment reports provided by his mental health treating team at the hospital; including the Historical Clinical and Risk Management - HCR 20. It was hypothesised that Sandeep was more likely to engage in aggressive behaviours with deteriorating mental health symptoms, and may be triggered by feelings of paranoia, anxiety, loss of control and distrust in others, particularly those in positions of perceived power. Data analysis of incidents showed that while the use of physical restraint prevented immediate risk of harm to Sandeep and others, it appeared to maintain the cycle of aggression. Sandeep would sometimes respond to the use of physical restraint with more aggression.

Comprehensive behaviour support plan:

Based on the functional behaviour assessment, the use of physical restraint was not only maintaining the cycle of aggressive behaviours but also exacerbating Sandeep's feelings of powerlessness, loss of control, and vulnerability. It also had a negative impact on staffs' therapeutic relationship with Sandeep, fostering an unequal power dynamic.

While the NDIS support staff were trained in the use of physical restraint, there was a high risk of physical injury to Sandeep and staff. Physical restraint was to be avoided as much as possible, and only used in emergencies as a last resort. This was outlined in the physical restraint protocol of the behaviour support plan (**Refer to [Appendix I](#) for an example of a physical restraint protocol**).

The NDIS behaviour support practitioner worked with Sandeep, his family, the NDIS provider, and the hospital mental health treating team to develop the comprehensive behaviour support plan. The aim was to balance the response strategies with positive behaviour support strategies, reduce and eliminate the use of physical restraint over time, and help Sandeep maintain stable accommodation and supports. Staff received training in understanding the function of the aggressive behaviour, his diagnosis of Autism Spectrum Disorder, psychosocial disability, and the positive behaviour support strategies.

Some of the strategies aimed to increase Sandeep's quality of life, and to reduce and eliminate the use of physical restraint focused on:

- Monitoring and regularly reviewing Sandeep's mental health treating team with his psychiatrist and his mental health team. Staff to notify the treating team if Sandeep's mental health deteriorated.
- Scheduling regular visits with Sandeep's family.
- Engaging Sandeep in meaningful cultural experiences such as celebrating Diwali that he identified as important to his identity.
- Teaching Sandeep functionally equivalent emotional regulation skills. This was matched to Sandeep's learning and communication skills. For example, helping Sandeep identify when he is starting to feel anxious, and assisting him to replace his response to feeling anxious (aggressive behaviours) with calming strategies.
- Developing a structured routine and scheduling pleasant activities throughout the day that Sandeep enjoyed, for example going for walks, listening to music, and drawing.
- Having more space in his environment away from others when he needs it.
- Increasing Sandeep's sense of control over his supports by making sure he has input into how he would like to be supported by staff. The emphasis was on engaging Sandeep positively, supporting him to control the aspects of his life that were previously out of reach and focusing on what he can do.
- Fostering choice making. Living in a hospital, and with several placement breakdowns Sandeep had limited opportunities to make choices for himself that were meaningful. Sandeep appears to cope better with choices when no more than four options are presented to him at once. For example offering Sandeep four different meal options for dinner using visual supports from his recipe book, or choosing between four activities to do on a weekend based on activities he enjoys.
- Teaching mindfulness techniques to both Sandeep and his support staff.

Outcomes:

As Sandeep settled into his new home in the community, there were significant changes to his behaviour. Physical restraint was used five times over the first year. While living in the hospital, physical restraint was used over 30 times in one year. In the following year, there were no incidents of physical restraint. The NDIS provider no longer required routine training in these techniques. To assist staff confidence, evasive strategies in how to avoid, release or move away when Sandeep's behaviours of concern presented a significant risk of harm were still provided if required.

The reduction and elimination of physical restraint occurred through the systematic use of positive behaviour support strategies in his behaviour support plan and staff having a good understanding of Sandeep's needs. The new environment also gave Sandeep more space to help him regulate his emotions. Sandeep's quality of life improved. He did more things that he enjoyed, and he was able to make meaningful choices in his day.

Key points

- Although physical restraint may be required in limited circumstances, it is nevertheless an intrusive restrictive practice that can have significant detrimental psychological effects and can result in significant injury to both the person being restrained and the person implementing the physical restraint.
- Studies have shown that teaching staff mindfulness techniques and practicing these techniques on an ongoing basis has helped reduce the use of physical restraint (Chapman et al, 2013).

Appendix I: Physical restraint protocol example

This resource is to help guide behaviour support practitioners detail the use of a restrictive practice in a behaviour support plan. Also see [Appendix A](#).

This physical restraint protocol does not specify the physical restraint technique as it is beyond the scope of this guide. Physical restraint techniques need to be specific to the person's circumstances and needs. Training in physical restraint strategies need to be provided by certified trainers in physical restraint whose certifications are up to date.

Rationale

Sandeep engages in aggressive behaviours, these include, hitting, grabbing, and kicking others. The use of physical restraint is to protect Sandeep from risk of harm to self and others. In limited circumstances, positive strategies alone are not effective in managing his safety and the safety of others. Less restrictive strategies are being trialled, however, Sandeep requires more time to adjust to his new environment and learn the alternative skills to support the fade out of this restrictive practice.

Frequency of use

PRN (as needed basis). Only to be used as a last resort.

Early warning signs that Sandeep is about to engage in aggressive behaviours;

- Sandeep may be yelling loudly and pacing.
- May make verbal threats that he is going to hurt someone.

Procedure

1. The primary way for ensuring the ongoing safety of Sandeep and others is by following the positive strategies listed in the behaviour support plan.
2. Attempt to identify potential triggers and remove if possible.
3. Attempt to problem solve reasons why Sandeep may be feeling distressed. Look for environmental and physical factors.
4. Attempt to verbally de-escalate Sandeep and provide alternative options to meet his needs.
5. Staff should be at 'two arm's length' distance from Sandeep to maintain safety while attempting to use verbal de-escalation strategies (**Refer to the response section of this behaviour support plan on de-escalation strategies**).
6. The decision to use physical restraint needs to be based on a risk assessment and characterised by respect and empathic decision-making.
7. If de-escalation strategies are not effective and Sandeep is at imminent risk of danger to himself or others, (for example he is running at in an attempt to hit or kick others), staff may need to use the evasive strategies (as detailed in the response section of the behaviour support plan). If evasive strategies are not effective staff may need to use the physical restraint procedure that has been approved.

Staff are to:

- a. inform Sandeep that they will be physically holding him to keep him and others safe.
 - b. staff to follow the physical restraint procedure as instructed in training received by the certified trainer in physical restraint techniques.
 - c. Staff who have not been trained in the procedure by a certified trainer must NOT use the physical restraint procedure.
 - d. Staff are to STOP the physical restraint procedure immediately when Sandeep is no longer at risk of harming himself or others. Staff are to also STOP physical restraint immediately if Sandeep or staff are injured during the restraint procedure.
8. Signs Sandeep is not at risk of harming himself or others include; not trying to physically kick or hit others. Also Sandeep will often indicate he is calming down by saying "I'm ok now".

Note: Physical restraint should generally not last more than 3 minutes. Staff should calmly speak to Sandeep during the duration of the physical restraint offering reassurance and letting him know you will let go as soon as it is safe.

9. Attempt to reengage Sandeep in a calming activity of his choosing when he is ready.
10. Ensure staff are available if Sandeep wants to talk/debrief about what happened (but do not force him). Staff should listen empathetically with unconditional positive regard.
11. Debriefing should be offered to all staff involved and should occur immediately or shortly after to offer support for the emotional impact. This should provide a good opportunity to identify learning and collaborative problem solving with the aim of preventing future incidents of the use of physical restraint.

Monitoring during and post physical restraint

- Staff to monitor Sandeep for signs of distress throughout the restraint process and after the use of physical restraint.
- Vigilantly monitor general physical health during and after restraint, including breathing, complexion and injuries. Observe and document verbal and/or behavioural cues. This should include any deterioration of condition, physical health, risk assessment (is he safe? Is it helping him calm down?), and an assessment of the need for continuing physical restraint.
- Seek immediate medical treatment if there is a concern to Sandeep, or others.

Data collection

- Document the incident of physical restraint, and appropriate information in an ABC chart, including the duration of physical restraint to the nearest half minute.
- Document any frustration shown by Sandeep, other issues in relation to the use of this practice, and any physical or psychological side effects in the physical restraint monitoring log.
- With Sandeep's consent, share the above with his NDIS behaviour support practitioner to assist in the behaviour support plan review, and in the reduction and elimination of the use of physical restraint.
- Complete reporting requirements for the use of physical restraint to the NDIS Commission.

The reduction and elimination of the physical restraint (fade out plan)

- The plan to reduce and eliminate the use of physical restraint is based on the outcomes of other less restrictive options and positive strategies as highlighted in Sandeep's behaviour support plan including developing Sandeep's emotional regulation skills.
- The aim is to reduce the amount of time and incidents Sandeep is exposed to physical restraint. For example reducing from 3 to 1 minute and or reducing incidents of physical restraint.
- The reduction and elimination of physical restraint will be measured over time recording the average and comparing this to previous months to see if there is a decline.
 - The total number of times (frequency) physical restraint is used.
 - The duration (minutes) of each incident of physical restraint (to the nearest half minute).
 - The total minutes of physical restraint each month are to be divided by the frequency (incidents) for that month to calculate the average duration per physical restraint incident.

Training

All staff including new staff need to be appropriately trained to implement positive behaviour support strategies and the physical restraint protocol. Training will be given by the behaviour support practitioner in team meetings and include training in understanding the function of the behaviour, the behaviour support plan, positive behaviour support, including the review of the physical restraint protocol. A certified trainer is to provide training in the physical restraint technique.

Appendix J: Seclusion case study

The following is a case example of seclusion. The case example is intended to be illustrative only.

Background

Emma is a 32 year-old female with a diagnosis of a mild intellectual disability and Autism Spectrum Disorder. She receives support from a registered NDIS provider in a Specialist Disability Accommodation (SDA) setting. Emma lives with two other people. Emma has a long history of aggressive behaviours; this includes hitting, biting, and pushing people to the ground.

Restrictive Practice

Emma's comprehensive behaviour support plan was due for a review. Her plan included a restrictive practice protocol for the use of seclusion. Seclusion was used as a strategy as a last resort when Emma:

- was at significant risk of hurting herself or others, and the
- preventative strategies and de-escalation strategies in her plan were not enough on their own to reduce the risk. (Refer to [Appendix K](#) for an example protocol of seclusion).

Functional behaviour assessment review

Emma's NDIS behaviour support practitioner reviewed the functional behaviour assessment, current and past psychiatric reports, and Antecedent Behaviour Consequences (ABC) data collection (3 months of records completed by Emma's NDIS Provider). The behaviour support practitioner also had meetings with Emma, conducted natural observations, completed a motivational assessment scale, and functional behaviour interviews with Emma's family, and NDIS support staff.

A review of the functional behaviour assessment indicated that one significant reason (function) for the behaviour of concern was escape; this was consistent with previous functional behaviour assessments. Emma would engage in aggressive behaviours to escape situations and tasks that she found overwhelming and stressful (for example cooking, and cleaning her room). Emma required support to build better coping skills. The aggressive behaviour was a way of coping with situations that were stressful and overwhelming.

New triggers were also identified from the data. This included social situations; for example, planning to see a friend, birthday parties, and loud noises (particularly when she could hear her co-residents fighting).

Comprehensive behaviour support plan review

Based on the findings of the functional behaviour assessment, Emma's NDIS behaviour support practitioner updated her comprehensive behaviour support plan.

Some of the strategies aimed to increase Emma's quality of life and help support the reduction and elimination of seclusion focused on:

- Encouraging Emma to ask for breaks with tasks she found overwhelming, breaking down the task using chaining methods, and staff offering more active support. These strategies were described in detail in her behaviour support plan.

- Supporting Emma to go to a quieter area of the house when others were arguing and intervening early.
- With Emma's consent, staff helped find an appropriately trained psychologist with experience in working with people with Autism Spectrum Disorder and intellectual disability. This was to support Emma develop her social skills and teach her emotion regulation strategies.
- Using calming routines before situations that were known to be potential triggers.
- A sensory room was designed for Emma tailored to her sensory needs. It included different items and activities, some of which were portable and could be used within the community when she needed them. An occupational therapist was consulted to help design the sensory room. Over time, it was hoped that having a sensory room would replace the use of seclusion. The sensory room was to be used proactively to assist Emma to feel calm when she was beginning to show early signs of distress.

Organisational change

The NDIS provider made an organisational commitment to gradually reduce and eliminate the use of seclusion. This involved weekly meetings where as a team they discussed all behavioural incidents including seclusion. These meetings were led by senior management in an effort to reduce seclusion. Staff reviewed what potentially triggered the behaviour, the frequency and duration of seclusion, and what could have been done differently. The NDIS provider also made sure Emma had a key role in informing these meetings.

Outcome

Previously, seclusion was used on average, once a fortnight. This gradually reduced over the next 18 months to the point it was no longer required. Emma felt supported, safe and developed alternative skills to manage stressful and overwhelming situations. Emma was also seeing a psychologist fortnightly and was learning emotional regulation and social skills. Emma shared these skills with her support staff and family so that they could support her to practice and build on them. Emma was getting better at expressing her feelings to staff and sharing what she was learning. Emma also enjoyed using the sensory room and would voluntarily use it during the day when she wanted to engage in relaxing activities or have some time out.

Key points

- For a shared vision and commitment of reducing restrictive practices to be successful, it is important that the person with disability is involved and provided with opportunities to be heard so that they can have input into their behaviour support plan as much as possible. This also gives the person a sense of agency over their environment and over time can assist them to better recognise and regulate their emotions.
- The process of reviewing, monitoring incidents and reflection helps reduce and eliminate the use of restrictive practices.

Appendix K: Seclusion protocol example

This resource is to help guide behaviour support practitioners detail the use of a restrictive practice in a behaviour support plan. Also see [Appendix A](#).

Rationale

Emma engages in aggressive behaviours, including hitting, kicking, biting and pushing people to the ground. This has resulted in significant physical injury to staff and co-residents in the past. The use of seclusion is to prevent harm to others and to Emma. Less restrictive strategies are being trialled, however, Emma requires more time to learn the alternative skills to support the fade out of this restrictive practice.

Seclusion place

Emma is only to be secluded within her house by removing all other people from her space and restricting her access to leave. Prior to any seclusion, all areas of Emma's house needs to be assessed for safety. This should always occur in advance.

When can it be used?

PRN (as needed). Only to be used as a last resort. Seclusion should not occur for more than 15 minutes.

Early warning signs that Emma is about to engage in a behaviour of concern:

- Emma may grab her legs, puts her hands between her legs and grab her inner thighs.
- Emma may be shaking and her face goes red.
- Emma may be jumping up and down making aggressive gestures with her hands at the same time.
- Emma may begin invading personal space of staff and co-residents, and yelling loudly.
- Emma may make verbal threats that she is going to hit someone.

Procedure

- The primary way for ensuring the ongoing safety of Emma and others is by following the positive strategies listed in the behaviour support plan.
- Attempt to identify potential triggers and remove if possible.
- Attempt to problem solve reasons Emma may be feeling distressed. Look for environmental and physical cues (is Emma feeling well? is it too noisy? is Emma overwhelmed with an activity/task?).
- Keep 'two arm's length' physical distance from Emma and support co-residents to also be at a safe distance where practically possible.
- Attempt to verbally de-escalate Emma and provide alternative options to meet her needs (**Refer to the response section of the behaviour support plan for more detailed instruction on the above points**).
- The decision to use seclusion needs to be based on a risk assessment and characterised by respect and empathic decision-making.

- If the response strategies are not effective and Emma is at imminent risk of danger to herself or others, (for example Emma is getting closer to staff and co-residents in an attempt to hit or kick, or an increase in verbal threats and emotional outbursts is observed) staff are to:
 1. Inform Emma that you will be giving her some time to calm down on her own.
 2. Lock the front door.
 3. Remove co-residents and yourself to the backyard under a covered area and lock the backdoor. *At this point seclusion is in place.*
- Staff should visually monitor Emma in the backyard from the kitchen and living room window while also supporting the other co-residents.
- One staff member should be allocated to vigilantly observe and document verbal and/or behavioural cues every 3 minutes. This should include, any deterioration of condition, physical health, risk assessment (is she safe? Is it helping her calm down?), and an assessment of the need for continuing seclusion.
- The same staff member is to speak to Emma through the window, ask Emma if she is OK, and let her know staff are there to help her. Support should be non-judgemental and empathetic at all times. Staff can also suggest ideas that may assist her to calm down.
- Seclusion should stop immediately when Emma is observed to have calmed down and is no longer at imminent risk of harm to herself or others. Signs Emma has calmed down include, not making verbal threats, tone of voice is calmer, and responding to staff support.
- Staff are to open the backdoor and slowly re-enter the house with co-residents.
- When staff return to Emma, they are to reassure Emma that everything is OK, and that they are there to help her.
- Close observation should be maintained after seclusion.
- Staff should slowly rebuild engagement with Emma and attempt to engage her in a relaxing activity of her choosing when she is ready.
- Emma's physical health should be monitored.
- Seek immediate medical treatment if there is a concern.
- If Emma wants to talk about what happened, staff should be available to support her and offer emotional care and validation.

Data Collection

- Document the incident of seclusion, and document appropriate information in an ABC chart.
- Document any frustration shown by Emma or other issues in relation to the use of seclusion and any physical or psychological side effects (in the seclusion log).
- With Emma's consent, share the above documentation with her NDIS behaviour support practitioner to assist in the behaviour support plan review.
- Complete reporting requirements for the use of seclusion to the NDIS Commission.

Reduction and elimination of the restrictive practice (fade out plan)

- The continued use and need for the use of seclusion will be impacted directly by the outcomes of other less restrictive options and positive strategies as highlighted in her behaviour support plan including developing Emma's emotional regulation skills.
- The aim is to reduce the amount of time and incidents Emma is exposed to seclusion. For example reducing from 15 minute to 10 minutes, and or reducing incidents of seclusion.

- The use of seclusion will be measured over time recording the average and comparing this to previous months to see if there is a decline.
 - The total number of times (frequency) seclusion is applied.
 - The duration (minutes) of each seclusion (to the nearest minute).
 - The total minutes of seclusion each month are to be divided by the frequency (incidents) for that month to calculate the average duration per seclusion incident.

Training

All staff, including new staff need to be appropriately trained to implement the positive behaviour support strategies and the seclusion protocol. A video training resource will be developed. Training will occur in team meetings where this protocol will also be reviewed