Interim response - debriefing, dignity and risk accessible slides

# Slide 1

## Interim response - debriefing, dignity and risk

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Supported through grant funding from the Australian Government

# Slide 2

## Learning Outcomes from today

1. Interim Response = quick, brief, clear, safe
2. Strategies
3. Restrictive Practices
   * Dignity and inherent human rights
4. Reduction and Elimination

* Decision points
* Debriefing

1. Process

# Slide 3

## Interim response = quick, brief, clear, safe

### Core

1.2 Know high risk behaviours need to be managed safely and effectively using least restrictive options

### Proficient

1.4 Develop an individualised immediate response plan

# Slide 4

## Interim Response = quick, brief

A timeline is shown.

The timeline starts at day one = Engage participant and supports, followed by time labels – 2 days, 5 days, 10 days, 20 days, 25 days, and 1 month. The label near the end of the timeline is Interim Plan (RP) uploaded. The timeline continues beyond 1 month to facilitate discussion about what barriers may prevent a plan being uploaded in 1 month.

At the 1 month mark

Factors that may contribute to a longer process:

1. Data not available/consent to release data delayed.
2. Outcome of medical reviews no known.
3. Stakeholder(s) unsure if restrictive practice is necessary for safety.
4. Practitioner unsure if restrictive practice is the least restrictive option.
5. Challenging system dynamics.
6. Funding.
7. Others factors?

# Slide 5

## Interim Response = quick, brief

### Samira

* Is an 8 year old girl.
* She enjoys one-on-one activities.
* Samira can find noises, lights and crowds distressing
* Samira has recently started banging her head on walls and other hard surfaces.

**Helmet is used to address the behaviours of concern**

A protocol to use the helmet when Samira is banging her head was developed in the Interim Plan.

# Slide 6

## Interim Response = quick, brief, clear, safe

### Interim behaviour support plan

* Keep Samira safe: Interim behaviour support plan, which included the restrictive practice for the use of a helmet with a detailed protocol for its use.
* Begin additional assessments: recommended that an occupational therapist assess and recommend the right type of helmet.
* Be clear about what is needed to be safe: Staff and family trained in the interim behaviour support plan.
* Involve Samira from the beginning: the helmet protocol was explained to Samira using visual support.

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# Slide 7

## Protocols

**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.

Copyright: Commonwealth of Australia 2021. NDIS Quality and Safeguards Commission (2020) Regulated Restrictive Practices Guide.

# Slide 8

## Interim Response = clear, safe

Five screenshots of Restrictive Practice protocols from the [Regulated restrictive practices NDIS Quality and Safeguards Commission](https://www.ndiscommission.gov.au/regulated-restrictive-practices) accessed 7 April 2021 are shown. They images overlap and the full detail is not able to be read. The illustration is to let behaviour support practitioners know about these resources, and to highlight the level of detail needed.

# Slide 9

## Interim Response = clear, safe

**The helmet is used to address the behaviours of concern for Samira**

A protocol to use the helmet when Samira is banging her head was developed in the Interim Plan:

1. What aspects of the Protocol suggests it is least restrictive?
2. What else has occurred that suggests this is a least restrictive response?

### A screenshot is shown of part of Appendix G: Mechanical restraint protocol example, from page 46 of the [NDIS Quality and Safeguards Commission - Regulated Restrictive Practices Guide](https://www.ndiscommission.gov.au/sites/default/files/documents/2021-03/regulated-restrictive-practice-guide-rrp-20200_0.docx).

Text from page 46 of the Guide:

“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 ..” see page 46 of the guide for the full protocol

# Slide 10

## Comprehensive PBSP after FBA

A screenshot from page 44-45 of the [Regulated Restrictive Practices Guide](https://www.ndiscommission.gov.au/sites/default/files/documents/2021-03/regulated-restrictive-practice-guide-rrp-20200_0.docx), titled ‘Comprehensive behaviour support plan’ is shown with arrows pointing to key points of the text. The highlighted points are:

1. Training about the purpose of the behaviour: “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.”
2. Remove trigger: “giving Samira more space from others when she needed it”
3. Support coping: “preparing Samira when someone new was attending after school care, including new staff and any changes to her routine by using visual supports”
4. Teach replacement behaviour: “supporting and praising Samira when she used her hand sign and responding immediately to her when she used it (positive reinforcement).”
5. Strategies supported fade-out: revisited each point above as supporting fade-out. Plus text on screen noted – “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.”

# Slide 11

**Procedure**

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 not 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.

# Slide 12

## Strategies:

* Positive
* Preventative
* Reactive
* Person-centered

# Slide 13

## Example of strategies in context

Kaplan and Wheeler’s 1983 graph of 5 stages of escalating crisis, graphed over the course of time, are shown alongside categories of positive behaviour support strategies helpful at that stage.

At baseline we consider the setting events that impact a person. At this stage we can consider preventative strategies:

* Changes to the environment
* Increase QOL
* Interactions
* Routines
* Schedules
* Choice and control
* Communication

When triggers occur or are present, or what can be labelled high risk situations, we see escalation beginning. At this stage we can consider in-the-moment prevention:

* Strategies to avoid or remove triggers
* Reduce triggers
* Support coping

At the escalation stage we can observe warning signs in the person’s behaviour. We aim to respond early and safely. A green curve returning to baseline is shown to illustrate success in early, safe responses. Non-aversive response strategies, for example:

* Give distance
* Disengage
* Empathy and listening
* Redirect
* Humour
* Reduce demands
* Sensory approaches

When an incident or crisis occurs we are at the peak of the crisis cycle. Our goal is to keep everyone safe. Strategies:

* are the Least restrictive alternatives.
* Follow Restrictive practice Protocol if needed

During the de-escalation stage:

* Support
* Acknowledge feelings
* Be close and available
* Avoid triggers
* Reengage in routine

During the recovery stage, there can be a depression, shown by a dip in the escalation curve. Strategies:

* Ensure everyone is safe
* Provide any first aid
* Reengage in routine

When the person we are working with is clam, we aim to avoid crisis through:

* Skill building
* Teach alternatives
* Life skills
* Coping skills
* Social skills

# Slide 14

## Example - strategies for Samira

Kaplan and Wheeler’s 1983 graph of 5 stages of escalating crisis, graphed over the course of time, are shown alongside categories of positive behaviour support strategies helpful at that stage. This time with strategies from the example of Samira.

At baseline we consider the setting events for Samira, and note she has had health reviews for:

* Medical
* Dental

At this stage we can consider preventative strategies for Samira:

* Find quieter environments
* Increase QOL:
* Positive interactions
* Refer to OT

We are aware that triggers for Samira include:

* Noise
* Lights
* crowds

At this stage we can consider in-the-moment prevention:

* Strategies to avoid triggers: invite Samira to move to a quieter spot if it becomes noisy
* Reduce triggers: Reassurance; notice changes in the environment and address
* Support coping: staff/adult sitting beside her

At the escalation stage we can observe warning signs:

* Moaning sound
* Hits head her once
* Grabs at her ears

We aim to respond early and safely. A green curve returning to baseline is shown to illustrate success in early, safe responses. Non-aversive response strategies, for Samira:

* Reduce noise
* Attempt to engage Samira in 1-to-1 activity she enjoys
* Reassure Samira "it's okay", "I can help"…
* Gently rub her back

When an incident or crisis occurs we are at the peak of the crisis cycle. For Samira the observable behaviour is:

* Samira repeatedly bangs her head on walls and hard surfaces.

Our goal is to keep everyone safe. Strategies:

* Non-aversive response strategies
* Continue to attempt to redirect gently
* Look for possible triggers
* Continue support and reassurance
* **If needed: Restrictive practice, s**ee Protocol – Helmet

During the de-escalation stage, we observe Samira:

* Slowing down of banging
* Looks towards staff/adult
* Quieter sounds

Strategies are, for example:

* Support
* Acknowledge feelings
* Be close and available
* Offer support to go to a quieter place
* As Samira calms – offer an enjoyable 1-to-1 activity

During the recovery stage, we observe:

* No longer banging her head
* Happily engaged in activity of her choice
* Happily resting

Strategies:

* Ensure everyone is safe
* Provide any first aid
* Offer support
* Focus on activity

When the Samira is clam, we aim to avoid crisis through:

* Skill building
* Teach alternatives
* Life skills
* Coping skills
* Social skills

# Slide 15

## Interim Response = clear, safe

### Daku

* Is an 14 year old boy.
* He enjoys going out. He is fascinated with shiny objects.
* Daku frequently wanders out and away from his home. At the moment Daku really likes shiny knives.
* Wandering and waving knives has caused Daku harm.

**His family have started locking the front door and locking the knives away**.

Protocols for these restrictive practices are included in an Interim Plan.

# Slide 16

## Example of strategies in context – Daku

Kaplan and Wheeler’s 1983 graph of 5 stages of escalating crisis, graphed over the course of time, are shown alongside categories of positive behaviour support strategies helpful at that stage. This time with strategies from the example of Daku, before providing positive behaviour support.

At baseline we consider the setting events for Daku, none are listed.

At this stage we can consider preventative strategies for Daku:

* Lock the door
* Lock knives away

Triggers for Daku are not listed.

In-the-moment prevention strategies are not listed.

At the escalation stage we can observe warning signs. None are listed for Daku.

We aim to respond early and safely. There are no listed early, safe, non-aversive response strategies for Daku. A green curve returning to baseline is not shown on this page.

When an incident or crisis occurs we are at the peak of the crisis cycle.

Our goal is to keep everyone safe. For Daku, routine **Restrictive practice**s are used - the doors are locked routinely, the knives are locked away routinely.

During the de-escalation stage no observations or strategies are listed.

During the recovery stage, no observations or strategies are listed for Daku.

Skill building: nil.

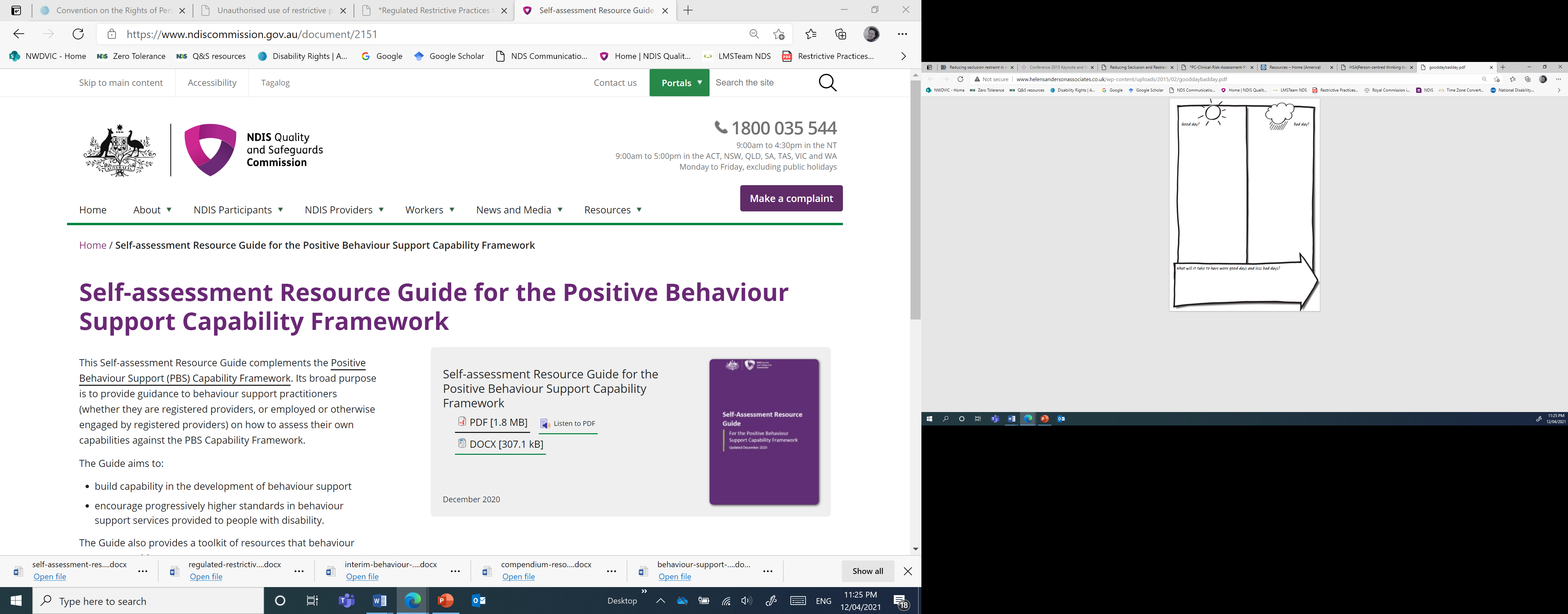
# Slide 17

## 1.4 Know how and why interim responses will be unique to the person

### Taking a Person-Centred approach

[HSA Person-centred thinking tools Good Day Bad Day Training](http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/good-daybad-day/)

[Person-Centred Practice Across Cultures resources](https://www.nds.org.au/resources/person-centred-practice-across-cultures-resources)



# Slide 18

“Risk assessments should not be designed to limit choice and freedom; their purpose should be enabling people to live the lives they want as safely as possible”

NSW Government (2014) Practice Guide to Person Centred Clinical Risk Assessment

# Slide 19

## 1.4 Know how and why interim responses will be unique to the person

Image is Figure 1: Person centred Approach to Clinical risk assessment from page 20 of the [Person Centred Clinical Risk Assessment Practice Guide](https://cds.org.au/wp-content/uploads/2017/06/PC-Clinical-Risk-Assessment-Practice-Guide-Final-Version-June-2014.pdf)

The approach sits within ongoing processes related to:

* Person centred thinking
* Monitor, review, evaluate
* Risk enablement culture

The steps within the assessment process include:

1. The person – what is important to and important for the person
2. Status quo – where are we now?
3. Goals and dreams – where do we want to be?
4. History – what have we tried and learned?
5. Action plan – what shall we do next?

The figure is from the Centre for Disability Studies 2013.

# Slide 20

## Restrictive Practices

Core

1.5 Be aware that interim risk management may (**or may not need to**) include restrictive practices

### Proficient

1.2 Be aware of the implications of using restrictive practices as a response

6.3 Understand that restrictive practice can represent serious human rights violations

# Slide 21

## Flow chart outlining how a reportable incident is defined

Is there a behaviour support plan in place that includes the regulated restrictive practice?

No: This **is** a reportable incident. Notify the NDIS Commission.

Yes: Is authorisation required for the regulated restrictive practice in your state or territory?

* No:
  + This is **not** a reportable incident
* Yes:
  + Has authorisation been received?
    - Yes: This is **not** a reportable incident
    - No: This **is** a reportable incident. Notify the NDIS Commission.

# Slide 22

A graph is shown from page 6 of the [NDIS Commission 12-monthly activity report: July 2019 - June 2020](https://www.ndiscommission.gov.au/document/2311)

Graph title: Numbers of URPs by State /Territory and Type

Grand totals: 302,690

* Seclusion: 423
* Physical: 1605
* Mechanical: 10,472
* Environmental: 112,579
* Chemical: 177,611

Totals for New South Wales:

* Grand total: 81,973
* Seclusion: 193
* Physical: 416
* Mechanical: 3181
* Environmental: 25,814
* Chemical: 52,369

Totals for South Australia:

* Grand total: 73,416
* Seclusion: 32
* Physical: 222
* Mechanical: 3056
* Environmental: 50,266
* Chemical: 19,840

Totals for Tasmania:

* Grand total: 60,232
* Seclusion: 8
* Physical: 151
* Mechanical: 1107
* Environmental: 5933
* Chemical: 53,033

Totals for Queensland:

* Grand total: 39,312
* Seclusion: 129
* Physical: 600
* Mechanical: 1117
* Environmental: 20,489
* Chemical: 16,977

Totals for Victoria:

* Grand total: 31511
* Seclusion: 39
* Physical: 148
* Mechanical: 1445
* Environmental: 4497
* Chemical: 25,382

Totals for Northern Territory:

* Grand total: 9799
* Seclusion: 13
* Physical: 6
* Mechanical: 15
* Environmental: 4587
* Chemical: 5178

Totals for Australian Capital Territory:

* Grand total: 6447
* Seclusion: 9
* Physical: 62
* Mechanical: 551
* Environmental: 993
* Chemical: 4832

# Slide 23

Extract:

**“Possible impacts of using restrictive practices on people with disability**

* “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).”

Commonwealth of Australia 2021. NDIS Quality and Safeguards Commission (2020) Regulated Restrictive Practices Guide, pages 6-7.

# Slide 24

“Restrictive practices do not address the underlying factors that cause the behaviour of concern”

LeBel, J., Nunno, M. A., Mohr, W. K., & O’Halloran, R. (2012). Restraint and seclusion use in U.S. school settings: Recommendations from allied treatment disciplines. American Journal of Orthopsychiatry, 82(1), 75–86

# Slide 25

## United Nations Convention on the Rights of People with Disabilities (U.N.C.R.P.D.)

* Liberty and security of the person (Article 14);
* Freedom from torture or cruel, inhuman or degrading treatment or punishment (Article 15);
* Freedom from exploitation, violence and abuse (Article 16);
* Respect for his or her physical and mental integrity on an equal basis with others (Article 17);
* Personal mobility with the greatest possible independence (Article 20);
* Freedom of expression and opinion and access to information (Article 21)

National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector (the ‘National Framework’)

# Slide 26

## Respect for the integrity of the person = Treating people with disabilities as a person first

Using restrictive practices was identified as something that shaped norms:

* the more that restrictive practices were used against people with disability, the more they were legitimised as ‘standard practice’.
* the use of restrictive practices is normalised, it trivialises interfering with the rights and freedoms of people with disability
* which ‘contributes to the dehumanisation of people with disability’

Commonwealth, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. (2021) Overview of responses to the Restrictive practices issues paper.

# Slide 27

## Respect for the integrity of the person = Treating people with disabilities as a person first

"In the context of behaviors of concern Article 17 is particularly directed towards protection from restrictive practices and compulsory treatment

and it provides a powerful mandate for a positive behavior support model that promotes a rights‐based approach to service delivery"

Nankervis, K & Chan, J. (2021) Applying the CRPD to People With Intellectual and Developmental Disability With Behaviors of Concern During COVID‐19. Journal of Policy and Practice in Intellectual Disabilities. Accessed at [Wiley Online Library](https://doi.org/10.1111/jppi.12374) on 7 April 2021

# Slide 28

The Empowerment Circle is a circle diagram, with a person at the centre in a dark green circle.

The circle is colour shaded divided into three zones (represented in rings from the green centre shading into orange and finally red on the outside of circle):

These colours represent:

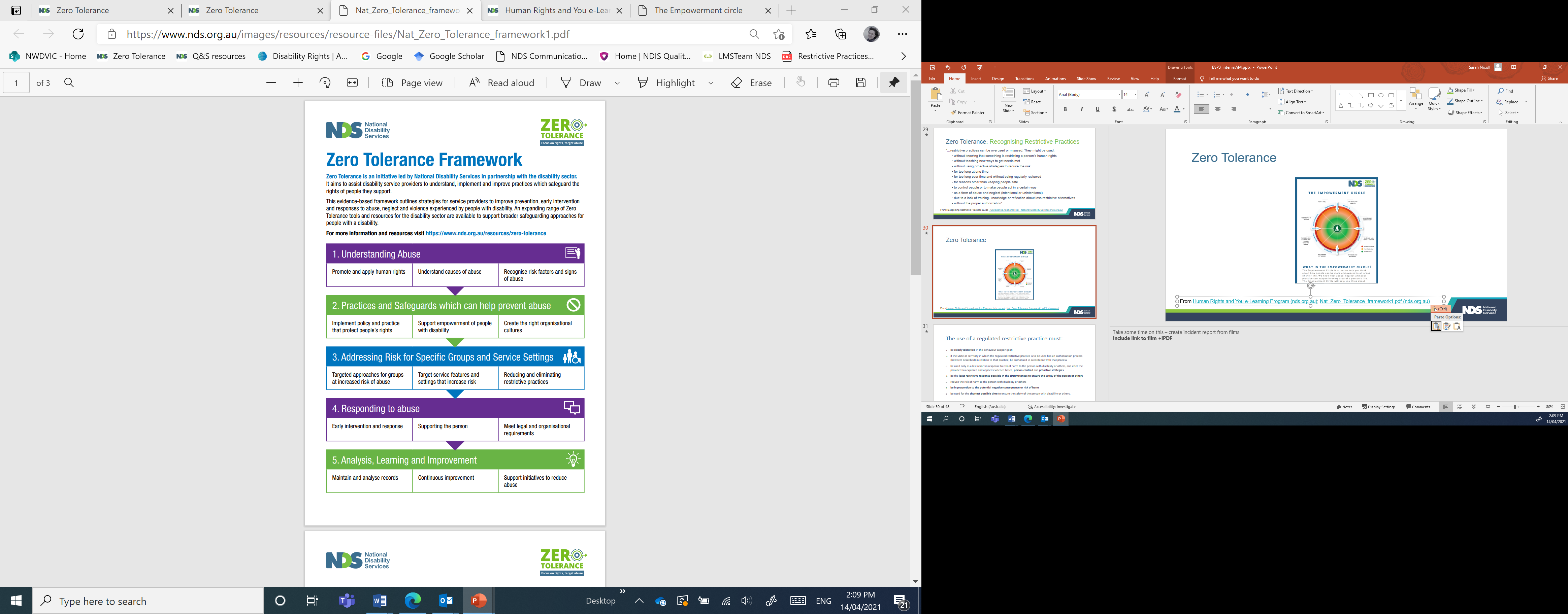
* **Green** for good or positive practice (centre)
* **Orange** for poor or neglectful practice (middle)
* **Red** for abusive or criminal practice (outer)

The circle is also divided into eight sections, like slices of a pizza. Each section represents one area of people’s lives: Physical; Emotional; Social; Identity; Material; Economic; Education; and Relationships.

Four white arrows, labelled ‘Freedom’, ‘Respect’, ‘Equality’ and ‘Dignity’ are placed on the outer edge of the four quarters of the circle pointing towards the centre of the circle, representing the idea that the closer we are to the middle, the more we are using and enjoying our human rights.

[Human Rights and You e-Learning Program](https://www.nds.org.au/events-and-training/all-events-and-training/human-rights-and-you-e-learning-program-2781) and [NDS Zero Tolerance Framework](file:///C:\Users\Tamara%20Rogers\Downloads\zerotolerance.docx)

# Slide 29



[Human Rights and You e-Learning Program](https://www.nds.org.au/events-and-training/all-events-and-training/human-rights-and-you-e-learning-program-2781) and [NDS Zero Tolerance Framework](file:///C:\Users\Tamara%20Rogers\Downloads\zerotolerance.docx)

# Slide 30

## Zero Tolerance: Recognising Restrictive Practices

“restrictive practices can be overused or misused. They might be used:

1. without knowing that something is restricting a person’s human rights
2. without teaching new ways to get needs met
3. without using proactive strategies to reduce the risk
4. for too long at one time
5. for too long over time and without being regularly reviewed
6. for reasons other than keeping people safe
7. to control people or to make people act in a certain way
8. as a form of abuse and neglect (intentional or unintentional)
9. due to a lack of training, knowledge or reflection about less restrictive alternatives
10. without the proper authorization”

From Recognising Restrictive Practices Guide [- Considering Additional Risk - National Disability Services](https://www.nds.org.au/zero-tolerance-framework/considering-additional-risk)

# Slide 31

## The use of a regulated restrictive practice must

1. be clearly identified in the behaviour support plan
2. 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
3. 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
4. be the least restrictive response possible in the circumstances to ensure the safety of the person or others
5. reduce the risk of harm to the person with disability or others
6. be in proportion to the potential negative consequence or risk of harm
7. be used for the shortest possible time to ensure the safety of the person with disability or others.

Screenshot from Commonwealth of Australia(2021)

# Slide 32

## Reduction and Elimination:

* Decision points
* Debriefing

# Slide 33

Decorative image omitted.

# Slide 34

## Least restrictive option?

* Stay at home
* Limited to an hour of outside exercise per day
* No visitors
* Curfew – stay home at night
* Mask wearing in all public places
* No large gatherings
* Only allowed travel up to 5km from your home to do shopping
* Only one person per home is allowed leave per day
* No dancing in shared indoor spaces
* No eating in restaurants
* Non-urgent medical procedures on hold until conditions are right

# Slide 35

## Decision points

2 possible outcomes

Engage participant and supporters

At one month

* Develop brief P.B.S.P. with no R.P.
* Interim Plan (R.P.) uploaded

# Slide 36

This is an image from the NDIS Quality and Safeguards Commission’s [Activity Report: 1 July 2020 to 31 December 2020](https://www.ndiscommission.gov.au/sites/default/files/documents/2021-03/ndis-commission-activity-report-july-december-2020.pdf).

The Commission undertook compliance activities for around 250,000 U.R.P’s. The results for those U.R.P’s as at 31 December 2020 were:

* 1% - single use, authorisation and behaviour support plan not required
* 5% - behaviour support funding needed
* 8% - behaviour support practitioner needed
* 11% - not seeking authorisation or behaviour support plan as not required
* 31% - authorised and behaviour support plan in place
* 44% - action required by providers to be compliant.

# Slide 37

## Extract: NDIS Quality and Safeguards Commission June 2019 Roadshows Behaviour Support Questions & Answers

**Question:**

If a behaviour support practitioner is asked to create a BSP for a participant because they have a restrictive practice in place, however after undertaking an assessment, they find that the restrictive practice is not necessary?

Should the practitioner decline to complete the BSP, or complete one which includes the restrictive practice with a plan for its reduction and elimination?

**Answer:**

A restrictive practice can only be used when it is part of a behaviour support plan developed by an NDIS behaviour support practitioner. If a restrictive practice is used, it must be the least restrictive response possible in the circumstances.

If it is identified in the functional assessment that preventative/ skills building strategies alone can manage the behaviour of concern without the use of a regulated restrictive practices, the practitioner needs to work with the implementing provider to develop fade out strategies of the restrictive practice.

[NDIS Commission June 2019 Roadshows Behaviour Support Questions & Answers](https://www.ndiscommission.gov.au/sites/default/files/documents/2019-09/behaviour-support-qas-august-2019.pdf) Accessed March 2020.

# Slide 38

## Be clear about your role and the legislation

### National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018

#### Part 3—Conditions of registration relating to the provision of specialist behaviour support services

**Div2**

19 Period within which behaviour support plan containing a regulated restrictive practice must be developed

(2) The registration of the specialist behaviour support provider is subject to the condition that the provider must develop:

(a) an interim behaviour support plan that includes provision for the use of the regulated restrictive practice within 1 month after being engaged to develop the plan;

# Slide 39

## Core strategy 6: Debriefing and practice review

An immediate debriefing should happen after an emergency use of a restrictive practice. The goal is to of this immediate debriefing is to:

* ensure that everyone is safe,
* satisfactory information is available to inform the later structured debriefing process, and
* the person who was restrained is safe and being appropriately monitored.

Australian Government. (2014). [National framework for reducing and eliminating the use of restrictive practices in the disability service sector](https://www.dss.gov.au/sites/default/files/documents/04_2014/national_fraemwork_restricitive_practices_0.pdf).

# Slide 40

## Core strategy 6: Debriefing and practice review

The goals of formal debriefing:

1. To reverse or minimize the negative effects of the use of seclusion and restraint.
2. To prevent future use of seclusion and restraint.
3. To address organizational problems (rules, attitudes, practices, training, environment of care) and make appropriate changes

(Massachusetts DMH, 2015; Huckshorn, 2013; Cook et al, 2002; Hardenstine, 2001) in Australian Government. (2014). [National framework for reducing and eliminating the use of restrictive practices in the disability service sector](https://www.dss.gov.au/sites/default/files/documents/04_2014/national_fraemwork_restricitive_practices_0.pdf).

# Slide 41

## Process and Decisions

1.11 Communicate clearly and effectively with relevant parties to gather information and provide direction

# Slide 42

Decorative image omitted.

# Slide 43

## 1.11 Communicate clearly and effectively with relevant parties to gather information and provide direction

Accept referral

* Time lag
* U.R.P. Person’s rights are restricted

Engage participant and supporters

At one month

* Develop brief P.B.S.P. with no R.P.
* Interim Plan (R.P.) uploaded

# Slide 44

## While you are waiting for a behaviour support practitioner to commence work

**The Commission recommends providers:**

* keep reporting as per legislation
* complete risk assessments to ensure safety
* **review restrictive practices - are they still required?**
* ensure current restrictive practices are the least restrictive options in the current circumstance
* ensure that medical reviews are followed up within appropriate time-frames
* ensure that allied health specialists reviews are followed up within appropriate time-frames
* (if relevant, ensure that medication reviews are followed up within appropriate time-frames)

**Practitioners notice:**

* Consent to release data is progressed
* All stakeholders aware and available?
* Delays for consent at the sign off stage?

[NDIS Commission Unauthorised use of restrictive practices Questions and answers](file:///C:\Users\Tamara%20Rogers\Downloads\unauthorised-use-restrictive-practices-questions-and-answers%20(1).docx)

# Slide 45

## The Positive Behaviour Support Framework – U.K. P.B.S. Alliance

The Positive Behaviour Support Framework shows a pyramid model.

The slide focuses on the strategies for everyone at the base of the pyramid. It is suggested that we might look for ways to highlight strategies on the base of the pyramid when a behaviour support practitioner accepts a referral, but has not yet directly engaged. Listed at the base of the pyramid, Tier one:

* Knowledge that all behaviour has a purpose
* Trauma-informed practice
* Active Support
* Total communication environment
* Capable environments
* Community presence
* Positive risk taking

Middle section, Tier two:

* Tier one, and
* brief functional assessment, function based PBS plans and individual strategies in key areas.

Top Section, Tier three:

* Comprehensive multi-element PBS.

# Slide 46

## Interim Response = quick, brief, clear, safe

An interim plan:

* has positive strategies
* and preventative response strategies
* protocols for the safe use of the regulated restrictive practice
* is about keeping people safe, quickly
* is the **start of a process**
* is the start to developing collaborative relationships
* is a chance to support the knowledge of a family or provider about

Adapted from: [Regulated restrictive practices NDIS Quality and Safeguards Commission](https://www.ndiscommission.gov.au/regulated-restrictive-practices) accessed 7 April 2021

# Slide 47

## Interim Response = quick, brief, clear, safe

An interim plan is **not**:

* a document to allow a restrictive practice to take place
* the end of a process
* a full functional behaviour assessment
* a comprehensive behaviour support plan
* always going to follow a referral for a person subject to an R.P.

Adapted from: [Regulated restrictive practices NDIS Quality and Safeguards Commission](https://www.ndiscommission.gov.au/regulated-restrictive-practices) accessed 7 April 2021

# Slide 48

## References and Resources

### Zero Tolerance

Zero Tolerance is an initiative led by NDS in partnership with the disability sector. Built around a national evidence-based framework, Zero Tolerance is a way for organisations to understand actions they can do to prevent and respond to abuse, neglect and violence of people with disability. [Zero Tolerance - National Disability Services](https://www.nds.org.au/zero-tolerance-framework/considering-additional-risk)

* Understanding Abuse: [Human Rights and You e-Learning Program](https://www.nds.org.au/events-and-training/all-events-and-training/human-rights-and-you-e-learning-program-2781)
* Quick easy reference to Zero Tolerance resources: [Zero Tolerance Resources Guide](file:///C:\Users\Tamara%20Rogers\Downloads\ZT_Resource_Guide-accessible.docx)
* [Recognising Restrictive Practice Guide](file:///C:\Users\Tamara%20Rogers\Downloads\RRP_ZT_Guide_AccWORD21_-_Copy.docx)
* [Empowerment Circle](file:///C:\Users\Tamara%20Rogers\Downloads\empowerment_circle_accessible-final.docx)

# Slide 49

## References and Resources

### Resources from the NDIS Q&S Commission

* [National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018](file:///C:\Users\Tamara%20Rogers\Desktop\F2020C01087.DOCX)
* [Regulated Restrictive Practices Guide NDIS Quality and Safeguards Commission](file:///C:\Users\Tamara%20Rogers\Desktop\regulated-restrictive-practice-guide-rrp-20200_0%20(2).docx) accessed 7 April 2021
* [Regulated restrictive practices with children and young people with disability: Practice guide NDIS Quality and Safeguards Commission](file:///C:\Users\Tamara%20Rogers\Desktop\regulated-restrictive-practices-children-and-young-people-disability-practice-guide-march-2021.docx) accessed 7 April 2021
* Activity report: [Activity Report: 1 July 2020 to 31 December 2020)](https://www.ndiscommission.gov.au/sites/default/files/documents/2021-03/ndis-commission-activity-report-july-december-2020.pdf)
* [NDIS Commission Unauthorised use of restrictive practices Questions and answers](file:///C:\Users\Tamara%20Rogers\Downloads\unauthorised-use-restrictive-practices-questions-and-answers%20(1).docx) accessed 7 April 2021
* [NDIS Commission June 2019 Roadshows Behaviour Support Questions & Answers](https://www.ndiscommission.gov.au/sites/default/files/documents/2019-09/behaviour-support-qas-august-2019.pdf)

# Slide 50

## References and Resources

**Person Centred Clinical Risk assessment**

* [PC Clinical Risk Assessment Practice Guide](https://cds.org.au/wp-content/uploads/2017/06/PC-Clinical-Risk-Assessment-Practice-Guide-Final-Version-June-2014.pdf)

**Person centred Resources**

* [HSA Person-centred thinking tools Good Day Bad Day Training](http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/good-daybad-day/)
* [Person-Centred Practice Across Cultures resources](https://www.nds.org.au/resources/person-centred-practice-across-cultures-resources)

**Debriefing**

Six Core strategies for reducing seclusion and restraint use, a snapshot

* [National Association of State Mental Health Program Directors](http://nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf)

**(Tiers of Support) U.K. P.B.S. Alliance – The Positive Behaviour Support Framework adjusted from**

* [The Positive Behaviour Support Framework diagram](https://hcpbs.org/wp-content/uploads/2020/07/PBS_framework_diagram_with_hands.pdf)
* [P.B.S. Workforce Development Framework](https://www.bild.org.uk/wp-content/uploads/2020/05/PBS_Workforce_Development_Framework_May-20.pdf)

# Slide 51

## References

Australian Government. (2014). [National framework for reducing and eliminating the use of restrictive practices in the disability service sector](https://www.dss.gov.au/sites/default/files/documents/04_2014/national_fraemwork_restricitive_practices_0.pdf)*.*

Commonwealth, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. (2021) Overview of responses to the Restrictive practices issues paper.

Kaplan, S. G., & Wheeler, E. G. (1983). Survival skills for working with potentially violent clients. Social Casework, 64 (6), 339–346

LeBel, J., Nunno, M. A., Mohr, W. K., & O’Halloran, R. (2012). Restraint and seclusion use in U.S. school settings: Recommendations from allied treatment disciplines. American Journal of Orthopsychiatry, 82(1), 75–86

Nankervis, K & Chan, J. (2021) Applying the CRPD to People With Intellectual and Developmental Disability With Behaviors of Concern During COVID‐19. Journal of Policy and Practice in Intellectual Disabilities. Accessed at [Wiley Online Library](https://doi.org/10.1111/jppi.12374) on 7 April 2021

NDIS Quality and Safeguards Commission (2020). Regulated Restrictive Practices Guide. Penrith, Australia: NDIS Quality and Safeguards Commission.

# Slide 52

Thank you for watching this webinar.

Best wishes in your work to improve the Quality of Life of people you work with.

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